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The Iowa Administrative Code Supplement is published biweekly pursuant to Iowa Code section 17A.6. The Supplement contains replacement chapters to be inserted in the loose-leaf Iowa Administrative Code (IAC) according to instructions included with each Supplement. The replacement chapters incorporate rule changes which have been adopted by the agencies and filed with the Administrative Rules Coordinator as provided in Iowa Code sections 7.17 and 17A.4 to 17A.6. To determine the specific changes in the rules, refer to the Iowa Administrative Bulletin bearing the same publication date.

In addition to the changes adopted by agencies, the replacement chapters may reflect objection to a rule or a portion of a rule filed by the Administrative Rules Review Committee (ARRC), the Governor, or the Attorney General pursuant to Iowa Code section 17A.4(6); an effective date delay imposed by the ARRC pursuant to section 17A.4(7) or 17A.8(9); rescission of a rule by the Governor pursuant to section 17A.4(8); or nullification of a rule by the General Assembly pursuant to Article III, section 40, of the Constitution of the State of Iowa.

The Supplement may also contain replacement pages for the IAC Index or the Uniform Rules on Agency Procedure.

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

Editor's telephone (515)281-3355 or (515)242-6873

Insurance Division[191]

Replace Analysis
Replace Chapter 4
Replace Chapter 20
Replace Chapter 30
Replace Chapter 35
Replace Chapters 39 and 40

Educational Examiners Board[282]

Replace Chapter 13
Replace Chapter 27

Inspections and Appeals Department[481]

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Replace Chapters 71 to 73
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[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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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.

4.24(1) *Criteria for order for waiver or variance.* In response to a petition completed pursuant to rule 191—4.26(17A), except for a petition seeking a waiver order issued pursuant to subrule 4.24(2), 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:

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

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

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

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

e. 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.

4.24(2) *Criteria for waiver or variance related to approval of a manner of electronic delivery of notices of cancellation, nonrenewal or termination.* This subrule is intended to implement Iowa Code sections 17A.9 and 505B.1.

a. For purposes of Iowa Code chapter 505B and this subrule, the following definitions shall apply:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Intended recipient" means the person to whom notice is required to be delivered, including but not limited to notices listed in the definition of "notice of cancellation, nonrenewal or termination" in this paragraph and in 191—paragraphs 20.80(1)*"b,"* 30.9(1)*"b,"* 35.9(1)*"b,"* 39.33(1)*"b,"* and 40.26(1)*"b."*

"Notice of cancellation, nonrenewal or termination" means:

1. Notice of an insurance company's termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company's decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code chapters 505B, 508, 509B, 513B, 514, 514B, 514D, 514G, 515, 515D, 518, 518A and 519, "notice of cancellation, nonrenewal or termination" includes but is not limited to the following:

- An insurance company's notice of cancellation, nonrenewal, suspension, exclusion, intention not to renew, failure to renew, termination, replacement, rescission, forfeiture or lapse in an annuity policy, a life insurance policy, a long-term care insurance policy, or an insurance policy other than life;
- An insurance company's rescission or discontinuance of an accident and health insurance policy;
- An insurance company's notice of cancellation of personal lines policies or contracts;
- A health maintenance organization's notice to an enrollee of cancellation or rescission of membership;
- An employer's or group policyholder's notice to an employee or member of the termination or substantial modification of the continuation of an employer group accident or health policy; or
- A carrier's or organized delivery system's advance notice to affected small employers, participants, and beneficiaries of its decision to discontinue offering a particular type of health insurance coverage.

b. This subrule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance in Iowa, health maintenance organizations, employers, group policyholders, carriers and organized delivery systems and to all requirements by statute or rule related to notices of cancellation, nonrenewal or termination. This subrule shall apply when an insurance company, health maintenance organization, employer, group policyholder, carrier or organized delivery system seeks the commissioner's approval of a manner for delivering by electronic means required notices of cancellation, nonrenewal or termination, as described in Iowa Code section 505B.1.

c. The commissioner, by order pursuant to this chapter, may approve a request for approval of a manner for delivering notices of cancellation, nonrenewal or termination by an electronic means if the commissioner has jurisdiction to enforce the statute or rule requiring the notice and if the requested approval is consistent with Iowa Code section 505B.1 and with this chapter.

d. In response to a petition submitted pursuant to rule 191—4.26(17A) and related statutes and rules, the commissioner may issue an order approving an insurer's proposed manner for delivering

notices of cancellation, nonrenewal or termination by an electronic means rather than mail, if the commissioner finds, based on clear and convincing evidence, all of the following:

(1) The proposed manner allows the commissioner, the insurer and the intended recipient to verify receipt by the intended recipient;

(2) The proposed manner provides for consent, by the intended recipient, to have notices or documents delivered by electronic means, in compliance with Iowa Code chapter 505B; and

(3) The proposed manner provides that the insurance company shall maintain adequate records of notices, receipts and consents. The records shall be available for review upon request by the commissioner and the intended recipient and be shall maintained for a period of five years from the date of cancellation, nonrenewal or termination.

e. Such an order would constitute approval by the commissioner to satisfy Iowa Code chapter 505B.

f. Although any proposed manner that complies with the above requirements may be approved, the following system is provided as an example, for purposes of guidance, of an insurer's system of verifiable receipt that will be approved by the commissioner, if the system includes all of the following aspects:

(1) The system provides that the intended recipients shall give written consent to the insurer of delivery of required notices of cancellation, nonrenewal and termination by electronic means, in compliance with Iowa Code section 505B.1.

(2) The system provides that, when an insurer is required to provide notices of cancellation, nonrenewal and termination, the insurer shall provide to the intended recipients a link to the required notice by electronic mail.

(3) The system provides that the insurer provide intended recipients with user names and passwords to log in to the insurer's notice system Web site.

(4) The system provides that the link required by subparagraph 4.24(2)*"f"*(2) shall be to a secure Web site that requires the intended recipients' user names and passwords for the intended recipients to access insurer's notice system Web site and the contents of the notices.

(5) The system provides that, when the intended recipients log in to the insurer's notice system Web site, either the insurer's notice to the intended recipients or the intended recipients' online inboxes will be the first thing automatically displayed.

(6) The system provides a procedure whereby, if the intended recipients do not log in to the intended recipients' accounts within seven days after the insurer sent the link to the intended recipients by e-mail, the insurer shall mail paper copies of the notices to the intended recipients' last-known physical addresses.

(7) The system provides for adequate maintenance of records by the insurer as required by subparagraph 4.24(2)*"d"*(3).

g. The commissioner may, upon proper request by an insurance company pursuant to rule 191—1.3(22,502,505) or another applicable rule, maintain the confidentiality of information in any document or materials submitted in support of a request for approval under this rule:

(1) If release of the specific information would disclose trade secrets protected by law pursuant to Iowa Code section 22.7(3) and rule 191—1.3(22,502,505); or

(2) If the specific information otherwise must be withheld from public inspection pursuant to Iowa Code chapter 22 or rule 191—1.3(22,502,505).

Only such information that requires confidentiality pursuant to Iowa Code section 22.7 and rule 191—1.3(22,502,505) may be withheld from public inspection, and any reasonably separable portion of a record shall be provided to any person requesting such record after deletion of the portions which are withheld pursuant to Iowa Code section 22.7 and rule 191—1.3(22,502,505).

[**ARC 2415C**, IAB 2/17/16, effective 3/23/16]

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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PROPERTY AND CASUALTY INSURANCE

CHAPTER 20
PROPERTY AND CASUALTY INSURANCE

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

DIVISION I
FORM AND RATE REQUIREMENTS

191—20.1(505,509,514A,515,515A,515F) General 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) Rescinded IAB 2/19/14, effective 3/26/14.

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.

[**ARC 1334C**, IAB 2/19/14, effective 3/26/14]

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(515F) Rate filings for crop-hail insurance. Rate filings for crop-hail insurance shall be submitted on or before January 31 of each calendar year. Each company may file one set of rates per policy plan per calendar year 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 justify the filed rate.
[**ARC 2227C**, IAB 10/28/15, effective 12/2/15]

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 515.102:

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.
[**ARC 1125C**, IAB 10/16/13, effective 11/20/13]

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 191—20.52(515,515F). Reasonable underwriting standards as set forth in 191—20.52(515,515F) shall not include neighborhood or area location or any environment hazard beyond the control of the property owner.

20.51(2) If the risk is accepted, the action report shall advise the applicant of:

a. The amount of coverage the Plan agrees to write.

b. The amount of coverage the Plan agrees to write if specified improvements are made.

c. The amount of coverage the Plan agrees to write only if a large or special deductible is agreed to by the applicant.

20.51(3) If the risk is accepted, the Plan, upon receipt of the premium, shall deliver the policy to the applicant or to the licensed producer designated by the applicant for delivery to the applicant. The Plan shall remit the commissions to the licensed producer designated by the applicant.

191—20.52(515,515F) Reasonable underwriting standards for property coverage.

20.52(1) The following characteristics may be used in determining whether a risk is acceptable for property coverage. Where there is more than one cause for declination, all causes shall be listed and complied with before the property may be accepted for insurance purposes.

a. Physical condition of property; however, the mere fact that a property does not satisfy all current building code specifications will not, of itself, suffice as a reason for declination.

b. The property's present use as extended vacancy or extended unoccupancy of the property for 60 consecutive days. Properties that are vacant or unoccupied for more than 60 days may be insured while rehabilitation or reconstruction work is actively in process, meaning that the insured or owner should make monthly progress in order to complete the rehabilitation or reconstruction within a one-year time frame.

c. Other specific characteristics of ownership, condition, occupancy or maintenance that violate the law and that result in substantial increased exposure to loss. Any circumstance considered under this paragraph must relate to the peril insured against.

d. Physical condition of buildings which results in an outstanding order to vacate, in an outstanding demolition order or in being declared unsafe in accordance with the applicable law.

e. One or more of the conditions for nonrenewal as listed in 191—20.54(515,515F) currently exist. The Plan shall upon notice that conditions at the buildings have changed consider new application for coverage.

f. 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.

g. Previous loss history or matters of public record concerning the applicant or any person defined as an insured under the policy.

h. Any other guidelines which have been approved by the commissioner.

20.52(2) Reserved.

[**ARC 8624B**, IAB 3/24/10, effective 4/28/10]

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 pursuant to paragraphs *"j"* and *"k."*

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. 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.

i. 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.

j. 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.

k. Theft frequency in which there have been more than two thefts, each loss amounting to at least $500, in a 12-month period.

l. Material misrepresentation in any statement to the Plan.

m. 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 515.125, 515.127, and 515.128.

20.54(3) At the completion of 36 months of coverage and prior to the completion of 48 months, each risk shall be reviewed for its eligibility for coverage in the voluntary market. The risk shall be submitted by the Plan to the producer of record, if any, for a search of the voluntary market. If the producer resubmits the risk to the Plan, the risk must be resubmitted with a new application and a written statement from the producer that a search of the voluntary market was performed.

[**ARC 8624B**, IAB 3/24/10, effective 4/28/10]

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 191—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.

191—20.61 to **20.69** Reserved.

These rules are intended to implement 2003 Iowa Acts, chapter 119.

DIVISION III
CERTIFICATES OF INSURANCE FOR COMMERCIAL LENDING TRANSACTIONS

191—20.70(515) Purpose. The purpose of division III is to clarify what information an insurance company regulated by the division may provide its customer in connection with a commercial real estate transaction between the customer and a lender.
[**ARC 0133C**, IAB 5/30/12, effective 5/9/12]

191—20.71(515) Definitions. For purposes of division III, the following definitions shall apply:

"ACORD" means the Association for Cooperative Operations Research and Development.

"Commercial real estate transaction" means a non-recourse commercial lending transaction in which the underlying property serves as the primary collateral securing the borrower's repayment of the loan and neither the borrower nor any of its members, partners, or shareholders, nor any related person to any of the aforementioned persons, bears the economic risk of loss in the event of a payment default under the terms of the lending transaction.

"Division" means the insurance division.

"ISO" means the insurance services office.
[**ARC 0133C**, IAB 5/30/12, effective 5/9/12]

191—20.72(515) Evidence of insurance.

20.72(1) Prior to the issuance of an insurance policy by an insurer, an insured who has entered into a commercial real estate transaction may request that the relevant insurer or a producer acting on behalf of the insurer provide the following items as evidence of insurance:

a. An ACORD Form 75, a successor ACORD form, an ISO binder form, or a substantially similar binder form approved by the division; and

b. An ACORD Form 28, a successor ACORD form, an ISO certificate form, or a substantially similar certificate of insurance form approved by the division.

The insurer or the producer acting on behalf of an insurer has the sole discretion to determine which division-approved binder form or certificate of insurance form the insurer or producer uses to comply with this rule.

20.72(2) An insurer or a producer acting on behalf of an insurer shall comply with a request made pursuant to this rule within 20 business days of the receipt of the request. The requirements of this rule shall not apply to an insurance producer who:

a. Is unauthorized to provide the documents described in this rule; and

b. Informs the insured of this fact within 20 business days of the receipt of the request.

20.72(3) Delivery of a binder along with a certificate of insurance requested pursuant to this rule may be accomplished by regular mail, overnight delivery, facsimile, physical delivery, electronic means, or other appropriate means.

20.72(4) Notwithstanding any language on a form provided pursuant to subrule 20.72(1) which language states that the form is for "information only," a binder together with a certificate of insurance delivered pursuant to this rule shall be valid and may be relied upon by the borrower or by the borrower's lender as evidence of insurance, including in any private civil action or administrative proceeding, until the delivery of the insurance policy to the borrower or the cancellation of the binder pursuant to Iowa Code sections 515.125 to 515.127.

20.72(5) An insurer or producer acting on behalf of an insurer that produces or delivers a binder and certificate of insurance to its customer pursuant to this rule may charge a reasonable fee for the production and delivery of the documents.

20.72(6) All insurers and all producers subject to this rule shall comply with the terms hereof within 90 days from May 9, 2012.

[**ARC 0133C**, IAB 5/30/12, effective 5/9/12]

These rules are intended to implement 2011 Iowa Code Supplement chapter 515.

191—20.73 to **20.79** Reserved.

DIVISION IV
CANCELLATIONS, NONRENEWALS AND TERMINATIONS

191—20.80(505B,515,515D,518,518A,519) Notice of cancellation, nonrenewal or termination of property and casualty insurance.

20.80(1) *Purpose and definitions.*

a. Purpose. The purpose of this rule is to implement the policyholder protections of Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 and chapter 505B by clarifying the authorized methods of delivery for notices of cancellation, nonrenewal or termination by an insurer.

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Notice of cancellation, nonrenewal or termination" means:

1. Notice of an insurance company's termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company's decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8, "notice of cancellation, nonrenewal or termination" includes but is not limited to an insurance company's notice of cancellation, forfeiture, suspension, exclusion, nonrenewal, intention not to renew, or failure to renew.

20.80(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to transact the business of insurance under the provisions of Iowa Code chapters 508, 515, 518, and 518A.

20.80(3) *Delivery.* For any notice of cancellation, nonrenewal or termination by an insurer under Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 to be effective, an insurer must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in

person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in the Iowa Code sections cited in this subrule for certified mail or certificate of mailing as proof of mailing.

20.80(4) *Electronic transmissions.* Notwithstanding the requirements of subrule 20.80(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code sections 515.125, 515.126, 515.127, 515.128, 515.129, 515.129A, 515.129B, 515.129C, 515D.5, 515D.7, 518.23, 518A.29 and 519.8 and chapter 505B.

This rule is intended to implement Iowa Code chapter 505B.

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[1] See IAB Insurance Division

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.

191—30.9(505,508) Notice of cancellation, nonrenewal or termination of life insurance and annuities.

30.9(1) *Purpose and definitions.*

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal or termination by an insurer or insurance producer required for contracts subject to approval by the commissioner pursuant to Iowa Code section 508.25, so as to require reasonable procedures for providing notice to policyholders of the consequences of cancellation, nonrenewal or termination of life insurance and annuity contracts. The Uniform Electronic Transactions Act, in Iowa Code section 554D.110(4)*"b,"* provides that a requirement under a law to send, communicate, or transmit a record by first-class mail postage prepaid may be varied by agreement to the extent permitted by the other law. Notification regulation should effectively require reasonable advance notice to life insurance and annuity policyholders that insurance coverage will cease or be placed under a nonforfeiture benefit on a date certain.

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Notice of cancellation, nonrenewal or termination" means:

1. Notice of an insurance company's termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company's decision or intention not to renew a policy; and

3. For purposes of notices of cancellation, nonrenewal or termination of contracts subject to approval by the commissioner pursuant to Iowa Code section 508.25, "notice of cancellation, nonrenewal or termination" includes but is not limited to the following:

- An insurance company's notice of cancellation, nonrenewal or termination of life insurance or annuities;
- Notice of replacement of life insurance, for which specific notice is required to be provided by the insurance producer pursuant to rule 191—16.24(507B); and
- Notice of termination of universal life contracts, for which specific advance notice is required to be provided by the insurance company pursuant to rule 191—92.6(508).

30.9(2) *Scope.* This rule shall apply to all insurance companies that issue contracts subject to approval by the commissioner pursuant to Iowa Code section 508.25.

30.9(3) *Delivery.* For any notice of cancellation, nonrenewal or termination by an insurer in contracts subject to approval by the commissioner pursuant to Iowa Code section 508.25 to be effective, an insurer must, within the time frame established by law, or such reasonable time in advance and as governed by contract, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. For replacements of life insurance, specific notice is required to be provided by the insurance producer pursuant to rule 191—16.24(507B). For universal life contracts, specific advance notice of termination is required to be provided by the insurance company pursuant to rule 191—92.6(508). The use of U.S. Postal Service Intelligent Mail® fulfills any requirement for the contracts subject to approval by the commissioner pursuant to Iowa Code section 508.25 and for notices required by rule 191—16.24(507B) or 191—92.6(508) for certified mail or certificate of mailing as proof of mailing.

30.9(4) *Electronic transmissions.* Notwithstanding the requirements of subrule 30.9(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice for cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the requirements of Iowa Code section 505B.1 or 508.25, rule 191—16.24(507B) or 191—92.6(508), or this rule.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15; **ARC 2415C**, IAB 2/17/16, effective 3/23/16]

These rules are intended to implement Iowa Code sections 505.8, 508.25, 508.28 and 508A.4 and Iowa Code chapters 505B and 509.

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[1] See IAB Insurance Division

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.

GENERAL ACCIDENT AND HEALTH INSURANCE REQUIREMENTS

191—35.9(509B,513B,514D) Notice of cancellation, nonrenewal or termination of accident and health insurance.

35.9(1) *Purpose and definitions.*

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal or termination by an insurer, issuer, employer, group policyholder, carrier or organized delivery system, so as to implement the various policyholder protections intended by Iowa Code sections 509B.5, 513B.5, 514D.3, 515.125 and 515.129A and chapter 505B.

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Notice of cancellation, nonrenewal or termination" means:

1. Notice of termination of an insurance policy at the end of a term or before the termination date;

2. Notice of a decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code sections 509B.5, 513B.5, 514D.3, 515.125 and 515.129A and chapter 505B, "notice of cancellation, nonrenewal or termination" includes but is not limited to the following:

- An employer's or group policyholder's notification to employees or members of the termination or substantial modification of the continuation of an employer group accident or health policy pursuant to Iowa Code section 509B.5;
- A carrier's or organized delivery system's advance notice to all affected small employers, participants, and beneficiaries of its decision to discontinue offering a particular type of small group health insurance plan pursuant to Iowa Code section 513B.5(1)*"e"*(2);
- An insurance company's notice of termination of an individual accident and sickness policy, pursuant to rules promulgated pursuant to Iowa Code section 514D.3;

- An insurance company's notice of forfeiture, suspension, cancellation, or intention not to renew, pursuant to Iowa Code section 515.125; or
- An insurance company's notice of cancellation of personal lines policies or contracts pursuant to Iowa Code section 515.129A.

35.9(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, 512B, 515, and 520.

35.9(3) *Delivery.* For any notice of cancellation, nonrenewal or termination by an insurer, employer, group policyholder, carrier or organized delivery system to be effective, an insurer, employer, group policyholder, carrier or organized delivery system must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in the Iowa Code sections cited in this subrule for certified mail or certificate of mailing as proof of mailing.

35.9(4) *Electronic transmissions.* Notwithstanding the requirements of subrule 35.9(3), if an insurer, issuer, employer, group policyholder, carrier or organized delivery system receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code sections 509B.5, 513B.5, 514D.3, 515.125 and 515.129A and chapter 505B.

This rule is intended to implement Iowa Code chapters 505B, 509B, 513B, 514D, and 515.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15; **ARC 2415C**, IAB 2/17/16, effective 3/23/16]

191—35.10 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.

191—35.40(514C) Autism spectrum disorders coverage.

35.40(1) *Purpose.* This rule implements Iowa Code section 514C.28, relating to autism spectrum disorders coverage in a group plan established pursuant to Iowa Code chapter 509A for employees of the state that provides for third-party payment or prepayment of health, medical, and surgical coverage benefits.

35.40(2) *Definitions*. For purposes of this rule, the definitions found in Iowa Code section 514C.28(2) shall apply. In addition, the following definitions shall apply:

"Autism spectrum disorders" means the following neurological disorders as defined under the following diagnostic classes within the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, edition DSM-IV-TR:

1. Autistic disorders. Diagnostic code 299.00.
2. Rett's Disorder. Diagnostic code 299.80.
3. Childhood Disintegrative Disorder. Diagnostic code 299.10.
4. Asperger's Disorder. Diagnostic code 299.80.
5. Pervasive Developmental Disorder NOS. Diagnostic code 299.80.

"Commissioner" means the commissioner of insurance.

"Group plan" or *"group health plan"* means a group health plan established for the employees of the state of Iowa under Iowa Code chapter 509A.

35.40(3) *Services.* A group plan is not required to provide coverage for any of the following:

a. Acupuncture.
b. Animal-based therapy including hippotherapy.
c. Auditory integration training.
d. Chelation therapy.
e. Child care.
f. Cranial sacral therapy.
g. Custodial or respite care.
h. Hyperbaric oxygen therapy.
i. Special diets or supplements.

35.40(4) *Parents or legal guardians of children diagnosed with autism spectrum disorders.* A group plan shall not be required to pay for treatment rendered by parents or legal guardians who are otherwise qualified providers, supervising providers, therapists, professionals or paraprofessionals for treatment rendered to their own children.

35.40(5) *Locations for services.*

a. A group plan shall provide coverage for treatments, therapies and services to an insured diagnosed with autism spectrum disorders by an autism service provider in locations including the provider's office or clinic or in a setting conducive to the acquisition of the target skill. Treatments may be provided in schools when the treatments, therapies, and services are related to the goals of the treatment plan and do not duplicate services provided by a school.

b. A group health plan is not required to provide coverage for therapy, treatment or services when the therapy, treatment or services are provided to an insured who is residing in a residential treatment center or inpatient treatment or day treatment facility.

35.40(6) *Verification of qualified provider.* A group health plan is required to verify the licensure, certification and all training or other credentials of a qualified provider or health professional. A group health plan shall not deny payment or reimbursement for the necessary diagnosis or treatment provided by a certified behavior analyst or a health professional licensed under Iowa Code chapter 147.

35.40(7) *Annual publication CPI adjustment.* The commissioner shall publish on or before April 1 of each year beginning April 1, 2014, an adjustment to the required maximum benefit equal to the percentage change in the United States Department of Labor Consumer Price Index for all urban consumers in the preceding year. The adjusted maximum benefit published each April shall be used by group health plans in order to comply with this rule and shall be effective January 1 for group plans issued or renewed on or after January 1 of the following calendar year.

35.40(8) *Notice to insureds.* A group plan shall provide written notice to the insured regarding claims submitted and processed for the treatment of autism spectrum disorders and shall include the total amount expended to date for the current policy year. The notice may be included with the explanation of benefits form or in a separate communication provided on a periodic basis during the course of treatment.

This rule is intended to implement Iowa Code section 514C.28.

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[1] See IAB Insurance Division

CHAPTER 39
LONG-TERM CARE INSURANCE

DIVISION I
GENERAL PROVISIONS

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 a producer 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.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

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 producer, except where the coverage is sold without a producer, 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) Producers 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 producer, 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 PRODUCER
[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 producer 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 Producer, Broker or Other Representative)
[Typed Name and Address of Producer 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 producer 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.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

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 producers or by 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 producer 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 producers; 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 or long-term care partnership insurance in Iowa. This additional training is necessary due to the complex nature of long-term care insurance and long-term care partnership insurance products. This additional training is also necessary to ensure that insurance producers are able to determine whether long-term care insurance or long-term care partnership insurance products are suitable for consumers and that producers are able to adequately explain to consumers how the long-term care insurance and long-term care partnership insurance products work. The ultimate goal of this subrule is to ensure that purchasers of long-term care insurance and long-term care partnership insurance products understand basic features of the products.

(1) This subrule applies to all long-term care insurance and long-term care partnership insurance products sold on or after January 1, 2010.

(2) For purposes of this subrule, "CE," "CE provider," "CE term" and "credit" shall mean the same as defined in rule 191—11.2(505,522B).

b. Required training.

(1) An individual may not sell, solicit or negotiate long-term care insurance or long-term care partnership insurance products unless the individual is licensed as an insurance producer with an accident and health or sickness line of authority and has completed a one-time training course and ongoing training every CE term thereafter. The training shall meet the requirements set forth in paragraph 39.15(4)*"c."*

(2) The training content of paragraph 39.15(4)*"c"* must be approved as continuing education courses under 191—Chapter 11, except that the one-time training required under subparagraph 39.15(4)*"b"*(1) must be classroom training. However, a CE provider may apply directly to the division and request that a self-study or on-line course be approved as a substitute. Ongoing training may be by any means allowable under 191—Chapter 11.

c. Training content.

(1) The one-time training required by this subrule shall be no less than eight credits and the ongoing training required by this subrule shall be no less than four credits, except that producers who have completed four credits of long-term care insurance training prior to January 1, 2010, shall complete only four credits of one-time training specifically related to the long-term care partnership program and Iowa-specific Medicaid requirements.

(2) The training required under subparagraph (1) shall consist of topics related to long-term care insurance, long-term care services and qualified state long-term care insurance partnership programs, including, but not limited to:

1. State and federal regulations and requirements and the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services, including Medicaid requirements;

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 or long-term care partnership insurance;

5. The effect of inflation on benefits and the importance of inflation protection;

6. Consumer suitability standards and guidelines;

7. The Deficit Reduction Act;

8. Iowa's laws regarding the long-term care partnership program;

9. The Iowa Medicaid program;

10. Miller trusts;

11. Spousal protection;

12. Transfer of assets;

13. Estate recovery; and

14. Eligibility.

(3) Unless otherwise required by state or federal law, the training required by this subrule shall not include training that is specific to a single insurer or company product and shall not include any sales or marketing information, materials, or training, other than those required by state or federal law.

d. Requirements for insurers.

(1) Insurers subject to this chapter shall obtain verification that a producer has received training required by subparagraph 39.15(4)*"b"*(1) before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance or long-term care partnership insurance products; shall make verifications available to the division upon request; and shall maintain records subject to the state's record retention requirements.

(2) Each insurer subject to this chapter shall maintain records with respect to the training of its producers concerning the distribution of its partnership policies that will allow the division to provide assurance to the Iowa department of human services that producers have received the training set forth in subparagraph 39.15(4)*"c"*(2), numbered paragraph "1," as required by subparagraph 39.15(4)*"b"*(1) and that producers have demonstrated an understanding of the partnership policies and the policies' relationship to public and private coverage of long-term care, including Medicaid, in this state. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the division upon request.

e. Training obtained in other states. The satisfaction of the training requirements in any state shall be deemed to satisfy the training requirements in this state.

f. Requirements for continuing education providers to provide long-term care partnership insurance training. In addition to having been approved as a CE provider under rule 191—11.9(505,522B), a CE provider intending to provide either the initial training or the ongoing continuing education required under subrule 39.15(4) shall:

(1) Provide only classroom training for the initial one-time training for providers. However, the CE provider may apply directly to the division and request that a self-study or on-line course be approved as a substitute. Ongoing training may be by any means allowable under 191—Chapter 11.

(2) If approved, comply with rules 191—11.10(505,522B) and 191—11.11(505,522B).

This rule is intended to implement Iowa Code section 514D.9 and chapter 514G.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

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 producers 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 producer 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 a producer is involved, the producer, 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 producer 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) Producers 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.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

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 producer solicitations, a producer 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 producers] Neither [insert company name] nor its producers 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. CONTACT THE STATE SENIOR HEALTH INSURANCE INFORMATION 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.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

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 producer solicitations, a producer 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).
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

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 a producer or a third-party administrator pursuant to the underwriting authority granted to the producer 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.
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

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 producer records of that producer's amount of replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales.

39.27(2) Every insurer shall report annually by June 30 the 10 percent of its producers 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 producer 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.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

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%

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
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(514G) Notice of cancellation, nonrenewal or termination of long-term care insurance.

39.33(1) *Purpose and definitions.*

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal or termination by an insurer, so as to implement the various policyholder protections intended by Iowa Code section 514G.111 and rule 191—39.22(514G).

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Notice of cancellation, nonrenewal or termination" means:

1. Notice of an insurance company's termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company's decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code section 514G.111 and rule 191—39.22(514G), at a minimum, an insurance company's notice of lapse or termination of a long-term care insurance policy.

39.33(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 chapter 508 or 515.

39.33(3) *Delivery.* For any notice of cancellation, nonrenewal or termination by an insurer under Iowa Code section 514G.111 and rule 191—39.22(514G) to be effective, an insurer must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in Iowa Code section 514G.111 and rule 191—39.22(514G) for certified mail or certificate of mailing as proof of mailing.

39.33(4) *Electronic transmissions.* Notwithstanding the requirements of subrule 39.33(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code section 514G.111 and rule 191—39.22(514G).

This rule is intended to implement Iowa Code chapter 505B.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15; **ARC 2415C**, IAB 2/17/16, effective 3/23/16]

191—39.34 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.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

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.

191—39.56 to **39.74** Reserved.

DIVISION III
LONG-TERM CARE PARTNERSHIP PROGRAM

191—39.75(514H,83GA,HF723) Purpose.

39.75(1) This division is intended to implement Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723, and Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171, to establish, in conjunction with the department of human services, a long-term care partnership program in Iowa to provide for financing of long-term care through a combination of private insurance and Iowa Medicaid.

39.75(2) The Iowa long-term care partnership program shall:

a. Provide incentive for individuals to insure against the costs of providing for long-term care needs;

b. Provide a mechanism for individuals to qualify for coverage under Iowa Medicaid while having certain assets disregarded for eligibility determinations and recovery; and

c. Reduce the financial burden on the state's Medicaid program by encouraging the pursuit of private initiatives using qualified long-term care partnership policies or certificates.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.76(514H,83GA,HF723) Effective date. The rules in this division shall apply to all long-term care partnership policies or certificates sold or issued for delivery on or after January 1, 2010.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.77(514H,83GA,HF723) Definitions. For purposes of this division, the definitions in Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723, and the definitions in rule 191—39.4(514G) shall apply. In addition, the following definitions shall apply:

"Asset disregard" means, with regard to the state's Medicaid program, disregarding assets in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified long-term care partnership policy.

"Division" means the Iowa insurance division.

"Iowa long-term care partnership policy" or *"partnership policy"* means an insurance policy that meets the following requirements:

1. The policy covers an insured who, when coverage first became effective under the policy, was a resident of Iowa or was an individual eligible under subrule 39.78(2).

2. The policy is a qualified long-term care insurance policy as defined in Section 7702B(b) of the Internal Revenue Code of 1986 and was issued no earlier than January 1, 2010.

3. The policy meets all of the applicable requirements of this chapter and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

4. The division has certified the policy as meeting the requirements of the following: Section 1917(b) of the Social Security Act, 42 U.S.C. 1396p; Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171; and any applicable federal regulations or guidelines.

5. The policy provides the following inflation protections:

- For a person who is less than 61 years of age as of the date of purchase of the policy or date of issuance of the certificate, the policy provides either annual compounded inflation protection of not less than 3 percent or annual compounded inflation protection of not less than a rate based on changes in the consumer price index. "Consumer price index" means consumer price index for all urban consumers, U.S. city average, all items, as determined by the Bureau of Labor Statistics of the United States Department of Labor.
- For a person who is at least 61 years of age but less than 76 years of age as of the date of purchase of the policy or date of issuance of the certificate, the policy provides either an inflation feature that meets the requirements of this definition, paragraph "5," first bulleted paragraph, or an automatic inflation feature that provides annual simple inflation increases at a rate of not less than 3 percent.
- For a person who is at least 76 years of age as of the date of purchase of the policy or date of issuance of the certificate, an inflation protection feature may be included in the policy but is not required.

"Long-term care partnership program" means a qualified state long-term care insurance partnership as defined in Section 1917(b) of the Social Security Act, 42 U.S.C. 1396p; Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171; and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

"Medicaid" means the program of medical assistance operated by the Iowa department of human services under Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and amendments thereto.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.78(514H,83GA,HF723) Eligibility.

39.78(1) An individual who is a beneficiary of an Iowa long-term care partnership policy or certificate may be eligible for assistance under the state's Medicaid program using the asset disregard as provided under Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

39.78(2) An individual who is a beneficiary of a long-term care partnership policy or certificate issued in another state which grants reciprocity to an Iowan who moves to that state is eligible for benefits under Iowa's Medicaid program using the asset disregard as provided in Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723. For purposes of this subrule, "reciprocity" means the granting of all the benefits by one state to an individual who becomes a resident of that state but who purchased a long-term care partnership policy while residing in another state.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.79(514H,83GA,HF723) Discontinuance of partnership program. If the Iowa long-term care partnership program established by this division and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723, is discontinued, any individual who purchased an Iowa long-term care partnership policy or certificate before the date the program was discontinued shall be eligible to receive asset

disregard if allowed as provided by Title VI, Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171.
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.80(514H,83GA,HF723) Required disclosures.

39.80(1) An insurer or a producer soliciting or offering to sell a partnership policy shall provide to each prospective applicant a Partnership Program Notice. The notice must be substantially similar to Appendix H of this chapter. The Partnership Program Notice shall be provided with the required outline of coverage.

39.80(2) An insurer or a producer soliciting or offering to sell a partnership policy shall provide to each prospective applicant a copy of the Iowa Long-Term Care Partnership Program Consumer Guide. The Iowa Long-Term Care Partnership Program Consumer Guide form may be found on the division's Web site, www.iid.state.ia.us.

39.80(3) A partnership policy or certificate issued or issued for delivery in Iowa shall be accompanied by a Partnership Status Disclosure Notice (Appendix I). A similar notice may be used if filed with and approved by the division.
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.81(514H,83GA,HF723) Form filings.

39.81(1) A partnership policy shall not be issued or issued for delivery in Iowa unless filed with and approved by the division. Any policy submitted for certification as a partnership policy shall be accompanied by a Partnership Issuer Certification. The Partnership Issuer Certification form may be found on the division's Web site, www.iid.state.ia.us. 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 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 forth on the SERFF Web site at www.serff.org.

39.81(2) Insurers may request to make use of a previously approved policy form as a qualified state long-term care partnership policy. Requests shall be filed electronically via SERFF and according to instructions on the SERFF Web site.
[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.82(514H,83GA,HF723) Exchanges.

39.82(1) An insurer must offer, on a one-time basis, in writing, to all existing policyholders that were issued long-term care policies between February 1, 2003, and January 1, 2010, the option to exchange their existing long-term care policies for an Iowa long-term care partnership policy. The insurer must make this offer within 18 months of the date the insurer begins the first marketing efforts for any long-term care partnership insurance product.

39.82(2) Under an exchange program, an insurer must comply with all of the following:

a. The mandatory offer of an exchange shall apply only to products issued by the insurer that are comparable to the type of policy, such as group policies and individual policies, and to the policy series that the company has certified as partnership-qualified.

b. An insurer must provide the insured a minimum of 90 days from the date of mailing of the offer by the insurer to accept or reject the offer.

c. An insurer must make the offer on a nondiscriminatory basis without regard to the age or health status of the insured. However, the insurer may underwrite if the policy is amended to provide additional benefits or if the exchange would require the issuance of a new policy, except as described in paragraph 39.82(2)*"d"* below. Any portion of the policy that was issued prior to the exchange date shall be priced based on the policyholder's age when the policy was originally issued. Any portion of the policy that is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.

d. If there is no change in coverage that is material to the risk, policies exchanged under this rule shall not be subject to any medical underwriting.

e. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the policy or certificate being replaced.

f. Any portion of the policy that was issued prior to the exchange date shall maintain the policy's original price based on the policyholder's age when the policy was originally issued. Any portion of the policy that is added as a result of the exchange may be priced based on the policyholder's age at the time of the exchange.

g. When the policy is issued to a group, the offer required in subrule 39.82(1) shall be made to the group policyholder.

h. Notwithstanding paragraphs 39.82(2)*"a"* and *"c,"* an insurer is not required to offer an exchange to an individual who is eligible for benefits within an elimination period, who is or who has been in claim status, or who would not be eligible to apply for coverage due to issue age or plan design limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including plan design, underwriting, if applicable, and payment of the required premium.

39.82(3) Policies issued pursuant to this rule shall be considered exchanges and not replacements and are not subject to rule 191—39.11(514D,514G).

39.82(4) A policy received in an exchange after January 1, 2010, is treated as newly issued and is eligible for long-term care partnership policy status. For purposes of applying the Medicaid rules relating to Iowa's long-term care partnership program, the addition of a rider, endorsement or change in schedule page for a policy may be treated as giving rise to an exchange.

39.82(5) An insurer or a producer offering an exchange shall provide to each prospective applicant a Partnership Program Notice, as required by subrule 39.80(1), and a copy of the Iowa Long-Term Care Partnership Program Consumer Guide, as required by subrule 39.80(2). An insurer issuing or issuing for delivery in Iowa an exchange shall provide the policyholder or certificate holder a Partnership Status Disclosure Notice, as required by subrule 39.80(3).

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.83(514H,83GA,HF723) Required policy terms and disclosures.

39.83(1) A policy or certificate designed or marketed as a long-term care insurance policy or certificate must prominently disclose on the schedule page the following statements:

"Some long-term care insurance [policies or certificates] may qualify under the state's Long-Term Care Partnership Program. Under this Program the [policyholder or certificate holder] may be able to protect some of the [policyholder's or certificate holder's] assets from Medicaid spend-down requirements through a feature known as 'Asset Disregard.' Nothing in this [policy or certificate] is a guarantee of Medicaid eligibility nor is it a guarantee of any ability to disregard assets for purposes of Medicaid eligibility. If you have questions about whether or not your policy currently qualifies under the Long-Term Care Partnership Program, please contact [the insurer at ###-###-####] and request a long-term care partnership program policy summary."

39.83(2) If a policyholder or certificate holder or that person's representative requests a long-term care partnership program policy summary, as provided in subrule 39.83(1), the information the insurer shall provide and the format of the long-term care partnership program policy summary shall be as set forth in Appendix J. An insurer may submit a form substantially similar to Appendix J to the commissioner for approval to use as a substitute for Appendix J.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.84(514H,83GA,HF723) Standards for marketing and suitability. The standards for marketing found in rule 191—39.15(514D,514G) and the suitability requirements of rule 191—39.16(514D,514G) shall apply to the marketing and sale of long-term care partnership policies.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

191—39.85(514H,83GA,HF723) Required reports.

39.85(1) Each issuer of partnership-qualified long-term care insurance in this state shall provide regular reports to the Secretary of the United States Department of Health and Human Services in accordance with federal law and regulations and to the Iowa department of human services and the division as provided in Section 6021 of the federal Deficit Reduction Act of 2005, Public Law 109-171. The report shall include information as required by the United States Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Submission of the report to the Iowa department of human services or the division is not required if the issuer files the report through the Centers for Medicare and Medicaid Services filing system.

39.85(2) When a policyholder or certificate holder begins receiving any benefits under a policy, the issuer shall begin providing to the policyholder or certificate holder statements of benefits either monthly or within a reasonable time after benefits have been paid. The statements of benefits shall include, at a minimum, detailed information regarding benefits paid and dates of service.

[**ARC 8271B**, IAB 11/4/09, effective 12/9/09]

These rules are intended to implement Iowa Code section 514D.9, Iowa Code chapter 514G and Iowa Code chapter 514H as amended by 2009 Iowa Acts, House File 723.

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[Filed 8/10/07, Notice 7/4/07—published 8/29/07, effective 10/3/07][1]
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[Filed ARC 2415C (Notice ARC 2078C, IAB 8/5/15), IAB 2/17/16, effective 3/23/16]

◊ 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 producer (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: _____ _____

(Producer) (Date)

Producer'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 producer 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 producer 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 producer 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 producer on that producer's amount of long-term care insurance replacement sales as a percent of the producer's total annual sales and the amount of lapses of long-term care insurance policies sold by the producer as a percent of the producer's total annual sales. The tables below should be used to report the ten percent (10%) of the insurer's producers with the greatest percentages of replacements and lapses.

Listing of the 10% of Producers with the Greatest Percentage of Replacements

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Replaced By This Producer	Number of Replacements As % of Number Sold By This Producer

Listing of the 10% of Producers with the Greatest Percentage of Lapses

Producer's Name	Number of Policies Sold By This Producer	Number of Policies Lapsed By This Producer	Number of Lapses As % of Number Sold By This Producer

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) _____%

APPENDIX H

Partnership Program Notice

Important Consumer Information Regarding the
Iowa Long-Term Care Partnership Program

Some long-term care insurance policies or certificates sold in Iowa may qualify for the Iowa Long-Term Care Partnership Program (the Partnership Program). The Partnership Program is a partnership between state government and private insurance companies to assist individuals in planning their long-term care needs. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain state and federal requirements. Long-term care insurance policies or certificates that qualify as partnership policies or certificates may protect the policyholder's or certificate holder's assets through a feature known as "Asset Disregard" under Iowa's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership policy or certificate will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership policy or certificate without affecting the person's eligibility for Medicaid.

All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance policy or certificate that is not a partnership policy or certificate. Therefore, you should consider if Asset Disregard is important to you and whether a partnership policy or certificate meets your needs. The purchase of a partnership policy or certificate does not automatically qualify you for Medicaid. There are other eligibility requirements you must meet, including resource and income requirements.

What Are the Requirements for a Partnership Policy or Certificate?

In order for a policy or certificate to qualify as a partnership policy or certificate, it must, among other requirements:

- Be issued to an individual on or after January 1, 2010;
- Be issued to an individual who is an Iowa resident when coverage first becomes effective under the policy;
- Be a tax-qualified policy under Section 7702B(b) of the Internal Revenue Code of 1986;
- Meet the following inflation protection requirements:
  → For a person less than 61 years of age – provides compound annual inflation protection
  → For a person at least 61 but less than 76 years of age – provides 3 percent inflation protection
  → For a person at least 76 years of age – inflation protection may be offered but is not required

If you apply and are approved for long-term care insurance coverage, [carrier name] will provide you with written documentation as to whether or not your policy or certificate qualifies as a partnership policy or certificate.

What Could Disqualify a Policy or Certificate as a Partnership Policy or Certificate?

Certain types of changes to a partnership policy or certificate could affect whether or not such policy or certificate continues to be a partnership policy or certificate. If you purchase a partnership policy or certificate and later decide to make *any* changes, you should first consult with your insurance producer or insurance company to determine the effect of a proposed change. If you move to a state that does not have a Partnership Program or does not recognize your policy or certificate as a partnership policy or certificate, you would not receive beneficial treatment of your policy or certificate under the Medicaid program of that state. The information contained in this disclosure is based on current Iowa and federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy or certificate under Iowa's Medicaid program.

Additional Information

If you have questions regarding the long-term care insurance policies or certificates, please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Iowa Department of Human Services (Sally Oudekerk, Medicaid Policy Specialist, Bureau of Medical Support, telephone number (515)281-3709, E-mail address soudeke@dhs.state.ia.us).

APPENDIX I

Partnership Status Disclosure Notice
Important Information Regarding Your Policy's or Certificate's
Long-Term Care Partnership Status

This disclosure notice is issued in conjunction with your long-term care policy.

Some long-term care insurance policies or certificates sold in Iowa qualify for the Iowa Long-Term Care Partnership Program. Long-term care insurance policies or certificates that qualify as partnership policies or certificates may be entitled to special treatment, in particular as "Asset Disregard" under Iowa's Medicaid program.

Asset Disregard means that an amount of the policyholder's or certificate holder's assets equal to the amount of long-term care insurance benefits received under a qualified partnership policy or certificate will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified partnership policy or certificate without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply, and special rules may apply to persons whose home equity exceeds $500,000. Asset Disregard is not available under a long-term care insurance policy or certificate that is not a partnership policy or certificate. The purchase of a partnership policy or certificate does not automatically qualify you for Medicaid. There are other eligibility requirements you must meet, including resource and income requirements.

Partnership Policy or Certificate Status

Your long-term care insurance policy or certificate is intended to qualify as a partnership policy or certificate under the Iowa Long-Term Care Partnership Program as of your policy's or certificate's effective date.

What Could Disqualify a Policy or Certificate as a Partnership Policy or Certificate?

Certain types of changes to a partnership policy or certificate could affect whether or not such policy or certificate continues to be a partnership policy or certificate. If you purchase a partnership policy or certificate and later decide to make *any* changes, you should first consult with your insurance producer or your insurance company to determine the effect of a proposed change. If you move to a state that does not maintain a Partnership Program or does not recognize your policy or certificate as a partnership policy or certificate, you would not receive beneficial treatment of your policy or certificate under the Medicaid program of that state. The information contained in this disclosure is based on current Iowa and federal laws. These laws may be subject to change. Any change on law could reduce or eliminate the beneficial treatment of your policy or certificate under Iowa's Medicaid program.

Additional Information

If you have questions regarding the long-term care insurance policies or certificates, please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Iowa Department of Human Services (Sally Oudekerk, Medicaid Policy Specialist, Bureau of Medical Support, telephone number (515)281-3709, E-mail address soudeke@dhs.state.ia.us).

APPENDIX J

Long-Time Care Partnership Program Policy Summary

1. Name of insured _____
2. Policy/certificate number _____
3. Effective date of coverage _____
4. The policy/certificate was issued in the state of _____
5. Issue age of the insured at the time the coverage was issued _____
6. The policy/certificate was issued ☐ With inflation protection coverage
   ☐ Without inflation protection coverage
7. The inflation protection coverage is ☐ Simple Inflation ☐ Compound Inflation ☐ None
8. The inflation protection coverage is currently in effect on the coverage ☐ Yes ☐ No
   If no, the date inflation protection coverage ceased _____
9. The policy is intended to meet the standards of a tax-qualified long-term care policy
   ☐ Yes ☐ No
10. The cumulative dollar amount of insurance benefits paid $_____
    (NOTE: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only.)
11. The total dollar amount of insurance benefits remaining available under the policy $_____
12. This information is correct as of the date this form was completed, which date was _____
13. The name, telephone number and E-mail address of the person completing this form

_____
Name

_____
Telephone Number

_____
E-mail Address

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 contracts 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, Two Ruan Center, 601 Locust Street, Fourth Floor, Des Moines, Iowa 50309.

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.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15]

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.

191—40.26(514B) Notice of cancellation, nonrenewal or termination of enrollment.

40.26(1) *Purpose and definitions.*

a. Purpose. The purpose of this rule is to clarify the authorized methods of delivery for notices of cancellation, nonrenewal or termination by a health maintenance organization, so as to implement the various consumer protections intended by Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B).

b. Definitions. As used in Iowa Code section 505B.1 and this rule:

"Commissioner" means the Iowa insurance commissioner or insurance division.

"Notice of cancellation, nonrenewal or termination" means:

1. Notice of an insurance company's termination of an insurance policy at the end of a term or before the termination date;

2. Notice of an insurance company's decision or intention not to renew a policy; and

3. For purposes of notices required by Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B), "notice of cancellation, nonrenewal or termination" includes but is not limited to a health maintenance organization's notice to an enrollee of cancellation or rescission of membership.

40.26(2) *Scope.* This rule shall apply to all insurance companies holding a certificate of authority to operate an HMO under the provisions of Iowa Code chapter 514B.

40.26(3) *Delivery.* For any notice of cancellation, nonrenewal or termination by a health maintenance organization under Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B) to be effective, a health maintenance organization must, within the time frame established by law, deliver the notice to the person to whom notice is required to be provided either in person or by mail through the U.S. Postal Service to the last-known address of the person to whom notice is required to be provided. The use of U.S. Postal Service Intelligent Mail® fulfills any requirement in Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B) for certified mail or certificate of mailing as proof of mailing.

40.26(4) *Electronic transmissions.* Notwithstanding the requirements of subrule 40.26(3), if an insurer receives, pursuant to 191—subrule 4.24(2), approval from the commissioner of a manner of electronic delivery of a notice of cancellation, nonrenewal or termination of a policy, the approved manner shall satisfy the notice requirements of Iowa Code sections 514B.17 and 514B.17A and rule 191—40.10(514B).

This rule is intended to implement Iowa Code chapter 505B.

[**ARC 1999C**, IAB 5/27/15, effective 7/1/15; **ARC 2415C**, IAB 2/17/16, effective 3/23/16]

These rules are intended to implement Iowa Code chapter 514B and 1999 Iowa Acts, Senate File 276.

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CHAPTER 13
ISSUANCE OF TEACHER LICENSES AND ENDORSEMENTS

[Prior to 1/14/09, see Educational Examiners Board[282] Ch 14]

282—13.1(272) All applicants desiring Iowa licensure.

13.1(1) *Licenses, authorizations, certificates, and statements of professional recognition.* Licenses, authorizations, certificates, and statements of professional recognition are issued upon application filed on a form provided by the board of educational examiners and upon completion of the following:

a. National criminal history background check. An initial applicant will be required to submit a completed fingerprint packet that accompanies the application to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet will be assessed to the applicant.

b. Iowa division of criminal investigation background check. An Iowa division of criminal investigation (DCI) background check will be conducted on initial applicants. The fee for the evaluation of the DCI background check will be assessed to the applicant.

c. Registries and records check. A check of the following registries and records will be conducted on initial applicants: the sex offender registry under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, the central registry for dependent adult abuse information maintained under Iowa Code chapter 235B, and the information in the Iowa court information system available to the general public. The fee for checks of these registries and records will be assessed to the applicant.

13.1(2) *Temporary permits.* The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application; determination that the applicant meets all applicable prerequisites for issuance of the license, certification, or authorization; and satisfactory evaluation of the Iowa criminal history background check. The temporary permit shall serve as evidence of the applicant's authorization to hold a position in Iowa schools, pending the satisfactory completion of the national criminal history background check. The temporary permit shall expire upon issuance of the requested license, certification, or authorization or 90 days from the date of issuance of the permit, whichever occurs first, unless the temporary permit is extended upon a finding of good cause by the executive director.

[**ARC 0563C**, IAB 1/23/13, effective 1/1/13; **ARC 2230C**, IAB 11/11/15, effective 12/16/15]

282—13.2(272) Applicants from recognized Iowa institutions. Rescinded **ARC 2016C**, IAB 6/10/15, effective 7/15/15.

282—13.3(272) Applicants from non-Iowa institutions. Rescinded **ARC 2016C**, IAB 6/10/15, effective 7/15/15.

282—13.4(272) Applicants from foreign institutions. Rescinded **ARC 2016C**, IAB 6/10/15, effective 7/15/15.

282—13.5(272) Teacher licenses. A license may be issued to applicants who fulfill the general requirements set out in subrule 13.5(1) and the specific requirements set out for each license.

13.5(1) *General requirements.* The applicant shall:

a. Have a baccalaureate degree from a regionally accredited institution.

b. Have completed a state-approved teacher education program.

c. Have completed the teacher preparation coursework set forth in 281—subrules 79.15(2) to 79.15(5).

d. Have completed student teaching in the subject area and grade level endorsement desired.

e. Have completed the requirements for one of the basic teaching endorsements.

f. Provide a recommendation for the specific license and endorsement(s) from the designated recommending official at the recognized institution where the preparation was completed.

13.5(2) *Applicants from non-Iowa institutions.*

a. Definitions.

"Nontraditional" means any method of teacher preparation that falls outside the traditional method of preparing teachers, that provides at least a one- or two-year sequenced program of instruction taught at regionally accredited and state-approved colleges or universities, that includes commonly recognized pedagogy classes being taught for course credit, and that requires a student teaching component.

"Proficiency," for the purposes of paragraph 13.5(2)*"e,"* means that an applicant has passed all parts of the standard.

"Recognized non-Iowa teacher preparation institution" means an institution that is state-approved and is accredited by the regional accrediting agency for the territory in which the institution is located.

b. In addition to the requirements set forth in subrule 13.5(1), applicants from non-Iowa institutions:

(1) Shall submit a copy of a valid or expired regular teaching certificate or license exclusive of a temporary, emergency or substitute license or certificate.

(2) Shall provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education if the teacher preparation program was completed on or after January 1, 2013. If the teacher preparation program was completed prior to January 1, 2013, the applicant must provide verification of successfully passing the mandated assessment(s) in the state in which the applicant is currently licensed (or verify highly qualified status) or must provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education.

(3) Shall provide an official institutional transcript(s) to be analyzed for the requirements necessary for Iowa licensure. An applicant must have completed at least 75 percent of the coursework as outlined in 281—subrules 79.15(2) to 79.15(5) and an endorsement requirement through a two- or four-year institution in order for the endorsement to be included on the license. An applicant who has not completed at least 75 percent of the coursework for at least one of the basic Iowa teaching endorsements completed will not be issued a license.

(4) Shall demonstrate recency of experience by providing verification of either one year of teaching experience or six semester hours of college credit during the five-year period immediately preceding the date of application.

(5) Shall not be subject to any pending disciplinary proceedings in any state or country.

(6) Shall comply with all requirements with regard to application processes and payment of licensure fees.

c. If through a transcript analysis, the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5) or one of the basic teaching endorsement requirements for Iowa is not met, the applicant may be eligible for the equivalent Iowa endorsement areas, as designated by the Iowa board of educational examiners, based on current and valid National Board Certification.

d. If the teacher preparation program was considered nontraditional, candidates will be asked to verify the following:

(1) That the program was for secondary education;

(2) A cumulative grade point average of 2.50 on a 4.0 scale from a regionally accredited institution; and

(3) The completion of a student teaching or internship experience or three years of teaching experience.

e. If the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5) cannot be reviewed through a traditional transcript evaluation, a portfolio review and evaluation process may be utilized.

(1) An applicant must demonstrate proficiency in a minimum of at least 75 percent of the teacher preparation coursework as outlined in 281—subrules 79.15(2) to 79.15(5).

(2) An applicant must meet with the board of educational examiners to answer any of the board's questions concerning the portfolio.

13.5(3) *Applicants from foreign institutions.* An applicant for initial licensure whose preparation was completed in a foreign institution must obtain a course-by-course credential evaluation report completed by one of the board-approved credential evaluation services and then file this report with the Iowa board

of educational examiners for a determination of eligibility for licensure. After receiving the notification of eligibility by the Iowa board of educational examiners, the applicant must provide verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education.
[**ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.6(272) Specific requirements for an initial license. An initial license valid for two years may be issued to an applicant who meets the general requirements set forth in rule 282—13.5(272).
[**ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.7(272) Specific requirements for a standard license. A standard license valid for five years may be issued to an applicant who:

1. Meets the general requirements set forth in rule 282—13.5(272), and
2. Shows evidence of successful completion of a state-approved mentoring and induction program by meeting the Iowa teaching standards as determined by a comprehensive evaluation and two years' successful teaching experience. In lieu of completion of an Iowa state-approved mentoring and induction program, the applicant must provide evidence of three years' successful teaching experience in an Iowa nonpublic school or three years' successful teaching experience in an out-of-state K-12 educational setting.

[**ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.8(272) Specific requirements for a master educator's license. A master educator's license is valid for five years and may be issued to an applicant who:

1. Is the holder of or is eligible for a standard license as set out in rule 282—13.7(272), and
2. Verifies five years of successful teaching experience, and
3. Completes one of the following options:

- Master's degree from a regionally accredited college or university in a recognized endorsement area, or
- Master's degree from a regionally accredited college or university in curriculum, effective teaching, or a similar degree program which has a focus on school curriculum or instruction.

[**ARC 1168C**, IAB 11/13/13, effective 12/18/13]

282—13.9(272) Teacher intern license.

13.9(1) *Authorization.* The teacher intern is authorized to teach in grades 7 to 12.

13.9(2) *Term.* The term of the teacher intern license will be one school year. This license is nonrenewable.

13.9(3) *Teacher intern requirements.* A teacher intern license may be issued to an applicant who has been recommended by an institution with a state-approved intern program and who has met the background check requirements set forth in rule 282—13.1(272).

13.9(4) *Requirements to convert the teacher intern license to the initial license.* An initial license shall be issued upon application provided that the teacher intern has met the requirements as verified by the recommendation from the state-approved program.

13.9(5) *Requirements to extend the teacher intern license if the teacher intern does not complete all of the education coursework during the term of the teacher intern license.*

a. A one-year extension of the teacher intern license may be issued upon application provided that the teacher intern has met both of the following requirements:

(1) Successful completion of one year of teaching experience during the teacher internship.

(2) Verification by the recommending official at the approved teacher intern program that the teacher intern has not completed all of the coursework required for the initial license.

b. Only one year of teaching experience during the term of the teacher intern license or the extension of a teacher intern license may be used to convert the teacher intern license to a standard teaching license.

[**ARC 8688B**, IAB 4/7/10, effective 5/12/10; **ARC 9925B**, IAB 12/14/11, effective 1/18/12; **ARC 0698C**, IAB 5/1/13, effective 6/5/13; **ARC 0865C**, IAB 7/24/13, effective 8/28/13; **ARC 1374C**, IAB 3/19/14, effective 4/23/14; **ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.10(272) Specific requirements for a Class A extension license. A nonrenewable Class A extension license valid for one year may be issued to an individual under one of the following conditions:

13.10(1) *Based on an expired Iowa certificate or license, exclusive of a Class A extension or Class B license.*

a. The holder of an expired license, exclusive of a Class A extension or Class B license, shall be eligible to receive a Class A extension license upon application. This license shall be endorsed for the type of service authorized by the expired license on which it is based.

b. The holder of an expired license who is currently under contract with an Iowa educational unit (area education agency/local education agency/local school district) and who does not meet the renewal requirements for the license held shall be required to secure the signature of the superintendent or designee before the license will be issued.

13.10(2) *Based on a mentoring and induction program.* An applicant may be eligible for a Class A extension license if the school district, after conducting a comprehensive evaluation, recommends and verifies that the applicant shall participate in the mentoring program for a third year. No further extensions are available for this type of Class A extension license.

[**ARC 7987B**, IAB 7/29/09, effective 9/2/09; **ARC 8134B**, IAB 9/9/09, effective 10/14/09; **ARC 8957B**, IAB 7/28/10, effective 9/1/10; **ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.11(272) Specific requirements for a Class B license. A Class B license, which is valid for two years and which is nonrenewable, may be issued to an individual under the following conditions:

13.11(1) *Endorsement in progress.* The individual has a valid initial, standard, master educator, permanent professional, Class A extension, exchange, or professional service license and one or more endorsements but is seeking to obtain some other endorsement. A Class B license may be issued if requested by an employer and if the individual seeking to obtain some other endorsement has completed at least two-thirds of the requirements, or one-half of the content requirements in a state-designated shortage area, leading to completion of all requirements for the endorsement. A Class B license may not be issued for the driver's education endorsement.

13.11(2) *Program of study for special education endorsement.* The college or university must outline the program of study necessary to meet the special education endorsement requirements. This program of study must be attached to the application.

13.11(3) *Request for executive director decision.* If the minimum content requirements have not been met for the Class B license, a one-year executive director decision license may be issued if requested by the school district and if the school district can demonstrate that a candidate with the proper endorsement was not found after a diligent search. The executive director decision license may not be renewed and will expire on June 30 of the fiscal year in which it was issued.

13.11(4) *Expiration.* The Class B license will expire on June 30 of the fiscal year in which it was issued plus one year.

[**ARC 7987B**, IAB 7/29/09, effective 9/2/09; **ARC 8133B**, IAB 9/9/09, effective 10/14/09; **ARC 9207B**, IAB 11/3/10, effective 12/8/10; **ARC 9573B**, IAB 6/29/11, effective 8/3/11; **ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.12(272) Specific requirements for a Class C license. Rescinded IAB 7/29/09, effective 9/2/09.

282—13.13(272) Specific requirements for a Class D occupational license. Rescinded IAB 7/29/09, effective 9/2/09.

282—13.14(272) Specific requirements for a Class E emergency extension license. A nonrenewable license valid for one year may be issued to an individual as follows:

13.14(1) *Expired license.* Based on an expired Class A or Class B license, the holder of the expired license shall be eligible to receive a Class E emergency extension license upon application and submission of all required materials.

13.14(2) *Application.* The application process will require transcripts of coursework completed during the term of the expired license, a program of study indicating the coursework necessary to obtain full licensure, and registration for coursework to be completed during the term of the Class E emergency extension license. The Class E emergency extension license will be denied if the applicant has not completed any coursework during the term of the Class A or Class B license unless extenuating circumstances are verified.

[**ARC 7987B**, IAB 7/29/09, effective 9/2/09; **ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.15(272) Specific requirements for a Class G license. A nonrenewable Class G license valid for one year may be issued to an individual who must complete a school counseling practicum or internship in an approved program in preparation for the professional school counselor endorsement. The Class G license may be issued under the following limited conditions:

1. Verification of a baccalaureate degree from a regionally accredited institution.
2. Verification from the institution that the individual is admitted and enrolled in a school counseling program.
3. Verification that the individual has completed the coursework and competencies required prior to the practicum or internship.
4. Written documentation of the requirements listed in "1" to "3" above, provided by the official at the institution where the individual is completing the approved school counseling program and forwarded to the Iowa board of educational examiners with the application form for licensure.

[**ARC 1328C**, IAB 2/19/14, effective 3/26/14]

282—13.16(272) Specific requirements for a substitute teacher's license.

13.16(1) *Substitute teacher requirements.* A substitute teacher's license may be issued to an individual who provides verification of successfully passing the Iowa-mandated assessment(s) by meeting the minimum score set by the Iowa department of education if the teacher preparation program was completed on or after January 1, 2013, and who:

a. Has completed a traditional teacher preparation program and been the holder of, or presently holds, or is eligible to hold, a license in Iowa; or

b. Holds a valid or expired teaching certificate based on a nontraditional teacher preparation program, is able to verify three years of teaching experience, and provides passing scores on tests mandated by the state that issued the certificate. The license issued will contain a disclaimer stating that the holder of this license may not be eligible for full Iowa teaching licensure.

13.16(2) *Validity.* A substitute license is valid for five years and for not more than 90 days of teaching in one assignment during any one school year. A school district administrator may file a written request with the board for an extension of the 90-day limit in one assignment on the basis of documented need and benefit to the instructional program. The board will review the request and provide a written decision either approving or denying the request.

13.16(3) *Authorization.* The holder of a substitute license is authorized to substitute teach in any school system in any position in which a regularly licensed teacher is employed except in the driver's education classroom. In addition to the authority inherent in the initial, standard, master educator, professional administrator, regional exchange, and permanent professional licenses and the endorsement(s) held, the holder of one of these regular licenses may substitute on the same basis as the holder of a substitute license while the regular license is in effect. The executive director may grant permission for a substitute to serve outside of a substitute's regular authority under unique circumstances.

[**ARC 9205B**, IAB 11/3/10, effective 12/8/10; **ARC 9206B**, IAB 11/3/10, effective 12/8/10; **ARC 0605C**, IAB 2/20/13, effective 3/27/13; **ARC 1324C**, IAB 2/19/14, effective 3/26/14; **ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.17(272) Specific requirements for exchange licenses.

13.17(1) *Teacher exchange license.*

a. For an applicant applying under 13.5(2), a one-year nonrenewable exchange license may be issued to the applicant under any of the following conditions:

(1) The applicant has met the minimum coursework requirements for licensure but has some coursework deficiencies. Any coursework deficiencies must be completed for college credit through a regionally accredited institution, with the exception of human relations which may be taken for licensure renewal credit through an approved provider.

(2) The applicant submits verification that the applicant has applied for and will receive the applicant's first teaching license and is waiting for the processing or printing of a valid and current out-of-state license. The lack of a valid and current out-of-state license will be listed as a deficiency.

(3) The applicant has not met the requirement for recency set forth in 13.5(2)*"b"*(4).

b. After the term of the exchange license has expired, the applicant may apply to be fully licensed if the applicant has completed all requirements and is eligible for full licensure.

13.17(2) *International teacher exchange license.*

a. A nonrenewable international exchange license may be issued to an applicant under the following conditions:

(1) The applicant has completed a teacher education program in another country; and

(2) The applicant is a participant in a teacher exchange program administered through the Iowa department of education, the U.S. Department of Education, or the U.S. Department of State.

b. Each exchange license shall be limited to the area(s) and level(s) of instruction as determined by an analysis of the application and the credential evaluation report.

c. This license shall not exceed one year unless the applicant can verify continued participation in the exchange program beyond one year.

d. After the term of the exchange license has expired, the applicant may apply to be fully licensed if the applicant has completed all requirements and is eligible for full licensure.

13.17(3) *Military exchange license.*

a. Definitions.

"Military service" means honorably serving on federal active duty, state active duty, or national guard duty, as defined in Iowa Code section 29A.1; in the military services of other states, as provided in 10 U.S.C. Section 101(c); or in the organized reserves of the United States, as provided in 10 U.S.C. Section 10101.

"Veteran" means an individual who meets the definition of "veteran" in Iowa Code section 35.1(2).

b. Spouses of active duty military service members applying under 13.5(2). A three-year nonrenewable military exchange license may be issued to the applicant under the following conditions:

(1) The applicant has completed a traditional teacher preparation program at a regionally accredited and state-approved two- or four-year college.

(2) The applicant is the holder of a valid and current or an expired teaching license from another state.

(3) The applicant provides verification of the applicant's connection to or the applicant's spouse's connection to the military by providing a copy of current military orders with either a marriage license or a copy of a military ID card for the applicant's spouse.

(4) This license may be converted to a one-year regional exchange license upon application and payment of fees.

c. Veterans or their spouses applying under 13.5(2). A three-year military exchange license may be issued to an applicant who meets the requirements of 13.17(3)*"b"*(1) and (2). A veteran must provide a copy of the veteran's DD 214. A spouse must provide a copy of the veteran spouse's DD 214 and the couple's marriage license.

d. Spouses of active duty military service veterans, or veterans' spouses applying under 13.5(2). If the applicant has completed a nontraditional teacher preparation program but is not eligible for a teaching license, the applicant will be issued a substitute license, and the initial review for the portfolio review

process will be completed by board staff. An applicant must provide verification of connection to the military outlined in 13.17(3)*"b"*(3) or 13.17(3)*"c."*

e. Military education, training, and service credit. An applicant for the military exchange license may apply for credit for verified military education, training, or service toward any experience or educational requirement for licensure by submitting documentation to the board of educational examiners. The applicant shall identify the experience or educational requirement to which the credit would be applied if granted. The board of educational examiners shall promptly determine whether the verified military education, training, or service will satisfy all or any part of the identified experience or educational requirement for licensure.

f. Fees. Fees for the background check, evaluation and license issued pursuant to 13.17(3) will be limited to the fee outlined in rule 282—12.1(272) for the issuance of a license.

[**ARC 8138B**, IAB 9/9/09, effective 10/14/09; **ARC 8604B**, IAB 3/10/10, effective 4/14/10; **ARC 9072B**, IAB 9/8/10, effective 10/13/10; **ARC 9840B**, IAB 11/2/11, effective 12/7/11; **ARC 0563C**, IAB 1/23/13, effective 1/1/13; **ARC 0868C**, IAB 7/24/13, effective 8/28/13; **ARC 1166C**, IAB 11/13/13, effective 12/18/13; **ARC 1323C**, IAB 2/19/14, effective 3/26/14; **ARC 1454C**, IAB 5/14/14, effective 6/18/14; **ARC 1878C**, IAB 2/18/15, effective 3/25/15; **ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.18(272) General requirements for an original teaching subject area endorsement. Rescinded **ARC 2016C**, IAB 6/10/15, effective 7/15/15.

282—13.19(272) NCATE-accredited programs. Rescinded IAB 6/17/09, effective 7/22/09.

282—13.20 Reserved.

282—13.21(272) Human relations requirements for practitioner licensure. Rescinded **ARC 2016C**, IAB 6/10/15, effective 7/15/15.

282—13.22(272) Development of human relations components. Rescinded **ARC 2016C**, IAB 6/10/15, effective 7/15/15.

282—13.23 to **13.25** Reserved.

282—13.26(272) Requirements for elementary endorsements.

13.26(1) *Teacher—prekindergarten-kindergarten.*

a. Authorization. The holder of this endorsement is authorized to teach at the prekindergarten-kindergarten level.

b. Content.

(1) Human growth and development: infancy and early childhood, unless completed as part of the professional education core.

(2) Curriculum development and methodology for young children.

(3) Child-family-school-community relationships (community agencies).

(4) Guidance of young children three to six years of age.

(5) Organization of prekindergarten-kindergarten programs.

(6) Child and family nutrition.

(7) Language development and learning.

(8) Kindergarten: programs and curriculum development.

13.26(2) *Teacher—prekindergarten through grade three.*

a. Authorization. The holder of this endorsement is authorized to teach children from birth through grade three.

b. Content.

(1) Child growth and development with emphasis on cognitive, language, physical, social, and emotional development, both typical and atypical, for infants and toddlers, preprimary, and primary school children (grades one through three), unless combined as part of the professional education core.

(2) Historical, philosophical, and social foundations of early childhood education.

(3) Developmentally appropriate curriculum with emphasis on integrated multicultural and nonsexist content including language, mathematics, science, social studies, health, safety, nutrition, visual and expressive arts, social skills, higher-thinking skills, and developmentally appropriate methodology, including adaptations for individual needs, for infants and toddlers, preprimary, and primary school children.

(4) Characteristics of play and creativity, and their contributions to the cognitive, language, physical, social and emotional development and learning of infants and toddlers, preprimary, and primary school children.

(5) Classroom organization and individual interactions to create positive learning environments for infants and toddlers, preprimary, and primary school children based on child development theory emphasizing guidance techniques.

(6) Observation and application of developmentally appropriate assessments for infants and toddlers, preprimary, and primary school children recognizing, referring, and making adaptations for children who are at risk or who have exceptional educational needs and talents.

(7) Home-school-community relationships and interactions designed to promote and support parent, family and community involvement, and interagency collaboration.

(8) Family systems, cultural diversity, and factors which place families at risk.

(9) Child and family health and nutrition.

(10) Advocacy, legislation, and public policy as they affect children and families.

(11) Administration of child care programs to include staff and program development and supervision and evaluation of support staff.

(12) Pre-student teaching field experience with three age levels in infant and toddler, preprimary, and primary programs, with no less than 100 clock hours, and in different settings, such as rural and urban, socioeconomic status, cultural diversity, program types, and program sponsorship.

(13) Student teaching experiences with two different age levels, one before kindergarten and one from kindergarten through grade three.

13.26(3) *Teacher—prekindergarten through grade three, including special education.*

a. Authorization. The holder of this endorsement is authorized to teach children from birth through grade three.

b. Content.

(1) Child growth and development.

1. Understand the nature of child growth and development for infants and toddlers (birth through age 2), preprimary (age 3 through age 5) and primary school children (age 6 through age 8), both typical and atypical, in areas of cognition, language development, physical motor, social-emotional, aesthetics, and adaptive behavior.

2. Understand individual differences in development and learning including risk factors, developmental variations and developmental patterns of specific disabilities and special abilities.

3. Recognize that children are best understood in the contexts of family, culture and society and that cultural and linguistic diversity influences development and learning.

(2) Developmentally appropriate learning environment and curriculum implementation.

1. Establish learning environments with social support, from the teacher and from other students, for all children to meet their optimal potential, with a climate characterized by mutual respect, encouraging and valuing the efforts of all regardless of proficiency.

2. Appropriately use informal and formal assessment to monitor development of children and to plan and evaluate curriculum and teaching practices to meet individual needs of children and families.

3. Plan, implement, and continuously evaluate developmentally and individually appropriate curriculum goals, content, and teaching practices for infants, toddlers, preprimary and primary children based on the needs and interests of individual children, their families and community.

4. Use both child-initiated and teacher-directed instructional methods, including strategies such as small and large group projects, unstructured and structured play, systematic instruction, group discussion and cooperative decision making.

5. Develop and implement integrated learning experiences for home-, center- and school-based environments for infants, toddlers, preprimary and primary children.

6. Develop and implement integrated learning experiences that facilitate cognition, communication, social and physical development of infants and toddlers within the context of parent-child and caregiver-child relationships.

7. Develop and implement learning experiences for preprimary and primary children with focus on multicultural and nonsexist content that includes development of responsibility, aesthetic and artistic development, physical development and well-being, cognitive development, and emotional and social development.

8. Develop and implement learning experiences for infants, toddlers, preprimary, and primary children with a focus on language, mathematics, science, social studies, visual and expressive arts, social skills, higher-thinking skills, and developmentally appropriate methodology.

9. Develop adaptations and accommodations for infants, toddlers, preprimary, and primary children to meet their individual needs.

10. Adapt materials, equipment, the environment, programs and use of human resources to meet social, cognitive, physical motor, communication, and medical needs of children and diverse learning needs.

(3) Health, safety and nutrition.

1. Design and implement physically and psychologically safe and healthy indoor and outdoor environments to promote development and learning.

2. Promote nutritional practices that support cognitive, social, cultural and physical development of young children.

3. Implement appropriate appraisal and management of health concerns of young children including procedures for children with special health care needs.

4. Recognize signs of emotional distress, physical and mental abuse and neglect in young children and understand mandatory reporting procedures.

5. Demonstrate proficiency in infant-child cardiopulmonary resuscitation, emergency procedures and first aid.

(4) Family and community collaboration.

1. Apply theories and knowledge of dynamic roles and relationships within and between families, schools, and communities.

2. Assist families in identifying resources, priorities, and concerns in relation to the child's development.

3. Link families, based on identified needs, priorities and concerns, with a variety of resources.

4. Use communication, problem-solving and help-giving skills in collaboration with families and other professionals to support the development, learning and well-being of young children.

5. Participate as an effective member of a team with other professionals and families to develop and implement learning plans and environments for young children.

(5) Professionalism.

1. Understand legislation and public policy that affect all young children, with and without disabilities, and their families.

2. Understand legal aspects, historical, philosophical, and social foundations of early childhood education and special education.

3. Understand principles of administration, organization and operation of programs for children from birth to age 8 and their families, including staff and program development, supervision and evaluation of staff, and continuing improvement of programs and services.

4. Identify current trends and issues of the profession to inform and improve practices and advocate for quality programs for young children and their families.

5. Adhere to professional and ethical codes.

6. Engage in reflective inquiry and demonstration of professional self-knowledge.

(6) Pre-student teaching field experiences. Complete 100 clock hours of pre-student teaching field experience with three age levels in infant and toddler, preprimary, and primary programs and in different

settings, such as rural and urban, encompassing differing socioeconomic status, ability levels, cultural and linguistic diversity and program types and sponsorship.

(7) Student teaching. Complete a supervised student teaching experience of a total of at least 12 weeks in at least two different classrooms which include children with and without disabilities in two of three age levels: infant and toddler, preprimary, and primary.

13.26(4) *Teacher—elementary classroom.* These requirements will sunset on August 31, 2015.

a. Authorization. The holder of this endorsement is authorized to teach in kindergarten and grades one through six.

b. Content.

(1) Child growth and development with emphasis on the emotional, physical and mental characteristics of elementary age children, unless completed as part of the professional education core.

(2) Methods and materials of teaching elementary language arts.

(3) Methods and materials of teaching elementary reading.

(4) Elementary curriculum (methods and materials).

(5) Methods and materials of teaching elementary mathematics.

(6) Methods and materials of teaching elementary science.

(7) Children's literature.

(8) Methods and materials of teaching elementary social studies.

(9) Methods and materials in two of the following areas:

1. Methods and materials of teaching elementary health.
2. Methods and materials of teaching elementary physical education.
3. Methods and materials of teaching elementary art.
4. Methods and materials of teaching elementary music.

(10) Pre-student teaching field experience in at least two different grades.

(11) A field of specialization in a single discipline or a formal interdisciplinary program of at least 12 semester hours.

13.26(5) *Teacher—elementary classroom.* Effective September 1, 2015, the following requirements apply to persons who wish to teach in the elementary classroom:

a. Authorization. The holder of this endorsement is authorized to teach in kindergarten and grades one through six.

b. Content.

(1) Child growth and development with emphasis on the emotional, physical and mental characteristics of elementary age children, unless completed as part of the professional education core.

(2) At least 9 semester hours in literacy which must include:

1. Content:

- Children's literature;
- Oral and written communication skills for the twenty-first century.

2. Methods:

- Assessment, diagnosis and evaluation of student learning in literacy;
- Integration of the language arts (to include reading, writing, speaking, viewing, and listening);
- Integration of technology in teaching and student learning in literacy;
- Current best-practice, research-based approaches of literacy instruction;
- Classroom management as it applies to literacy methods;
- Pre-student teaching clinical experience in teaching literacy.

(3) At least 9 semester hours in mathematics which must include:

1. Content:

- Numbers and operations;
- Algebra/number patterns;
- Geometry;
- Measurement;
- Data analysis/probability.

2. Methods:

- Assessment, diagnosis and evaluation of student learning in mathematics;
- Current best-practice, research-based instructional methods in mathematical processes (to include problem solving; reasoning; communication; the ability to recognize, make and apply connections; integration of manipulatives; the ability to construct and to apply multiple connected representations; and the application of content to real world experiences);
- Integration of technology in teaching and student learning in mathematics;
- Classroom management as it applies to mathematics methods;
- Pre-student teaching clinical experience in teaching mathematics.

(4) At least 9 semester hours in social sciences which must include:

1. Content:
- History;
- Geography;
- Political science/civic literacy;
- Economics;
- Behavioral sciences.

2. Methods:
- Current best-practice, research-based approaches to the teaching and learning of social sciences;
- Integration of technology in teaching and student learning in social sciences;
- Classroom management as it applies to social science methods.

(5) At least 9 semester hours in science which must include:

1. Content:
- Physical science;
- Earth/space science;
- Life science.

2. Methods:
- Current best-practice, research-based methods of inquiry-based teaching and learning of science;
- Integration of technology in teaching and student learning in science;
- Classroom management as it applies to science methods.

(6) At least 3 semester hours to include all of the following:

1. Methods of teaching elementary physical education, health, and wellness;
2. Methods of teaching visual arts for the elementary classroom;
3. Methods of teaching performance arts for the elementary classroom.

(7) Pre-student teaching field experience in at least two different grade levels to include one primary and one intermediate placement.

(8) A field of specialization in a single discipline or a formal interdisciplinary program of at least 12 semester hours.

[**ARC 8400B**, IAB 12/16/09, effective 1/20/10; **ARC 8401B**, IAB 12/16/09, effective 1/20/10; **ARC 8402B**, IAB 12/16/09, effective 1/20/10; **ARC 8607B**, IAB 3/10/10, effective 4/14/10; **ARC 0446C**, IAB 11/14/12, effective 12/19/12; **ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.27(272) Requirements for middle school endorsements.

13.27(1) *Authorization.* The holder of this endorsement is authorized to teach in the two concentration areas in which the specific requirements have been completed as well as in other subject areas in grades five through eight which are not the core content areas. The holder is not authorized to teach art, industrial arts, music, reading, physical education, talented and gifted, English as a second language, and special education.

13.27(2) *Program requirements.*

a. Be the holder of a currently valid Iowa teacher's license with either the general elementary endorsement or one of the subject matter secondary level endorsements set out in rule 282—13.28(272).

b. A minimum of 9 semester hours of required coursework in the following:

(1) Coursework in the growth and development of the middle school age child, specifically addressing the social, emotional, physical and cognitive characteristics and needs of middle school age children in addition to related studies completed as part of the professional education core.

(2) Coursework in middle school design, curriculum, instruction, and assessment including, but not limited to, interdisciplinary instruction, teaming, and differentiated instruction in addition to related studies completed as part of the professional education core.

(3) Coursework to prepare middle school teachers in literacy (reading, writing, listening and speaking) strategies for students in grades five through eight and in methods to include these strategies throughout the curriculum.

c. Thirty hours of middle school field experiences included in the coursework requirements listed in 13.27(2)*"b"*(1) to (3).

13.27(3) *Concentration areas.* To obtain this endorsement, the applicant must complete the coursework requirements in two of the following content areas:

a. Social studies concentration. The social studies concentration requires 12 semester hours of coursework in social studies to include coursework in United States history, world history, government and geography.

b. Mathematics concentration. The mathematics concentration requires 12 semester hours in mathematics to include coursework in algebra.

c. Science concentration. The science concentration requires 12 semester hours in science to include coursework in life science, earth science, and physical science.

d. Language arts concentration. The language arts concentration requires 12 semester hours in language arts to include coursework in composition, language usage, speech, young adult literature, and literature across cultures.

[**ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.28(272) Minimum content requirements for teaching endorsements.

13.28(1) *Agriculture.* 5-12. Completion of 24 semester credit hours in agriculture and agriculture education to include:

a. Foundations of vocational and career education.

b. Planning and implementing courses and curriculum.

c. Methods and techniques of instruction to include evaluation of programs and students.

d. Coordination of cooperative education programs.

e. Coursework in each of the following areas and at least three semester credit hours in five of the following areas:

(1) Agribusiness systems.

(2) Power, structural, and technical systems.

(3) Plant systems.

(4) Animal systems.

(5) Natural resources systems.

(6) Environmental service systems.

(7) Food products and processing systems.

13.28(2) *Art.* K-8 or 5-12. Completion of 24 semester hours in art to include coursework in art history, studio art, and two- and three-dimensional art.

13.28(3) *Business—all.* 5-12. Completion of 30 semester hours in business to include 6 semester hours in accounting, 3 semester hours in business law to include contract law, 3 semester hours in computer and technical applications in business, 6 semester hours in marketing to include consumer studies, 3 semester hours in management, 6 semester hours in economics, and 3 semester hours in business communications to include formatting, language usage, and oral presentation. Coursework in entrepreneurship and in financial literacy may be a part of, or in addition to, the coursework listed above.

13.28(4) *Driver education.* 5-12. Completion of 9 semester hours in driver education to include coursework in accident prevention that includes drug and alcohol abuse; vehicle safety; and behind-the-wheel driving.

13.28(5) *English/language arts.*

a. K-8. Completion of 24 semester hours in English and language arts to include coursework in oral communication, written communication, language development, reading, children's literature, creative drama or oral interpretation of literature, and American literature.

b. 5-12. Completion of 24 semester hours in English to include coursework in oral communication, written communication, language development, reading, American literature, English literature and adolescent literature.

13.28(6) *Language arts.* 5-12. Completion of 40 semester hours in language arts to include coursework in the following areas:

a. Written communication.

(1) Develops a wide range of strategies and appropriately uses writing process elements (e.g., brainstorming, free-writing, first draft, group response, continued drafting, editing, and self-reflection) to communicate with different audiences for a variety of purposes.

(2) Develops knowledge of language structure (e.g., grammar), language conventions (e.g., spelling and punctuation), media techniques, figurative language and genre to create, critique, and discuss print and nonprint texts.

b. Oral communication.

(1) Understands oral language, listening, and nonverbal communication skills; knows how to analyze communication interactions; and applies related knowledge and skills to teach students to become competent communicators in varied contexts.

(2) Understands the communication process and related theories, knows the purpose and function of communication and understands how to apply this knowledge to teach students to make appropriate and effective choices as senders and receivers of messages in varied contexts.

c. Language development.

(1) Understands inclusive and appropriate language, patterns and dialects across cultures, ethnic groups, geographic regions and social roles.

(2) Develops strategies to improve competency in the English language arts and understanding of content across the curriculum for students whose first language is not English.

d. Young adult literature, American literature, and world literature.

(1) Reads, comprehends, and analyzes a wide range of texts to build an understanding of self as well as the cultures of the United States and the world in order to acquire new information, to respond to the needs and demands of society and the workplace, and for personal fulfillment. Among these texts are fiction and nonfiction, graphic novels, classic and contemporary works, young adult literature, and nonprint texts.

(2) Reads a wide range of literature from many periods in many genres to build an understanding of the many dimensions (e.g., philosophical, ethical, aesthetic) of human experience.

(3) Applies a wide range of strategies to comprehend, interpret, evaluate, and appreciate texts. Draws on prior experience, interactions with other readers and writers, knowledge of word meaning and of other texts, word identification strategies, and an understanding of textual features (e.g., sound-letter correspondence, sentence structure, context, graphics).

(4) Participates as a knowledgeable, reflective, creative, and critical member of a variety of literacy communities.

e. Creative voice.

(1) Understands the art of oral interpretation and how to provide opportunities for students to develop and apply oral interpretation skills in individual and group performances for a variety of audiences, purposes and occasions.

(2) Understands the basic skills of theatre production including acting, stage movement, and basic stage design.

f. Argumentation/debate.

(1) Understands concepts and principles of classical and contemporary rhetoric and is able to plan, prepare, organize, deliver and evaluate speeches and presentations.

(2) Understands argumentation and debate and how to provide students with opportunities to apply skills and strategies for argumentation and debate in a variety of formats and contexts.

g. Journalism.

(1) Understands ethical standards and major legal issues including First Amendment rights and responsibilities relevant to varied communication content. Utilizes strategies to teach students about the importance of freedom of speech in a democratic society and the rights and responsibilities of communicators.

(2) Understands the writing process as it relates to journalism (e.g., brainstorming, questioning, reporting, gathering and synthesizing information, writing, editing, and evaluating the final media product).

(3) Understands a variety of forms of journalistic writing (e.g., news, sports, features, opinion, Web-based) and the appropriate styles (e.g., Associated Press, multiple sources with attribution, punctuation) and additional forms unique to journalism (e.g., headlines, cutlines, and/or visual presentations).

h. Mass media production.

(1) Understands the role of the media in a democracy and the importance of preserving that role.

(2) Understands how to interpret and analyze various types of mass media messages in order for students to become critical consumers.

(3) Develops the technological skills needed to package media products effectively using various forms of journalistic design with a range of visual and auditory methods.

i. Reading strategies (if not completed as part of the professional education core requirements).

(1) Uses a variety of skills and strategies to comprehend and interpret complex fiction, nonfiction and informational text.

(2) Reads for a variety of purposes and across content areas.

13.28(7) *Foreign language.* K-8 and 5-12. Completion of 24 semester hours in each foreign language for which endorsement is sought.

13.28(8) *Health.* K-8 and 5-12. Completion of 24 semester hours in health to include coursework in public or community health, personal wellness, substance abuse, family life education, mental/emotional health, and human nutrition. A current certificate of CPR training is required in addition to the coursework requirements.

For holders of physical education or family and consumer science endorsements, completion of 18 credit hours in health to include coursework in public or community health, personal wellness, substance abuse, family life education, mental/emotional health, and human nutrition. A current certificate of CPR training is required in addition to the coursework requirements.

13.28(9) *Family and consumer sciences—general.* 5-12. Completion of 24 semester hours in family and consumer sciences to include coursework in lifespan development, parenting and child development education, family studies, consumer resource management, textiles or apparel design and merchandising, housing, foods and nutrition, and foundations of career and technical education as related to family and consumer sciences.

13.28(10) *Industrial technology.* 5-12. Completion of 24 semester hours in industrial technology to include coursework in manufacturing, construction, energy and power, graphic communications and transportation. The coursework is to include at least 6 semester hours in three different areas.

13.28(11) *Journalism.* 5-12. Completion of 15 semester hours in journalism to include coursework in writing, editing, production and visual communications.

13.28(12) *Mathematics.*

a. K-8. Completion of 24 semester hours in mathematics to include coursework in algebra, geometry, number theory, measurement, computer programming, and probability and statistics.

b. 5-12.

(1) Completion of 24 semester hours in mathematics to include a linear algebra or an abstract (modern) algebra course, a geometry course, a two-course sequence in calculus, a computer programming course, a probability and statistics course, and coursework in discrete mathematics.

(2) For holders of the physics 5-12 endorsement, completion of 17 semester hours in mathematics to include a geometry course, a two-course sequence in calculus, a probability and statistics course, and coursework in discrete mathematics.

(3) For holders of the all science 9-12 endorsement, completion of 17 semester hours in mathematics to include a geometry course, a two-course sequence in calculus, a probability and statistics course, and coursework in discrete mathematics.

c. 5-8 algebra for high school credit. For a 5-8 algebra for high school credit endorsement, hold either the K-8 mathematics or middle school mathematics endorsement and complete a college algebra or linear algebra class. This endorsement allows the holder to teach algebra to grades 5-8 for high school credit.

13.28(13) *Music.*

a. K-8. Completion of 24 semester hours in music to include coursework in music theory (at least two courses), music history, and applied music, and a methods course in each of the following: general, choral, and instrumental music.

b. 5-12. Completion of 24 semester hours in music to include coursework in music theory (at least two courses), music history (at least two courses), applied music, and conducting, and a methods course in each of the following: general, choral, and instrumental music.

13.28(14) *Physical education.*

a. K-8. Completion of 24 semester hours in physical education to include coursework in human anatomy, human physiology, movement education, adaptive physical education, personal wellness, human growth and development of children related to physical education, and first aid and emergency care. A current certificate of CPR training is required in addition to the coursework requirements.

b. 5-12. Completion of 24 semester hours in physical education to include coursework in human anatomy, kinesiology, human physiology, human growth and development related to maturational and motor learning, adaptive physical education, curriculum and administration of physical education, personal wellness, and first aid and emergency care. A current certificate of CPR training is required in addition to the coursework requirements.

13.28(15) *Reading.*

a. K-8 requirements. Completion of 24 semester hours in reading to include all of the following requirements:

(1) Foundations of reading. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of the psychological, sociocultural, and linguistic foundations of reading and writing processes and instruction.

2. The practitioner demonstrates knowledge of a range of research pertaining to reading, writing, and learning, including scientifically based reading research, and knowledge of histories of reading. The range of research encompasses research traditions from the fields of the social sciences and other paradigms appropriate for informing practice.

3. The practitioner demonstrates knowledge of the major components of reading, such as phonemic awareness, word identification, phonics, vocabulary, fluency, and comprehension, and effectively integrates curricular standards with student interests, motivation, and background knowledge.

(2) Reading in the content areas. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of text structure and the dimensions of content area vocabulary and comprehension, including literal, interpretive, critical, and evaluative.

2. The practitioner provides content area instruction in reading and writing that effectively uses a variety of research-based strategies and practices.

(3) Practicum. This requirement includes the following competencies:

1. The practitioner works with licensed professionals who observe, evaluate, and provide feedback on the practitioner's knowledge, dispositions, and performance of the teaching of reading and writing.

2. The practitioner effectively uses reading and writing strategies, materials, and assessments based upon appropriate reading and writing research and works with colleagues and families in the support of children's reading and writing development.

(4) Language development. This requirement includes the following competency: The practitioner uses knowledge of language development and acquisition of reading skills (birth through sixth grade), and the variations related to cultural and linguistic diversity to provide effective instruction in reading and writing.

(5) Oral communication. This requirement includes the following competencies:

1. The practitioner has knowledge of the unique needs and backgrounds of students with language differences and delays.

2. The practitioner uses effective strategies for facilitating the learning of Standard English by all learners.

(6) Written communication. This requirement includes the following competency: The practitioner uses knowledge of reading-writing-speaking connections; the writing process; the stages of spelling development; the different types of writing, such as narrative, expressive, persuasive, informational and descriptive; and the connections between oral and written language development to effectively teach writing as communication.

(7) Reading assessment, diagnosis and evaluation. This requirement includes the following competencies:

1. The practitioner uses knowledge of a variety of instruments, procedures, and practices that range from individual to group and from formal to informal to alternative for the identification of students' reading proficiencies and needs, for planning and revising instruction for all students, and for communicating the results of ongoing assessments to all stakeholders.

2. The practitioner demonstrates awareness of policies and procedures related to special programs, including Title I.

(8) Children's nonfiction and fiction. This requirement includes the following competency: The practitioner uses knowledge of children's literature for:

1. Modeling the reading and writing of varied genres, including fiction and nonfiction; technology- and media-based information; and nonprint materials;

2. Motivating through the use of texts at multiple levels, representing broad interests, and reflecting varied cultures, linguistic backgrounds, and perspectives; and

3. Matching text complexities to the proficiencies and needs of readers.

(9) Reading instructional strategies. This requirement includes the following competency: The practitioner uses knowledge of a range of research-based strategies and instructional technology for designing and delivering effective instruction across the curriculum, for grouping students, and for selecting materials appropriate for learners at various stages of reading and writing development and from varied cultural and linguistic backgrounds.

b. 5-12 requirements. Completion of 24 semester hours in reading to include all of the following requirements:

(1) Foundations of reading. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of the psychological, sociocultural, and linguistic foundations of reading and writing processes and instruction.

2. The practitioner demonstrates knowledge of a range of research pertaining to reading, writing, and learning, including scientifically based reading research, and knowledge of histories of reading. The range of research encompasses research traditions from the fields of the social sciences and other paradigms appropriate for informing practice.

3. The practitioner demonstrates knowledge of the major components of reading such as phonemic awareness, word identification, phonics, vocabulary, fluency, and comprehension, and integrates curricular standards with student interests, motivation, and background knowledge.

(2) Reading in the content areas. This requirement includes the following competencies:

1. The practitioner demonstrates knowledge of text structure and the dimensions of content area vocabulary and comprehension, including literal, interpretive, critical, and evaluative.

2. The practitioner provides content area instruction in reading and writing that effectively uses a variety of research-based strategies and practices.

(3) Practicum. This requirement includes the following competencies:

1. The practitioner works with licensed professionals who observe, evaluate, and provide feedback on the practitioner's knowledge, dispositions, and performance of the teaching of reading and writing.

2. The practitioner effectively uses reading and writing strategies, materials, and assessments based upon appropriate reading and writing research, and works with colleagues and families in the support of students' reading and writing development.

(4) Language development. This requirement includes the following competency: The practitioner uses knowledge of the relationship of language acquisition and language development with the acquisition and development of reading skills, and the variations related to cultural and linguistic diversity to provide effective instruction in reading and writing.

(5) Oral communication. This requirement includes the following competency: The practitioner demonstrates knowledge of the unique needs and backgrounds of students with language differences and uses effective strategies for facilitating the learning of Standard English by all learners.

(6) Written communication. This requirement includes the following competency: The practitioner uses knowledge of reading-writing-speaking connections to teach the skills and processes necessary for writing narrative, expressive, persuasive, informational, and descriptive texts, including text structures and mechanics such as grammar, usage, and spelling.

(7) Reading assessment, diagnosis and evaluation. This requirement includes the following competencies:

1. The practitioner uses knowledge of a variety of instruments, procedures, and practices that range from individual to group and from formal to informal to alternative for the identification of students' reading proficiencies and needs, for planning and revising instruction for all students, and for communicating the results of ongoing assessments to all stakeholders.

2. The practitioner demonstrates awareness of policies and procedures related to special programs.

(8) Adolescent or young adult nonfiction and fiction. This requirement includes the following competency: The practitioner uses knowledge of adolescent or young adult literature for:

1. Modeling the reading and writing of varied genres, including fiction and nonfiction; technology and media-based information; and nonprint materials;

2. Motivating through the use of texts at multiple levels, representing broad interests, and reflecting varied cultures, linguistic backgrounds and perspectives; and

3. Matching text complexities to the proficiencies and needs of readers.

(9) Reading instructional strategies. This requirement includes the following competency: The practitioner uses knowledge of a range of research-based strategies and instructional technology for designing and delivering instruction across the curriculum, for grouping students, and for selecting materials appropriate for learners at various stages of reading and writing development and from varied cultural and linguistic backgrounds.

13.28(16) *Reading specialist.* K-12. The applicant must have met the requirements for the standard license and a teaching endorsement, and present evidence of at least one year of experience which included the teaching of reading as a significant part of the responsibility.

a. Authorization. The holder of this endorsement is authorized to serve as a reading specialist in kindergarten and grades one through twelve.

b. Program requirements. Degree—master's.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements. This sequence is to be at least 27 semester hours to include the following:

(1) Educational psychology/human growth and development.

(2) Educational measurement and evaluation.

(3) Foundations of reading.

(4) Diagnosis of reading problems.

(5) Remedial reading.

(6) Psychology of reading.

(7) Language learning and reading disabilities.

(8) Practicum in reading.

(9) Administration and supervision of reading programs at the elementary and secondary levels.

13.28(17) *Science.*

a. Science—basic. K-8.

(1) Required coursework. Completion of at least 24 semester hours in science to include 12 hours in physical sciences, 6 hours in biology, and 6 hours in earth/space sciences.

(2) Pedagogy competencies.

1. Understand the nature of scientific inquiry, its central role in science, and how to use the skills and processes of scientific inquiry.

2. Understand the fundamental facts and concepts in major science disciplines.

3. Be able to make conceptual connections within and across science disciplines, as well as to mathematics, technology, and other school subjects.

4. Be able to use scientific understanding when dealing with personal and societal issues.

b. Biological science. 5-12. Completion of 24 semester hours in biological science or 30 semester hours in the broad area of science to include 15 semester hours in biological science.

c. Chemistry. 5-12. Completion of 24 semester hours in chemistry or 30 semester hours in the broad area of science to include 15 semester hours in chemistry.

d. Earth science. 5-12. Completion of 24 semester hours in earth science or 30 semester hours in the broad area of science to include 15 semester hours in earth science.

e. Basic science. 5-12. Completion of 24 semester hours of credit in science to include the following:

(1) Six semester hours of credit in earth and space science to include the following essential concepts and skills:

1. Understand and apply knowledge of energy in the earth system.

2. Understand and apply knowledge of geochemical cycles.

(2) Six semester hours of credit in life science/biological science to include the following essential concepts and skills:

1. Understand and apply knowledge of the cell.

2. Understand and apply knowledge of the molecular basis of heredity.

3. Understand and apply knowledge of the interdependence of organisms.

4. Understand and apply knowledge of matter, energy, and organization in living systems.

5. Understand and apply knowledge of the behavior of organisms.

(3) Six semester hours of credit in physics/physical science to include the following essential concepts and skills:

1. Understand and apply knowledge of the structure of atoms.

2. Understand and apply knowledge of the structure and properties of matter.

3. Understand and apply knowledge of motions and forces.

4. Understand and apply knowledge of interactions of energy and matter.

(4) Six semester hours of credit in chemistry to include the following essential concepts and skills:

1. Understand and apply knowledge of chemical reactions.

2. Be able to design and conduct scientific investigations.

f. Physical science. Rescinded IAB 11/14/12, effective 12/19/12.

g. Physics.

(1) 5-12. Completion of 24 semester hours in physics or 30 semester hours in the broad area of science to include 15 semester hours in physics.

(2) For holders of the mathematics 5-12 endorsement, completion of:

1. 12 credits of physics to include coursework in mechanics, electricity, and magnetism; and

2. A methods class that includes inquiry-based instruction, resource management, and laboratory safety.

(3) For holders of the chemistry 5-12 endorsement, completion of 12 credits of physics to include coursework in mechanics, electricity, and magnetism.

h. All science I. Rescinded IAB 11/14/12, effective 12/19/12.

i. All science. 5-12.

(1) Completion of 36 semester hours of credit in science to include the following:

1. Nine semester hours of credit in earth and space science to include the following essential concepts and skills:

- Understand and apply knowledge of energy in the earth system.
- Understand and apply knowledge of geochemical cycles.
- Understand and apply knowledge of the origin and evolution of the earth system.
- Understand and apply knowledge of the origin and evolution of the universe.

2. Nine semester hours of credit in life science/biological science to include the following essential concepts and skills:

- Understand and apply knowledge of the cell.
- Understand and apply knowledge of the molecular basis of heredity.
- Understand and apply knowledge of the interdependence of organisms.
- Understand and apply knowledge of matter, energy, and organization in living systems.
- Understand and apply knowledge of the behavior of organisms.
- Understand and apply knowledge of biological evolution.

3. Nine semester hours of credit in physics/physical science to include the following essential concepts and skills:

- Understand and apply knowledge of the structure of atoms.
- Understand and apply knowledge of the structure and properties of matter.
- Understand and apply knowledge of motions and forces.
- Understand and apply knowledge of interactions of energy and matter.
- Understand and apply knowledge of conservation of energy and increase in disorder.

4. Nine semester hours of credit in chemistry to include the following essential concepts and skills:

- Understand and apply knowledge of chemical reactions.
- Be able to design and conduct scientific investigations.

(2) Pedagogy competencies.

1. Understand the nature of scientific inquiry, its central role in science, and how to use the skills and processes of scientific inquiry.

2. Understand the fundamental facts and concepts in major science disciplines.

3. Be able to make conceptual connections within and across science disciplines, as well as to mathematics, technology, and other school subjects.

4. Be able to use scientific understanding when dealing with personal and societal issues.

13.28(18) *Social sciences.*

a. American government. 5-12. Completion of 24 semester hours in American government or 30 semester hours in the broad area of social sciences to include 15 semester hours in American government.

b. American history. 5-12. Completion of 24 semester hours in American history or 30 semester hours in the broad area of social sciences to include 15 semester hours in American history.

c. Anthropology. 5-12. Completion of 24 semester hours in anthropology or 30 semester hours in the broad area of social sciences to include 15 semester hours in anthropology.

d. Economics. 5-12. Completion of 24 semester hours in economics or 30 semester hours in the broad area of social sciences to include 15 semester hours in economics, or 30 semester hours in the broad area of business to include 15 semester hours in economics.

e. Geography. 5-12. Completion of 24 semester hours in geography or 30 semester hours in the broad area of social sciences to include 15 semester hours in geography.

f. History. K-8. Completion of 24 semester hours in history to include at least 9 semester hours in American history and 9 semester hours in world history.

g. Psychology. 5-12. Completion of 24 semester hours in psychology or 30 semester hours in the broad area of social sciences to include 15 semester hours in psychology.

h. Social studies. K-8. Completion of 24 semester hours in social studies, to include coursework from at least three of these areas: history, sociology, economics, American government, psychology and geography.

i. Sociology. 5-12. Completion of 24 semester hours in sociology or 30 semester hours in the broad area of social sciences to include 15 semester hours in sociology.

j. World history. 5-12. Completion of 24 semester hours in world history or 30 semester hours in the broad area of social sciences to include 15 semester hours in world history.

k. All social sciences. 5-12. Completion of 51 semester hours in the social sciences to include 9 semester hours in each of American and world history, 9 semester hours in government, 6 semester hours in sociology, 6 semester hours in psychology other than educational psychology, 6 semester hours in geography, and 6 semester hours in economics.

13.28(19) *Speech communication/theatre.*

a. K-8. Completion of 20 semester hours in speech communication/theatre to include coursework in speech communication, creative drama or theatre, and oral interpretation.

b. 5-12. Completion of 24 semester hours in speech communication/theatre to include coursework in speech communication, oral interpretation, creative drama or theatre, argumentation and debate, and mass media communication.

13.28(20) *English as a second language (ESL).* K-12.

a. Authorization. The holder of this endorsement is authorized to teach English as a second language in kindergarten and grades one through twelve.

b. Content. Completion of 18 semester hours of coursework in English as a second language to include the following:

(1) Knowledge of pedagogy to include the following:

1. Methods and curriculum to include the following:

- Bilingual and ESL methods.
- Literacy in native and second language.
- Methods for subject matter content.
- Adaptation and modification of curriculum.

2. Assessment to include language proficiency and academic content.

(2) Knowledge of linguistics to include the following:

1. Psycholinguistics and sociolinguistics.
2. Language acquisition and proficiency to include the following:

- Knowledge of first and second language proficiency.
- Knowledge of first and second language acquisition.
- Language to include structure and grammar of English.

(3) Knowledge of cultural and linguistic diversity to include the following:

1. History.
2. Theory, models, and research.
3. Policy and legislation.

(4) Current issues with transient populations.

13.28(21) *Elementary school teacher librarian.*

a. Authorization. The holder of this endorsement is authorized to serve as a teacher librarian in prekindergarten through grade eight.

b. Content. Completion of 24 semester hours in school library coursework to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy in children.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading among children, based on familiarity with selection tools and current trends in literature for children.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

(3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the elementary level.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the elementary level.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the elementary level.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula at the elementary level.

13.28(22) *Secondary school teacher librarian.*

a. Authorization. The holder of this endorsement is authorized to serve as a teacher librarian in grades five through twelve.

b. Content. Completion of 24 semester hours in school library coursework to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy in young adults.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading among young adults, based on familiarity with selection tools and current trends in literature for young adults.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

(3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the secondary level.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the secondary level.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the secondary level.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula at the secondary level.

13.28(23) *School teacher librarian.* PK-12.

a. Authorization. The holder of this endorsement is authorized to serve as a teacher librarian in prekindergarten through grade twelve. The applicant must be the holder of or eligible for the initial license.

b. Program requirements. Degree—master's.

c. Content. Completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements. This sequence is to be at least 30 semester hours in school library coursework, to include the following:

(1) Literacy and reading. This requirement includes the following competencies:

1. Practitioners collaborate with other teachers to integrate developmentally appropriate literature in multiple formats to support literacy for youth of all ages.

2. Practitioners demonstrate knowledge of resources and strategies to foster leisure reading and model personal enjoyment of reading, based on familiarity with selection tools and current trends in literature for youth of all ages.

3. Practitioners understand how to develop a collection of reading and informational materials in print and digital formats that supports the diverse developmental, cultural, social and linguistic needs of all learners and their communities.

4. Practitioners model and teach reading comprehension strategies to create meaning from text for youth of all ages.

(2) Information and knowledge. This requirement includes the following competencies:

1. Practitioners teach multiple strategies to locate, analyze, evaluate, and ethically use information in the context of inquiry-based learning.

2. Practitioners advocate for flexible and open access to library resources, both physical and virtual.

3. Practitioners uphold and promote the legal and ethical codes of their profession, including privacy, confidentiality, freedom and equity of access to information.

4. Practitioners use skills and knowledge to assess reference sources, services, and tools in order to mediate between information needs and resources to assist learners in determining what they need.

5. Practitioners model and facilitate authentic learning with current and emerging digital tools for locating, analyzing, evaluating and ethically using information resources to support research, learning, creating, and communicating in a digital society.

6. Practitioners demonstrate knowledge of creative and innovative uses of technologies to engage students and facilitate higher-level thinking.

7. Practitioners develop an articulated information literacy curriculum grounded in research related to the information search process.

8. Practitioners understand the process of collecting, interpreting, and using data to develop new knowledge to improve the school library program.

9. Practitioners employ the methods of research in library and information science.

(3) Program administration and leadership. This requirement includes the following competencies:

1. Practitioners evaluate and select print, nonprint, and digital resources using professional selection tools and evaluation criteria to develop and manage a quality collection designed to meet the diverse curricular, personal, and professional needs of the educational community.

2. Practitioners demonstrate knowledge necessary to organize the library collections according to current standard library cataloging and classification principles.

3. Practitioners develop policies and procedures to support ethical use of information, intellectual freedom, selection and reconsideration of library materials, and the privacy of users of all ages.

4. Practitioners develop strategies for working with regular classroom teachers, support services personnel, paraprofessionals, and other individuals involved in the educational program.

5. Practitioners demonstrate knowledge of best practices related to planning, budgeting (including alternative funding), organizing, and evaluating human and information resources and facilities to ensure equitable access.

6. Practitioners understand strategic planning to ensure that the school library program addresses the needs of diverse communities.

7. Practitioners advocate for school library and information programs, resources, and services among stakeholders.

8. Practitioners promote initiatives and partnerships to further the mission and goals of the school library program.

(4) Practicum. This requirement includes the following competencies:

1. Practitioners apply knowledge of learning styles, stages of human growth and development, and cultural influences of learning at the elementary and secondary levels.

2. Practitioners implement the principles of effective teaching and learning that contribute to an active, inquiry-based approach to learning in a digital environment at the elementary and secondary levels.

3. Practitioners understand the teacher librarian role in curriculum development and the school improvement process at the elementary and secondary levels.

4. Practitioners collaborate to integrate information literacy and emerging technologies into content area curricula.

13.28(24) *Talented and gifted teacher.*

a. Authorization. The holder of this endorsement is authorized to serve as a teacher or a coordinator of programs for the talented and gifted from the prekindergarten level through grade twelve. This authorization does not permit general classroom teaching at any level except that level or area for which the holder is eligible or holds the specific endorsement.

b. Program requirements—content. Completion of 12 undergraduate or graduate semester hours of coursework in the area of the talented and gifted to include the following:

(1) Psychology of the gifted.

1. Social needs.

2. Emotional needs.

(2) Programming for the gifted.

1. Prekindergarten-12 identification.

2. Differentiation strategies.

3. Collaborative teaching skills.

4. Program goals and performance measures.

5. Program evaluation.

(3) Practicum experience in gifted programs.

NOTE: Teachers in specific subject areas will not be required to hold this endorsement if they teach gifted students in their respective endorsement areas.

13.28(25) *American Sign Language endorsement.*

a. Authorization. The holder of this endorsement is authorized to teach American Sign Language in kindergarten and grades one through twelve.

b. Content. Completion of 18 semester hours of coursework in American Sign Language to include the following:

(1) Second language acquisition.

(2) Sociology of the deaf community.

(3) Linguistic structure of American Sign Language.

(4) Language teaching methodology specific to American Sign Language.

(5) Teaching the culture of deaf people.

(6) Assessment of students in an American Sign Language program.

c. Other. Be the holder of or be eligible for one other teaching endorsement.

13.28(26) *Elementary professional school counselor.*

a. Authorization. The holder of this endorsement is authorized to serve as a professional school counselor in kindergarten and grades one through eight.

b. Program requirements. Master's degree from an accredited institution of higher education.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include the following:

(1) Nature and needs of individuals at all developmental levels.

1. Develop strategies for facilitating development through the transition from childhood to adolescence and from adolescence to young adulthood.

2. Apply knowledge of learning and personality development to assist students in developing their full potential.

(2) Social and cultural foundations.

1. Demonstrate awareness of and sensitivity to the unique social, cultural, and economic circumstances of students and their racial/ethnic, gender, age, physical, and learning differences.

2. Demonstrate sensitivity to the nature and the functioning of the student within the family, school and community contexts.

3. Demonstrate the counseling and consultation skills needed to facilitate informed and appropriate action in response to the needs of students.

(3) Fostering of relationships.

1. Employ effective counseling and consultation skills with students, parents, colleagues, administrators, and others.

2. Communicate effectively with parents, colleagues, students and administrators.

3. Counsel students in the areas of personal, social, academic, and career development.

4. Assist families in helping their children address the personal, social, and emotional concerns and problems that may impede educational progress.

5. Implement developmentally appropriate counseling interventions with children and adolescents.

6. Demonstrate the ability to negotiate and move individuals and groups toward consensus or conflict resolution or both.

7. Refer students for specialized help when appropriate.

8. Value the well-being of the students as paramount in the counseling relationship.

(4) Group work.

1. Implement developmentally appropriate interventions involving group dynamics, counseling theories, group counseling methods and skills, and other group work approaches.

2. Apply knowledge of group counseling in implementing appropriate group processes for elementary, middle school, and secondary students.

(5) Career development, education, and postsecondary planning.

1. Assist students in the assessment of their individual strengths, weaknesses, and differences, including those that relate to academic achievement and future plans.

2. Apply knowledge of career assessment and career choice programs.

3. Implement occupational and educational placement, follow-up and evaluation.

4. Develop a counseling network and provide resources for use by students in personalizing the exploration of postsecondary educational opportunities.

(6) Assessment and evaluation.

1. Demonstrate individual and group approaches to assessment and evaluation.

2. Demonstrate an understanding of the proper administration and uses of standardized tests.

3. Apply knowledge of test administration, scoring, and measurement concerns.

4. Apply evaluation procedures for monitoring student achievement.

5. Apply assessment information in program design and program modifications to address students' needs.

6. Apply knowledge of legal and ethical issues related to assessment and student records.

(7) Professional orientation.

1. Apply knowledge of history, roles, organizational structures, ethics, standards, and credentialing.

2. Maintain a high level of professional knowledge and skills.

3. Apply knowledge of professional and ethical standards to the practice of school counseling.

4. Articulate the professional school counselor role to school personnel, parents, community, and students.

(8) School counseling skills.

1. Design, implement, and evaluate a comprehensive, developmental school counseling program.

2. Implement and evaluate specific strategies designed to meet program goals and objectives.

3. Consult and coordinate efforts with resource persons, specialists, businesses, and agencies outside the school to promote program objectives.

4. Provide information appropriate to the particular educational transition and assist students in understanding the relationship that their curricular experiences and academic achievements will have on subsequent educational opportunities.

5. Assist parents and families in order to provide a supportive environment in which students can become effective learners and achieve success in pursuit of appropriate educational goals.

6. Provide training, orientation, and consultation assistance to faculty, administrators, staff, and school officials to assist them in responding to the social, emotional, and educational development of all students.

7. Collaborate with teachers, administrators, and other educators in ensuring that appropriate educational experiences are provided that allow all students to achieve success.

8. Assist in the process of identifying and addressing the needs of the exceptional student.

9. Apply knowledge of legal and ethical issues related to child abuse and mandatory reporting.

10. Advocate for the educational needs of students and work to ensure that these needs are addressed at every level of the school experience.

11. Promote use of school counseling and educational and career planning activities and programs involving the total school community to provide a positive school climate.

(9) Classroom management.

1. Apply effective classroom management strategies as demonstrated in delivery of classroom and large group school counseling curriculum.

2. Consult with teachers and parents about effective classroom management and behavior management strategies.

(10) Curriculum.

1. Write classroom lessons including objectives, learning activities, and discussion questions.

2. Utilize various methods of evaluating what students have learned in classroom lessons.

3. Demonstrate competency in conducting classroom and other large group activities, utilizing an effective lesson plan design, engaging students in the learning process, and employing age-appropriate classroom management strategies.

4. Design a classroom unit of developmentally appropriate learning experiences.

5. Demonstrate knowledge in writing standards and benchmarks for curriculum.

(11) Learning theory.

1. Identify and consult with teachers about how to create a positive learning environment utilizing such factors as effective classroom management strategies, building a sense of community in the classroom, and cooperative learning experiences.

2. Identify and consult with teachers regarding teaching strategies designed to motivate students using small group learning activities, experiential learning activities, student mentoring programs, and shared decision-making opportunities.

3. Demonstrate knowledge of child and adolescent development and identify developmentally appropriate teaching and learning strategies.

(12) Teaching and counseling practicum. The candidate will complete a preservice supervised practicum of a minimum of 100 hours, and at least 40 of these hours must be direct service. Candidates will complete a supervised internship for a minimum of 600 hours, and at least 240 of these hours must be direct service. For candidates seeking both the K-8 and 5-12 professional school counselor endorsements, a minimum of 100 hours of the practicum or internship experiences listed above must be completed at each of the desired endorsement levels.

13.28(27) *Secondary professional school counselor.*

a. Authorization. The holder of this endorsement is authorized to serve as a professional school counselor in grades five through twelve.

b. Program requirements. Master's degree from an accredited institution of higher education.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

(1) The competencies listed in subparagraphs 13.28(26)*"c"*(1) to (11).

(2) The teaching and counseling practicum. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 13.28(26)*"c"*(12).

13.28(28) *School nurse endorsement.* The school nurse endorsement does not authorize general classroom teaching, although it does authorize the holder to teach health at all grade levels. Alternatively, a nurse may obtain a statement of professional recognition (SPR) from the board of educational examiners, in accordance with the provisions set out in 282—Chapter 16, Statements of Professional Recognition (SPR).

a. Authorization. The holder of this endorsement is authorized to provide service as a school nurse at the prekindergarten and kindergarten levels and in grades one through twelve.

b. Content.

(1) Organization and administration of school nurse services including the appraisal of the health needs of children and youth.

(2) School-community relationships and resources/coordination of school and community resources to serve the health needs of children and youth.

(3) Knowledge and understanding of the health needs of exceptional children.

(4) Health education.

c. Other. Hold a license as a registered nurse issued by the Iowa board of nursing.

13.28(29) *Athletic coach.* K-12. An applicant for the coaching endorsement must hold a teacher's license with one of the teaching endorsements.

a. Authorization. The holder of this endorsement may serve as a head coach or an assistant coach in kindergarten and grades one through twelve.

b. Program requirements.

(1) One semester hour college or university course in the structure and function of the human body in relation to physical activity, and

(2) One semester hour college or university course in human growth and development of children and youth as related to physical activity, and

(3) Two semester hour college or university course in athletic conditioning, care and prevention of injuries and first aid as related to physical activity, and

(4) One semester hour college or university course in the theory of coaching interscholastic athletics, and

(5) Successful completion of the concussion training approved by the Iowa High School Athletic Association or Iowa Girls High School Athletic Union.

13.28(30) *Content specialist endorsement.* The applicant must have met the requirements for the standard license and a teaching endorsement.

a. Authorization. The holder of this endorsement is authorized to serve as a content specialist in kindergarten and grades one through twelve in the specific content listed on the authorization.

b. Requirements.

(1) Hold a master's degree in the content area or complete 30 semester hours of college course work in the content area.

(2) Complete 15 semester hours of credit in professional development in three or more of the following areas:

1. Using research-based content teaching strategies;
2. Integrating appropriate technology into the learning experiences for the specific content;
3. Engaging the learner in the content through knowledge of learner needs and interests;
4. Using reflective thinking to solve problems in the content area;
5. Making data-driven decisions in the content area;
6. Utilizing project-based learning in the content area;
7. Developing critical thinking skills in the content area;
8. Forming partnerships to collaborate with content experts within the community;
9. Relating content with other content areas;
10. Facilitating content learning in large and small teams;
11. Implementing response to intervention (RTI) to close achievement gaps in the content area.

(3) Complete an internship, externship, or professional experience for a minimum of 90 contact hours in the content area.

13.28(31) *Engineering.* 5-12.

a. Completion of 24 semester hours in engineering coursework.

b. Methods and strategies of STEM instruction or methods of teaching science or mathematics.

13.28(32) *STEM.*

a. K-8.

(1) Authorization. The holder of this endorsement is authorized to teach science, mathematics, and integrated STEM courses in kindergarten through grade eight.

(2) Program requirements. Be the holder of the teacher—elementary classroom endorsement.

(3) Content.

1. Completion of a minimum of 12 semester hours of college-level science.
2. Completion of a minimum of 12 semester hours of college-level math (or the completion of Calculus I) to include coursework in computer programming.
3. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:

- Engineering and technological design courses for education majors;
- Technology or engineering content coursework.

4. Completion of a minimum of 6 semester hours of required coursework in STEM curriculum and methods to include the following essential concepts and skills:

- Comparing and contrasting the nature and goals of each of the STEM disciplines;
- Promoting learning through purposeful, authentic, real-world connections;
- Integration of content and context of each of the STEM disciplines;
- Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
- Curriculum and standards mapping;
- Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;
- Assessment of integrative learning approaches;
- Information literacy skills in STEM;
- Processes of science and scientific inquiry;
- Mathematical problem-solving models;
- Communicating to a variety of audiences;
- Classroom management in project-based classrooms;
- Instructional strategies for the inclusive classroom;
- Computational thinking;
- Mathematical and technological modeling.

5. Completion of a STEM field experience of a minimum of 30 contact hours that may be met through the following:

- Completing a STEM research experience;
- Participating in a STEM internship at a STEM business or informal education organization; or
- Leading a STEM extracurricular activity.

b. 5-8.

(1) Authorization. The holder of this endorsement is authorized to teach science, mathematics, and integrated STEM courses in grades five through eight.

(2) Program requirements. Be the holder of a 5-12 science, mathematics, or industrial technology endorsement or 5-8 middle school mathematics or science endorsement.

(3) Content.

1. Completion of a minimum of 12 semester hours of college-level science.

2. Completion of a minimum of 12 semester hours of college-level math (or the completion of Calculus I) to include coursework in computer programming.

3. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:

- Engineering and technological design courses for education majors;
- Technology or engineering content coursework.

4. Completion of a minimum of 6 semester hours of required coursework in STEM curriculum and methods to include the following essential concepts and skills:

- Comparing and contrasting the nature and goals of each of the STEM disciplines;
- Promoting learning through purposeful, authentic, real-world connections;
- Integration of content and context of each of the STEM disciplines;
- Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
- Curriculum and standards mapping;
- Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;
- Assessment of integrative learning approaches;
- Information literacy skills in STEM;

- Processes of science and scientific inquiry;
- Mathematical problem-solving models;
- Communicating to a variety of audiences;
- Classroom management in project-based classrooms;
- Instructional strategies for the inclusive classroom;
- Computational thinking;
- Mathematical and technological modeling.

5. Completion of a STEM field experience of a minimum of 30 contact hours that may be met through the following:

- Completing a STEM research experience;
- Participating in a STEM internship at a STEM business or informal education organization; or
- Leading a STEM extracurricular activity.

c. Specialist K-12.

(1) Authorization. The holder of this endorsement is authorized to serve as a STEM specialist in kindergarten and grades one through twelve.

(2) Program requirements.

1. The applicant must have met the requirements for a standard Iowa teaching license and a teaching endorsement in mathematics, science, engineering, industrial technology, or agriculture.

2. The applicant must hold a master's degree from a regionally accredited institution. The master's degree must be in math, science, engineering or technology or another area with at least 12 hours of college-level science and at least 12 hours of college-level math (or completion of Calculus I) to include coursework in computer programming.

(3) Content.

1. Completion of a minimum of 3 semester hours of coursework in content or pedagogy of engineering and technological design that includes engineering design processes or programming logic and problem-solving models and that may be met through either of the following:

- Engineering and technological design courses for education majors;
- Technology or engineering content coursework.

2. Completion of 9 semester hours in professional development to include the following essential concepts and skills:

- STEM curriculum and methods:

- Comparing and contrasting the nature and goals of each of the STEM disciplines;
- Promoting learning through purposeful, authentic, real-world connections;
- Integration of content and context of each of the STEM disciplines;
- Interdisciplinary/transdisciplinary approaches to teaching (including but not limited to problem-based learning and project-based learning);
- Curriculum/standards mapping;
- Assessment of integrative learning approaches;
- Information literacy skills in STEM;
- Processes of science/scientific inquiry;
- Mathematical problem-solving models;
- Classroom management in project-based classrooms;
- Instructional strategies for the inclusive classroom;
- Computational thinking;
- Mathematical and technological modeling.

- STEM experiential learning:

- Engaging subject-matter experts (including but not limited to colleagues, parents, higher education faculty/students, business partners, and informal education agencies) in STEM experiences in and out of the classroom;
- STEM research experiences;
- STEM internship at a STEM business or informal education organization;
- STEM extracurricular activity;

- Communicating to a variety of audiences.

● Leadership in STEM:

- STEM curriculum development and assessment;
- Curriculum mapping;
- Assessment of student engagement;
- STEM across the curriculum;
- Research on best practices in STEM;
- STEM curriculum accessibility for all students.

3. Completion of an internship/externship professional experience or prior professional experience in STEM for a minimum of 90 contact hours.

13.28(33) *Multioccupations.* Completion of any 5-12 endorsement and, in addition thereto, coursework in foundations of career and technical education, coordination of cooperative programs, and competency-based curriculum development. Four thousand hours of career and technical experience in two or more occupations. The multioccupations endorsement also authorizes the holder to supervise students in cooperative programs, school-to-work programs, and similar programs in which the student is placed in school-sponsored, on-the-job situations.

[**ARC 7986B**, IAB 7/29/09, effective 9/2/09; **ARC 8248B**, IAB 11/4/09, effective 10/12/09; **ARC 8403B**, IAB 12/16/09, effective 1/20/10; **ARC 9070B**, IAB 9/8/10, effective 10/13/10; **ARC 9071B**, IAB 9/8/10, effective 10/13/10; **ARC 9210B**, IAB 11/3/10, effective 12/8/10; **ARC 9211B**, IAB 11/3/10, effective 12/8/10; **ARC 9212B**, IAB 11/3/10, effective 12/8/10; **ARC 9838B**, IAB 11/2/11, effective 12/7/11; **ARC 9839B**, IAB 11/2/11, effective 12/7/11; **ARC 0448C**, IAB 11/14/12, effective 12/19/12; **ARC 0449C**, IAB 11/14/12, effective 12/19/12; **ARC 0866C**, IAB 7/24/13, effective 8/28/13; **ARC 0875C**, IAB 7/24/13, effective 8/28/13; **ARC 0986C**, IAB 9/4/13, effective 10/9/13; **ARC 1085C**, IAB 10/16/13, effective 11/20/13; **ARC 1171C**, IAB 11/13/13, effective 12/18/13; **ARC 1328C**, IAB 2/19/14, effective 3/26/14; **ARC 1327C**, IAB 2/19/14, effective 3/26/14; **ARC 2015C**, IAB 6/10/15, effective 7/15/15; **ARC 2016C**, IAB 6/10/15, effective 7/15/15; **ARC 2397C**, IAB 2/17/16, effective 3/23/16]

282—13.29(272) Adding, removing or reinstating a teaching endorsement.

13.29(1) *Adding an endorsement.* After the issuance of a teaching license, an individual may add other endorsements to that license upon proper application, provided current requirements for that endorsement have been met. An updated license with expiration date unchanged from the original or renewed license will be prepared.

a. Options. To add an endorsement, the applicant must follow one of these options:

(1) Option 1. Receive the Iowa teacher education institution's recommendation that the current approved program requirements for the endorsement have been met.

(2) Option 2. Receive verification from the Iowa teacher education institution that the minimum state requirements for the endorsement have been met in lieu of the institution's approved program.

(3) Option 3. Apply for a review of the transcripts by the board of educational examiners' staff to determine if all Iowa requirements have been met. The applicant must submit documentation that all of the Iowa requirements have been met by filing transcripts and supporting documentation for review. The fee for the transcript evaluation is in 282—Chapter 12. This fee shall be in addition to the fee for adding the endorsement.

b. Additional requirements for adding an endorsement.

(1) In addition to meeting the requirements for Iowa licensure, applicants for endorsements shall have completed a methods class appropriate for teaching the general subject area of the endorsement added.

(2) Practitioners who are adding an elementary or early childhood endorsement and have not student taught on the elementary or early childhood level shall complete a teaching practicum appropriate for teaching at the level of the new endorsement.

(3) Practitioners who are adding a secondary teaching endorsement and have not student taught on the secondary level shall complete a teaching practicum appropriate for teaching at the level of the new endorsement.

(4) Practitioners holding the K-8 endorsement in the content area of the 5-12 endorsement being added may satisfy the requirement for the secondary methods class and the teaching practicum by completing all required coursework and presenting verification of competence. This verification of competence shall be signed by a licensed evaluator who has observed and formally evaluated the

performance of the applicant at the secondary level. This verification of competence may be submitted at any time during the term of the Class B license. The practitioner must obtain a Class B license while practicing with the 5-12 endorsement.

13.29(2) *Removal of an endorsement; reinstatement of removed endorsement.*

a. Removal of an endorsement. A practitioner may remove an endorsement from the practitioner's license as follows:

(1) To remove an endorsement, the practitioner shall meet the following conditions:

1. A practitioner who holds a standard or master educator license is eligible to request removal of an endorsement from the license if the practitioner has not taught in the subject or assignment area of the endorsement in the five years prior to the request for removal of the endorsement, and

2. The practitioner must submit a notarized written application form furnished by the board of educational examiners to remove an endorsement at the time of licensure renewal (licensure renewal is limited to one calendar year prior to the expiration date of the current license), and

3. The application must be signed by the superintendent or designee in the district in which the practitioner is under contract. The superintendent's signature shall serve as notification and acknowledgment of the practitioner's intent to remove an endorsement from the practitioner's license. The absence of the superintendent's or designee's signature does not impede the removal process.

(2) The endorsement shall be removed from the license at the time of application.

(3) If a practitioner is not employed and submits an application, the provisions of 13.29(2)*"a"*(1)"3" shall not be required.

(4) If a practitioner submits an application that does not meet the criteria listed in 13.29(2)*"a"*(1)"1" to "3," the application will be rendered void and the practitioner will forfeit the processing fee.

(5) The executive director has the authority to approve or deny the request for removal. Any denial is subject to the appeal process set forth in rule 282—11.35(272).

b. Reinstatement of a removed endorsement.

(1) If the practitioner wants to add the removed endorsement at a future date, all coursework for the endorsement must be completed within the five years preceding the application to add the endorsement.

(2) The practitioner must meet the current endorsement requirements when making application.

[**ARC 8248B**, IAB 11/4/09, effective 10/12/09; **ARC 2016C**, IAB 6/10/15, effective 7/15/15]

282—13.30(272) Licenses—issue dates, corrections, duplicates, and fraud.

13.30(1) *Issue date on original license.* A license is valid only from and after the date of issuance.

13.30(2) *Correcting licenses.* If a licensee notifies board staff of a typographical or clerical error on the license within 30 days of the date of the board's mailing of a license, a corrected license shall be issued without charge to the licensee. If notification of a typographical or clerical error is made more than 30 days after the date of the board's mailing of a license, a corrected license shall be issued upon receipt of the fee for issuance of a duplicate license. For purposes of this rule, typographical or clerical errors include misspellings, errors in the expiration date of a license, errors in the type of license issued, and the omission or misidentification of the endorsements for which application was made. A licensee requesting the addition of an endorsement not included on the initial application must submit a new application and the appropriate application fee.

13.30(3) *Duplicate licenses.* Upon application and payment of the fee set out in 282—Chapter 12, a duplicate license shall be issued.

13.30(4) *Fraud in procurement or renewal of licenses.* Fraud in procurement or renewal of a license or falsifying records for licensure purposes will constitute grounds for filing a complaint with the board of educational examiners.

These rules are intended to implement Iowa Code chapter 272 and 2014 Iowa Acts, chapter 1116, division VI.

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CHAPTER 27
ISSUANCE OF PROFESSIONAL SERVICE LICENSES

282—27.1(272) Professional service license. A professional service licensee is an individual prepared to provide professional services in Iowa schools but whose preparation has not required completion of the teacher preparation coursework set forth in rule 281—79.15(256). The professional service license may be issued in the following areas:

1. School counselor.
2. School psychologist.
3. Speech-language pathologist.
4. Supervisor of special education (support).
5. Director of special education of an area education agency.
6. School social worker.
7. School audiologist.

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282—27.2(272) Requirements for a professional service license.

27.2(1) *Initial professional service license.* An initial professional service license valid for two years may be issued to an applicant for licensure to serve as a school audiologist, school psychologist, school social worker, speech-language pathologist, supervisor of special education (support), director of special education of an area education agency, or school counselor who:

a. Has a master's degree in a recognized professional educational service area from a regionally accredited institution.

b. Has completed a state-approved program which meets the requirements for an endorsement in a professional educational service area.

c. Has completed the requirements for one of the professional educational service area endorsements.

d. Meets the recency requirement of 282—subparagraph 13.5(2)*"b"*(4).

e. Completes the background check requirements set forth in rule 282—13.1(272).

27.2(2) *Standard professional service license.* A standard professional service license valid for five years may be issued to an applicant who:

a. Completes requirements listed under 27.2(1)*"a"* to *"d."*

b. Shows evidence of successful completion of a state-approved mentoring and induction program by meeting the Iowa standards as determined by a comprehensive evaluation and two years' successful service experience in an Iowa public school. In lieu of completion of an Iowa state-approved mentoring and induction program, the applicant must provide evidence of three years' successful service area experience in an Iowa nonpublic school or three years' successful service area experience in an out-of-state K-12 educational setting.

c. Meets the recency requirement of 282—subparagraph 13.5(2)*"b"*(4).

27.2(3) *Renewal.* Renewal requirements for this license are set out in 282—Chapter 20.

[**ARC 7980B**, IAB 7/29/09, effective 9/2/09; **ARC 2016C**, IAB 6/10/15, effective 7/15/15; **ARC 2230C**, IAB 11/11/15, effective 12/16/15]

282—27.3(272) Specific requirements for professional service license endorsements.

27.3(1) *Elementary professional school counselor.*

a. Authorization. The holder of this endorsement has not completed the teacher preparation coursework set forth in rule 281—79.15(256) but is authorized to serve as a professional school counselor in kindergarten and grades one through eight.

b. Program requirements.

(1) Master's degree from an accredited institution of higher education.

(2) Completion of an approved human relations component.

(3) Completion of an approved exceptional learner component.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

(1) The competencies listed in 282—subparagraphs 13.28(26)*"c"*(1) to (11).

(2) The teaching and counseling practicum. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 282—subparagraph 13.28(26)*"c"*(12).

27.3(2) *Secondary professional school counselor.*

a. Authorization. The holder of this endorsement has not completed the teacher preparation coursework set forth in rule 281—79.15(256) but is authorized to serve as a professional school counselor in grades five through twelve.

b. Program requirements.

(1) Master's degree from an accredited institution of higher education.

(2) Completion of an approved human relations component.

(3) Completion of an approved exceptional learner component.

c. Content. Completion of a sequence of courses and experiences which may have been a part of, or in addition to, the degree requirements to include:

(1) The competencies listed in 282—subparagraphs 13.28(26)*"c"*(1) to (11).

(2) The teaching and counseling practicum. The candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 282—subparagraph 13.28(26)*"c"*(12).

27.3(3) *School psychologist.*

a. Authorization. The holder of this endorsement is authorized to serve as a school psychologist with pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

(1) An applicant shall have completed a program of graduate study that is currently approved (or that was approved at the time of graduation) by the National Association of School Psychologists or the American Psychological Association, or be certified as a Nationally Certified School Psychologist by the National Association of School Psychologists, in preparation for service as a school psychologist through one of the following options:

1. Completion of a master's degree with sufficient graduate semester hours beyond a baccalaureate degree to total 60; or

2. Completion of a specialist's degree of at least 60 graduate semester hours with or without completion of a terminal master's degree program; or

3. Completion of a doctoral degree program of at least 60 graduate semester hours with or without completion of a terminal master's degree program or specialist's degree program.

(2) The program shall include an approved human relations component.

(3) The program must include preparation that contributes to the education of students with disabilities and students who are gifted and talented.

c. School psychologist one-year Class A license.

(1) Requirements for a one-year Class A license. A nonrenewable Class A license valid for one year may be issued to an individual who must complete an internship or thesis as an aspect of an approved program in preparation for the school psychologist endorsement. The one-year Class A license may be issued under the following limited conditions:

1. Verification from the institution that the internship or thesis is a requirement for successful completion of the program.

2. Verification that the employment situation will be satisfactory for the internship experience.

3. Verification from the institution of the length of the approved and planned internship or the anticipated completion date of the thesis.

4. Verification of the evaluation processes for successful completion of the internship or thesis.

5. Verification that the internship or thesis is the only requirement remaining for successful completion of the approved program.

(2) Written documentation of the above requirements must be provided by the official at the institution where the individual is completing the approved school psychologist program and forwarded to the board of educational examiners with the application form for licensure.

27.3(4) *Speech-language pathologist.* A person who meets the requirements set forth below may be issued an endorsement. Alternatively, a person may meet the requirements for a statement of professional recognition (SPR) issued by the board of educational examiners in this area as set forth in 282—Chapter 16.

a. Authorization. The holder of this endorsement is authorized to serve as a speech-language pathologist to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

(1) An applicant must hold a master's degree in speech pathology.

(2) Content. An applicant must have completed the requirements in speech pathology and in the professional education sequence, i.e., 20 semester hours including student teaching/internship as a school speech-language pathologist. Courses in the following areas may be recognized for fulfilling the 20-hour sequence:

1. Curriculum courses (e.g., reading, methods, curriculum development).
2. Foundations (e.g., philosophy of education, foundations of education).
3. Educational measurements (e.g., school finance, tests and measurements, measures and evaluation of instruction).
4. Educational psychology (e.g., educational psychology, educational psychology measures, principles of behavior modification).
5. Courses in special education (e.g., introduction to special education, learning disabilities).
6. Child development courses (e.g., human growth and development, principles and theories of child development, history and theories of early childhood education).

NOTE: General education courses (e.g., introduction to psychology, sociology, history, literature, humanities) will not be credited toward fulfillment of the required 20 hours.

(3) The applicant must complete an approved human relations component.

(4) The program must include preparation that contributes to the education of individuals with disabilities and the gifted and talented.

27.3(5) *Professional service administrator.*

a. Authorization. The holder of this endorsement is authorized to serve as a supervisor of special education support programs. However, an individual holding a statement of professional recognition is not eligible for the professional service administrator endorsement.

b. Program requirements.

(1) An applicant must hold a master's degree in preparation for school psychology, speech/language pathology, audiology (or education of the hearing impaired), or social work.

(2) Content. The program shall include a minimum of 16 graduate semester hours to specifically include the following:

1. Consultation process in special or regular education.
2. Current issues in special education administration including school law/special education law.
3. Program evaluation.
4. Educational leadership.
5. Administration and supervision of special education.
6. Practicum: Special education administration. NOTE: This requirement may be waived based on two years of experience as a special education administrator.
7. School personnel administration.
8. Evaluator approval component.

c. Other. The applicant must:

(1) Have four years of support service in a school setting with special education students in the specific discipline area desired.

(2) Meet the practitioner licensure requirements of one of the following endorsements:

1. School audiologist (or hearing impaired at K-8 and 5-12).
2. School psychologist.
3. School social worker.
4. Speech-language pathologist.

27.3(6) *Director of special education of an area education agency.*

a. Authorization. The holder of this endorsement is authorized to serve as a director of special education of an area education agency. Assistant directors are also required to hold this endorsement. However, an individual holding a statement of professional recognition is not eligible for the director of special education of an area education agency endorsement.

b. Program requirements.

(1) Degree—specialist or its equivalent. An applicant must hold a master's degree plus at least 32 semester hours of planned graduate study in administration or special education beyond the master's degree.

(2) Endorsement. An applicant must hold or meet the requirements for one of the following:

1. PK-12 principal and PK-12 supervisor of special education (see rule 282—18.9(272));
2. Supervisor of special education—instructional (see rule 282—15.5(272));
3. Professional service administrator (see subrule 27.3(5)); or
4. A letter of authorization for special education supervisor issued prior to October 1, 1988.

(3) Content. An applicant must have completed a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements to include the following:

1. Knowledge of federal, state and local fiscal policies related to education.
2. Knowledge of school plant/facility planning.
3. Knowledge of human resources management, including recruitment, personnel assistance and development, evaluations, and negotiations.
4. Knowledge of models, theories and philosophies that provide the basis for educational systems.
5. Knowledge of current issues in special education.
6. Knowledge of special education school law and legislative and public policy issues affecting children and families.
7. Knowledge of the powers and duties of the director of special education of an area education agency as delineated in Iowa Code section 273.5.
8. Practicum in administration and supervision of special education programs.

(4) Experience. An applicant must have three years of administrative experience as a PK-12 principal or PK-12 supervisor of special education.

(5) Competencies. Through completion of a sequence of courses and experiences which may have been part of, or in addition to, the degree requirements, the director of special education accomplishes the following:

1. Facilitates the development, articulation, implementation and stewardship of a vision of learning that is shared and supported by the school community.
2. Advocates, nurtures and sustains a school culture and instructional program conducive to student learning and staff professional growth.
3. Ensures management of the organization, operations and resources for a safe, efficient and effective learning environment.
4. Collaborates with educational staff, families and community members; responds to diverse community interests and needs; and mobilizes community resources.
5. Acts with integrity and fairness and in an ethical manner.
6. Understands, responds to, and influences the larger political, social, economic, legal, and cultural context.
7. Collaborates and assists in supporting integrated work of the entire agency.

c. Other.

(1) Option 1: Instructional. An applicant must meet the requirements for one special education teaching endorsement and have three years of teaching experience in special education.

(2) Option 2: Support. An applicant must meet the practitioner licensure requirements for one of the following endorsements and have three years of experience as a:

1. School audiologist;
2. School psychologist;
3. School social worker; or
4. Speech-language pathologist.

27.3(7) *School social worker.* A person who meets the requirements set forth below may be issued an endorsement. Alternatively, a person may meet the requirements for a statement of professional recognition (SPR) issued by the board of educational examiners in this area as set forth in 282—Chapter 16.

a. Authorization. An individual who meets the requirements of 282—paragraph 15.7(5)*"b"* or 282—subrule 16.6(2) is authorized to serve as a school social worker to pupils from birth to age 21 (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Endorsement requirements. An applicant must hold a master's degree in social work from an accredited school of social work to include a minimum of 20 semester hours of coursework (including practicum experience) which demonstrates skills, knowledge, and competencies in the following areas:

(1) Social work.

1. Assessment (e.g., social, emotional, behavioral, and familial).
2. Intervention (e.g., individual, group, and family counseling).
3. Related studies (e.g., community resource coordination, multidiscipline teaming, organizational behavior, and research).

(2) Education.

1. General education (e.g., school law, foundations of education, methods, psychoeducational measurement, behavior management, child development).
2. Special education (e.g., exceptional children, psychoeducational measurement, behavior management, special education regulations, counseling school-age children).

(3) Practicum experience. A practicum experience in a school setting under the supervision of an experienced school social work practitioner is required. The practicum shall include experiences that lead to the development of professional identity and the disciplined use of self. These experiences will include: assessment, direct services to children and families, consultation, staffing, community liaison and documentation. If a person has served two years as a school social worker, the practicum experience can be waived.

(4) Completion of an approved human relations component is required.

(5) The program must include preparation that contributes to the education of students with disabilities and students who are gifted and talented.

27.3(8) *School audiologist.* A person who meets the requirements set forth below may be issued an endorsement. Alternatively, a person may meet the requirements for a statement of professional recognition (SPR) issued by the board of educational examiners in this area as set forth in 282—Chapter 16.

a. Authorization. The holder of this endorsement is authorized to serve as a school audiologist to pupils from birth to age 21 who have hearing impairments (and to a maximum allowable age in accordance with Iowa Code section 256B.8).

b. Program requirements.

(1) An applicant must hold a master's degree in audiology.

(2) Content. An applicant must complete the requirements in audiology and in the professional education sequence, i.e., 20 semester hours including student teaching/internship as a school audiologist. Courses in the following areas may be recognized for fulfilling the 20-hour sequence:

1. Curriculum courses (e.g., reading, methods, curriculum development).
2. Foundations (e.g., philosophy of education, foundations of education).
3. Educational measurements (e.g., school finance, tests and measurements, measures and evaluation of instruction).

4. Educational psychology (e.g., educational psychology, educational psychology measures, principles of behavior modification).

5. Courses in special education (e.g., introduction to special education, learning disabilities).

6. Child development courses (e.g., human growth and development, principles and theories of child development, history of early childhood education).

NOTE: General education courses (e.g., introduction to psychology, sociology, history, literature, humanities) will not be credited toward fulfillment of the required 20 hours.

(3) An applicant must complete an approved human relations component.

(4) The program must include preparation that contributes to the education of individuals with disabilities and the gifted and talented.

[**ARC 7980B**, IAB 7/29/09, effective 9/2/09; **ARC 9074B**, IAB 9/8/10, effective 10/13/10; **ARC 9076B**, IAB 9/8/10, effective 10/13/10; **ARC 1328C**, IAB 2/19/14, effective 3/26/14; **ARC 2016C**, IAB 6/10/15, effective 7/15/15; **ARC 2397C**, IAB 2/17/16, effective 3/23/16]

282—27.4(272) Specific renewal requirements for the initial professional service license.

27.4(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth under rule 282—20.3(272).

27.4(2) If a person meets all requirements for the standard professional service license except for the requirements in paragraph 27.2(2)*"b,"* the initial professional service license may be renewed upon written request. A second renewal may be granted if the holder of the initial license has not met the requirements in paragraph 27.2(2)*"b"* and if the license holder can provide evidence of employment which will be acceptable for the experience requirement.

[**ARC 8609B**, IAB 3/10/10, effective 4/14/10]

282—27.5(272) Specific renewal requirements for the standard professional service license.

27.5(1) In addition to the provisions set forth in this rule, an applicant must meet the general requirements set forth in rule 282—20.3(272).

27.5(2) Four units are needed for renewal. These units may be earned in any combination listed below:

a. One unit may be earned for each semester hour of graduate credit, completed from a regionally accredited institution, which leads toward the completion of a planned master's, specialist's, or doctor's degree program.

b. One unit may be earned for each semester hour of graduate or undergraduate credit, completed from a regionally accredited institution, which may not lead to a degree but which adds greater depth/breadth to present endorsements held.

c. One unit may be earned for each semester hour of credit, completed from a regionally accredited institution, which may not lead to a degree but which leads to completion of requirements for an endorsement not currently held.

d. One unit may be earned upon completion of each licensure renewal course or activity approved pursuant to guidelines established by the board of educational examiners.

[**ARC 8609B**, IAB 3/10/10, effective 4/14/10]

282—27.6(272) Specific requirements for a Class B license. A Class B license, which is valid for two years and which is nonrenewable, may be issued to an individual under the following conditions:

27.6(1) *Endorsement in progress.* The individual has a valid professional service license and one or more professional service endorsements, but is seeking to obtain some other professional service endorsement. A Class B license may be issued if requested by an employer and if the individual seeking to obtain some other professional service endorsement has completed at least two-thirds of the requirements, or one-half of the content requirements in a state-designated shortage area, leading to completion of all requirements for the endorsement.

27.6(2) *Request for exception.* A school district administrator may file a written request with the board for an exception to the minimum content requirements on the basis of documented need and benefit to the instructional program. The board will review the request and provide a written decision either approving or denying the request.

27.6(3) *Expiration.* This license will expire on June 30 of the fiscal year in which it was issued plus one year.
[**ARC 8959B**, IAB 7/28/10, effective 9/1/10]

282—27.7(272) Timely renewal. A license may only be renewed less than one year before it expires.
[**ARC 9452B**, IAB 4/6/11, effective 5/11/11]

These rules are intended to implement Iowa Code chapter 272.

[Filed ARC 7980B (Notice ARC 7743B, IAB 5/6/09), IAB 7/29/09, effective 9/2/09]
[Filed ARC 8609B (Notice ARC 8410B, IAB 12/30/09), IAB 3/10/10, effective 4/14/10]
[Filed ARC 8959B (Notice ARC 8689B, IAB 4/7/10), IAB 7/28/10, effective 9/1/10]
[Filed ARC 9074B (Notice ARC 8829B, IAB 6/2/10), IAB 9/8/10, effective 10/13/10]
[Filed ARC 9076B (Notice ARC 8831B, IAB 6/2/10), IAB 9/8/10, effective 10/13/10]
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[Filed ARC 1328C (Notice ARC 1236C, IAB 12/11/13), IAB 2/19/14, effective 3/26/14]
[Filed ARC 2016C (Notice ARC 1918C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]
[Filed ARC 2230C (Notice ARC 2130C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]
[Filed ARC 2397C (Notice ARC 2237C, IAB 11/11/15), IAB 2/17/16, effective 3/23/16]

CHAPTER 10
CONTESTED CASE HEARINGS

[Prior to 2/10/88, see Inspections and Appeals Department[481],Ch 4]

481—10.1(10A) Definitions.

"Administrative law judge (ALJ)" means the person who presides over contested cases and other proceedings.

"Agency" means the agency as defined in Iowa Code subsection 17A.2(1) which has original subject matter jurisdiction in the contested case.

"Appointing authority" means the appointed or elected chief administrative head of a department, commission, board, independent agency, or statutory office or that person's designee or in the case of gubernatorial appointees, the governor.

"Board" means a licensing board as defined in Iowa Code chapter 272C.

"Department" means the department of inspections and appeals (DIA).

"Division" means the division of administrative hearings in the department of inspections and appeals.

"Ex parte" means a communication, oral or written, to an ALJ or other decision maker in a contested case without notice and an opportunity for all parties to be heard.

"Filing" is defined in subrule 10.12(3) except where otherwise specifically defined by law.

"Issuance" means the date of mailing of a decision or order or date of delivery if service is by other means.

"Party" means a party as defined in Iowa Code subsection 17A.2(5).

"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.

"Presiding officer" means, as used in the code of administrative judicial conduct, all persons who preside in contested case proceedings under Iowa Code section 17A.11(1) as amended by 1998 Iowa Acts, chapter 1202, section 15.

"Proposed decision" means the administrative law judge's recommended findings of fact, conclusions of law, and decision and order in contested cases where the agency did not preside.

481—10.2(10A,17A) Time requirements. Time shall be computed as provided in Iowa Code subsection 4.1(22). For good cause, the administrative law judge may extend or shorten the time to take any action, except as provided otherwise by rule or law.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.22.

481—10.3(10A) Requests for a contested case hearing. Requests for a contested case hearing are made to the agency with subject matter jurisdiction. That agency shall determine whether to initiate a contested case proceeding.

This rule is intended to implement Iowa Code section 10A.202(1).

481—10.4(10A) Transmission of contested cases.

10.4(1) In every proceeding filed with the division, the agency shall complete a transmittal form. The following information is required:

a. The name of the transmitting agency;

b. The name, address and telephone number of the contact person in the transmitting agency;

c. The name or title of the proceeding, which may include a file number;

d. Any agency docket or reference number;

e. A citation to the jurisdictional authority of the agency regarding the matter in controversy;

f. Any anticipated special features or requirements which may affect the hearing;
g. Whether the hearing should be held in person or by telephone conference call;
h. Any special legal or technical expertise needed to resolve the issues in the case;
i. The names and addresses of all parties and their attorneys or other representatives;
j. The date the request for a contested case hearing was received by the agency;
k. A statement of the issues involved and a reference to statutes and rules involved;
l. Any mandatory time limits that apply to the processing of the case;
m. Earliest appropriate hearing date; and
n. Whether a petition or answer is required.

10.4(2) The agency and the department determine by agreement whether the agency or the department shall issue the notice of hearing.

a. If agreed by the agency and the department, the agency shall attach a notice of hearing to the transmittal form.

b. If the division by agreement issues the notice of hearing, the agency must provide the information required by Iowa Code section 17A.12(2) (except for the date, time and place of the hearing) for inclusion in the notice.

c. The agency, and not the division, shall prepare:
(1) The citation to the jurisdictional authority of the agency regarding the matter in controversy;
(2) A statement of the issues involved;
(3) A reference to statutes and rules involved; and
(4) The remaining information required by the transmittal form as stated in subrule 10.4(1).

10.4(3) The following documents shall be attached to the completed transmittal form when it is sent to the division:

a. A copy of the document showing the agency action in controversy; and
b. A copy of any document requesting a contested case hearing.

10.4(4) When a properly transmitted case is received, it is marked with the date of receipt by the division. An identifying number shall be assigned to each contested case upon receipt.

This rule is intended to implement Iowa Code section 10A.202(1).

481—10.5(17A) Notices of hearing.

10.5(1) Responsibility for issuance of notice of hearing and the manner of service shall be resolved by agreement between the division and the transmitting agency.

10.5(2) Notices of hearing shall contain the information required by Iowa Code subsection 17A.12(2) and any additional information required by statute or rule. Notices shall be served by first-class mail, unless otherwise required by statute or rule, or agreed pursuant to subrule 10.5(1).

This rule is intended to implement Iowa Code sections 17A.12(1) and 17A.12(2).

481—10.6(10A) Waiver of procedures. Unless otherwise precluded, the parties in a contested case may waive any provision of this chapter pursuant to Iowa Code section 17A.10.

This rule is intended to implement Iowa Code section 10A.202(2).

481—10.7(10A,17A) Telephone proceedings. A prehearing conference or a hearing may be held by telephone conference call pursuant to a notice of hearing or an order of the ALJ. The division shall determine the location of the parties and witnesses in telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, shall be considered when location is chosen.

481—10.8(10A,17A) Scheduling. Contested case hearings are scheduled according to the following criteria:

10.8(1) *Agency hearings.* The division shall promptly schedule hearings. The availability of an administrative law judge and any special circumstances shall be considered.

10.8(2) *Board hearings.* Boards are requested to consult with the division prior to scheduling hearings to determine the availability of an administrative law judge. The board shall determine the time and place of hearing.

481—10.9(17A) Disqualification.

10.9(1) An administrative law judge shall withdraw from contested cases for lack of impartiality or other legally sufficient cause including, but not limited to, cases where:

a. The ALJ has a personal bias or prejudice concerning a party, or personal knowledge of disputed evidentiary facts concerning the case;

b. The ALJ has prosecuted or advocated in connection with the case, the specific controversy underlying the case, or another pending factually related contested case or pending factually related controversy that may culminate in a contested case involving the same parties;

c. A private party is a client or has been a client of the ALJ within the past two years;

d. The ALJ has a financial interest in the case or any other interest that could be substantially affected by the outcome of the case; or

e. The ALJ, the ALJ's spouse, or relative within the third degree of relationship:

(1) Is a party to the case or an officer, director or trustee of a party;

(2) Is a lawyer in the case;

(3) Is known by the ALJ to have an interest that could be substantially affected by the outcome of the case; or

(4) Is to the ALJ's knowledge likely to be a material witness in the case.

10.9(2) If an ALJ does not withdraw, the ALJ shall disclose on the record any information relevant to the grounds listed in subrule 10.9(1).

10.9(3) If a party asserts disqualification on any appropriate ground, including those listed in subrule 10.9(1), the party shall file an affidavit pursuant to Iowa Code subsection 17A.17(4). The affidavit must be filed with the division within 15 days of the date of the notice of hearing, or as soon as the reason alleged in the affidavit becomes known to the party, but in any case shall be filed prior to the hearing.

This rule is intended to implement Iowa Code section 17A.17.

481—10.10(10A,17A) Consolidation—severance.

10.10(1) *Consolidation.* The administrative law judge may, upon motion by any party or the ALJ's own motion, consolidate any or all matters at issue in two or more proceedings docketed under these rules where:

a. There exist common parties or common questions of fact or law;

b. Consolidation would expedite and simplify consideration of the issues; and

c. Consolidation would not adversely affect the rights of parties engaged in otherwise separate proceedings.

At any time prior to the hearing, any party may on motion request that the matters not be consolidated, and the motion shall be granted for good cause shown.

10.10(2) *Severance.* The administrative law judge may, upon motion by any party or upon the ALJ's own motion, for good cause shown, order any proceeding or portion thereof severed.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.22.

481—10.11(10A,17A) Pleadings. Pleadings may be required by the notice of hearing or by order of the administrative law judge. If pleadings are required, they shall be filed as follows:

10.11(1) *Petition.* When an action of the agency is appealed and pleadings are required under subrule 10.10(1), the aggrieved party shall file the petition.

a. Any required petition shall be filed within 20 days of delivery of the notice of hearing, unless otherwise ordered.

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

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

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

(3) On whose behalf the petition is filed; and

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

10.11(2) *Answer.* If pleadings are required, the answer shall be filed within 20 days of service of the petition or notice of hearing, unless otherwise ordered.

a. Any party may move to dismiss or apply for a more definite, detailed statement when appropriate.

b. The 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 may contain as many defenses as the pleader may claim.

c. The answer shall state the name, address and telephone number of the person filing the answer and of the attorney representing that person, if any.

d. Any allegation in the petition not denied in the answer is considered admitted. Any defense not raised which could have been raised on the basis of facts known when the answer was written may be waived unless manifest injustice would result.

10.11(3) *Amendment.* Any petition, notice of hearing or other charging document may be amended before a responsive pleading has been filed. Amendments to pleadings after a responsive pleading has been filed may be allowed at the discretion of the ALJ or board if applicable. The presiding ALJ or board may impose terms or grant a continuance without terms, as a condition of allowing late amendments.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.12(6)*"a."*

481—10.12(17A) Service and filing of documents.

10.12(1) *When service is required.* Except where otherwise specifically authorized by law, every pleading, motion, or other document filed in the contested case proceeding and every document relating to discovery in the proceeding shall be served upon each of the parties to the proceeding, including the originating agency. Except for the notice of the hearing and an application for rehearing as provided in Iowa Code subsection 17A.16(2), the party filing a document is responsible for service on all parties.

10.12(2) *Methods of performing service.* Service upon a party represented in the contested case proceeding by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivering, mailing, or transmitting by facsimile (fax) or by electronic mail (e-mail) a copy to the party or attorney at the party's or attorney's last-known mailing address, fax number, or e-mail address. Service by first-class mail is complete upon mailing, except where otherwise specifically provided by statute, rule or order. Service by fax or electronic mail is complete upon transmission unless the party making service learns that the attempted service did not reach the person to be served.

10.12(3) *Filing with the division.* After a matter has been assigned to the division, and until a proposed decision is issued, every pleading, motion, or other document shall be filed with the division, rather than the originating agency. All documents that are required to be served upon a party shall be filed simultaneously with the division.

a. Except where otherwise provided by law, a document is deemed filed with the division at the time it is:

(1) Delivered to the division at the Wallace State Office Building, Third Floor, 502 East Ninth Street, Des Moines, Iowa, and date-stamped received;

(2) Delivered to an established courier service for immediate delivery to the division;

(3) Mailed to the division by first-class mail or by state interoffice mail so long as there is adequate proof of mailing; or

(4) Transmitted by facsimile (fax) to (515)281-4477, by electronic mail (e-mail) to adminhearings@dia.iowa.gov, or by other electronic means approved by the division, as provided in subrule 10.12(3), paragraph *"b."*

b. All documents filed with the division pursuant to these rules, except a person's request or demand for a contested case proceeding (see Iowa Code subsection 17A.12(9)), may be filed by facsimile (fax), electronic mail (e-mail), or other electronic means approved by the division. A document filed by fax, e-mail, or other approved electronic means is presumed to be an accurate reproduction of the original. If a document filed by fax, e-mail, or other approved electronic means is illegible, a legible copy may

be substituted and the date of filing shall be the date the illegible copy was received. The date of filing by fax, e-mail, or other approved electronic means shall be the date the document is received by the division. The division will not provide a mailed file-stamped copy of documents filed by fax, e-mail, or other approved electronic means.

10.12(4) *Proof of mailing.* Adequate proof of mailing includes the following:

a. A legible United States postal service postmark on the envelope;

b. A certificate of service;

c. A notarized affidavit; or

d. 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 Department of Inspections and Appeals, Administrative Hearings Division, Wallace State Office Building, Third Floor, 502 East Ninth Street, Des Moines, Iowa 50319, and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed) or (state interoffice mail).
>
> (date) (signature)

[**ARC 1993C**, IAB 5/27/15, effective 7/1/15]

481—10.13(17A) Discovery.

10.13(1) Pursuant to Iowa Code section 17A.13, discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by rules of the agency or by a ruling by the ALJ, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

10.13(2) Any motion relating to discovery shall allege that the moving party has made a good faith attempt to resolve the issues raised by the motion with the opposing party. Motions in regard to discovery shall be ruled on by the ALJ. 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 10.13(1). The ALJ may rule on the basis of the written motion and any response or may order argument on the motion.

This rule is intended to implement Iowa Code section 17A.13.

481—10.14(10A,17A) Subpoenas.

10.14(1) *Issuance.*

a. Pursuant to Iowa Code subsection 17A.13(1), the division shall issue an agency subpoena to a party on request unless otherwise excluded pursuant to this rule. A request for a subpoena shall be in writing. The request may be made in person or by mail, facsimile (fax), electronic mail (e-mail), or other electronic means approved by the division. The request shall include the names of the parties, the case number, the name and address of the requested witness, and a description or list of any documents or other items requested. The request shall also note the nature of the proceeding at which the witness is requested to testify (e.g., deposition, telephone hearing, or in-person hearing), the date and time of the proceeding, whether the witness is requested to appear in person or by telephone, the location of the proceeding if it is being conducted in a location other than the Wallace State Office Building, and the method of recording any deposition. A request for a subpoena shall be received by the division at least seven calendar days before the scheduled hearing. The request shall include the name, address, e-mail address, and telephone number of the requesting party.

b. The division shall provide the subpoena to the requesting party by regular mail, fax, e-mail, or other electronic means or allow for pickup during the department's regular business hours.

c. When authorized by law, an administrative law judge (ALJ) may issue a subpoena on the ALJ's own motion.

d. When there is reasonable ground to believe a subpoena is requested for the purpose of harassment, or that the subpoena requests irrelevant evidence or is untimely, the division may refuse to issue the subpoena. If the division refuses to issue a subpoena, the division shall provide a written

statement of the ground for refusal. A party to whom a refusal is issued may obtain a prompt hearing before an ALJ regarding the refusal by filing with the division and serving on all parties a written request for a hearing, including a statement of testimony, documents, or other items expected to be elicited from the subpoenaed witness and a showing of relevancy to the proceeding.

e. The issuance of a subpoena by the division does not constitute a ruling by the ALJ that the subpoenaed witness may testify at the hearing or that a subpoenaed document may be admitted into evidence. A party seeking to call a subpoenaed witness to testify or seeking to introduce a subpoenaed document at a hearing must comply with any applicable requirement in statute, administrative rule, or ALJ order regarding the submission of witness or exhibit lists and the disclosure of proposed exhibits to opposing parties.

10.14(2) *Form and contents.*

a. Requirements. Any subpoena issued after the commencement of a contested case or other proceeding conducted by the division shall be issued on a form approved by the division and must:

(1) State that the subpoena is issued by the administrative hearings division of the department of inspections and appeals;

(2) State the title of the proceeding and its case number;

(3) Command each person to whom it is directed to do the following at a specified time and place: attend and testify; produce designated documents, electronically stored information, or tangible things in that person's possession, custody or control; or permit the inspection of premises; and

(4) Include a guidance document for subpoenaed persons that has been approved by the division and that shall include the text of subrules 10.14(4) and 10.14(5).

b. Command to attend a deposition; notice of the recording method. A subpoena commanding attendance at a deposition must state the method for recording the testimony.

c. Combining or separating a command to produce or to permit inspection; specifying the form for electronically stored information. A command to produce documents, electronically stored information, or tangible things or to permit the inspection of premises may be included in a subpoena commanding attendance at a deposition, hearing, or trial or may be set out in a separate subpoena. A subpoena may specify the form or forms in which electronically stored information is to be produced.

d. Command to produce; included obligations. A command in a subpoena to produce documents, electronically stored information, or tangible things requires the responding party to permit inspection, copying, testing, or sampling of the materials.

10.14(3) *Service of subpoenas.*

a. The requesting party is responsible for arranging service of a subpoena prior to the hearing or deposition at which the testimony is commanded or the time at which the requested documents must be produced. The party is responsible for any cost associated with serving a subpoena and for the payment of witness fees and mileage expenses. If requested, pursuant to Iowa Code section 622.69, the witness fee is $10 for a full day's attendance and is $5 for attendance less than a full day, and mileage shall be paid for each mile actually traveled to participate in an in-person hearing or deposition at the rate established by the supreme court for witnesses in court proceedings, except that:

(1) No peace officer who receives a regular salary, or any other public official shall in any case receive fees as a witness for testifying in regard to any matter coming to the officer's or official's knowledge in the discharge of the officer's or official's official duties in a telephone hearing or an in-person hearing held in the county of the officer's or official's residence, except police officers who are called as witnesses when not on duty. An officer is on duty when paid by the officer's employing agency regardless whether the officer would regularly be on duty at the time of the hearing.

(2) A volunteer fire fighter, as defined in Iowa Code section 85.61, who is subpoenaed to appear as a witness in connection with a matter regarding an event or transaction which the fire fighter perceived or investigated in the course of duty as a volunteer fire fighter shall receive a fee only as provided for under Iowa Code section 622.71A.

b. Any person who is at least 18 years old and not a party may serve a subpoena. Serving a subpoena requires delivering a copy to the named person and, if the subpoena requires that person's attendance and, if demanded, tendering the fees for one day's attendance and traveling fees to and

from the proceeding. If the subpoena commands the production of documents, electronically stored information, or tangible things, then before it is served, a notice must be served on each party. For purposes of this rule, an employee of a state or local governmental agency is not a party merely because the agency is a party and may serve a subpoena unless the employee is also a named party in the proceeding or otherwise ineligible to serve a subpoena.

c. Permissible place of service. A subpoena may be served any place within the state of Iowa.

d. Proof of service. Proving service, when necessary, requires filing with the division a statement showing the date and manner of service and the names of persons served. The server must certify the statement in accordance with Iowa Code section 622.1.

10.14(4) *Protecting a person subject to a subpoena.*

a. Avoiding undue burden or expense; sanctions. A party or attorney responsible for serving a subpoena must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena. The administrative law judge must enforce this duty and impose an appropriate sanction, which may include lost earnings and reasonable attorney's fees, on a party or attorney who fails to comply.

b. Command to produce materials or permit inspection.

(1) Appearance not required. A person commanded to produce documents, electronically stored information, or tangible things, or to permit the inspection of premises, need not appear in person at the place of production or inspection unless also commanded to appear for a deposition or hearing.

(2) Objections. A person commanded to produce documents or tangible things or to permit inspection may serve on the party or attorney designated in the subpoena a written objection to inspecting, copying, testing or sampling any or all of the materials or to inspecting the premises, or to producing electronically stored information in the form or forms requested. The objection must be served before the earlier of the time specified for compliance or 14 days after the subpoena is served. If an objection is made, the following rules apply:

1. At any time, on notice to the commanded person, the serving party may move for an order compelling production or inspection.

2. These acts may be required only as directed in the order, and the order must protect a person who is neither a party nor a party's officer from significant expense resulting from compliance.

c. Attendance. Any party shall be permitted to attend at the same time and place and for the same purposes specified in the subpoena. No prior notice of intent to attend is required.

d. Quashing or modifying a subpoena.

(1) When required. On timely motion, the administrative law judge must quash or modify a subpoena that:

1. Fails to allow a reasonable time to comply;

2. Requires a person who is neither a party nor a party's officer to travel more than 50 miles from where that person resides, is employed, or regularly transacts business in person, except that a person may be ordered to attend a hearing anywhere within the state in which the person is served with a subpoena;

3. Requires disclosure of privileged or other protected matter, if no exception or waiver applies; or

4. Subjects a person to undue burden.

(2) When permitted. To protect a person subject to or affected by a subpoena, the administrative law judge may, on motion, quash or modify the subpoena if it requires:

1. Disclosing a trade secret or other confidential research, development, or commercial information;

2. Disclosing an unretained expert's opinion or information that does not describe specific occurrences in dispute and results from the expert's study that was not requested by a party; or

3. A person who is neither a party nor a party's officer to incur substantial expense to travel more than 50 miles to attend a hearing.

(3) Specifying conditions as an alternative. In the circumstances described in subparagraph 10.14(4)*"d"*(2), the administrative law judge, instead of quashing or modifying a subpoena, may order appearance or production under specified conditions if the serving party:

1. Shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship; and

2. Ensures that the subpoenaed person will be reasonably compensated.

(4) A motion to quash or modify a subpoena shall be filed with the division and served on all parties of record pursuant to rule 481—10.12(17A), except that a motion filed by or on behalf of a person who is neither a party nor a party's officer may be filed with the division and served only on the agency with a request for the division to provide a copy of the motion to all non-agency parties. The division may require a person requesting the division to provide the motion to a non-agency party to provide an additional paper copy of the motion and any attached exhibits for the division to provide to the non-agency party.

(5) The motion may be set for argument at the discretion of the administrative law judge. The administrative law judge may limit the participation of a person who is not a party, or the representative of such a person, to the extent necessary to protect any confidential information related to the proceeding.

10.14(5) *Duties in responding to a subpoena.*

a. Producing documents or electronically stored information. These procedures apply to producing documents or electronically stored information:

(1) Documents. A person responding to a subpoena to produce documents must produce them as they are kept in the ordinary course of business or must organize and label them to correspond to the categories in the demand.

(2) Form for producing electronically stored information not specified. If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms.

(3) Electronically stored information produced in only one form. The person responding need not produce the same electronically stored information in more than one form.

(4) Inaccessible electronically stored information. The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the administrative law judge may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Iowa Rule of Civil Procedure 1.504(1)(b). The administrative law judge may specify conditions for the discovery.

b. Claiming privilege or protection.

(1) Information withheld. A person withholding subpoenaed information under a claim that it is privileged or subject to protection as trial-preparation material must:

1. Expressly make the claim; and

2. Describe the nature of the withheld documents, communications, or tangible things in a manner that, without revealing information itself privileged or protected, will enable the parties to assess the claim.

(2) Information produced. If information produced in response to a subpoena is subject to a claim of privilege or of protection as trial-preparation material, the person making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has; must not use or disclose the information until the claim is resolved; must take reasonable steps to retrieve the information if the party disclosed it before being notified; and may promptly present the information to the court under seal for a determination of the claim. The person who produced the information must preserve the information until the claim is resolved.

This rule is intended to implement Iowa Code sections 10A.104(6) and 17A.13.

[**ARC 9616B**, IAB 7/13/11, effective 8/17/11; **ARC 2404C**, IAB 2/17/16, effective 3/23/16]

481—10.15(10A,17A) Motions.

10.15(1) No technical form is required for motions. Prehearing motions, however, must be written, state the grounds for relief and state the relief sought. Any motion for summary judgment shall be filed in compliance with the requirements of Iowa Rules of Civil Procedure.

10.15(2) Any party may file a written resistance or response to a motion within 14 days after the motion is served, unless the time period is extended or shortened by rules of the agency or the administrative law judge. The ALJ may consider a failure to respond within the required time period in ruling on a motion.

10.15(3) The administrative law judge may schedule oral argument on any motion on the request of any party or the ALJ's own motion.

10.15(4) Except for good cause, all motions pertaining to the hearing must be filed and served at least ten days prior to the hearing date unless the time period is shortened or lengthened by rules of the agency or the administrative law judge.

481—10.16(17A) Prehearing conference.

10.16(1) Any party may request a prehearing conference. A request for prehearing conference or an order for prehearing conference on the ALJ's own motion shall be filed in writing and served on all parties of record not less than ten days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Notice of the prehearing conference shall be given by the division to all parties. For good cause the ALJ may permit variances from this rule.

10.16(2) Each party shall bring to the prehearing conference:

a. A final list of witnesses who the party reasonably anticipates will testify at the hearing. Witnesses not listed may be excluded from testifying.

b. A final list of exhibits which the party reasonably anticipates will be introduced at the hearing. Exhibits not listed, except rebuttal exhibits, may be excluded from admission into evidence.

10.16(3) In addition to the requirements of subrule 10.16(2), the parties at a prehearing conference may:

a. Enter into stipulations of law;

b. Enter into stipulations of fact;

c. Enter into stipulations on the admissibility of exhibits;

d. Identify matters which the parties intend to request be officially noticed;

e. Unless precluded by statute, enter into stipulations for waiver of the provisions of Iowa Code chapter 17A allowed by Iowa Code section 17A.10(2) or waiver of agency rules; and

f. Consider any additional matters which will expedite the hearing.

10.16(4) A prehearing conference shall be conducted by telephone conference call unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists prior to a telephone prehearing conference.

This rule is intended to implement Iowa Code section 17A.10.

481—10.17(10A) Continuances. Unless otherwise provided, application for continuance shall be made to the ALJ or to the division if an ALJ has not been assigned.

10.17(1) A written application for continuance shall:

a. Be made before the hearing;

b. State the specific reasons for the request; and

c. Be signed by the requesting party or their representative.

10.17(2) If the ALJ waives the requirement for a written motion, an oral application for continuance may be made. A written application shall be submitted no later than five days after the oral request. The ALJ may waive this requirement. No application for continuance will be made or granted ex parte without notice except in an emergency where notice is not feasible. The agency may waive notice of requests for a case or a class of cases.

10.17(3) Except where otherwise provided, a continuance may be granted at the discretion of the ALJ. The administrative law judge shall consider, in addition to the grounds stated in the motion:

a. Any prior continuances;
b. The interests of all parties;
c. The likelihood of informal settlement;
d. Existence of emergency;
e. Objection to the continuance;
f. Any applicable state or federal statutes or regulations;
g. The existence of a conflict in the schedules of counsel or parties or witnesses; and
h. The timeliness of the request.

The ALJ may require documentation of any ground for continuance.

This rule is intended to implement Iowa Code section 10A.202(1).

481—10.18(10A,17A) Withdrawals. The party which requested an evidentiary hearing regarding agency action may withdraw prior to the hearing only in accordance with agency rules. Requests for withdrawal may be oral or written. If oral, the ALJ may require the party to submit a written request after the oral request. Unless otherwise provided, a withdrawal shall be with prejudice.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.22.

481—10.19(10A,17A) Intervention.

10.19(1) *Motion.* A motion for leave to intervene shall be served on all parties and shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within ten days of service of the motion to intervene unless the time period is extended or shortened by the ALJ.

10.19(2) *When filed.* Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the disposition of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if one is held, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. The 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 hearing will be denied.

10.19(3) *Grounds for intervention.* The movant shall demonstrate that:

a. Intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties;

b. The movant will be aggrieved or adversely affected by a final order; and

c. The interests of the movant are not being adequately represented by existing parties; or that it is otherwise entitled to intervene.

10.19(4) *Effect of intervention.* If appropriate, the ALJ may order consolidation of petitions and briefs and limit the number of representatives allowed to participate in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues to be raised or otherwise condition the intervenor's participation in the proceeding.

This rule is intended to implement Iowa Code sections 10A.202(1) and 17A.22.

481—10.20(17A) Hearing procedures.

10.20(1) When an ALJ has been appointed as the presiding officer in a contested case, the ALJ may:

a. Rule on motions;
b. Preside at the hearing;
c. Require the parties to submit briefs;
d. Issue a proposed decision; and
e. Issue orders and rulings to ensure the orderly conduct of the proceedings.

10.20(2) All objections to procedures, admission of evidence or any other matter shall be timely made and stated on the record.

10.20(3) Parties in a contested case 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 as otherwise authorized by law.

10.20(4) Parties in a contested case have the right to introduce evidence on points at issue, to cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, to present evidence in rebuttal and to submit briefs.

10.20(5) The ALJ shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly or disruptive.

10.20(6) Witnesses may be sequestered during the hearing.

10.20(7) The ALJ shall conduct the hearing in the following manner:

a. The ALJ shall give an opening statement briefly describing the nature of the proceeding;

b. The parties shall be given an opportunity to present opening statements;

c. Parties shall present their cases in the sequence determined by the ALJ;

d. Each witness shall be sworn or affirmed by the ALJ or the court reporter, and be subject to examination. The ALJ may limit questioning consistent with Iowa Code section 17A.14;

e. The ALJ has the authority to fully and fairly develop the record and may inquire into the matters at issue and shall receive in evidence the testimony of witnesses and any documents which are relevant and material; and

f. When all parties and witnesses have been heard, parties shall be given the opportunity to present final arguments.

This rule is intended to implement Iowa Code sections 17A.11 to 17A.14.

481—10.21(17A) Evidence.

10.21(1) The ALJ shall rule on admissibility of evidence in accordance with Iowa Code section 17A.14 and may take official notice of facts pursuant to Iowa Code subsection 17A.14(4).

10.21(2) Stipulation of facts is encouraged. The ALJ may make a decision based on stipulated facts.

10.21(3) Evidence shall be confined to the issues on which there has been fair notice prior to the hearing. The ALJ may take testimony on a new issue if the parties waive the right to notice and no other objection is made. If there is objection, the ALJ may refuse to hear the new issue and may make a decision on the original issue in the notice, or may grant a continuance to allow the parties adequate time to amend pleadings and prepare their cases on the additional issue.

10.21(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.

All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

10.21(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. The party objecting shall briefly state the grounds for the objection. The objection, the ruling on the objection and the reasons for the ruling shall be noted in the record. The ALJ may rule on the objection at the time it is made or may reserve a ruling until the written decision.

10.21(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. If the evidence excluded consists of a document or exhibits, it shall be marked as part of an offer of proof and inserted in the record.

This rule is intended to implement Iowa Code sections 17A.11 to 17A.14.

481—10.22(17A) Default.

10.22(1) If a party fails to appear in a contested case proceeding after proper service of notice, the ALJ may, if no adjournment is granted, proceed with the hearing and make a decision in the absence of the party.

10.22(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested an evidentiary hearing to contest adverse agency action which has already occurred, but has failed to file a required pleading or has failed to appear after proper service.

10.22(3) Where authorized by law, an ALJ may issue a default order.

481—10.23(17A) Ex parte communication.

10.23(1) Ex parte communication is prohibited as provided in Iowa Code section 17A.17. Parties or their representatives and ALJs shall not communicate directly or indirectly in connection with any issue of fact or law in a contested case except upon notice and an opportunity for all parties to participate. The ALJ may communicate with persons who are not parties as provided in subrule 10.23(2).

10.23(2) However, the ALJ may communicate with members of the agency and may have the aid and advice of persons other than those with a personal interest in, or those prosecuting or advocating in the case under consideration or a factually related case involving the same parties.

10.23(3) Any party or ALJ who receives prohibited communication shall submit the written communication or a summary of the oral communication for inclusion in the record. Copies shall be sent to all parties. There shall be opportunity to respond.

10.23(4) Prohibited communications may result in sanctions as provided in agency rule. In addition, the department, through the ALJ, may censure the person or may prohibit further appearance before the department.

This rule is intended to implement Iowa Code sections 17A.14 and 17A.17.

481—10.24(10A,17A) Decisions.

10.24(1) *Proposed decisions.* The ALJ shall issue a proposed decision which includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case.

The record in a contested case shall include all materials specified in Iowa Code subsection 17A.12(6). This shall include any request for a contested case hearing and other relevant procedural documents regardless of their form.

A ruling dismissing all of a party's claims or a voluntary dismissal is a proposed decision under Iowa Code section 17A.15.

10.24(2) *Review of proposed decisions.* Request for review of a proposed decision shall be made to the agency in which the contested case originated in the manner and within the time specified by that agency's rules. In contested cases in which the director of DIA has final decision-making authority, request for review shall be made as provided in rule 481—10.25(10A,17A).

10.24(3) *Final decisions.* If there is no appeal from or review of the proposed decision, the ALJ's proposed decision becomes the final decision of the agency.

10.24(4) *Agency reports.* The agency shall send a copy of any request for review of a proposed decision to the division. The agency shall notify the division of the results of the review, the final decision and any judicial decision issued.

481—10.25(10A,17A) DIA appeals.

10.25(1) A request for review of a proposed decision in which DIA is the final decision maker shall be made within 15 days of issuing the proposed decision, unless otherwise provided by statute. Requests shall be mailed or delivered by either party to the Director, Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319-0083. Failure to request review will preclude judicial review unless the department reviews on its own motion as follows. The department may review a proposed decision upon its own motion within 15 days of its issuance.

10.25(2) A review shall be based on the record and limited to issues raised in the hearing. The issues shall be specified in the party's request for review.

10.25(3) Each party shall have opportunity to file exceptions and present briefs. The director or a designee may set a deadline for submission of briefs. When the director or designee consents, oral

arguments may be presented. A party wishing to make an oral argument shall specifically request it. All parties shall be notified in advance of the scheduled time and place.

10.25(4) The director or designee shall not take any further evidence with respect to issues of fact heard in the hearing except as set forth below. Application may be filed for leave to present evidence in addition to that found in the record of the case. If it is shown to the satisfaction of the director or designee that the additional evidence is material and that there were good reasons for failure to present it in the hearing, the director or designee may order the additional evidence taken upon conditions determined by the director or designee.

10.25(5) Final decisions shall be issued by the director or the director's designee.

10.25(6) Requests for rehearing shall be made to the director of the department within 20 days of issuing a final decision. A rehearing may be granted when new legal issues are raised, new evidence is available, an obvious mistake is corrected, or when the decision failed to include adequate findings or conclusions on all issues.

A request for rehearing is not necessary to exhaust administrative remedies.

10.25(7) Judicial review of department final decisions may be sought in accordance with Iowa Code section 17A.19.

This rule is intended to implement Iowa Code sections 17A.15 and 17A.19.

481—10.26(10A,17A,272C) Board hearings. In scheduling hearings, boards should consult with the division to determine the availability of an ALJ. The board shall determine the time and place of hearing. At the request of the board, an ALJ shall assist in the conduct of a contested case.

10.26(1) The ALJ may rule on preliminary matters, including motions, and conduct prehearing conferences referred by the board.

10.26(2) The ALJ may conduct the hearing for the board, and may, when delegated by the board, perform duties including, but not limited to, the following:

a. Open the record and receive appearances;
b. Administer oaths and issue subpoenas;
c. Enter the notice of hearing into the record;
d. Enter the statement of charges into the record;
e. Receive testimony and exhibits presented by the parties;
f. Rule on objections and motions;
g. Close the hearing; and
h. Prepare findings of fact, conclusions of law and decision and order.

This rule is intended to implement Iowa Code sections 10A.202, 17A.11 and 272C.6.

[1]**481—10.27(10A) Transportation hearing fees.** Any hearing on an application required by Iowa Code Supplement chapter 325A shall require:

10.27(1) The applicant and any persons objecting to the granting of a certificate to submit a hearing fee of $350 to be shared equally to cover payment of all costs and expenses of the hearing. The department may require additional amounts as necessary and shall provide a written itemized account of all additional expenses to the parties. The hearing fee shall be made by check payable to the Iowa Department of Inspections and Appeals.

10.27(2) The hearing fee to be received no later than 14 days after the notice of hearing, unless otherwise ordered. Failure to timely submit the hearing fee may result in cancellation of the hearing and denial of the application.

10.27(3) If a scheduled hearing is canceled, that the hearing fee, less expenses incurred by the department, be refunded to the payers. This shall not be interpreted to authorize a refund to an applicant who fails to appear at a scheduled hearing.

10.27(4) The applicant and any persons objecting to the granting of a certificate to submit a hearing fee of $150 to be shared equally if the hearing is held by a summary proceeding conducted without a

personal appearance before the ALJ and where pleadings, affidavits, records, or other documents are submitted to the division for a decision by an ALJ.

[1] Hearing fees under jurisdiction of Department of Transportation [761] prior to 5/16/90. See IAB 6/26/91 for rescission of 761—525.5(3) and 528.4(3).

481—10.28(10A) Recording costs. The department may provide a copy of the tape-recorded hearing or a printed transcript of the hearing when a record of the hearing is requested. The cost of preparing the tape or transcript shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters shall bear the cost, unless otherwise provided by law.

481—10.29(10A) Code of administrative judicial conduct. The code of administrative judicial conduct is designed to govern the conduct, in relation to their adjudicative functions in contested cases, of all persons who act as presiding officers under the authority of Iowa Code section 17A.11(1). The canons are rules of reason. The canons shall be applied consistent with constitutional requirements, statutes, administrative rules, and decisional law and in the context of all relevant circumstances. The canons must be harmonized with the dictates of the administrative process as established by the legislature. While Canons 1, 2, and 3 are generally applicable to both administrative law judges and agency heads or members of multimember agency heads when these persons act as presiding officers, these canons shall be applied to agency heads and members of multimember agency heads only as expressly mandated by statute and as reasonably practicable when taking into account the fact that agency heads and members of multimember agency heads, unlike administrative law judges, have multiple duties imposed upon them by law. The provisions of Canon 4 concerning the regulation of extrajudicial activities are not applicable to agency heads or members of multimember agency heads. This code is to be construed so as to promote the essential independence of presiding officers in making judicial decisions.

Whether disciplinary action is appropriate, and the degree of discipline to be imposed, shall be determined by the appointing authority through a reasonable and reasoned application of the text and shall depend on such factors as the seriousness of the transgression, whether there is a pattern of improper activity, and the effect of improper activity on others or on the administrative system. This code is not designed or intended as a basis for civil liability or criminal prosecution.

10.29(1) *Canon 1.* A presiding officer shall uphold the integrity and independence of the administrative judiciary.

a. An independent and honorable administrative judiciary is indispensable to justice in society.

b. A presiding officer shall participate in establishing, maintaining, and enforcing high standards of conduct and shall personally observe those standards so that the integrity and independence of the administrative judiciary will be preserved.

c. The provisions of this code are to be construed and applied to further that objective.

10.29(2) *Canon 2.* A presiding officer shall avoid impropriety and the appearance of impropriety in all adjudicative functions in contested cases.

a. A presiding officer shall respect and comply with the law and at all times shall act in a manner that promotes public confidence in the integrity and impartiality of the administrative judiciary.

b. A presiding officer shall not allow family, social, political, or other relationships to influence the presiding officer's judicial conduct or judgment. This provision shall not be construed as prohibiting the development of public policy by contested case adjudication. A presiding officer shall not lend the prestige of the office to advance the private interests of the presiding officer or others; nor shall a presiding officer convey or permit others to convey the impression that they are in a special position to influence the presiding officer.

c. A presiding officer shall not hold membership in any organization that the presiding officer knows practices invidious discrimination on the basis of race, sex, religion or national origin.

10.29(3) *Canon 3.* A presiding officer shall perform the duties of the office impartially and diligently.

a. Adjudicative responsibilities. A presiding officer in the performance of adjudicative duties in contested case proceedings shall follow these standards:

(1) A presiding officer shall be faithful to the law, unswayed by partisan interests, public clamor, or fear of criticism.

(2) A presiding officer shall maintain order and decorum in proceedings before the presiding officer.

(3) A presiding officer shall be patient, dignified, and courteous to litigants, witnesses, attorneys, representatives, and others with whom the presiding officer deals in an official capacity, and shall require similar conduct of attorneys, representatives, staff members and others subject to the presiding officer's direction and control.

(4) A presiding officer shall not, in the performance of adjudicative duties by words or conduct, manifest bias or prejudice, including but not limited to bias or prejudice based upon sex, race, national origin or ethnicity and shall not permit staff and others subject to the presiding officer's direction and control to do so.

(5) A presiding officer shall accord to all persons who are legally interested in a proceeding, or their representatives, full right to be heard according to law, and neither initiate nor consider ex parte communications prohibited by Iowa Code section 17A.17.

(6) A presiding officer shall dispose of all adjudicative matters promptly, efficiently and fairly.

(7) A presiding officer shall abstain from public comment about a pending or impending contested case proceeding that might reasonably be expected to affect the outcome or impair the fairness of the proceeding, and shall require similar abstention by agency personnel subject to the presiding officer's direction and control. This subparagraph does not prohibit a presiding officer from making public statements in the course of official duties or from explaining for public information the hearing procedures of agencies.

(8) A presiding officer shall not disclose or use, for any purpose unrelated to adjudicative duties, nonpublic information acquired in an adjudicative capacity except as lawfully permissible in the performance of official duties by an agency head or member of a multimember agency head.

(9) A presiding officer shall report any violation of this code to the appropriate authority for any disciplinary proceedings provided by law.

b. Disqualification. 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:

(1) Has a personal bias or prejudice concerning a party or a representative of a party;

(2) Has personally investigated, prosecuted or advocated, in connection with that case, the specific controversy underlying that case, or another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;

(3) Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;

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

(5) 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;

(6) Has a spouse or relative within the third degree of relationship that:

1. Is a party to the case, or an officer, director or trustee of a party;
2. Is an attorney in the case;
3. Is known to have an interest that could be substantially affected by the outcome of the case; or
4. Is likely to be a material witness in the case; or

(7) Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

c. Disclosure on record. In a situation where a presiding officer knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, the presiding officer shall disclose the relevant information on the record and shall state reasons why voluntary withdrawal is unnecessary.

10.29(4) *Canon 4.* An administrative law judge shall regulate extrajudicial activities to minimize the risk of conflict with judicial duties.

In general, an administrative law judge shall conduct all of the administrative law judge's extrajudicial activities so that the administrative law judge does not:

1. Cast reasonable doubt on the administrative law judge's capacity to act impartially as a judge;
2. Create the appearance of impropriety or demean the adjudicative office; or
3. Interfere with the proper performance of adjudicative duties.

These rules are intended to implement Iowa Code sections 10A.104, 10A.202, 17A.10 to 17A.17, 17A.19, 17A.22, 272C.1 and 272C.6.

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IOWA PUBLIC EMPLOYEES' RETIREMENT SYSTEM[495]

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CHAPTER 4
EMPLOYERS
[Prior to 6/9/04, see 581—Ch 21]

495—4.1(97B) Covered employers.

4.1(1) Definition. All public employers in the state of Iowa, its cities, counties, townships, agencies, political subdivisions, instrumentalities and public schools are required to participate in IPERS. For the purposes of these rules, the following definitions also apply:

a. *"Political subdivision"* means a geographic area or territorial division of the state which has responsibility for certain governmental functions. Political subdivisions are characterized by public election of officers and taxing powers. The following examples are representative: cities, municipalities, counties, townships, schools and school districts, drainage and levee districts, and utilities.

b. *"Instrumentality of the state or a political subdivision"* means an independent entity that is organized to carry on some specific function of government. Public instrumentalities are created by some form of governmental body, including federal and state statutes and regulations, and are characterized by being under the control of a governmental body. Such control may include final budgetary authorization, general policy development, appointment of a board by a governmental body, and allocation of funds.

c. *"Public agency"* means state agencies and agencies of political subdivisions. Representative examples include an executive board, commission, bureau, division, office, or department of the state or a political subdivision.

d. Effective July 1, 1994, the definition of employer includes an area agency on aging that does not offer an alternative plan to all of its employees that is qualified under the federal Internal Revenue Code.

Covered employers include, but are not limited to: the state of Iowa and its administrative agencies; counties, including their hospitals and county homes; cities, including their hospitals, park boards and commissions; recreation commissions; townships; public libraries; cemetery associations; municipal utilities including waterworks, gasworks, electric light and power; school districts including their lunch and activity programs; state colleges and universities; and state hospitals and institutions.

An entity not already reporting to IPERS which meets the conditions for becoming an IPERS covered employer shall immediately contact IPERS to provide notice which includes the name and address of the entity and other information required by IPERS. If, after review of this information, IPERS determines that the entity should be enrolled as a covered employer, IPERS will notify the entity and provide an IPERS account number for the entity to use when submitting information. IPERS shall not be required to provide benefits otherwise available under Iowa Code chapter 97B for periods of service prior to the effective date for which IPERS actually approves the entity for coverage, unless the employer agrees to pay the full actuarial cost of providing such benefits.

An employer may request a revised beginning date for its status as a covered employer. The employer must submit acceptable proof to IPERS that its status as a covered employer began earlier than the date previously provided. In such case, the employer shall provide IPERS coverage retroactively to all employees providing services to that employer on or after the revised beginning date and shall pay all actuarial costs.

4.1(2) Name change. Any employer which has a change of name, address, title of the employer, its reporting official or any other identifying information shall immediately give notice in writing to IPERS. The notice shall provide IPERS with the following information:

a. Former name;
b. Former address;
c. IPERS account number;
d. New name, address, and telephone number of the employer;
e. Reason for the change if other than a change of reporting official; and
f. Effective date of the change.

4.1(3) Termination. Any employer which terminates or is dissolved for any reason shall provide IPERS with the following:

a. Complete name and address of the dissolved entity;
b. Assigned IPERS account number;
c. Last date on which wages were paid;
d. Date on which the entity dissolved;
e. Reason for the dissolution;
f. Whether or not the entity expects to pay wages in the future;
g. Whether the entity is being absorbed by another covered employer;
h. Name and address of absorbing employer if applicable; and
i. Name and address of employer that will retain the records of the dissolved entity.

4.1(4) Reports of dissolved or absorbed employers. An employer that has been dissolved or entirely absorbed by another employer is required to file a monthly report with IPERS through the effective date on which it was dissolved or absorbed. Any wages paid after this date are reported under the account number assigned to the new or successor employer, if any.

4.1(5) IPERS account number. Each employer is assigned an IPERS account number. This number should be used on all correspondence and reporting forms directed to IPERS.

4.1(6) For patient advocates employed under Iowa Code section 229.19, the county or counties for which services are performed shall be treated as the covered employer(s) of such individuals, and each such employer is responsible for forwarding reports and for withholding and forwarding the applicable IPERS contributions on wages paid by each employer.

495—4.2(97B) Records to be kept by the employer.

4.2(1) General. Each employer shall maintain records to show the information hereinafter indicated. Records shall be kept in the form and manner prescribed by IPERS. Records shall be open to inspection and may be copied by IPERS and its authorized representatives at any reasonable time.

4.2(2) Records shall show with respect to each employee:

a. Employee's name, address, gender, and social security account number, and other demographic information that may be required;
b. Each date the employee was paid wages or other wage equivalent (e.g., room, board);
c. Total amount of wages paid on each date including noncash wage equivalents;
d. Total amount of wages including wage equivalents on which IPERS contributions are payable;
e. Amount withheld from wages or wage equivalents for the employee's share of IPERS contributions; and
f. Effective January 1, 1995, records will show, with respect to each employee, member contributions picked up by the employer.

4.2(3) Reports.

a. Each employer shall make reports as IPERS may require and shall comply with the instructions provided by IPERS for the reports.
b. Effective July 1, 1991, employers must report all terminating employees to IPERS within seven working days following the employee's termination date. This report shall contain the employee's last-known mailing address and such other information as IPERS might require.
c. Effective December 31, 2004, and annually thereafter, employers whose job classes include correctional officers, correctional supervisors, and others whose primary purpose is, through ongoing direct inmate contact, to enforce and maintain discipline, safety and security within a correctional facility shall submit to IPERS each calendar year a list of jobs that qualify for protection occupation class coverage. This report shall also contain any changes in the designation of jobs as qualifying or not qualifying for protection occupation class coverage and effective dates of changes. IPERS' sole responsibility with respect to protection occupation status determinations is to ascertain whether IPERS' records correctly reflect service credit and contributions that are in accordance with the employer's designation of a position as being within a protection occupation class.

4.2(4) Fees. IPERS may assess to the employer a fee for administrative costs as described in subrule 4.3(6).

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10]

495—4.3(97B) Wage reporting and payment of contributions by employers.

4.3(1) *Payment of contributions.* For wages paid on or after July 1, 2008, all covered employers are required to pay contributions on a monthly basis. Upon enrollment as an IPERS covered employer, the employer shall receive the appropriate forms and instructions from IPERS to submit contributions. IPERS will provide monthly statements to each employer.

IPERS accepts the payment of contributions through electronic funds transfer. Payments utilizing the electronic funds transfer system shall be made according to the procedure described in subrule 4.3(3).

IPERS accepts the payment of contributions using checks and remittance advice forms. Employers filing monthly employer remittance advice forms on paper for two or more employers shall attach the checks to each remittance form. Checks shall be made payable to the Iowa Public Employees' Retirement System and mailed with the employer remittance advice form to IPERS, P.O. Box 9117, Des Moines, Iowa 50306-9117. Effective August 1, 2008, such payments and reports shall be subject to a fee as described in subrule 4.3(6).

4.3(2) *Wage reports.* For wages paid on or after July 1, 2008, all IPERS covered employers are required to file wage reports on a monthly basis. IPERS will provide the forms and instructions for wage reporting to employers. Each wage report must include the required information for all employees who earned reportable wages or wage equivalents under IPERS. The reports must be received by IPERS on or before the fifteenth day of the month following the month in which the wages were paid. If the fifteenth day falls on a weekend or holiday, the wage report is due on the next regularly scheduled business day.

Effective August 1, 2008, IPERS shall accept wage reports electronically via the IPERS' employer self service Web application, on compact discs, or as a paper report. However, for those employers submitting reports on compact discs or on paper, IPERS shall charge a fee as described in subrule 4.3(6).

4.3(3) *Deadlines for payment of contributions.*

a. Contributions must be paid monthly and must be received by IPERS on or before the fifteenth day of the month following the month in which wages were paid. If the fifteenth day falls on a weekend or holiday, the contribution is due on the next regularly scheduled business day.

b. For employers paying contributions by electronic funds transfer, wage reports and contributions may be submitted at the same time.

4.3(4) *Request for time extension.* A request for an extension of time to file a wage report or pay a contribution may be granted by IPERS for good cause if a request is made before the due date, but no extension shall exceed 15 days beyond the due date. If an employer that has been granted an extension fails to submit the wage report or pay the contribution on or before the end of the extension period, the applicable interest and fees shall be charged and paid from the original due date as if no extension had been granted. If the fifteenth day falls on a weekend or holiday, the contribution or report is due on the next regularly scheduled business day.

To establish good cause for an extension of time to file a wage report or pay contributions, the employer must show that the delinquency was not due to mere negligence, carelessness or inattention. The employer must affirmatively show that it did not file the report or timely pay because of some occurrence beyond the control of the employer.

4.3(5) *No reportable wages.* When an employer has no reportable wages during the applicable reporting period, the wage reporting document shall be filed according to subrule 4.3(2). Even if there are no reportable wages, the employer's account is considered delinquent for the reporting period and is subject to a fee until the report is filed. However, if the employer has notified IPERS on or before the due date that there are no wages to report, IPERS will adjust the due date, and no fee will be charged.

4.3(6) *Fees for noncompliance.* IPERS is authorized to impose reasonable fees on employers that do not file wage reports through the IPERS' employer self service Web application as described in subrule 4.3(2), that fail to timely file accurate wage reports, or that fail to pay contributions when due pursuant to subrule 4.3(3).

For submissions filed on or after August 1, 2008, IPERS shall charge employers a processing fee of $20 plus 25 cents per employee for late submissions and manual processing of wage reports by IPERS. Employers that are late or that do not use IPERS' employer self service Web application may be charged both fees. In addition, if a fee for noncompliance is not paid by the fifteenth day of the month after the fee

is assessed, the fee will accrue interest daily at the interest rate provided in Iowa Code section 97B.70. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full.

If the due date for a fee falls on a weekend or holiday, the due date shall be the next regularly scheduled business day.

4.3(7) *Erroneously reported wages for employees not covered under IPERS.* Employers that erroneously report wages for employees who are not eligible for coverage under IPERS may file an IPERS wage reporting adjustment form. IPERS shall return a warrant or issue a credit for both the employer and employee contributions made in error. The employer is responsible for returning the employees' share and for filing corrected federal and state wage reporting forms. Adjustments in such cases will be reported on the employer's monthly statement. Under no circumstance shall the employer adjust these wages by underreporting wages on a future periodic wage reporting document. Wages shall never be reported as a negative amount. An employer that completes the employer portion of an employee's request for a refund on an IPERS refund application form will not be permitted to file a periodic wage reporting adjustment form for that employee for the same time period. No fee will be assessed to employers that correct information as provided under this subrule.

4.3(8) *Contributions paid on wages in excess of the annual covered wage maximum.* For wages paid on or after July 1, 2008, whenever IPERS determines that an employee's wages will exceed the annual maximum established under Section 401(a)(17)(A) and the cost-of-living adjustments to that maximum permitted under Section 401(a)(17)(B) of the Internal Revenue Code during a given month, IPERS shall notify the applicable employer and shall return the related excess contributions. IPERS will detail on the monthly report those employees for whom wages were reported in excess of the covered wage ceiling. The employer is responsible for returning the employee's share of excess contributions and making the applicable tax corrections.

4.3(9) *Termination within less than six months of the date of employment.* If an employee hired for permanent employment terminates within six months of the date of employment, the employer may file an IPERS form for reporting adjustments to receive a warrant or a credit, as elected by the employer, for both the employer's and employee's portions of the contributions. It is the responsibility of the employer to return the employee's share. "Termination within less than six months of the date of employment" means employment is terminated prior to the day before the employee's six-month anniversary date. For example, an employee hired on February 10 whose last day is August 8 would be treated as having resigned within less than six months. An employee hired on February 10 whose last day is August 9 (the day before the six-month anniversary date, August 10) would be treated as having worked six months and would be eligible for a refund.

4.3(10) *Reinstatement following an employment dispute.* Employees who are reinstated following an employment dispute may restore membership service credit as described in 495—9.5(97B).

[**ARC 9397B**, IAB 2/23/11, effective 3/30/11]

495—4.4(97B) Accrual of interest and application of employer payments. Interest or charges as provided under Iowa Code section 97B.9 shall accrue on all employer payments not received by IPERS by the due date, except that interest or charges may be waived by IPERS if the employer requests an extension of time under subrule 4.3(4) prior to the due date. Effective August 1, 2008, employers that remit late contributions shall be charged a minimum of $20 or interest at the rate provided in Iowa Code section 97B.70, whichever is greater. No fee will be charged on late contributions received as a result of a wage adjustment, but interest on the amount due will be charged until paid in full. Payments received from employers having unpaid account balances shall first be applied to the oldest outstanding balance.

495—4.5(97B) Credit memos voided. Rescinded IAB 3/26/08, effective 4/30/08.

495—4.6(97B) Contribution rates. The following contribution rate schedule, payable on the covered wage of the member, is determined by the position or classification and the occupation class code of the member.

4.6(1) Contribution rates for regular class members.

a. The following contribution rates were established by the Iowa legislature for all regular class members for the indicated periods:

	Effective July 1, 2007	Effective July 1, 2008	Effective July 1, 2009	Effective July 1, 2010	Effective July 1, 2011
Combined rate	9.95%	10.45%	10.95%	11.45%	13.45%
Employer	6.05%	6.35%	6.65%	6.95%	8.07%
Employee	3.90%	4.10%	4.30%	4.50%	5.38%

b. Effective July 1, 2012, and every year thereafter, the contribution rates for regular members shall be publicly declared by IPERS staff no later than the preceding December as determined by the annual valuation of the preceding fiscal year. The public declaration of contribution rates will be followed by rule making that will include a notice and comment period and that will become effective July 1 of the next fiscal year. Contribution rates for regular members are as follows.

	Effective July 1, 2012	Effective July 1, 2013	Effective July 1, 2014	Effective July 1, 2015	Effective July 1, 2016
Combined rate	14.45%	14.88%	14.88%	14.88%	14.88%
Employer	8.67%	8.93%	8.93%	8.93%	8.93%
Employee	5.78%	5.95%	5.95%	5.95%	5.95%

4.6(2) Contribution rates for sheriffs and deputy sheriffs are as follows.

	Effective July 1, 2012	Effective July 1, 2013	Effective July 1, 2014	Effective July 1, 2015	Effective July 1, 2016
Combined rate	19.80%	19.76%	19.76%	19.76%	19.26%
Employer	9.90%	9.88%	9.88%	9.88%	9.63%
Employee	9.90%	9.88%	9.88%	9.88%	9.63%

4.6(3) Contribution rates for protection occupations are as follows.

	Effective July 1, 2012	Effective July 1, 2013	Effective July 1, 2014	Effective July 1, 2015	Effective July 1, 2016
Combined rate	17.11%	16.90%	16.90%	16.40%	16.40%
Employer	10.27%	10.14%	10.14%	9.84%	9.84%
Employee	6.84%	6.76%	6.76%	6.56%	6.56%

4.6(4) Members employed in a "protection occupation" shall include:

a. Conservation peace officers. Effective July 1, 2002, all conservation peace officers, state and county, as described in Iowa Code sections 350.5 and 456A.13.

b. Effective July 1, 1994, a marshal in a city not covered under Iowa Code chapter 400 or a firefighter or police officer of a city not participating under Iowa Code chapter 410 or 411. (See employee classifications in rule 495—5.1(97B).) Effective January 1, 1995, part-time police officers shall be included.

c. Correctional officers as provided for in Iowa Code section 97B.49B. Employees who, prior to December 22, 1989, were in a "correctional officer" position but whose position is found to no longer meet this definition on or after that date shall retain coverage, but only for as long as the employee is in that position or another "correctional officer" position that meets this definition. Movement to a position that does not meet this definition shall cancel "protection occupation" coverage.

d. Airport firefighters employed by the military division of the department of public defense (airport firefighters). Effective July 1, 2004, airport firefighters become part of and shall make the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1,

1994, through June 30, 2004, airport firefighters were grouped with and made the same contributions as sheriffs and deputy sheriffs. From July 1, 1988, through June 30, 1994, airport firefighters were grouped with and made the same contributions as the other members covered under Iowa Code section 97B.49B. From July 1, 1986, through June 30, 1988, airport firefighters were a separate protection occupation group and made contributions at a rate calculated for members of that group. Prior to July 1, 1986, airport firefighters were grouped with regular members and made the same contributions as regular members.

Notwithstanding the foregoing, all airport firefighter service prior to July 1, 2004, shall be coded by IPERS as sheriff/deputy sheriff/airport firefighter service, and all airport firefighter service after June 30, 2004, shall be coded by IPERS as protection occupation service. This coding, however, shall not supersede provisions of this title that require members to make contributions at higher rates in order to receive certain benefits, such as in the hybrid formula pursuant to 495—12.4(97B).

e. Airport safety officers employed under Iowa Code chapter 400 by an airport commission in a city with a population of 100,000 or more, and employees covered by the Iowa Code chapter 8A merit system whose primary duties are providing airport security and who carry or are licensed to carry firearms while performing those duties.

f. Effective July 1, 1990, an employee of the state department of transportation who is designated as a "peace officer" by resolution under Iowa Code section 321.477.

g. Effective July 1, 1992, a fire prevention inspector peace officer employed by the department of public safety. Effective July 1, 1994, a fire prevention inspector peace officer employed before that date who does not elect coverage under Iowa Code chapter 97A in lieu of IPERS.

h. Effective July 1, 1994, through June 30, 1998, a parole officer III with a judicial district department of correctional services.

i. Effective July 1, 1994, through June 30, 1998, a probation officer III with a judicial district department of correctional services.

j. Effective July 1, 2008, county jailers and detention officers working as jailers.

k. Effective July 1, 2008, National Guard installation security officers.

l. Effective July 1, 2008, emergency medical care providers.

m. Effective July 1, 2008, special investigators who are employed by county attorneys.

n. Effective July 1, 2014, an employee of the insurance division of the department of commerce who as a condition of employment is required to be certified by the Iowa law enforcement academy and who is required to perform the duties of a peace officer as provided in Iowa Code section 507E.8.

o. Effective July 1, 2014, an employee of a judicial district department of correctional services whose condition of employment requires the employee to be certified by the Iowa law enforcement academy and who is required to perform the duties of a parole officer as provided in Iowa Code section 906.2.

4.6(5) Service reclassification.

a. Prior to July 1, 2006, except as otherwise indicated in the implementing legislation or these rules, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall be coded by IPERS staff as special service if certified by the employer as constituting special service under current law. No additional contributions shall be required by regular service reclassified as special service under this paragraph.

b. Effective July 1, 2006, for a member whose prior regular service position is reclassified by the legislature as a special service position, all prior service by the member in such regular service position shall continue to be coded by IPERS staff as regular service unless the legislature specifically provides in its legislation for payment of the related actuarial costs of such reclassified service as required under Iowa Code section 97B.65.

4.6(6) Effective July 1, 2006, in the determination of a sheriff's or deputy sheriff's eligibility for benefits and the amount of such benefits under Iowa Code section 97B.49C, all protection occupation service credits for that member shall count toward the total years of eligible service as a sheriff or deputy sheriff. However, this subrule shall not be construed to alter the statutory requirement that a sheriff or

deputy sheriff must be employed as a sheriff or deputy sheriff at termination of covered employment in order to qualify for benefits under Iowa Code section 97B.49C.

4.6(7) Pretax.

a. Effective January 1, 1995, employers must pay member contributions on a pretax basis for federal income tax purposes only. Such contributions are considered employer contributions for federal income tax purposes and employee contributions for all other purposes. Employers must reduce the member's salary reportable for federal income tax purposes by the amount of the member's contribution.

b. Salaries reportable for purposes other than federal income tax will not be reduced, including for IPERS, FICA, and, through December 31, 1998, state income tax purposes.

c. Effective January 1, 1999, employers must pay member contributions on a pretax basis for both federal and state income tax purposes.

[**ARC 7591B**, IAB 2/25/09, effective 7/1/09; **ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09; **ARC 8601B**, IAB 3/10/10, effective 4/14/10; **ARC 9397B**, IAB 2/23/11, effective 3/30/11; **ARC 0017C**, IAB 2/22/12, effective 3/28/12; **ARC 0662C**, IAB 4/3/13, effective 5/8/13; **ARC 1348C**, IAB 2/19/14, effective 3/26/14; **ARC 1887C**, IAB 2/18/15, effective 3/25/15; **ARC 2402C**, IAB 2/17/16, effective 3/23/16]

495—4.7(97B) Employee information to be provided by covered employers. Covered employers are required to enroll new employees prior to reporting wages for the new employees. Enrollment information shall include, but is not limited to, the following: member's name, social security number, date of birth, date of hire, occupation code, gender, mailing address, termination date and last check date, when appropriate, and employer identification number.

For new employee enrollments submitted on or after August 1, 2008, employers shall submit the required information using IPERS' employer self service Web application, on compact discs, or on paper. However, those employers submitting information on compact discs or on paper will be charged a fee as described in subrule 4.3(6).

495—4.8(97B) Additional employer contributions from employer-mandated reduction in hours or by the exercise of bumping rights to avoid a layoff. Effective January 1, 2009, this rule applies to the restoration of covered wages reduced by an employer-mandated reduction in hours (EMRH) or the restoration of covered wages reduced by the exercise of bumping rights to avoid a layoff. It does not apply to reductions in base wages, reduced overtime wages, permanent layoffs or other termination of employment situations. EMRH references in this rule shall apply both to situations involving the loss of covered wages due to employer-mandated reductions in hours and to the loss of covered wages due to the exercise of bumping rights to avoid a layoff.

4.8(1) A member may restore the member's three-year average covered wage to the amount that it would have been but for an EMRH by completing the IPERS EMRH application form and related payroll deduction authorization and by filing the application and payroll deduction authorization forms with the employer. By so doing, the member agrees to pay the employee and employer contributions for all reduced work hours and bumping reductions between January 1, 2009, through June 30, 2011.

4.8(2) A member cannot pay the EMRH contributions described under this rule in any manner except through payroll deductions.

4.8(3) The payroll deduction authorization described under this rule shall be irrevocable, except upon death, retirement or termination of employment. If revoked by the member's death, retirement, or termination of employment, all amounts held by an employer in the member's name shall be forwarded to the member along with the member's final wages.

4.8(4) A member may obtain a refund of EMRH contributions collected under this rule as part of a refund of the member's entire account balance or an actuarial equivalent (AE) payment, but a member who commences a monthly retirement allowance shall not receive a refund of any amounts contributed, even if the covered wages being restored are not used in the member's three-year average covered wage.

4.8(5) A covered employer must cooperate with an eligible member's request for payroll deductions using the applicable IPERS forms. Employers shall be required to complete and submit wage certifications showing the covered wages that would have been reported but for the EMRH.

4.8(6) After IPERS has received and processed wage certification forms, the employer will be billed for the applicable EMRH contributions on the next employer monthly statement. If contributions are not paid by the employer statement's due date, the employer will be assessed late fees and interest in accordance with rule 495—4.3(97B).

4.8(7) In completing the federal and state wage reporting forms to be filed with the federal and state tax authorities, an employer shall treat the EMRH contributions collected and forwarded to IPERS the same as pretax IPERS employee contributions.

4.8(8) Upon receipt of the contributions pursuant to this rule, IPERS shall apply them to the member's account as pretax employee contributions.

4.8(9) This rule applies to reductions in wages caused by an EMRH through June 30, 2011. An employer's collection of contributions from such wages shall terminate as of midnight, July 31, 2011. All completed EMRH forms and contributions collected under this rule must be forwarded to IPERS by a covered employer no later than August 15, 2011.

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09; **ARC 8929B**, IAB 7/14/10, effective 6/21/10; **ARC 9068B**, IAB 9/8/10, effective 10/13/10]

These rules are intended to implement Iowa Code sections 97B.4, 97B.9, 97B.14, 97B.14A, 97B.38, 97B.49A to 97B.49I, 97B.65 and 97B.70 and 2009 Iowa Acts, chapter 170, section 51, as amended by 2010 Iowa Acts, House File 2518, sections 36 and 41.

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CHAPTER 5
EMPLOYEES
[Prior to 6/9/04, see 581—Ch 21]

495—5.1(97B) Identification of employees covered by the IPERS retirement law.

5.1(1) *Definition of employee—generally.* A person is in employment as defined by Iowa Code chapter 97B if the person and the covered employer enter into a relationship which both recognize to be that of employer/employee. An employee is an individual who is subject to control by the agency for whom the individual performs services for wages. The term "control" refers only to employment and includes control over the way the employee works, where the employee works and the hours the employee works. The control need not be actually exercised for an employer/employee relationship to exist; the right to exercise control is sufficient. A public official may be an "employee" as defined in the agreement between the state of Iowa and the Secretary of Health and Human Services, without the element of direction and control.

A person is not in employment if the person volunteers services to a covered employer for which the person receives no remuneration.

5.1(2) *Optional coverage procedures—July 1, 1994, through December 31, 1998.* Effective July 1, 1994, a person who is employed in a position which allows IPERS coverage to be elected as specified in Iowa Code section 97B.1A(8) must file a one-time election form with IPERS for coverage. If the person was employed before July 1, 1994, the election must be postmarked on or before July 1, 1995. If the person was employed on or after July 1, 1994, the election must be postmarked within 60 days from the date the person was employed. Coverage will be prospective from the date the election is approved by IPERS. The election, once filed, is irrevocable and continues until the member terminates covered employment. The election window does not allow members who had been in coverage to elect out.

5.1(3) *Election out of Iowa Code chapter 97B coverage by certain protection occupation groups.* Effective July 1, 1994, members employed before that date as a gaming enforcement officer, a fire prevention inspector peace officer, or an employee of the division of capitol police (except clerical workers), may elect coverage under Iowa Code chapter 97A in lieu of IPERS. The election must be directed to the board of trustees established in Iowa Code section 97A.5 and postmarked on or before July 1, 1995.

5.1(4) *Optional coverage procedures—January 1, 1999.* Effective January 1, 1999, new hires who may elect out of IPERS coverage shall be covered on the date of hire and shall have 60 days to elect out of coverage in writing using IPERS' forms. Notwithstanding the foregoing, employees who had the right to elect IPERS coverage prior to January 1, 1999, but did not do so, shall be covered as of January 1, 1999, and shall have until December 31, 1999, to elect out of coverage.

495—5.2(97B) Coverage treatment for specific employee classifications. Employment as defined in Iowa Code chapter 97B is not synonymous with IPERS membership. Some classes of employees are explicitly excluded or membership is made optional under Iowa Code section 97B.1A(8)*"b,"* while other classes are excluded or membership is made optional by their nature. The following subrules are designed to clarify the status of certain employee positions.

5.2(1) Elected officials. Effective January 1, 1999, the following persons shall be covered by IPERS unless they elect out of coverage:

a. Elected officials in positions for which the compensation is on a fee basis;

b. Elected officials of school districts;

c. Elected officials of townships; and

d. Elected officials of other political subdivisions who are in part-time positions.

An elected official who becomes covered under this chapter may later terminate membership by informing IPERS in writing of the expiration of the member's term of office or, if a member of the general assembly, of the intention to terminate coverage.

An elected official does not terminate covered employment with the end of each term of office if the official has been reelected for the same position. If elected for another position, the official shall be covered unless the official elects out of coverage.

5.2(2) County and municipal court bailiffs who receive compensation for duties shall be covered.

5.2(3) Full-time city attorneys shall be covered. Part-time city attorneys who are considered to be public officers or public employees shall be covered.

5.2(4) Magistrates shall be covered unless they elect out of IPERS coverage. Having made a choice to remain in IPERS coverage, a magistrate may not revoke that election and discontinue such coverage.

5.2(5) Office and clerical staff of a county medical examiner's office shall be covered. Effective January 1, 1995, county medical examiners and deputy county medical examiners who are full-time county employees shall be covered.

5.2(6) Police, firefighters, emergency personnel, and certain peace officers.

a. Effective July 1, 1994, police officers and firefighters of a city not participating in the retirement systems established under Iowa Code chapter 410 or 411 shall be covered.

b. Emergency personnel, such as ambulance drivers, who are deemed to be firefighters by the employer shall be covered as firefighters.

c. Effective January 1, 1995, part-time police officers shall be covered in the same manner as full-time police officers.

d. Reserve peace officers employed under Iowa Code chapter 80D shall not be covered in accordance with Iowa Code section 80D.14.

e. A police chief or fire chief who has submitted a written request to the board of trustees created by Iowa Code section 411.36 to be exempt from coverage under Iowa Code chapter 411 shall not be covered under IPERS in accordance with Iowa Code sections 384.6(1) and 411.3. The city shall make on behalf of such person the contributions required under Iowa Code section 384.6(1) to the International City Management Association/Retirement Corporation.

f. Peace officer candidates of the department of public safety shall not be covered.

5.2(7) County social welfare employees shall be covered.

5.2(8) Members of county soldiers relief commissions and their administrative or clerical employees shall be covered.

5.2(9) Part-time elected mayors, mayors of townships, and mayors who are paid on a fee basis are covered under IPERS unless they elect out of coverage. All other mayors, including appointed mayors and full-time elected mayors, whether elected by popular vote or by some other means, are covered.

5.2(10) Field assessors shall be covered.

5.2(11) Members of county boards of supervisors who receive an annual salary shall be covered. Effective for terms of office beginning January 1, 1999, part-time members of county boards of supervisors who receive an annual salary or are paid on a per diem basis shall be covered unless they elect out of coverage.

5.2(12) Temporary employees of the general assembly who are employed for less than six months in a calendar year or work less than 1,040 hours in a calendar year shall be covered unless the employee elects out of coverage. If coverage is elected, the member may not terminate coverage until termination of covered employment.

5.2(13) Effective July 1, 2008, temporary employees shall not be covered provided that they have not established an ongoing relationship with an IPERS covered employer. An ongoing relationship with an IPERS covered employer is established when:

a. The employee is paid covered wages of $1,000 or more per quarter in two consecutive quarters; or

b. The employee is employed by a covered employer for 1,040 or more hours in a calendar year.

Coverage shall begin when the permanency of the relationship is established and shall continue until the employee's relationship with the covered employer is severed. If there is no formal severance, coverage for a person hired for temporary employment who has established an ongoing relationship with a covered employer shall continue until that person completes four consecutive calendar quarters in which no services are performed for that employer after the last covered calendar quarter.

No service credit will be granted to a temporary employee who has become a covered employee under this rule for any quarter in which no covered wages are reported unless the employee is on a leave of absence that qualifies for service credit under Iowa Code section 97B.1A(20). Contributions shall be paid, and service credit shall be accrued, when wages are paid in the quarter after the ongoing relationship has been established.

5.2(14) Drainage district employees who have vested rights to IPERS through earlier participation or employees of drainage districts shall be covered unless they elect out of coverage.

5.2(15) Full-time and part-time county attorneys shall be covered.

5.2(16) Tax study committee employees shall be covered.

5.2(17) School bus drivers who are considered to be public employees shall be covered. School bus drivers who are independent contractors shall not be covered. A determination must be made by IPERS on the facts presented on a case-by-case basis.

5.2(18) Persons who are enrolled as students and whose primary occupations are as students shall not be covered. Full-time or part-time students employed part-time by the educational institution where they are enrolled shall not be covered. All other students beyond high school are not exempt from IPERS coverage. Full-time and part-time student status is as defined by the individual educational institutions. Full-time and part-time employment status is as defined by the individual employers.

The paragraph above shall not be construed to require or permit IPERS coverage for high school students and students in the lower grades who are concurrently employed (including employment during breaks between quarters, semesters, or annual academic terms) by a covered employer.

5.2(19) Foreign exchange teachers and visitors including alien scholars, trainees, professors, teachers, research assistants and specialists in their fields of specialized knowledge or skill shall not be covered.

5.2(20) Members of any other retirement system in Iowa maintained in whole or in part by public funds shall not be covered. However, effective July 1, 1996, an employee who has two jobs, one covered by IPERS and one covered by another retirement system in Iowa, shall remain an IPERS covered employee, unless the employee receives credit in such other retirement system for both jobs.

5.2(21) Members who are contributing to the federal civil service retirement system or federal employees retirement system shall not be covered. However, effective July 1, 1996, an employee who has two jobs, one covered by IPERS and one covered by a federal retirement system, shall be considered as an IPERS covered employee, unless the employee receives credit in such federal retirement system for both jobs.

5.2(22) Employees of credit unions without capital stock organized and operated for mutual purposes without profit shall not be covered.

5.2(23) Members of the ministry, rabbinate or other religious order who perform full-time or part-time religious service for a covered employer shall be covered. However, members of the ministry, rabbinate or other religious order who have taken the vow of poverty may elect out of coverage.

5.2(24) Any physician, surgeon, dentist or member of other professional groups employed full-time by a covered employer shall be covered. However, any member of a professional group who performs part-time service for any public agency but whose private practice provides the major source of income shall not be covered, except for city attorneys and health officials.

5.2(25) Interns and resident doctors employed by a state or local hospital, school or institution shall not be covered.

5.2(26) Professional personnel who acquire the status of an officer of the state of Iowa or a political subdivision thereof, even though they engage in private practice and render government service only on a part-time basis, shall be covered.

5.2(27) Effective July 1, 1994, volunteer firefighters and special police officers are considered temporary employees and shall be covered if they meet the requirements of subrule 5.2(13).

5.2(28) Residents or inmates of county homes shall not be covered.

5.2(29) Members of the state transportation commission, the board of parole, and the state health facilities council shall be covered unless they elect out of coverage.

5.2(30) Employees of an interstate agency established under Iowa Code chapter 28E, and similar enabling legislation in an adjoining state, if the city had made contributions to the system for employees performing functions which are transferred to the interstate agency shall be considered employees of the city for the sole purpose of membership in IPERS, although the employer contributions for those employees are made by the interstate agency.

5.2(31) City managers, or city administrators performing the duties of city managers, under a form of city government listed in Iowa Code chapter 372 or 420 shall be covered unless they elect out of coverage.

5.2(32) Employees appointed by the state board of regents shall be covered unless, at the discretion of the state board of regents, they elect coverage in an alternate retirement system qualified by the state board of regents.

5.2(33) Employees who work in additional positions with additional duties, along with normal duties with the same employer, shall be considered covered employees until all of their compensated duties to their employer cease. (Examples include teacher/coach; teacher/summer driver's education instructor; and city employee/paid firefighter.)

5.2(34) Adjunct instructors employed by a community college or university shall not be covered. Adjunct instructors are persons employed by a community college or university without a continuing contract and whose teaching load does not exceed one-half time for two full semesters or three full quarters for the calendar year. The determination of whether a teaching load exceeds one-half time shall be based on the number of credit hours or noncredit contact hours that the community college or university considers to be a full-time teaching load for a regular full semester or quarter. An adjunct instructor whose teaching load exceeds the foregoing limitations shall be covered.

In determining whether an adjunct instructor is a covered employee, no credit shall be granted for teaching periods of shorter duration than a regular semester or regular quarter (such as summer semesters), regardless of the number of credit or contact hours assigned to that period.

If there is no formal severance, an adjunct instructor who becomes a covered employee shall remain a covered employee until that person completes four consecutive calendar quarters in which no services are performed for that covered employer after the last covered calendar quarter. Notwithstanding the foregoing sentence, no service credit will be granted to any adjunct instructor who has become a covered employee under this rule for any calendar quarter in which no covered wages are reported unless the adjunct instructor is on an approved leave of absence that qualifies for service credit under Iowa Code section 97B.1A(20).

5.2(35) Effective July 1, 1992, enrollees of a senior community service employment program authorized by Title V of the Older Americans Act and funded by the United States Department of Labor shall not be covered unless:

a. Both the enrollee and the covered employer elect coverage; or

b. The enrollee is currently contributing to IPERS.

For purposes of this subrule only, a covered employer is defined as the host agency where the enrollee is placed for training.

5.2(36) Employees of area agencies on aging shall be included. However, effective July 1, 1994, employees of area agencies on aging shall not be covered if the area agency has provided for participation by all of its eligible employees in an alternative qualified plan pursuant to the requirements of the federal Internal Revenue Code. If an area agency on aging does not participate in an alternative plan, or terminates participation in such plan, IPERS coverage shall begin immediately.

5.2(37) Effective July 1, 1994, arson investigators shall not be covered. They were transferred to the public safety peace officers' retirement, accident and disability system as found in Iowa Code chapter 97A.

5.2(38) Persons who meet the requirements of independent contractor status as determined by IPERS using the criteria established by the federal Internal Revenue Service shall not be covered.

5.2(39) Effective July 1, 1994, a person employed on or after that date for certain public safety positions shall not be covered. These positions are gaming enforcement officers employed by the division

of criminal investigation for excursion boat gambling enforcement activities, fire prevention inspector peace officers, and employees of the division of capitol police (except clerical workers).

5.2(40) Employees of area community colleges shall be covered unless they elect coverage under an alternative system pursuant to a one-time irrevocable election.

5.2(41) Volunteer emergency personnel, such as ambulance drivers, shall be considered temporary employees and shall be covered if they meet the requirements of subrule 5.2(13). Persons who meet such requirements shall be covered under the protection occupation requirements of Iowa Code section 97B.49B if they are considered firefighters by their employers; otherwise they shall be covered under Iowa Code section 97B.11.

5.2(42) Persons employed through any program described in Iowa Code section 84A.7 and provided by the Iowa conservation corps shall not be covered.

5.2(43) Appointed and full-time elective members of boards and commissions who receive a set salary shall be covered. Effective January 1, 1999, part-time elective members of boards and commissions not otherwise described in these rules who receive a set salary shall be covered unless they elect out of coverage. Members of boards, other than county boards of supervisors, and commissions, including appointed and elective full-time and part-time members, who receive only per diem and expenses shall not be covered.

5.2(44) Persons receiving rehabilitation services in a community rehabilitation program, rehabilitation center, sheltered workshop, and similar organizations whose primary purpose is to provide vocational rehabilitation services to target populations shall not be covered.

5.2(45) Persons who are members of a community service program authorized under and funded by grants made pursuant to the federal National and Community Service Act of 1990 shall not be covered.

5.2(46) Persons who are employed by professional employment organizations, temporary staffing agencies, and similar noncovered employers and are leased to covered employers shall not be covered.

5.2(47) Persons who are employed by a covered employer and leased to a noncovered employer shall be covered.

5.2(48) Effective July 1, 1999, persons performing referee services for a covered employer shall not be covered, unless the performance of such services is included in the persons' regular job duties for the employer for which such services are performed.

5.2(49) Effective July 1, 2000, patient advocates appointed under Iowa Code section 229.19 shall be covered.

5.2(50) Employees of the Iowa student loan liquidity corporation shall not be covered.

[**ARC 0662C**, IAB 4/3/13, effective 5/8/13; **ARC 2402C**, IAB 2/17/16, effective 3/23/16]

495—5.3(97B) Participation in IPERS and another retirement system. Effective July 1, 1996, an employee may actively participate in IPERS and another retirement system supported by public funds if the person does not receive credit under both IPERS and such other retirement system for any position held.

These rules are intended to implement Iowa Code sections 97B.1A, 97B.4, 97B.11, 97B.42, 97B.42A, 97B.49B, 97B.49C, and 97B.49G.

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CHAPTER 6
COVERED WAGES
[Prior to 6/9/04, see 581—Ch 21]

495—6.1(97B) IRS requirements. Wages as discussed in this chapter shall not exceed the amount permitted for a given year under Sections 401(a)(17)(A) and (B) of the Internal Revenue Code, which are incorporated herein by this reference.
[**ARC 9397B**, IAB 2/23/11, effective 3/30/11]

495—6.2(97B) Definition of wages. "Wages" means all compensation earned by employees including, except as otherwise provided under this chapter, vacation pay; sick pay; back pay; amounts deducted from the employee's pay at the employee's discretion for tax-sheltered annuities, dependent care and cafeteria plans; and the cash value of wage equivalents. This definition applies to these rules, regulations, interpretations, forms and other IPERS publications unless the context otherwise requires.

495—6.3(97B) IPERS coverage for various forms of compensation. The following is a list of various types of compensation and the corresponding IPERS coverage treatment:

6.3(1) *Vacation pay or annual leave pay.* Vacation pay or annual leave pay means the amount paid to an employee during a period of vacation.

6.3(2) *Sick pay.* Sick pay means payments made for sick leave which are a continuation of salary payments.

6.3(3) *Workers' compensation payments and other third-party payments.* Workers' compensation payments, unemployment payments, or short-term and long-term disability payments made by an insurance company or third-party payer, such as a trust, are not included as wages. Payments for sick leave which are a continuation of salary payments if paid from the employer's general assets, regardless of whether the employer labels the payments as sick leave, short-term disability, or long-term disability, are covered wages.

6.3(4) *Compensatory time.* Wages include amounts paid for compensatory time taken in lieu of regular work hours or when paid as a lump sum. However, compensatory time paid in a lump sum shall not exceed 240 hours per employee per year or any lesser number of hours set by the employer. Each employer shall determine whether to use the calendar year or a fiscal year other than the calendar year when setting its compensatory time policy.

6.3(5) *Banked holiday pay.* If an employer codes banked holiday time as holiday or additional accrued vacation time, the banked holiday pay will be vacation pay under subrule 6.3(1). If an employer codes banked holiday time as compensatory time, the banked holiday pay will be combined with compensatory pay and subject to the limits set forth in subrule 6.3(4).

6.3(6) *Special lump sum payments.* Wages do not include special lump sum payments made during or at the end of service as a payoff of unused accrued sick leave or of unused accrued vacation. Wages do not include special lump sum payments made during or at the end of service as an incentive to retire early or as payments made upon dismissal, severance, or a special bonus payment intended as an early retirement incentive. Wages do not include: catastrophic leave paid in a lump sum, bonuses, tips or honoraria. Exclusion of payments as described in this subrule applies whether the payment is in a lump sum or in installments.

6.3(7) *Covered wage treatment for supplemental payments.*

a. Payments excluded from covered wages as bonuses include the following:

(1) Recruitment payments.

(2) Retention payments.

(3) Payments to members who achieve improvements in their employer's financial status or performance ratings.

(4) Employee performance incentive payments.

(5) Extraordinary job performance payments.

(6) Payments for the possession, attainment, or maintenance of special skills or professional certifications (does not apply to advancements in a member's placement in wage or salary schedule, or placement in a higher tier wage or salary schedule).

(7) Payments to members made in lieu of merit increases because the members' wage or salary scales are capped.

(8) Payments similar in substance to those enumerated above without regard to the payments' titles, tag lines, labels or classifications by employers.

b. Payments included in covered wages that are not to be treated as bonuses include the following:

(1) Payments authorized by statute and used to increase the general level of teacher pay, except as otherwise provided in this subrule (for example, when such moneys are used to pay retention bonuses).

(2) Payments for which additional, or new and different, job duties are required in order to receive the payment.

(3) Payments for employment longevity.

c. Payments that are otherwise to be treated as covered wages under paragraph *"b"* shall not be covered if IPERS determines that the payments are made for paragraph *"a,"* subparagraphs (1) to (8), of this subrule or other subrules, including, but not limited to, recruitment or retention bonuses, retirement incentive and severance payments, reimbursements of business expenses, and payment of allowances.

d. IPERS shall have the final authority to determine if supplemental payments not described in paragraphs *"a," "b"* and *"c"* of this subrule should be treated as excluded bonus payments or covered wages. In making its determination, IPERS may consider, but is not limited to, such factors as the supplemental payments' similarity to payments described in paragraphs *"a," "b"* and *"c"* of this subrule, whether such payments are discretionary with the employer, and whether, on the one hand, the payments are regular and periodic over the working careers of a broad group of individuals or, on the other hand, are short-term, irregular, or ad hoc payments whose primary effect is to spike certain members' final average salaries.

6.3(8) *Other special payment arrangements.* Wages do not include amounts paid pursuant to special arrangements between an employer and employee whereby the employer pays increased wages and the employee reimburses the employer or a third-party obligor for all or part of the wage increase. This limitation includes, but is not limited to, the practice of increasing an employee's wages by the employer's share of health care costs and having the employee reimburse the employer or a third-party provider for such health care costs. Wages do not include amounts paid pursuant to a special arrangement between an employer and employee whereby wages in excess of the covered wage ceiling for a particular year are deferred to one or more subsequent years. Wages do not include employer contributions to a plan, program, or arrangement that are not included in the employee's federal taxable income. However, certain employer contributions under IRC Section 125 plans are permitted to be treated as covered wages under rule 495—6.5(97B) subject to the terms of that rule.

Employers and employees that knowingly and willfully enter into the types of arrangements described in this subrule, causing an impermissible increase in the payments authorized under Iowa Code chapter 97B, may be prosecuted under Iowa Code section 97B.40 for engaging in a fraudulent practice. If IPERS determines that its calculation of a member's monthly benefit includes amounts paid under an arrangement described in this subrule, IPERS shall recalculate the member's monthly benefit, after making the appropriate wage adjustments. IPERS may recover the amount of overpayments caused by the inclusion of the payments described in this subrule from the monthly amounts plus interest payable to the member or amounts payable to the member's successor(s) in interest, regardless of whether or not IPERS chooses to prosecute the employers and employees under Iowa Code section 97B.40.

6.3(9) *Wage equivalents.* Items such as food, lodging and transportation are includable as employee income, if they are paid as compensation for employment. The basic test is whether or not such wage equivalent was given for the convenience of the employee or employing unit. Wage equivalents are not reportable under IPERS if given for the convenience of the employing unit or are not reasonably quantifiable. Wage equivalents that are not included in the member's federal taxable income shall be deemed to be for the convenience of the employer. A wage equivalent is not reportable if the employer

certifies that there was a substantial business reason for providing the wage equivalent, even if the wage equivalent is included in the employee's federal taxable income. Wages paid in any other form than money are measured by the fair market value of the meals, lodging, travel or other wage equivalents.

6.3(10) *Members of the general assembly.* Wages for a member of the general assembly means the total compensation received by a member of the general assembly, whether paid in the form of per diem or annual salary. Wages include per diem payments paid to members of the general assembly during interim periods between sessions of the general assembly. Wages do not include expense payments except that, effective July 1, 1990, wages include daily allowances to members of the general assembly for nontravel expenses of office during a session of the general assembly. Such nontravel expenses of office during a session of the general assembly shall not exceed the maximum established by law for members from Polk County. A member of the general assembly who has elected to participate in IPERS shall receive four quarters of service credit for each calendar year during the member's term of office, even if no wages are reported in one or more quarters during a calendar year.

6.3(11) *Wages restored following an employer-mandated reduction in hours.* Notwithstanding rule 495—6.4(97B), wages restored following the receipt of contributions forwarded pursuant to 495—4.8(97B) shall be credited to quarters in which the wages would have been received but for the employer-mandated reduction in hours (EMRH).

6.3(12) *Wages paid as a back pay settlement.* IPERS contributions must be calculated on the gross amount of a back pay settlement before the settlement is reduced for taxes, interim wages, unemployment compensation, and similar mitigation of damages adjustments. IPERS contributions must be calculated by reducing the gross amount of a back pay settlement by any amounts not considered covered wages such as, but not limited to, lump sum payments for medical expenses.

Notwithstanding the foregoing, a back pay settlement that does not require the reinstatement of a terminated employee and payment of the amount of wages that would have been paid during the period of severance (before adjustments) shall be treated by IPERS as a "special lump sum payment" under subrule 6.3(6) and shall not be covered.

6.3(13) *Limitations on benefits and contributions.*

a. Section 415(b) limitations on benefits. A member may not receive an annual benefit that exceeds the dollar amount specified in Section 415(b)(1)(A) of the Internal Revenue Code, subject to the applicable adjustments in Internal Revenue Code Sections 415(b) and 415(d). For purposes of applying the limits under Internal Revenue Code Section 415(b) (Limit), the following will apply:

(1) With respect to a member who does not receive a portion of the member's annual benefit in a lump sum:

1. The member's Limit will be applied to the member's annual benefit in the first limitation year without regard to any automatic cost-of-living increases;

2. To the extent the member's annual benefit equals or exceeds the Limit, the member will no longer be eligible for cost-of-living increases under the IPERS trust fund until such time as the benefit plus the accumulated increases are less than the applicable Limit; and

3. Thereafter, in any subsequent limitation year, the member's annual benefit including any automatic cost-of-living increase shall be tested under the then applicable benefit Limit, including any adjustment to the Internal Revenue Code Section 415(b)(1)(A) dollar limit under Internal Revenue Code Section 415(d) (cost-of-living adjustments) and the regulations thereunder; and

(2) With respect to a member who receives a portion of the member's annual benefit in a lump sum:

1. The member's applicable Limit shall be applied taking into consideration automatic cost of living increases as required by Internal Revenue Code Section 415(b) and applicable Treasury Regulations; and

2. In no event shall a member's annual benefit payable under the system in any limitation year be greater than the Limit applicable at the annuity starting date, as increased in subsequent years pursuant to Internal Revenue Code Section 415(d) and the regulations thereunder. If the form of benefit without regard to the automatic benefit increase feature is not a straight life or a qualified joint and survivor annuity, then the preceding sentence is applied by either reducing the Limit applicable at the annuity starting date or adjusting the form of benefit to an actuarially equivalent straight life annuity benefit

determined using the assumptions required by Treasury Regulations, including the mortality table specified in Revenue Ruling 2001-62 or Revenue Ruling 2007-67, as applicable.

b. Section 415(c) limitations on contributions and other member additions. Member contributions and other additions paid to the system may not exceed the annual limits on contributions and other additions allowed by Internal Revenue Code Section 415(c). For purposes of applying these limits, the definition of "compensation," where applicable, will be compensation as defined in Treasury Regulation Section 1.415(c)-2(d)(3), or successor regulation. The foregoing definition of compensation will exclude member contributions picked up under Internal Revenue Code Section 414(h)(2) and, for plan years beginning after December 31, 1997, compensation will include the amount of any elective deferrals, as defined in Internal Revenue Code Section 402(g)(3), and any amount contributed or deferred by the employer at the election of the member and which is not includible in the gross income of the member by reason of Internal Revenue Code Section 125 or 457 and, for plan years beginning on and after January 1, 2001, pursuant to Internal Revenue Code Section 132(f)(4).

c. Limitation year. The limitation year is the calendar year.

6.3(14) *Employer payments treated as remuneration counted against the reemployment earnings limit.* All taxable or nontaxable compensation, regardless of the title, tag line, label, or classification attributed to that compensation paid by IPERS-covered employers to retired reemployed IPERS members, shall be considered remuneration when determining reemployment earnings limits and reductions as set forth under Iowa Code section 97B.48A and rule 495—12.8(97B). This rule shall apply whether the compensation is paid pursuant to individual contracts or otherwise, and regardless of whether it is considered covered or noncovered compensation under Iowa Code section 97B.1A(26) and the administrative rules thereunder, except for:

a. Contributions to health insurance plans and programs, and

b. Reimbursements of actual work-related expenses required by the retired reemployed members' jobs.

6.3(15) *Employer contributions as remuneration counted against the reemployment earnings limit.* Employer contributions made on behalf of retired reemployed members to tax qualified and nonqualified retirement and deferred compensation plans and to other fringe benefit arrangements, excluding health insurance plans and programs, shall constitute remuneration from employment which shall be applied to the reemployment earnings limits and reductions set forth under rule 495—12.8(97B). Such contributions, even if counted as remuneration hereunder, shall not be counted as covered wages, unless the facts in the particular case indicate that, under the circumstances, the arrangement should be treated as covered wages under rules 495—6.1(97B) through 495—6.5(97B). Nonelective employer contributions to the following shall constitute remuneration when determining reemployment earnings limits: tax qualified retirement and deferred compensation plans; all nonqualified retirement plans and deferred compensation arrangements; IRAs; rabbi, secular, and other trust arrangements; split dollar and other life insurance arrangements; and long-term care insurance.

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09]

495—6.4(97B) Month for which wages are to be reported. Wages are reportable for the month in which they are actually paid to the employee, except when employees are awarded lump sum payments of back wages, whether as a result of litigation or otherwise, receive lump sum payments of extra duty pay, or request wage restorations following EMRH, and similar situations involving regular and periodic lump sum payments which IPERS in its sole discretion determines should be treated as covered wages. The employer shall file wage adjustment reporting forms with IPERS allocating the wages to the periods of service for which such payments are awarded. Employers shall forward the required employer and employee contributions and interest to IPERS.

6.4(1) Actual and constructive receipt. An employer cannot report wages as having been paid to employees as of a monthly reporting date if the employee has not actually or constructively received the payments in question. For example, wages that are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on June 30 would be reported as June wages, but wages that

are mailed, transmitted via electronic funds transfer for direct deposit, or handed to an employee on July 3 would be reported as July wages.

6.4(2) One quarter of service will be credited for each quarter in which a member is paid IPERS covered wages.

a. "Covered wages" means wages of a member during periods of service that do not exceed the annual covered wage maximum as permitted for a given year under Sections 401(a)(17)(A) and (B) of the Internal Revenue Code, which are incorporated herein by this reference.

b. Effective January 1, 1988, covered wages shall include wages paid a member regardless of age. (From July 1, 1978, until January 1, 1988, covered wages did not include wages paid a member on or after the first day of the month in which the member reached the age of 70.)

c. If a member is employed by more than one employer during the calendar year, the total amount of wages paid by all covered employers shall be included in determining the annual covered wage limit established under Sections 401(a)(17)(A) and (B) of the Internal Revenue Code. If the amount of wages paid to a member by several employers during any given month exceeds the covered wage limit as determined for that calendar year, the amount of the excess shall not be subject to contributions required by Iowa Code section 97B.11. IPERS shall not accept excess wages and applicable contributions from employers and shall return excess contributions as provided in 495—subrule 4.3(8).

[**ARC 7759B**, IAB 5/6/09, effective 4/17/09; **ARC 7916B**, IAB 7/1/09, effective 8/5/09; **ARC 9397B**, IAB 2/23/11, effective 3/30/11]

495—6.5(97B) Covered wage treatment for employer contributions to IRC Section 125 plans. If certain conditions are met, employer contributions to fringe benefit programs that qualify under IRC Section 125 may be treated as covered wages. The following subrules set forth IPERS' regulations for determining covered wage treatment and for making wage adjustments when employer-paid contributions have been covered or excluded in violation of the standards set forth below.

6.5(1) *Section 125 plans.* For purposes of this rule, a Section 125 plan means an employer-sponsored fringe benefit plan that is subject to Section 125 of the federal Internal Revenue Code (IRC). Some of the common names for this type of plan are cafeteria plan, flexible benefits plan, flex plan, and flexible spending arrangement.

a. Effective January 1, 2017, employers must annually certify to IPERS, on a form approved by the system, that their Section 125 plans meet all IRC requirements.

b. If an employer does not certify its Section 125 plan's compliance with the IRC, all employer contributions to fringe benefit plans will be excluded from IPERS coverage.

6.5(2) *Elective employer contributions.* For purposes of this rule, "elective employer contributions" means employer contributions made to a Section 125 plan that can be received in cash or used to purchase benefits under the Section 125 plan. Generally, elective employer contributions that are not subject to special eligibility requirements qualify as covered wages.

6.5(3) *Mandatory minimum coverage requirements.* The term "elective employer contributions" does not include employer contributions that must be used to purchase benefits under a Section 125 plan. For example, if an employer provides $2,500 to its employees to purchase benefits in a Section 125 plan, but requires that all employees must use $1,000 of that amount to purchase single health coverage, the cost of the single coverage is deducted. In this example, $1,000 would be subtracted from the $2,500 provided, resulting in $1,500 of covered wages.

6.5(4) *Uniformity determined coverage group by coverage group.* Iowa Code section 97B.1A(26)*"a"*(1)*"b"* states that elective employer contributions shall be treated as covered wages only if made uniformly available and not limited to highly compensated employees. The application of the uniformity concept may be illustrated as follows: Employer Z has two major groupings of employees covered under its cafeteria plan: teaching staff and support staff. Every member of the teaching staff is provided $3,000 to purchase benefits under the Section 125 plan. Every member of the teaching staff must take single coverage costing $1,500. Every member of the support staff is provided $2,500 and must also take the single coverage costing $1,500. Each member of the teaching staff would have $1,500 treated as covered wages, and each member of the support staff would have $1,000 treated as covered wages. This would be considered uniform treatment.

Uniformity is not destroyed by the fact that the amount available to members of a coverage group varies because the actual cost of mandatory minimum coverage varies depending on actuarial factors that apply to each individual. For example, assume Employer Z above also requires each employee to have long-term disability coverage. In Employer Z's case, the actual cost of disability coverage will vary from individual to individual. In that case, Employer Z would also deduct the actual cost of the required disability coverage, individual by individual, when determining IPERS covered wages.

Uniformity is not destroyed if an employer has two groups of employees who, as a result of collective bargaining, have differing entitlements to employer contributions. For example, Employer Y has a contract that provides $3,500 to each employee to purchase benefits under the Section 125 plan. Every employee may take all the cash by waiving participation in the plan, or may use all or part of the employer contributions to the Section 125 plan. In the collective bargaining process, a new contract is adopted which states that the employer will still provide $3,500 to each employee to purchase benefits under the Section 125 plan. However, under the new contract, persons who waived participation before April 15 may still waive participation in the plan and take all the cash, but persons who did not waive participation and those hired after April 15 must have single coverage costing $1,700. Employer Y would be treated as having two groups of employees with different elective employer contribution amounts. The grandfathered group (employees who waived participation before April 15) would have covered wages of $3,500, and the group consisting of those who did not waive participation before April 15 and new employees would have covered wages of $1,800.

6.5(5) *Highly compensated employee test.* Iowa Code chapter 97B provides that, in addition to being uniformly available, employer contributions must not discriminate in favor of highly compensated employees (HCEs). For purposes of this subrule, an HCE is an employee who has reported wages and tips subject to Medicare tax in excess of the IRC Section 414(q) limit then in effect. IPERS shall apply the HCE limitation as follows. If elective employer contributions are made available to HCEs, the total elective employer contributions made available to the HCE group must not exceed 25 percent of the total elective employer contributions made available under the Section 125 plan to all employees, including the HCEs. If the elective employer contributions available to the HCE group exceed the 25 percent limit (or if it is determined that the Section 125 plan discriminates in favor of HCEs under other IRS rules), elective employer contributions for HCEs shall not exceed the highest amount available to a nonexecutive coverage group of employees covered under such plan. The general application of these principles is illustrated below, using the 2002 IRC Section 414(q) dollar limit of $90,000.

Employer W has a Section 125 plan that provides elective employer contributions totaling $7,000 to executive staff, $4,500 to teaching staff, and $3,500 to support staff. There are no other limits or exclusions that apply. These amounts are treated as covered wages for each member of each group, provided that the total amount of contributions made available to HCEs does not exceed 25 percent of the total elective employer contributions for all employees covered under the plan. If elective employer contributions for the executive staff totaled $70,000, and total elective employer contributions for the remainder of the staff totaled $500,000, the HCE percentage of total elective employer contributions would be 12 percent ($70,000 divided by $570,000), and all elective employer contributions would be treated as covered wages for all groups. However, if elective employer contributions for the executive staff totaled $70,000, and elective employer contributions for the remainder of the staff totaled $200,000, the HCE percentage would be 26 percent ($70,000 divided by $270,000), and HCEs' elective employer contributions would be limited to $4,500 per HCE for covered wage purposes.

6.5(6) *Elective employer contributions limited to dual coverage employees.* In some cases, a Section 125 plan provides for what appear to be mandatory employer contributions for health plan coverage, but the terms of the Section 125 plan permit dual coverage employees to waive coverage and receive the employer contributions in cash, if the employee can prove coverage under another health care plan. IPERS shall continue to treat the full amount of employer contributions in such cases as not being IPERS covered wages, even though individual employees with the described dual coverage may actually receive the employer contribution in cash.

6.5(7) *Corrections for overpayments and underpayments of contributions and benefits caused by Section 125 plan covered wage errors.* IPERS shall use the following guidelines in requiring corrections

for overpayments and underpayments of contributions and benefits caused by the erroneous inclusion or exclusion of employer contributions to a Section 125 plan. Corrections must be made for all active, terminated and retired members, subject to the following limitations:

a. If elective employer contributions that should have been covered were not covered, wage adjustments shall be filed, and employers shall be billed for all shortages plus interest. Employers shall be entitled to collect reimbursement for the employee share of contributions as provided in Iowa Code section 97B.9. If retirement benefits, death benefits or refunds have been underpaid as a result of the error, IPERS shall, upon receipt of the contribution shortage, make the appropriate adjustments and pay all back benefits.

b. If employer contributions that should not have been covered were covered, wage adjustments shall be filed, and the appropriate contribution amounts shall be repaid to employers for distribution to the respective employee and employer contributors. If the reporting error caused an overpayment of retirement benefits, death benefits, or refunds, IPERS shall offset excess contributions received against overpayments and shall request a repayment of the remainder of the overpayment, if any, from the recipient.

Wage adjustments, overpayments, and underpayments and unintentional reporting errors shall be determined as of the onset of the error, but shall be limited to three years before the beginning of the current contract year for school employers, or current fiscal year for all other covered employers. IPERS may go back to the onset of the error, even if the period exceeds three years, if the error is caused by intentional misconduct or gross neglect. Notwithstanding the foregoing adjustment and collection standards, IPERS reserves the right to negotiate adjustments with individual employers in special situations, and no negotiated settlement with an employer shall be deemed to constitute a waiver of this rule or a binding precedent for other employers.

6.5(8) *Bounties.*

a. Effective prior to June 21, 2010, in some cases, an employer has a Section 125 plan with employer contributions, and what IPERS refers to as a bounty option. A bounty is an amount that may be elected by all employees, or by a subset of that group, such as employees with coverage under another health care plan, either in lieu of any coverage under the employer's health care plan, or in lieu of family coverage. A bounty is generally set at an amount that is less than the amount that would otherwise be available to purchase benefits under the Section 125 plan. IPERS does not treat bounties as covered wages. The uniformity and nondiscrimination principles described in subrule 6.5(4) do not apply to such benefits.

b. Paragraph *"a"* no longer applies effective June 21, 2010. An employer that has relied on the bounty rule to exclude bounty payments from covered wages shall have until September 1, 2010, to bring payroll processes and prospective wage coverage into compliance. No retroactive adjustment shall be required for employers that relied on paragraph *"a"* for periods prior to September 1, 2010.

[**ARC 8929B**, IAB 7/14/10, effective 6/21/10; **ARC 9068B**, IAB 9/8/10, effective 10/13/10; **ARC 2402C**, IAB 2/17/16, effective 3/23/16]

These rules are intended to implement Iowa Code sections 97B.1A(26), 97B.9, 97B.11, 97B.14 and 97B.14A.

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CHAPTER 8
SERVICE PURCHASES
[Prior to 11/24/04, see 581—Ch 21]

495—8.1(97B) Service eligible for purchase.

8.1(1) *Prior service buy-back.*

a. Effective July 1, 1990, a member who was active, vested or retired on or after July 1, 1978, and who made contributions to IOASI between January 1, 1946, and June 30, 1953, and took a refund of those contributions, may buy back the amount of that refund plus interest in order to establish quarters of service covered by the refund. Less than a full quarter of service will be considered equivalent to a full quarter of service. A teacher who has three quarters of service and a contract for the following year will be granted four quarters of service. IPERS may require the submission of a copy of the contract.

b. Prior to July 1, 1990, a member who was active, vested or retired as of July 1, 1978, and who made contributions to IOASI between January 1, 1946, and June 30, 1953, and who took a refund of those contributions, was able to buy back the amount of that refund and establish years of service covered by the refund.

c. A member cannot participate in the prior service buy-back if the member had taken an IPERS refund (contributions made after July 4, 1953) unless the member first participated in the IPERS buy-back in accordance with this rule.

If a member decides to buy back prior service credit, the member must repay the entire refunded amount plus the accumulated interest and interest dividends on that amount.

If a member participating in a prior service buy-back had years of public service within Iowa prior to January 1, 1946, those years of service will also be added to the member's account at no cost, subject to the member's providing verification of public service.

8.1(2) *Service credit for other public employment.*

a. Effective July 1, 1992, a vested or retired member may make application to IPERS for purchasing credit for service rendered to another public employer. In order to be eligible, a member must:

(1) Have been a public employee in a position comparable to an IPERS covered position at the time the application for buy-in is processed. Effective July 1, 1990, "public employee" includes a member who had service as a public employee in another state, or for the federal government, or within other retirement systems established in the state of Iowa; and

(2) Submit verification of service for that other public employer to IPERS.

A quarter of credit may be purchased for each quarter the employee received wages.

b. Effective July 1, 1992, through June 30, 1999, a qualifying member who decides to purchase IPERS credit must make employer and employee contributions to IPERS for each calendar quarter of service allowed in this buy-in. This contribution shall be determined using the member's IPERS covered wages for the most recent full calendar year of IPERS coverage, the applicable rates established in Iowa Code sections 97B.11, 97B.49B and 97B.49C, and multiplied by the number of quarters being purchased from other public employment. "Applicable rates" means the rates in effect at the time of purchase for the types of service being purchased. A member must have at least four quarters of reported wages in any calendar year before a buy-in cost may be calculated.

c. Effective July 1, 1992, through June 30, 1999, if a vested or retired member does not have wages in the most recent calendar year, the cost of the buy-in will be calculated using the member's last calendar year of reported wages, adjusted by an inflation factor based on the Consumer Price Index as published by the United States Department of Labor.

d. Members eligible to complete the buy-in may buy the entire period of service for a public employer or may buy credit in increments of one or more calendar quarters. The quarters need not be specifically identified to particular calendar quarters. A period of service is defined as follows: (1) if a member was continuously employed by an employer, the entire time is one period of employment, regardless of whether a portion or all of the service was covered by one or more retirement systems; and (2) if a member is continuously employed by multiple employers within a single retirement system, the

entire service credited by that retirement system is one period of employment. A member with service credit under another public employee retirement system who wishes to transfer only a portion of the service value of the member's public service in another public system to IPERS must provide a waiver of that service time to IPERS together with proof that the other public system has accepted this waiver and allowed partial withdrawal of service credit. Members are allowed to purchase time credited by the other public employer as a leave of absence in the same manner as other service credit. However, members wishing to receive free credit for military service performed while in the employ of a qualifying non-IPERS covered public employer must purchase the entire period of service encompassing the service time for that public employer or in the other retirement system, excluding the military time. Veterans' credit originally purchased in another retirement system may be purchased in the same manner as other service credit.

e. The total amount paid will be added to the member's contributions, and the years of service this amount represents will be added to the member's IPERS years of service. Effective January 1, 1993, the purchase will not affect the member's three-year average covered wage.

f. Effective July 1, 1999, an eligible member must pay the actuarial cost of a buy-in, as certified by IPERS. In calculating the actuarial cost of a buy-in, IPERS shall apply the same actuarial assumptions and cost methods used in preparing IPERS' annual actuarial valuation, except that: (1) the retirement assumption shall be changed to 100 percent at the member's earliest unreduced retirement age; and (2) if gender-distinct mortality assumptions are used in the annual actuarial valuation, the system shall use blended mortality assumptions reasonably representative of the system's experience. The actuarial cost of a service purchase shall be the difference between (1) the actuarial accrued liability for the member using the foregoing assumptions and current service credits, and (2) the actuarial accrued liability for the member using the foregoing assumptions, current service credits, and all quarters of service credit available for purchase. If IPERS changes the service purchase mortality assumptions, all outstanding service purchase quotes shall be binding for the remainder of the periods for which the cost quotes were issued. A cost quote for a service purchase shall expire six months after the date printed on the cost quote letter. After that time, a new cost quote must be obtained for any quarters not previously purchased.

g. Effective January 1, 2016, for new service purchase applications and updated cost requests received, the following procedures and calculations shall apply:

(1) Service purchase estimate prior to retirement. Members who are vested by service may request a service purchase estimate by completing and submitting a service purchase application. Once the application is submitted, IPERS shall complete a cost estimate. This calculation is an estimate only and is not considered binding. The cost estimate shall be calculated as follows:

1. IPERS will calculate the cost by capturing the baseline benefit attributes at the member's anticipated retirement date without any service purchase quarterly credits including: average salary, years of service, the Option 2 benefit amount, current member investment amount and the calculated present-day reserve value. The present-day reserve value is a lump sum value calculated with actuarial tables provided by the system's actuary which represents the lump sum value sufficient to pay the monthly benefits over the member's expected life span.

2. With each potential purchasable quarterly service credit, IPERS will recalculate the Option 2 benefit amount. A new present-day reserve value will also be calculated. The cost of each quarterly service credit will be the difference between the new reserve amount and the previous one.

(2) Final service purchase cost quote at retirement. On or before the date that a member's first benefit payment is issued, a member who is vested by service may request a final service purchase cost quote by completing and submitting an application for retirement/disability benefit indicating the member's desire to receive a final service purchase cost quote. After the completed application has been submitted, IPERS shall generate a final service purchase cost quote once all of the member's wages are submitted to IPERS, which may be after the member's first month of entitlement. The final cost quote shall be calculated as follows:

1. IPERS will calculate the cost by capturing the baseline benefit attributes at the member's first month of entitlement without any service purchase quarterly credits including: average salary, years of service, the Option 2 benefit amount, current member investment amount and the calculated present-day

reserve value. The present-day reserve value is a lump sum value calculated with actuarial tables provided by the system's actuary which represents the lump sum value sufficient to pay the monthly benefits over the member's expected life span. With each potential purchasable service credit, IPERS will recalculate the Option 2 benefit amount. A new present-day reserve value will also be calculated. The cost of each purchasable quarter of service credit will be the difference between the new reserve amount and the previous one.

2. The retired member will have six months from the date in which IPERS generates the final service purchase cost quote to purchase additional service.

3. If the retired member purchases service within the six-month deadline, the increase in the retirement benefit shall be made effective with the month of the service purchase payment.

4. Retired members who do not indicate their desire for a final service purchase cost quote on or before the date their first payment is issued or do not complete the purchase within the six-month deadline indicated on the final service purchase cost quote shall not be eligible to purchase additional credit.

5. Retired members who selected Option 1 upon retirement may request the lump sum death benefit to be increased to take into account the additional contributions from making a service purchase. If the member requests an increase in the death benefit, the monthly benefit will be reduced to take into account the increased death benefit.

(3) Cost adjustments due to changes in the original retirement benefit. If an error in the service purchase cost is discovered or a retired member's account is adjusted in any manner after a purchase is made, IPERS may rescind the service purchase, make adjustments to the service purchase cost, or adjust the retirement allowance to ensure the member paid the actuarial cost of buying additional service. In the event that a retired member overpays due to an adjustment, IPERS will issue a refund to the retired member directly or to the rollover institution.

8.1(3) *IPERS buy-back.* Effective July 1, 1996, only vested or retired members may buy back previously refunded IPERS credit. For the period beginning July 1, 1996, and ending June 30, 1999, an eligible member is required to make membership contributions equal to the accumulated contributions received by the member for the period of service being purchased plus accumulated interest and interest dividends. Effective July 1, 1999, an eligible member must pay the actuarial cost of a buy-back, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions and cost methods used in preparing IPERS' annual actuarial valuation, except that: (1) the retirement assumption shall be changed to 100 percent at the member's earliest unreduced retirement age; and (2) if gender-distinct mortality assumptions are used in the annual actuarial valuation, the system shall use blended mortality assumptions reasonably representative of the system's experience. The actuarial cost of a service purchase shall be the difference between (1) the actuarial accrued liability for the member using the foregoing assumptions and current service credits, and (2) the actuarial accrued liability for the member using the foregoing assumptions, current service credits, and all quarters of service credit available for purchase. If IPERS changes the service purchase mortality assumptions, all outstanding service purchase quotes shall be binding for the remainder of the periods for which the cost quotes were issued. A cost quote for a service purchase shall expire six months after the date printed on the cost quote letter. After that time, a new cost quote must be obtained for any quarters not previously purchased.

Effective July 1, 1996, buy-backs may be made in increments of one or more calendar quarters. Prior to July 1, 1996, the member was required to repurchase the entire period of service and repay the total amount received plus accumulated interest and interest dividends.

A member who is vested solely by having attained the age of 55 must have at least one calendar quarter of wages on file with IPERS before completing a buy-back.

For persons who submitted requests for buy-back cost quotes on or before January 14, 2004, IPERS shall restore the wage records of a member who makes a buy-back based on those quotes and utilize those wage records in subsequent benefit calculations for that member.

For persons who submit requests for buy-back cost quotes and make purchases based on those quotes after January 14, 2004, IPERS shall not restore the wage records for the purchased quarters. After

January 14, 2004, such buy-backs shall be treated like all other service purchases and IPERS will only restore service credit.

Effective January 1, 2016, the member must be vested by service and must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

8.1(4) *Prior service credit prior to January 1946.* A member who had service before January of 1946 but no service between January 1, 1946, and June 30, 1953, is eligible to receive credit for that service at no cost, subject to the member's providing verification of that service. If the member was employed after July 4, 1953, and took a refund of contributions, that member must first participate in the membership service buy-back (see subrule 8.1(3)) before receiving credit for service prior to 1946.

A member must submit proof of service in order to qualify.

8.1(5) *Veterans' credit.*

a. Effective July 1, 1992, a vested or retired member, in order to receive service credit under the IPERS system, may elect to make employer and employee contributions to IPERS for a period of active duty service in the armed forces of the United States, in increments of one or more calendar quarters, if the member produces verification of active duty service in the armed forces of the United States.

b. A member must have at least four quarters of reported wages in any calendar year before a buy-in cost may be calculated.

c. A service purchase shall not affect the member's high three-year average wage.

d. Effective July 1, 1999, an eligible member must pay the actuarial cost of a military service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions and cost methods as those in paragraph 8.1(2)*"f."*

e. Effective January 1, 2016, the member must be vested by service and must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

8.1(6) *Legislative members.*

a. Active members. Persons who are members of the Seventy-first General Assembly or a succeeding general assembly during any period beginning July 4, 1953, may, upon proof of such membership in the general assembly, make contributions to the system for all or a portion of the period of such service in the general assembly. The contributions made by the member shall be determined in the same manner as provided in paragraph 8.1(2)*"f."*

b. Vested or retired former members of the general assembly.

(1) A vested or retired member of the system who was a member of the general assembly prior to July 1, 1988, may make contributions to the system for all or a portion of the period of service in the general assembly.

(2) The contributions made by the member shall be equal to the accumulated contributions as defined in Iowa Code section 97B.1A(2), which would have been made if the member of the general assembly had been a member of the system during the period of service in the general assembly being purchased.

(3) The member shall submit to IPERS proof of membership in the general assembly for the period claimed.

(4) Upon determining a member eligible and receiving the appropriate contributions from the member, IPERS shall credit the member with the period of membership service for which contributions are made.

c. Incremental purchases. Service purchased under this subrule must be purchased in increments of one or more calendar quarters.

d. Actuarial cost. Effective July 1, 1999, an eligible member must pay 40 percent and the Iowa legislature shall pay 60 percent of the actuarial cost of a legislative service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions and cost methods as those in paragraph 8.1(2)*"f."*

e. Effective January 1, 2016, the member must be vested by service and must pay 40 percent and the Iowa legislature shall pay 60 percent of the actuarial cost of a service purchase, as certified by IPERS.

In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

8.1(7) *Vocational school (area community college) employees who may elect coverage under another retirement system.*

a. Effective July 1, 1990, a person newly entering employment with an area vocational school or area community college may choose to forego IPERS coverage and elect coverage under an alternative retirement benefits system, which is issued by or through a nonprofit corporation issuing retirement annuities exclusively to educational institutions and their employees. This option is available only to those newly hired persons who are already members of the alternative retirement system. Such an election by a newly employed person is irrevocable.

b. Effective July 1, 1994, and providing that the board of directors of the area vocational school or area community college have approved participation in an alternative retirement system pursuant to Iowa Code section 260C.23, a member employed by an area vocational school or an area community college may elect coverage under an alternative retirement benefits system, which is issued by or through a nonprofit corporation issuing retirement annuities exclusively to educational institutions and their employees, in lieu of continuing or commencing contributions to IPERS.

c. Effective July 1, 1994, a person who is employed before that date with an area community college may file a one-time irrevocable election form with IPERS and the employer electing participation in an alternative plan. The election form must be postmarked by December 31, 1995. If a person is employed July 1, 1994, or later, the person may file a one-time election form with IPERS and the employer electing participation in the alternative plan. The election form must be postmarked within 60 days from the date employed. The employee will be a member of IPERS unless an election is filed within the specified time frames. An employee vested with IPERS retains all of the rights of any vested member for as long as the contributions remain with the fund. Such members may not, however, apply for retirement benefits until attaining the age of 70, or until they terminate employment with all public employers.

d. Effective July 1, 1999, an eligible member must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions and cost methods as those in paragraph 8.1(2)*"f."*

e. Effective January 1, 2016, the member must be vested by service and must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

8.1(8) *Leaves of absence.* Service credit for leaves of absence that begin on or after July 1, 1998, may be purchased. A member must be vested or retired and must have one calendar year of wages on file in order to make such a purchase.

For a leave of absence beginning on or after July 1, 1998, and purchased before July 1, 1999, the service purchase cost shall be equal to the employer and employee contributions and interest payable for the employee's most recent year of covered wages, adjusted by the inflation factor used in paragraph 8.1(2)*"c."* For a leave of absence beginning on or after July 1, 1998, and purchased on or after July 1, 1999, the service purchase cost shall be the actuarial cost, as certified by IPERS. In calculating the actuarial cost of a service purchase under this subrule, IPERS shall apply the same actuarial assumptions and cost methods as those in paragraph 8.1(2)*"f."*

Effective January 1, 2016, the member must be vested by service and must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

8.1(9) *Service credit for elective coverage positions—coverage not elected.* Service credit for periods of time prior to January 1, 1999, when the member was employed in a position for which coverage could have been elected, but was not, may be purchased. The cost of such service purchases shall be calculated in the same manner as provided for buy-ins under paragraph 8.1(2)*"f."* In addition, a member must be vested or retired, and must have one calendar year of wages on file in order to make such a purchase.

Effective January 1, 2016, the member must be vested by service and must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

8.1(10) *Service credit for noncovered public employment in Iowa.* A vested or retired member who has one or more years of service credit and who was previously employed in public employment for which optional coverage was not available, such as substitute teaching or other temporary employment, may purchase service credit for such employment subject to the requirements of Iowa Code section 97B.80C. Service credit may not be purchased under this subrule for periods in which the individual was performing services as an independent contractor. The contributions required under this subrule shall be in an amount equal to the actuarial cost of the service purchase as determined under paragraph 8.1(2)*"f."*

Effective January 1, 2016, the member must be vested by service and must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

8.1(11) *Federal Peace Corps program service credit under Iowa Code section 97B.80C.* Rescinded IAB 7/16/08, effective 6/25/08.

8.1(12) *Purchase of service credit for employment with a qualified Canadian governmental entity.* Rescinded IAB 7/16/08, effective 6/25/08.

8.1(13) *Patient advocate service purchases.* Rescinded IAB 7/16/08, effective 6/25/08.

[**ARC 1887C**, IAB 2/18/15, effective 3/25/15; **ARC 2402C**, IAB 2/17/16, effective 3/23/16]

495—8.2(97B) Revocation of service purchase application and refund of amounts paid. A member may revoke a service purchase application and receive a refund without interest of all or a portion of amounts paid to IPERS to buy back prior service credit or to purchase credit for other service pursuant to Iowa Code chapter 97B. The revocation must be made in writing within 60 days after the date of receipt of such amounts by IPERS. Such refunds shall be in increments representing one or more quarters. No refund shall be made if a member has made a service purchase under this chapter and one or more monthly retirement allowance payments have been made thereafter. Furthermore, this rule shall not limit IPERS' ability to refund service purchase amounts when required in order to meet the provisions of the Internal Revenue Code that apply to IPERS. This rule shall be effective for revocation requests received by IPERS on or after May 3, 1996.

495—8.3(97B) IRC Section 415(n) compliance. Service purchases made under this chapter and other posttax contributions shall not exceed the defined contribution limit then in effect under Internal Revenue Code Section 415(c), per calendar year. In addition, the amounts contributed for service purchases under this chapter shall not exceed the amount required to purchase the service according to the current cost schedules. In implementing these and the other requirements of IRC Section 415(n), IPERS shall use the following procedures.

8.3(1) If the member's total benefit at retirement passes the fully reduced IRC Section 415(b) dollar limit test, IPERS shall pay the total benefit.

8.3(2) If the member's total benefit at retirement fails the fully reduced IRC Section 415(b) dollar limit test, and the member made one or more service purchases, IPERS shall perform the applicable IRC Section 415 tests, with adjustments for posttax service purchases and other posttax contributions, and pay excess amounts, if any, under a qualified benefits arrangement authorized under Iowa Code section 97B.49I.

8.3(3) IPERS permits the purchase of nonqualified service credit, as defined under IRC Section 415(n). "Nonqualified service" means:

a. Service that is not qualified service under Iowa Code section 97B.80C; and

b. Service for which no services were performed; and

c. Service for which the member is entitled to receive retirement benefits under another retirement plan. A member must have 20 quarters of existing service to make such a purchase. Nonqualified service credit purchased shall not exceed 20 quarters. This limit is an aggregate limit that applies to all quarters categorized as nonqualified service credit.

8.3(4) The limitations of this rule shall not apply to buy-backs of prior refunds. In addition, the annual limit under this rule shall not apply to service purchases grandfathered under the provisions of the Iowa Code and Section 1526 of the Taxpayer Relief Act of 1997.

8.3(5) If IPERS adopts rules and procedures permitting service to be purchased on a pretax basis, the amounts contributed will not be combined with posttax service purchases and other posttax contributions in applying the foregoing procedures.

8.3(6) The provisions of this rule shall apply to all vested members who have an account balance and to retired members.

8.3(7) The IRC Section 415(c) limitations shall not apply to a service purchase that qualifies as a direct rollover for an eligible retirement plan or a direct transfer from a plan qualified under IRC Section 403(b) or 457. The IRC Section 415(c) limits also shall not apply to a service purchase under subrule 8.1(3).

8.3(8) IPERS reserves the right to apply the limitations of IRC Section 415(n) on a case-by-case basis to ensure that such limits are not exceeded.

495—8.4(97B) Required quarters of wages on file.

8.4(1) If a member is attempting to purchase service credit under this chapter, and any particular rule under this chapter requires that the member must have four calendar quarters of wages on file as a precondition to making the purchase, and the member's regular job duties are performed in fewer than four calendar quarters each year, the four-calendar-quarter requirement shall be reduced to the number of calendar quarters regularly worked by the member.

8.4(2) Effective January 1, 2016, the member must be vested by service.

[**ARC 1887C**, IAB 2/18/15, effective 3/25/15]

495—8.5(97B) Additional information, procedures and limitations.

8.5(1) *Information required for service purchase cost quotes.*

a. Active and inactive members. For active and inactive members, a service purchase cost quote must include the following information: member's date of birth, the applicable occupation class code, total years of current unused IPERS service credit, highest calendar year of covered wages on file, member's current investment, and the total number of quarters available to purchase on this cost quote.

Effective January 1, 2016, the member must be vested by service and must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

b. Retired members. For retired members, a service purchase cost quote must include the following information: member's date of birth, the applicable occupation class code, average of the highest three calendar years of covered wages, the option the member selected at retirement, the total number of quarters available to purchase on this cost quote, and a calculation of the member's new benefit amount if the member actually purchases all of the quarters in this service purchase cost quote.

If the member retired under Option 4 or 6, IPERS must be provided with either the date of death or the date of birth, as applicable, for the contingent annuitant, and the percent selected by the member for continuation of benefits to the contingent annuitant upon the member's death. If the member retired under Option 6, IPERS shall calculate how the member's benefits will change under Option 2 upon the contingent annuitant's death. In preparing cost quotes for retired members who selected Option 4 or 6, IPERS shall use for beneficiary mortality assumption the reverse of the assumption used for benefit mortality.

If the member retired under Option 5, a service purchase cost quote shall also include information on how many months are remaining on the guaranteed ten-year payout.

Effective January 1, 2016, the member must be vested by service and must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

c. Reemployment. If the member is retired and subsequently reemployed in IPERS covered employment and then requests a service purchase cost quote, IPERS shall apply the service to be

purchased to the member's original annuity. IPERS shall use the same information as described in paragraphs *"a"* and *"b"* of this subrule, and IPERS shall appropriately calculate the service purchase cost quote.

Effective January 1, 2016, retired and subsequently reemployed members are no longer eligible.

d. Wage records restored. When buy-back quarters are purchased based on cost quotes requested prior to January 14, 2004, the member's wage record shall be restored, beginning with the lowest wage quarter and restoring additional quarters in ascending order based on the covered wages reported for such quarters. Wage records shall not be created or restored for any other type of service purchase.

e. Wage records not restored. For members who submit requests for buy-back cost quotes and make purchases based on those quotes after January 14, 2004, IPERS shall not restore the wage records for the purchased quarters. After January 14, 2004, such buy-backs shall be treated like all other service purchases, and IPERS will only restore service credit.

8.5(2) *Additional service purchase procedures.*

a. Service purchase cost quotes for members currently in special service positions shall be prepared as special service credit.

b. Members covered under another retirement plan. Members who wish to buy service credit for employment that is covered by another retirement plan qualified under IRC Section 401, IRC Section 403 or 457 and similar plans and retirement pay from the United States government for active duty in the armed forces (except retirement pay for nonregular service pursuant to 10 U.S.C. Sections 12731-12739) must waive their right to benefits based on the service credit that is being purchased under IPERS. If a waiver is not obtained, however, service purchases for such employment may still be made but shall be limited to 20 quarters.

c. Members retired under IPERS' disability formula. A retired member receiving IPERS benefits as a result of a disability shall receive a service purchase cost quote which reflects no penalty for early age reduction.

d. Effective January 1, 2007, IPERS may, notwithstanding certain provisions of Iowa Code section 97B.82 adopted in order to comply with prior rollover provisions of the Internal Revenue Code, utilize forms and procedures permitting direct rollover service purchases to include after-tax amounts as provided under the applicable rollover provisions of the Internal Revenue Code as amended subsequent to the enactment of Iowa Code section 97B.82.

8.5(3) *Additional service purchase limitations.*

a. Under no circumstances shall service purchases be allowed for quarters already on file with IPERS as covered quarters.

b. If a member has requested a service purchase cost quote and, before the six-month expiration has passed, submits another request for a service purchase cost quote for the same or different employer, the new service purchase cost quote will be based on a combination of the two service purchase cost quotes. The latest service purchase cost quote shall supersede all prior cost quotes provided to the member for the quarters that the member purchases after the issuance of the second cost quote.

c. If before the six-month expiration has passed a member has made a partial purchase under a service purchase cost quote and requests another service purchase cost quote, the quarters covered by the original cost quote will be added to the new request. IPERS will prepare a new service purchase cost quote. The latest service purchase cost quote shall supersede all prior quotes provided to the member for quarters that the member purchases after the issuance of the second cost quote. For example, if the member receives a cost quote of $300 per quarter for 6 quarters of Illinois public employment and, three months later, after buying 3 Illinois quarters, requests a service purchase cost quote for 8 quarters of military service, the second quote would be prepared using 11 quarters as the basis for the cost quote. The per-quarter cost quote prepared using the 11 quarters would supersede the $300 per-quarter cost previously quoted. This superseding cost principle will apply regardless of whether the recalculated cost is greater or less than the superseded quote. Thus, in the above example, if the second cost quote is $350 per quarter, that would be the price for all 11 quarters for the next six months. However, if the second quote comes in at $250 per quarter, that would be the cost for all 11 quarters for the next six months.

d. Self-employed members. Because of the difficulty in documenting what portion of the amounts paid are actually related to the performance of services, including amounts reported to the federal and state tax authorities, members shall not be permitted to purchase service credit for periods of self-employment.

8.5(4) *"Buy up" of service credit through service purchase.* Effective July 1, 2008, IPERS members may be allowed to "buy up" service credit. The term "buy up" means to convert regular service credit to special service credit by payment of the actuarial cost. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions and cost methods as those in paragraph 8.1(2)*"f,"* except as modified according to the actuary's recommendations.

Effective January 1, 2016, the member must be vested by service and must pay the actuarial cost of a service purchase, as certified by IPERS. In calculating the actuarial cost, IPERS shall apply the same actuarial assumptions, procedures and cost methods as those described in paragraph 8.1(2)*"g."*

a. Active, retired and inactive members. Effective January 1, 2016, a member must have at least one quarter of available or retired special service wages on file and must be vested by years of service at the time of the buy-up.

b. Mixture of service time. If a member's service time contains a mixture of regular, protection and sheriff service credit, IPERS shall prepare buy-up cost quotes as follows:

(1) If the member is currently employed in the sheriff class or retired as a sheriff, the cost quote shall be prepared reflecting a buy-up to sheriff service credit.

(2) If the member is not currently employed in the sheriff class or did not retire as a sheriff, the cost quote shall be prepared reflecting a buy-up to protection occupation service credit.

c. Wage adjustment after a buy-up. If an employer wage adjustment completely removes a member's service credit in a buy-up quarter, IPERS shall correct the service credit and perform the necessary recalculations.

d. IRS limitations. Buy-up service purchases will be aggregated with buy-in service purchases during a calendar year and subjected to the applicable limits of Section 415(c) of the Internal Revenue Code. Amounts that are rolled over from other qualified plans for service purchases are excluded from these limits.

[**ARC 1887C**, IAB 2/18/15, effective 3/25/15]

495—8.6(97B) Adjustments. If an error in the service purchase cost is discovered or a member's account is adjusted in any manner after a purchase is made, IPERS may rescind the service purchase, make adjustments to the service purchase cost, or adjust the retirement allowance to ensure the active or retired member is paying the actuarial cost of buying additional service.

[**ARC 1887C**, IAB 2/18/15, effective 3/25/15]

These rules are intended to implement Iowa Code sections 97B.1A, 97B.1A(13), 97B.1A(20), 97B.43, 97B.80, 97B.80C, and 97B.82.

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CHAPTER 9
REFUNDS
[Prior to 11/24/04, see 581—Ch 21]

495—9.1(97B) Refunds for members with only one type of service credit. A member is eligible for a refund of the employee accumulated contributions as soon as practicable after the last date the member is considered an employee, provided that the employee has filed the required forms and has not returned to covered employment before the date the refund is paid. Effective July 1, 1999, a vested member's refund shall also include a portion of the employer accumulated contributions. Refund amounts are determined as follows:

9.1(1) Employee accumulated contributions. Upon receiving an eligible member's application for refund, IPERS shall pay to the terminated member the amount of the employee accumulated contributions currently reported to, and processed by, IPERS as of the date of the refund. Upon reconciliation of the final employee contributions for that member, a supplemental refund of the employee accumulated contributions will be paid if funds remain in the member account.

9.1(2) Employer accumulated contributions. IPERS shall also pay to vested members, in addition to the employee accumulated contributions, a refund of a portion of the employer accumulated contributions. The refundable portion shall be calculated by multiplying the employer accumulated contributions by the "service factor." The "service factor" is a fraction, the numerator of which is the member's quarters of service and the denominator of which is the "applicable quarters." The "applicable quarters" shall be 120 for regular members and 88 for all special service members.

All quarters of service credit shall be included in the numerator of the service factor. In no event will a member ever receive an amount in excess of 100 percent of the employer accumulated contributions for that member.

In addition to the foregoing provisions, IPERS shall calculate the refundable portion of the employer accumulated contributions as follows:

a. Upon reconciliation of the final employer contributions for that member, the member's portion of the employer accumulated contributions will be recalculated. IPERS will add the additional quarter(s) of service to the numerator of the service factor. The adjusted service factor will be multiplied by the sum of the original employer accumulated contributions plus the supplemental employer accumulated contributions. The employer accumulated contributions included in the original refund will then be subtracted from that recalculated figure to determine the amount of employer accumulated contributions to be included in the supplemental refund.

b. The member's portion of employer accumulated contributions shall be determined under rule 495—9.2(97B) if the member had a combination of regular service and special service, or a combination of different types of special service.

9.1(3) In making calculations under this rule and rule 495—9.2(97B), IPERS shall round to not less than six decimal places to the right of the decimal point.

495—9.2(97B) Refunds for members eligible for a hybrid refund. The calculation of the member's portion of employer accumulated contributions for a "hybrid refund" shall be as follows:

9.2(1) A "hybrid refund" is a refund that is calculated for a member who has a combination of regular service and special service quarters.

9.2(2) If a member is eligible for a hybrid refund, the member's portion of employer accumulated contributions shall be calculated by multiplying the total employer accumulated contributions by: (a) the member's regular service factor, if any; and (b) the special service factor, if any (except as otherwise provided in this subrule). The amounts obtained will be added together to determine the amount of the employer accumulated contributions payable. In no event will a member ever receive an amount in excess of 100 percent of the employer accumulated contributions for that member.

9.2(3) Upon reconciliation of the final contributions from a member's employer, the member's portion of the employer accumulated contributions under this rule will be recalculated. IPERS will add the additional quarter(s) of service to the numerator of the applicable service factor. The adjusted

service factor will be multiplied by the sum of the original employer accumulated contributions plus the supplemental employer accumulated contributions. The employer accumulated contributions included in the original refund will then be subtracted from that recalculated figure to determine the amount of the employer accumulated contributions to be included in the supplemental refund.

9.2(4) If wages reported for a quarter are a combination of regular and special service wages, IPERS will classify the service credit for each quarter based on the largest dollar amount reported for that quarter. A member shall not receive more than one quarter of service credit for any calendar quarter, even though more than one type of service credit is recorded for that quarter.

9.2(5) If a member is last employed in a sheriff or deputy sheriff position, all quarters of "eligible service" shall be counted as quarters of sheriff or deputy sheriff service credit.

9.2(6) A special limitation applies to hybrid refunds where the member and employer contributed at regular rates for quarters that are eligible for coverage under Iowa Code section 97B.49B or Iowa Code section 97B.49C. If a member has regular service credit and special service credit and any part of the special service credit consists of quarters for which only regular contributions were made, such quarters will be counted as regular service quarters. However, the foregoing limitation will not apply if the member only has service credit eligible for coverage under Iowa Code section 97B.49B or only has service credit eligible for coverage under Iowa Code section 97B.49C.

495—9.3(97B) Refund of retired reemployed members' contributions. Rescinded IAB 7/14/10, effective 6/21/10.

495—9.4(97B) General administrative provisions. In addition to the foregoing, IPERS shall administer a member's request for a refund as follows:

9.4(1) To obtain a refund, a member must file a refund application form, which is available directly from IPERS or which can be reprinted from IPERS' Web site: www.ipers.org. Effective December 31, 2002, refund application forms shall only be available from IPERS. If the member is married, election of a refund under this chapter requires the written acknowledgment of the member's spouse. However, the system may accept a married member's election of a refund under this chapter without the written acknowledgment of the member's spouse if the member submits a notarized statement indicating that, after reasonable diligent efforts, the member has been unable to locate the member's spouse to obtain the written acknowledgment of the spouse. The member's election of a refund shall become effective upon filing the necessary forms, including the notarized statement, with the system. The system shall not be liable to the member, the member's spouse, nor to any other person affected by the member's election of a refund based upon an election of a refund accomplished without the written acknowledgment of the member's spouse.

9.4(2) The last date the member is considered an employee and the date of the last paycheck from which IPERS contributions will be deducted must be certified by the employer on the refund application unless the member has not been paid covered wages for at least one year or the employer has provided the termination date and date of the last paycheck on the monthly wage reports. Terminated employees must keep IPERS advised in writing of any change in address so that refunds and tax documents may be delivered.

9.4(3) Unless otherwise specified by the member, the refund warrant will be mailed to the member at the address listed on the application for refund. If a member so desires, the warrant may be delivered to the member or the member's agent at IPERS' principal office. The member must show verification of identification by presenting a picture identification containing both name and social security number. If a member designates in writing an agent to pick up the refund warrant, the agent must present to IPERS both the written designation and the described picture identification.

9.4(4) No payment of any kind is required under this rule if the amount due is less than $1.

9.4(5) Effective July 1, 2004, an employee must sever all covered employment for 30 days after the date the employee was last considered an employee, and not for 30 days after the date of the last paycheck containing IPERS covered wages.

9.4(6) Effective November 2006, an individual who previously stopped participating in IPERS to begin participating in an alternative plan shall not receive a refund of that individual's IPERS account while still employed by a covered employer, even if the member is no longer in IPERS covered employment.
[**ARC 1348C**, IAB 2/19/14, effective 3/26/14; **ARC 1887C**, IAB 2/18/15, effective 3/25/15]

495—9.5(97B) Termination of employment—refund option. If a member is involuntarily terminated from covered employment, has been issued payment for a refund, and is retroactively reinstated in covered employment as a remedy for an employment dispute, the member may receive credit for membership service for the period covered by the refund payment upon repayment to the system, within 90 days after the date of the order or agreement requiring reinstatement, of the amount of the refund plus interest that would have accrued, as determined by the system. A reinstatement following an employment dispute shall not constitute a violation of Iowa Code section 97B.53(4), even if the reinstatement occurs less than 30 days after the date of termination.
[**ARC 2402C**, IAB 2/17/16, effective 3/23/16]

495—9.6(97B) Refund followed by commencement of disability benefits under Iowa Code section 97B.50(2). If a vested member terminates covered employment, takes a refund, and is subsequently approved for disability under the federal Social Security Act or the federal Railroad Retirement Act, the member may reinstate membership service credit for the period covered by the refund by paying the actuarial cost as determined by IPERS' actuary. Repayments must be made by:

1. For members whose federal social security or railroad retirement disability payments begin before July 1, 2000, within 90 days after July 1, 2000; or
2. For members whose social security or railroad retirement disability payments begin on or after July 1, 2000, within 90 days after the date federal social security or railroad retirement payments begin.

These rules are intended to implement Iowa Code sections 97B.50 and 97B.53.

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CHAPTER 11
APPLICATION FOR, MODIFICATION OF, AND TERMINATION OF BENEFITS
[Prior to 11/24/04, see 581—Ch 21]

495—11.1(97B) Application for benefits.

11.1(1) *Form used.* It is the responsibility of the member to notify IPERS of the intention to retire. This should be done 60 days before the expected retirement date. The application for monthly retirement benefits is obtainable from IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. The printed application form shall be completed by each member applying for benefits and shall be mailed, sent by fax or brought in person to IPERS. An application that is incomplete or incorrectly completed will be returned to the member. To be considered complete, an application must include the following:

a. Proof of date of birth for the member.

b. Option selected, and

(1) If Option 1 is selected, the death benefit amount.

(2) If Option 4 or 6 is selected, the contingent annuitant's name, social security number, proof of date of birth, and relationship to member. The member must designate the survivor benefit percentage, which shall be limited to one of the following:

1. One hundred percent of the member's benefit amount.
2. Seventy-five percent of the member's benefit amount.
3. Fifty percent of the member's benefit amount.
4. Twenty-five percent of the member's benefit amount.

(3) If Option 1, 2, or 5 is selected, a list of beneficiaries.

c. If the member has been terminated less than one year, or is applying for disability benefits, the employer certification page must be completed by the employer unless the employer has provided the termination date and date of the last paycheck on the monthly wage reports.

d. Signature of member and spouse, both properly notarized unless witnessed by an authorized employee of the system.

e. If the member has no spouse, "NONE" must be designated.

f. If the member is applying for regular disability benefits, a copy of the award letter from the Social Security Administration or railroad retirement.

A retirement application is deemed to be valid and binding on the date the first payment is paid. Members shall not cancel their applications, change their option choice, or change an IPERS option containing contingent annuitant benefits after that date.

11.1(2) *Proof required in connection with application.* Proof of date of birth to be submitted with an application for benefits shall be in the form of a birth certificate, a U.S. passport, an infant baptismal certificate, a state identification card that is issued in compliance with the REAL ID Act of 2005, or a driver's license that is issued in compliance with the REAL ID Act of 2005. If these records do not exist, the applicant shall submit two other documents or records which will verify the day, month and year of birth. A photographic identification record may be accepted even if now expired unless the passage of time has made it impossible to determine if the photographic identification record is that of the applicant. The following records or documents are among those deemed acceptable to IPERS as proof of date of birth:

a. United States census record;

b. Military record or identification card;

c. Naturalization record;

d. A marriage license showing age of applicant in years, months and days on date of issuance;

e. A life insurance policy;

f. Records in a school's administrative office;

g. An official document from the U.S. Citizenship and Immigration Services, such as a "green card," containing such information;

h. Driver's license or Iowa nondriver identification card;

i. Adoption papers;

j. A family Bible record. A photocopy will be accepted with a notarized certification that the record appears to be genuine; or

k. Any other document or record ten or more years old, or certification from the custodian of such records which verifies the day, month, and year of birth.

If the member, the member's representative, or the member's beneficiary is unable or unwilling to provide proof of birth, or in the case of death, proof of death, IPERS may rely on such resources as it has available, including but not limited to records from the Social Security Administration, Iowa division of records and statistics, IPERS' own internal records, or reports derived from other public records, and other departmental or governmental records to which IPERS may have access.

IPERS is required to begin making payments to a member or beneficiary who has reached the required beginning date specified by Internal Revenue Code Section 401(a)(9). In order to begin making such payments and to protect IPERS' status as a plan qualified under Internal Revenue Code Section 401(a), IPERS may rely on its internal records with regard to date of birth, if the member or beneficiary is unable or unwilling to provide the proofs required by this subrule within 30 days after written notification of IPERS' intent to begin mandatory payments.

11.1(3) *Benefits estimates.* Prior to submitting an application for benefits, a member may request IPERS to prepare estimates of projected benefits under the various options as described under Iowa Code section 97B.51. A benefit estimate shall not bind IPERS to payment of the projected benefits under the various options specified in Iowa Code chapter 97B. A member cannot rely on the benefit estimate in making any retirement-related decision or taking any action with respect to the member's account, nor shall IPERS assume any liability for such actions. An estimate will not include deductions for a QDRO or any other legal assignments or orders on a member's account, unless specifically requested by the member. A member's actual benefit can only be known and officially calculated when an eligible member applies for benefits.

11.1(4) *Revocation of application.* If IPERS determines an application for benefits is invalid for any reason, IPERS shall revoke, in whole or in pertinent part, the application for benefits and the recipient shall repay all payments made under the revoked application or all payments made pursuant to the revoked part of the application. The terms of repayment shall be subject to the provisions of 495—11.7(97B).

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10; **ARC 1348C**, IAB 2/19/14, effective 3/26/14; **ARC 1887C**, IAB 2/18/15, effective 3/25/15; **ARC 2402C**, IAB 2/17/16, effective 3/23/16]

495—11.2(97B) Retirement benefits and the age reduction factor.

11.2(1) *Normal retirement.*

a. A member shall be eligible for monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 65, if otherwise eligible.

b. Effective July 1, 1998, a member shall be eligible for full monthly retirement benefits with no age reduction effective with the first of the month in which the member attains the age of 62, if the member has 20 full years of service and is otherwise eligible.

c. Effective July 1, 1997, a member shall be eligible to receive monthly retirement benefits with no age reduction effective the first of the month in which the member's age on the last birthday and the member's years of service equal or exceed 88, provided that the member is at least the age of 55 and is otherwise eligible.

11.2(2) *Early retirement.* A member shall be eligible to receive benefits for early retirement effective with the first of the month in which the member attains the age of 55 or the first of any month after attaining the age of 55 before the member's normal retirement date, provided the date is after the last day of service and the member is otherwise eligible.

11.2(3) *Aged 70 and older retirees.* A member shall be eligible to receive monthly retirement benefits with no age reduction effective with the first day of the month in which the member attains the age of 70, even if the member continues to be employed.

11.2(4) *Required beginning date.*

a. Notwithstanding the foregoing, IPERS shall commence payment of a member's retirement benefit under Iowa Code sections 97B.49A to 97B.49I (under Option 2) no later than the "required beginning date" specified under Internal Revenue Code Section 401(a)(9), even if the member has not submitted the application for benefits. If the lump sum actuarial equivalent could have been elected by the member, payments shall be made in such a lump sum rather than as a monthly allowance. The "required beginning date" is defined as the later of: (1) April 1 of the year following the year that the member attains the age of 70½, or (2) April 1 of the year following the year that the member actually terminates all employment with employers covered under Iowa Code chapter 97B.

b. If IPERS distributes a member's benefits without the member's consent in order to begin benefits on or before the required beginning date, the member may elect to receive benefits under an option other than the default option described above, or as a refund, if the member contacts IPERS in writing within 60 days of the first mandatory distribution. IPERS shall inform the member which adjustments or repayments are required in order to make the change.

c. If a member cannot be located to commence payment on or before the required beginning date described above, the member's benefit shall be forfeited. However, if a member later contacts IPERS and wishes to file an application for retirement benefits, the member's benefits shall be reinstated.

d. For purposes of determining benefits, the life expectancy of a member, a member's spouse, or a member's beneficiary shall not be recalculated after benefits commence.

e. If an IPERS member has a qualified domestic relations order (QDRO) on file when a mandatory distribution is required, and the QDRO requires the member to choose a specific retirement option, IPERS shall pay benefits under the option required by the order.

11.2(5) *Mandatory distribution of small inactive accounts.* As soon as practicable after July 1, 2004, IPERS shall distribute small inactive accounts to members and beneficiaries as authorized in Iowa Code section 97B.48(5).

11.2(6) *Federal tax code limitation for selection of survivor percentages for same gender spouses.* Rescinded IAB 2/19/14, effective 3/26/14.

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10; **ARC 1348C**, IAB 2/19/14, effective 3/26/14; **ARC 1887C**, IAB 2/18/15, effective 3/25/15]

495—11.3(97B) First month of entitlement (FME).

11.3(1) *General.* A member shall submit a written application to IPERS setting forth the retirement date, provided the member has attained at least age 55 by the retirement date and the retirement date is after the member's last day of service. A member's first month of entitlement shall be no earlier than the first day of the first month after the member's last day of service or, if later, the month provided for under subrule 11.3(2). No payment shall be made for any month prior to the month the completed application for benefits is received by IPERS.

If a member files a retirement application but fails to select a valid first month of entitlement, IPERS will select by default the earliest month possible. A member may appeal this default selection by sending written notice of the appeal postmarked on or before 30 days after a notice of the default selection was mailed to the member. Notice of the default selection is deemed sufficient if sent to the member at the member's address.

11.3(2) *Additional FME provisions.*

a. Effective through December 31, 1992, the first month of entitlement of a member who qualifies for retirement benefits is the first month following the member's date of termination or last day of leave, with or without pay, whichever is later.

b. Effective January 1, 1993, the first month of entitlement of an employee who qualifies for retirement benefits shall be the first month after the employee is paid the last paycheck, if paid more than one calendar month after termination. If the final paycheck is paid within the month after termination, the first month of entitlement shall be the month following termination.

c. Effective January 1, 2001, employees of a school corporation who are permitted by the terms of their employment contracts to receive their annual salaries in monthly installments over periods ranging

from 9 to 12 months may retire at the end of a school year and receive trailing wages through the end of the contract year if they have completely fulfilled their contract obligations at the time of retirement. For purposes of this paragraph, "school corporation" means body politic described in Iowa Code sections 260C.16 (community colleges), 273.2 (area education agencies) and 273.1 (K-12 public schools). For purposes of this paragraph, "trailing wages" means previously earned wage payments made to such employees of a school corporation after the first month of entitlement. This exception does not apply to hourly employees, including those who make arrangements with their employers to hold back hourly wages for payment at a later date, to employees who are placed on sick or disability leave or leave of absence, or to employees who receive lump sum leave, vacation leave, early retirement incentive pay or any other lump sum payments in installments.

For all employees of all IPERS covered employers who terminate employment in January 2003, or later, if the final paycheck is paid within the same quarter or within one quarter after termination and wages are reported under the normal pay schedule, the first month of entitlement shall be the month following termination. However, if the last paycheck is paid more than one quarter after the termination, the first month of entitlement shall be the first month after the employee is paid the last paycheck. Under no circumstances shall such trailing wages result in more than one quarter of service credit being added to retiring members' earning records.

11.3(3) *Survival into designated FME.* To be eligible for a monthly retirement benefit, the member must survive into the designated first month of entitlement. If the member dies prior to the first month of entitlement, the member's application for monthly benefits is canceled and the distribution of the member's account is made pursuant to Iowa Code section 97B.52. Cancellation of the application shall not invalidate a beneficiary designation. If the application is dated later in time than any other designations, IPERS will accept the designation in a canceled application as binding until a subsequent designation is filed.

11.3(4) *Members retiring under the rule of 88.* The first month of entitlement of a member qualifying under the rule of 88 shall be the first of the month when the member's age as of the last birthday and years of service equal 88. The fact that a member's birthday allowing a member to qualify for the rule of 88 is the same month as the first month of entitlement does not affect the retirement date.

495—11.4(97B) Termination of monthly retirement allowance. A member's retirement benefit shall terminate after payment is made to the member for the entire month during which the member's death occurs. Death benefits shall begin with the month following the month in which the member's death occurs.

Upon the death of the retired member, IPERS will reconcile the decedent's account to determine if an overpayment was made to the retired member and if further payment(s) is due to the retired member's named beneficiary, contingent annuitant, heirs at law or estate. If an overpayment has been made to the retired member, IPERS will determine if steps should be taken to seek collection of the overpayment from the named beneficiary, contingent annuitant, estate, heirs at law, or other interested parties.

495—11.5(97B) Bona fide retirement and bona fide refund.

11.5(1) *Bona fide retirement—general.* To receive retirement benefits, a member under the age of 70 must officially leave employment with all IPERS covered employers, give up all rights as an employee, and complete a period of bona fide retirement. A period of bona fide retirement means four or more consecutive calendar months for which the member qualifies for monthly retirement benefit payments. The qualification period begins with the member's first month of entitlement for retirement benefits as approved by IPERS. A member may not return to covered employment before filing a completed application for benefits. Notwithstanding the foregoing, the continuation of group insurance coverage at employee rates for the remainder of the school year for a school employee who retires following completion of services by that individual shall not cause that person to be in violation of IPERS' bona fide retirement requirements.

A member will not be considered to have a bona fide retirement if the member is a school or university employee and returns to work with the employer after the normal summer vacation. In other positions,

temporary or seasonal interruption of service which does not terminate the period of employment does not constitute a bona fide retirement. A member also will not be considered to have a bona fide retirement if the member has, prior to or during the member's first month of entitlement, entered into contractual arrangements with the employer to return to employment after the expiration of the four-month bona fide retirement period.

Effective July 1, 1990, a school employee will not be considered terminated if, while performing the normal duties, the employee performs for the same employer additional duties which take the employee beyond the expected termination date for the normal duties. Only when all the employee's compensated duties cease for that employer will that employee be considered terminated.

The bona fide retirement period will be waived, however, if the member is elected to public office which term begins during the normal four-month bona fide retirement period. This waiver does not apply if the member was an elected official who was reelected to the same position for another term. The bona fide retirement period will also be waived for state legislators who terminate their nonlegislative employment and the IPERS coverage for their legislative employment and begin retirement but wish to continue with their legislative duties.

A member will have a bona fide retirement if the member returns to work as an independent contractor with a public employer during the four-month qualifying period. Independent contractors are not covered under IPERS.

Effective July 1, 1998, through June 30, 2000, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered by 495—Chapter 4, is terminated and the member receives at least four monthly benefit payments. In order to receive retirement benefits, the member must file a completed application for benefits with IPERS before returning to any employment with the same employer.

Effective July 1, 2000, a member does not have a bona fide retirement until all employment with covered employers, including employment which is not covered under this chapter, is terminated for at least one month, and the member does not return to covered employment for an additional three months. In order to receive retirement benefits, the member must file a completed application for benefits before returning to any employment with a covered employer.

11.5(2) *Bona fide retirement—licensed health care professionals.* For retirees whose first month of entitlement is no earlier than July 2004 and no later than June 2014, a retiree who is reemployed as a "licensed health care professional" by a "public hospital" does not have a bona fide retirement until all employment with covered employers is terminated for at least one calendar month. In order to receive retirement benefits, the member must file a completed application for benefits form before returning to any employment with a covered employer.

"Licensed health care professional" means a public employee who is a physician, surgeon, podiatrist, osteopath, psychologist, physical therapist, physical therapist assistant, nurse, speech pathologist, audiologist, occupational therapist, respiratory therapist, pharmacist, social worker, dietitian, mental health counselor, or physician assistant who is required to be licensed under Iowa Code chapter 147.

"Public hospital" means a governmental entity of a political subdivision of the state of Iowa that is authorized by legislative authority. For purposes of this subrule, a "public hospital" must also meet the requirements of Iowa Code section 249J.3. Under Iowa Code section 249J.3, a "public hospital" must be licensed pursuant to Iowa Code chapter 135B and governed pursuant to Iowa Code chapter 145A (merged hospitals), Iowa Code chapter 347 (county hospitals), Iowa Code chapter 347A (county hospitals payable from revenue), or Iowa Code chapter 392 (creation by city of a hospital or health care facility). For the purposes of this definition, "public hospital" does not include a hospital or medical care facility that is funded, operated, or administered by the Iowa department of human services, Iowa department of corrections, or board of regents, or the Iowa Veterans Home.

A "public hospital" possesses the powers conferred upon it by statute, the Iowa Constitution, and regulatory provisions that are unique to governmental entities and hospitals. For example, a "public hospital" may finance its activities by tax levies or the issuance of bonds, condemn property, hold elections, and join forces with other governmental entities in cooperative ventures that are authorized under Iowa Code chapter 28D and Iowa Code chapter 28E. "Public hospitals" are subject to scrutiny

by the public by complying with Iowa Code chapter 21 (open meetings Act) and Iowa Code chapter 22 (open records Act). Public employees of a "public hospital" are covered by Iowa Code chapter 20 (public employment relations Act). A "public hospital" can be distinguished from a profit or not-for-profit hospital by examining whether the focus of the hospital is community service with profits being applied not to rates of return to investors, but to enhance community services, facility upgrading, or subsidized care for persons unable to pay the full cost of service.

This subrule only applies to reemployments that meet all the foregoing requirements and in addition occur following a "complete termination of employment." A "complete termination of employment" means: (1) the employer must post the opening and conduct a job search; (2) the retired member must receive all termination payouts that are mandatory for other terminated employees of that employer; (3) the retired member must give up all perquisites of seniority, to the extent applicable to all other terminated employees of that employer; and (4) the retired member must not enter into a reemployment agreement with the prior employer or another public hospital as defined in this subrule prior to or during the first month of entitlement.

11.5(3) *Bona fide refund.* The 30-day bona fide refund period shall be waived for an elected official covered under Iowa Code section 97B.1A(8)*"a"*(1), and for a member of the general assembly covered under Iowa Code section 97B.1A(8)*"a"*(2), when the elected official or legislator notifies IPERS of the intent to terminate IPERS coverage for the elective office and, at the same time, terminates all other IPERS covered employment prior to the issuance of the refund. Such an official may remain in the elective office and receive an IPERS refund without violating IPERS' bona fide refund rules. If such elected official terminates coverage for the elective office and also terminates all other IPERS covered employment but is then reemployed in covered employment, and has not received a refund as of the date of hire, the refund shall not be made. Furthermore, if such elected official is reemployed in covered employment, the election to revoke IPERS coverage for the elective position shall remain in effect, and the public official shall not be eligible for new IPERS coverage for such elected position.

The prior election to revoke IPERS coverage for the elected position shall also remain in effect if such elected official is reelected to the same position without an intervening term out of office. The waiver granted in this subrule shall be applicable to such elected officials who were in violation of the prior bona fide refund rules on and after November 1, 2002, when such individuals have not repaid the previously invalid refund.

If a member takes a refund in violation of the bona fide refund requirements of Iowa Code section 97B.53(4), the member shall have 30 days from the date of written notice by IPERS to repay the refund in full without interest. Thereafter, in order to receive service credit for the period covered by the refund, the member shall be required to buy back the period of service at its full actuarial cost.

11.5(4) *Part-time appointed members of boards or commissions receiving minimal noncovered wages.* Solely for purposes of determining whether a member has severed all employment with all covered employers and has remained out of employment as required under Iowa Code section 97B.52A, persons who have been appointed as part-time members of boards or commissions prior to or during their first month of entitlement and who receive only per diem and reimbursements for reasonable business expenses for such positions will be deemed not to be in employment prohibited under Iowa Code section 97B.52A.

For purposes of this subrule, per diem shall not exceed the amount authorized under Iowa Code section 7E.6(1)*"a"* for members of boards, committees, commissions, and councils within the executive branch of state government. This limit shall apply regardless of whether or not the position in question is within the executive branch of state government.

Members of boards and commissions not exempted under this subrule include: (a) those who are entitled to the payment of per diem regardless of attendance at board or commission meetings, and (b) those who would have received per diem in excess of the amount authorized under Iowa Code section 7E.6(1)*"a"* were it not for an agreement by the member to waive such compensation.

Persons appointed as part-time board or commission members who receive only per diem as set forth above and reimbursements of reasonable business expenses may continue in or accept appointments to such positions without violating the bona fide retirement rules under Iowa Code section 97B.52A.

11.5(5) *Members of the national guard who are called into state active duty.* Effective May 25, 2008, members of the national guard who are called into state active duty as defined in Iowa Code section 29A.1 in noncovered positions during the required period of complete severance will not be in violation of the bona fide retirement requirements of Iowa Code section 97B.52A as amended by 2010 Iowa Acts, House File 2518, section 33.
[**ARC 8929B**, IAB 7/14/10, effective 6/21/10; **ARC 9068B**, IAB 9/8/10, effective 10/13/10; **ARC 0662C**, IAB 4/3/13, effective 5/8/13]

495—11.6(97B) Payment processing and administration.

11.6(1) *Monthly paper warrants processing fee.* Effective July 1, 2005, IPERS shall charge a per-warrant processing fee to members who choose to receive paper warrants in lieu of electronic deposits of their monthly retirement allowance. The fee may be waived if the person establishes that it would be an undue hardship for the person to do what is necessary to receive payment of the person's IPERS monthly retirement allowance by electronic deposit. The processing fee will be deducted from the member's retirement allowance on a posttax basis.

For purposes of this subrule, a member claiming undue hardship must establish that the cost normally assessed for the processing of paper warrants would be unduly burdensome because of the member's limited income, or is otherwise financially burdensome or physically impracticable.

11.6(2) *Repeated requests for replacement warrants.* Effective July 1, 2002, for a member or beneficiary who, due to the member's or beneficiary's own actions or inactions, has benefits warrants replaced twice in a six-month period, except when the need for a replacement warrant is caused by IPERS' failure to mail to the address specified by the recipient, payment shall be suspended until such time as the recipient establishes a direct deposit account in a bank, credit union or similar financial institution and provides IPERS with the information necessary to make electronic transfer of said monthly payments. Persons subject to said cases may be required to provide a face-to-face interview and additional documentation to prove that such a suspension would result in an undue hardship.

11.6(3) *Forgery claims.* When a forgery of a warrant issued in payment of an IPERS refund or benefit is alleged, the claimant must complete and sign an affidavit before a notary public that the endorsement is a forgery. A supplementary statement must be attached to the affidavit setting forth the details and circumstances of the alleged forgery.

11.6(4) *Rollover fees.* Effective January 1, 2007, if the recipient of a lump-sum distribution which qualifies to be rolled over requests that a rollover be made to more than one IRA or other qualified plan, IPERS may assess a $5 administrative fee for each additional rollover beyond the first one. The fee will be deducted from the gross amount of each distribution, less federal and state income tax.

11.6(5) *Offsets against amounts payable.* IPERS may, with or without consent and upon reasonable proof thereof, offset amounts currently payable to a member or the member's designated beneficiaries, heirs, assigns or other successors in interest by the amount of IPERS benefits paid in error to or on behalf of such member or the member's designated beneficiaries, heirs, assigns or other successors in interest.

11.6(6) *Lump sum paper warrants processing fee.* Effective April 1, 2012, and thereafter, IPERS shall charge $1 for paper warrants issued in payment of all nonrecurring lump sum distributions. If a nonrecurring lump sum distribution is followed by a supplemental lump sum distribution due to the reporting of additional covered wages, the $1 processing fee shall also be charged. This $1 processing fee shall not apply to a direct rollover described under Iowa Code section 97B.53B (however, processing fees may be charged for multiple rollover requests), lump sum mandatory account distributions required under Iowa Code section 97B.48(5), mandatory lump sum distributions required under Internal Revenue Code Section 401(9), or warrants reissued in forged endorsement or other fraudulent payment situations.
[**ARC 0017C**, IAB 2/22/12, effective 3/28/12]

495—11.7(97B) Overpayment of IPERS benefits.

11.7(1) *Overpayments—general.*

a. An "overpayment" means a payment of money by IPERS that results in a recipient receiving a higher payment than the recipient is entitled to under the provisions of Iowa Code chapter 97B.

b. A "recipient" is a person or beneficiary, heir, assign, or other successor in interest who receives an overpayment from an IPERS benefit and is liable to repay the amount(s) upon receipt of a written explanation and request for the amounts to be repaid.

c. If IPERS determines that the cost of recovering the amount of an overpayment is estimated to exceed the overpayment, the repayment may be deemed to be unrecoverable.

d. If the overpayment is equal to or less than $50 and cannot be recovered from other IPERS payments, IPERS may limit its recovery efforts to written requests for repayment and other nonjudicial remedies.

11.7(2) *Overpayment made to a retired member.* A retired member shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and a limited opportunity to repay the overpayment in full without interest. If a retired member repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. A retired member may repay an overpayment out of pocket or direct IPERS to recover the overpayment from future retirement benefit payments, or a combination of both. If the retired member cannot repay an overpayment in full, either out of pocket or from the next monthly installment of retirement benefits, or both, interest shall be charged. A retired member who cannot repay the full amount of the overpayment within 30 days after the date of the notice must enter into an agreement with IPERS to make monthly installment payments, or to have the overpayment offset against future monthly benefit payments or death benefits, if any, and authorize any unpaid balance as a first priority claim in the recipient's estate.

11.7(3) *Overpayment made to a person other than a retired member.* A recipient other than a retired member, except a recipient listed in subrule 11.7(4), shall receive written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and the opportunity to repay the overpayment in full without interest. If such a recipient repays an overpayment in full within 30 days after the date of the notice, there will be no interest charge. If such a recipient cannot repay an overpayment in full within 30 days after the date of the notice, interest shall be charged. If repayment in full cannot be made within 30 days, such a recipient shall make repayment arrangements subject to IPERS' approval within 30 days of the written notice and request for repayment.

If the overpayment recipient cannot be located to receive notice of the overpayment at the recipient's last-known address, IPERS shall, after trying to locate the person, consider the recipient to have waived entitlement to the quarters covered by the refund.

11.7(4) *Overpayment made to a person who violates a bona fide severance period.* If a recipient takes a refund and does not complete the required period of severance, the recipient shall receive a written notice of overpayment, including the reason for the overpayment, the amount of the overpayment, and the opportunity to repay the overpayment in full without interest. The recipient shall have 30 days after the date of notice to repay the full amount of the refund without interest. If the repayment is not made within 30 days after the date of notice, the person shall receive no credit for the period of employment covered by the refund and shall be required to buy back the refund at its actuarial cost if the member later decides that the member wants service credit for any portion of the period of employment covered by the refund.

11.7(5) *Interest charges.*

a. Overpayment not fraudulent. If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.7(4), was not the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of 5 percent, or the rate IPERS determines, on the outstanding balance, beginning 30 days after the date of notice of the overpayment(s) is provided by IPERS.

b. Overpayments in violation of Iowa Code section 97B.40 or 715A.8. If the overpayment of benefits, other than an overpayment that results from a violation described in subrule 11.7(4), was the result of wrongdoing, negligence, misrepresentation, or omission of the recipient, the recipient is liable to pay interest charges at the rate of 7.5 percent on the outstanding balance, beginning on the date of the overpayment(s).

c. Overpayments that result in a judgment. In addition to other remedies, IPERS may file a civil action to recover overpayments, and the interest rate may be set by the court.

11.7(6) *Recovery of overpayment from a deceased recipient.* If a recipient dies prior to the full repayment of an erroneous overpayment of benefits, IPERS shall be entitled to apply to the estate of the deceased to recover the remaining balance.

11.7(7) *Offsets against amounts payable.* IPERS may, in addition to other remedies and after notice to the recipient, request an offset against amounts owing to the recipient by the state according to the offset procedures pursuant to Iowa Code sections 8A.504 and 421.17.

11.7(8) *Rights of appeal.* A recipient who is notified of an overpayment and required to make repayments under this rule may appeal IPERS' determination in writing to the chief executive officer. The written request must explain the basis of the appeal and must be received by IPERS' office within 30 days of overpayment notice pursuant to 495—Chapter 26.

11.7(9) *Release of overpayment.* IPERS may release a recipient from liability to repay an overpayment, in whole or in part, if IPERS determines that the receipt of overpayment is not the fault of the recipient, and that it would be contrary to equity and good conscience to collect the overpayment. No release of an individual recipient's obligation to repay an overpayment shall stand as precedent for release of another recipient's obligation to repay an overpayment.

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10; **ARC 1887C**, IAB 2/18/15, effective 3/25/15]

These rules are intended to implement Iowa Code sections 97B.4, 97B.9A, 97B.15, 97B.25, 97B.38, 97B.40, 97B.45, 97B.47, 97B.48, 97B.48A, 97B.49A to 97B.49I, 97B.50, 97B.51, 97B.52, 97B.52A, 97B.53, and 97B.53B.

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CHAPTER 13
DISABILITY FOR REGULAR AND SPECIAL SERVICE MEMBERS
[Prior to 11/24/04, see 581—Ch 21]

495—13.1(97B) Disability for persons retiring under Iowa Code section 97B.50(2).

13.1(1) For IPERS regular class members retiring because of a disability:

a. The member must be awarded federal social security benefits due to a disability which existed on or before the member's first month of entitlement.

b. Effective July 1, 1990, the member may also qualify for the IPERS disability provision by being awarded, and commencing to receive, disability benefits through the federal Railroad Retirement Act, 45 U.S.C. Section 231 et seq., due to a disability which existed at the time of retirement.

c. The period for which up to 36 months of retroactive payments under Iowa Code section 97B.50(2) shall be paid is for up to 36 months preceding the month in which such completed application for IPERS disability is received by IPERS. In no event shall retroactive disability benefits payments under Iowa Code section 97B.50(2) precede the month the member actually receives the member's first social security or railroad retirement disability payment. The member shall provide IPERS with a copy of the Social Security Administration or railroad retirement award letter showing dates of eligibility.

d. Continued qualification monitoring.

(1) For a member retiring due to a disability under Iowa Code section 97B.50(2), on or after July 1, 2009, the member shall provide IPERS with proof of continuing eligibility for federal social security disability benefits or railroad retirement disability benefits by June 30 of each calendar year, in order to continue qualification for IPERS disability benefits.

(2) For a member retiring due to a disability under Iowa Code section 97B.50A, the member shall provide IPERS complete copies of the member's state and federal income tax returns, including all supporting schedules, by June 30 of each calendar year, in order to continue qualification for IPERS disability benefits.

IPERS shall suspend the disability benefits of any member if the records required under these subparagraphs are not timely provided.

13.1(2) If a member returns to covered employment after achieving a bona fide retirement, the benefits being provided to the member under Iowa Code section 97B.50(2)*"a"* or *"b"* shall be suspended or reduced as follows. If the member has not attained the age of 55 upon reemployment, benefit payments shall be suspended in their entirety until the member subsequently terminates employment, applies for, and is approved to receive benefits under the provisions of Iowa Code chapter 97B. If the member has attained the age of 55 or older upon reemployment, the member shall continue to receive monthly benefits adjusted as follows. Monthly benefits shall be calculated under the same benefit option that was first selected, based on the member's age, years of service, and the applicable reductions for early retirement as of the month that the member returns to covered employment. The member's benefit shall also be subject to the applicable provisions of Iowa Code section 97B.48A pertaining to reemployed retired members.

13.1(3) Upon terminating a reemployment that resulted in the suspension of all or a portion of the member's disability retirement allowance, the member's benefits shall be recomputed under Iowa Code section 97B.48A and rule 495—12.8(97B). To requalify for a monthly retirement allowance under Iowa Code section 97B.50(2), the member must furnish a new or updated Social Security Administration disability award letter, or other acceptable documentation from the Social Security Administration, indicating that the member is currently eligible for social security disability benefits.

13.1(4) If a member whose IPERS disability benefits were suspended because of the member's return to covered employment provides proof acceptable to IPERS that the member remains eligible for federal social security disability benefits or railroad retirement disability benefits, IPERS shall reinstate the member's disability benefits, subject to the member's continued compliance with paragraph 13.1(1)*"d."*

[**ARC 1348C**, IAB 2/19/14, effective 3/26/14; **ARC 1887C**, IAB 2/18/15, effective 3/25/15]

495—13.2(97B) Disability claim process for special service members. Except as otherwise indicated, this rule shall apply only to disability claims initiated under Iowa Code section 97B.50A. Except as

otherwise indicated, disability claims under Iowa Code section 97B.50(2) shall be administered under rule 495—13.1(97B).

13.2(1) *Initiation of disability claim.* The disability claim process shall originate as an application to the system by the member. The application shall be forwarded to the system's designated retirement benefits officer. An application shall be sent upon request to members who qualify pursuant to Iowa Code section 97B.50A(13). The application consists of the following sections which must be completed and returned to the system's designated retirement benefits officer:

1. General applicant information.
2. Applicant's statement.
3. Employer's statement.
4. Member's assigned duties.
5. Disability/injury reports.
6. Medical information release.

13.2(2) *Preliminary processing.* Completed forms shall be returned to the disability retirement benefits officer. If the forms are not complete, they will be returned for completion. The application package shall contain copies of all relevant medical records and the names, addresses, and telephone numbers of all relevant physicians. If medical records are not included, the designated retirement benefits officer shall have the authority to contact the listed physicians for copies of the files on the individual and shall request that any applicable files be sent to the medical board. In addition, IPERS may request workers' compensation records, social security records and such other official records as are deemed necessary. The application, including copies of the medical information, shall be forwarded to the medical board for review. All medical records that will be part of a member's permanent file shall be kept in locked locations separate from the member's other retirement records.

13.2(3) *Scheduling of appointments.* Upon receipt and forwarding of the application and sufficient medical records to the medical board, the disability retirement benefits officer shall establish an appointment for the applicant to be seen by the medical board in Iowa City. The member shall be notified by telephone and in writing of the appointment, and shall be given general instructions about where to go for the examinations. The appointment for the examinations shall be no later than 60 days after the completed application, including sufficient medical records, is provided. All examinations must be scheduled and completed on the same date. The member shall also be notified about the procedures to follow for reimbursement of travel expenses and lodging. Fees for physical examinations and medical records costs shall be paid directly by IPERS pursuant to its contractual arrangements with the medical providers required to implement Iowa Code section 97B.50A.

13.2(4) *Medical board examinations.* The medical board, consisting of three physicians from the University of Iowa occupational medicine clinic and other departments as required, shall examine the member and perform the relevant tests and examinations.

The medical board shall submit a letter of recommendation to the system, based on its findings and the job duties supplied in the member's application, whether or not the member is mentally or physically incapacitated from the further performance of the member's duties and whether or not the incapacity is likely to be permanent. "Permanent" means that the mental or physical incapacity is reasonably expected to last more than one year. The medical board's letter of recommendation shall include a recommended schedule for reexaminations to determine the continued existence of the disability in question.

IPERS shall not be liable for any diagnostic testing procedures performed in accordance with Iowa Code section 97B.50A and this rule which are alleged to have resulted in injury to the members being examined.

The medical board shall furnish its determination, test results, and supporting notes to the system no later than ten working days after the date of the examination. The medical board may use electronic signatures in fulfilling its reporting obligations under this rule.

The medical board shall not be required to have regular meetings, but shall be required to meet with IPERS' representatives at reasonable intervals to discuss the implementation of the program and performance review.

13.2(5) *Member and employer comments.* Upon receipt by the system, the medical board's determination regarding the existence or nonexistence of a permanent disability shall be distributed to the member and to the employer for review. The member and the employer may forward to the system written statements pertaining to the medical board's findings within ten days of transmittal. If relevant medical information not considered in materials previously forwarded to the medical board is contained within such written statements, the system shall submit such information to the medical board for review and comment.

13.2(6) *Fast-track review.* IPERS' disability retirement benefits officer may refer any case to IPERS' chief benefits officer (CBO) for fast-track review. The CBO or the CBO's designee may, based upon a review of the member's application and medical records, determine that the medical board be permitted to make its recommendations based solely upon a review of the application and medical records, without requiring the member to submit to additional medical examinations by, or coordinated through, the medical board.

13.2(7) *Initial administrative determination.* The medical board's letter of recommendation, test results, and supporting notes, and the member's file shall be forwarded to IPERS. Except as otherwise requested by IPERS, the medical board shall forward hospital discharge summary reports rather than the entire set of hospital records. The complete file shall be reviewed by the system's disability retirement benefits officer, who shall, in consultation with the system's legal counsel, make the initial disability determination. Written notification of the initial disability determination shall be sent to the member and the member's employer within 14 business days after a complete file has been returned to IPERS for the initial disability determination.

13.2(8) *General benefits provisions.* Effective July 1, 2000, if an initial disability determination is favorable, benefits shall begin as of the date of the initial disability determination or, if earlier, the member's last day on the payroll, but no more than six months of retroactive benefits are payable, subject to Iowa Code section 97B.50A(13). "Last day on the payroll" shall include any form of authorized leave time, whether paid or unpaid. If a member receives short-term disability benefits from the employer while awaiting a disability determination hereunder, disability benefits will accrue from the date the member's short-term disability payments are discontinued. If an initial favorable determination is appealed, the member shall continue to receive payments pending the outcome of the appeal.

Any member who is awarded disability benefits under Iowa Code section 97B.50A and this rule shall be eligible to elect any of the benefit options available under Iowa Code section 97B.51. All such options shall be the actuarial equivalent of the lifetime monthly benefit provided in Iowa Code section 97B.50A(2) and (3).

The disability benefits established under this subrule shall be eligible for the favorable experience dividends payable under Iowa Code section 97B.49F(2).

If the award of disability benefits is overturned upon appeal, the member may be required to repay the amount already received or, upon retirement, have payments suspended or reduced until the appropriate amount is recovered.

IPERS shall, at the member's written request, precertify a member's medical eligibility through the procedures set forth in subrules 13.2(3) and 13.2(4), provided that IPERS shall have full discretion to request additional medical information and to redetermine the member's medical eligibility if the member chooses not to apply for disability benefits at the time of the precertification. IPERS shall not pay for the costs of more than one such precertification per 12-month period.

13.2(9) *In-service disability determinations.* Subject to the presumptions contained in Iowa Code section 97B.50A in determining whether a member's mental or physical incapacity arises in the actual performance of duty, "duty" shall mean:

a. For special service members other than firefighters, any action that the member, in the member's capacity as a law enforcement officer:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs in the course of controlling or reducing crime or enforcing the criminal law; or

b. For firefighters, any action that the member, in the member's capacity as a firefighter:

(1) Is obligated or authorized by rule, regulation, condition of employment or service, or law to perform; or

(2) Performs while on the scene of an emergency run (including false alarms) or on the way to or from the scene.

c. A presumption shall exist that a special service member contracted a disease while on active duty only if the disease is defined by Iowa Code section 97B.50A(2)*"c"* as amended by 2010 Iowa Acts, House File 2518, section 31. If a presumption exists, IPERS may, in making its determination as to whether a disability was incurred while the member was on active duty, go forward with evidence to rebut the presumption. IPERS can rebut the presumption when credible evidence exists to the contrary or when the requirements are met in Iowa Code section 97B.50A(2)*"c"* as amended by 2010 Iowa Acts, House File 2518, section 31. Under no circumstances shall the burden of proof shift from the special service member to IPERS.

13.2(10) *Appeal rights.* The member or the employer, or both, may appeal IPERS' initial disability determination. Within 30 days after the notification of IPERS' initial disability determination was mailed, the member shall submit to IPERS' CEO or CEO's designee a notice of appeal in writing setting forth:

a. The name, address, and social security number of the member or employee number of the employer;

b. A reference to the decision from which the appeal is being made;

c. The fact that an appeal from the decision is being made;

d. The grounds upon which the appeal is based;

e. Additional medical or other evidence to support the appeal; and

f. The request that a different decision be made by IPERS.

The system shall conduct an internal review of the initial disability determination, and the CEO or CEO's designee shall notify in writing the party who filed the appeal of IPERS' final disability determination with respect to the appeal. The CEO or CEO's designee may appoint a review committee to make nonbinding recommendations on such appeals. The disability retirement benefits officer, if named to the review committee, shall not vote on any such recommendations, nor shall any members of IPERS' legal staff participate in any capacity other than a nonvoting capacity. Further appeals shall follow the procedures set forth in 495—Chapter 26.

13.2(11) *Notice of abuse of disability benefits.* The system has the obligation and full authority to investigate allegations of abuse of disability benefits. The scope of the investigation to be conducted shall be determined by the system, and may include the ordering of a sub rosa investigation of a disability recipient to verify the facts relating to an alleged abuse. A sub rosa investigation shall only be considered upon receipt and evaluation of an acceptable notice of abuse. The notification must be in writing and include:

a. The informant's name, address, telephone number, and relationship to the disability recipient; and

b. A statement pertaining to the circumstances that prompted the notification, such as activities which the informant believes are inconsistent with the alleged disability.

c. Anonymous calls shall not constitute acceptable notification.

IPERS may employ such investigators and other personnel, in IPERS' sole discretion, as may be deemed necessary. IPERS may also, in its sole discretion, decline to carry out such investigations if more than five years have elapsed since the date of the disability determination.

13.2(12) *Qualification for social security or railroad retirement disability benefits.* Upon qualifying for social security or railroad retirement disability benefits, a special service member may contact the system to have the member's disability benefits calculated under Iowa Code section 97B.50(2). The member and spouse must complete the designated application to stop having benefits calculated under Iowa Code section 97B.50A and to start having benefits calculated under Iowa Code section 97B.50(2). The decision is irrevocable, and must be made within 60 days after the member receives written notification of eligibility for disability benefits from social security or railroad retirement and has commenced receiving such payments.

13.2(13) *Reemployment/income monitoring.* A member who retires under Iowa Code section 97B.50A and this rule shall be required to supply a copy of a complete set of the member's state and federal income tax returns, including all supporting schedules, by June 30 of each calendar year. IPERS may suspend the benefits of any such member if such records are not timely provided.

Only wages and self-employment income shall be counted in determining a member's reemployment comparison amount, as adjusted for health care coverage for the member and member's dependents.

13.2(14) *Offset to allowance.* A member who retires under Iowa Code section 97B.50A shall have benefits reduced by other disability-related payments the member receives for the same disability, including, but not limited to benefits from:

a. Social security.
b. Long-term disability insurance.
c. Workers' compensation.
d. Unemployment insurance.
e. Employer-paid disability plans, programs, or policies.
f. Other laws.

For purposes of calculating the income offsets required under Iowa Code section 97B.50A, IPERS shall convert any lump sum workers' compensation award, disability insurance payments, or similar lump sum awards for the same illnesses or injuries to an actuarial equivalent, as determined by IPERS. IPERS shall convert any monthly, weekly, or other stated period workers' compensation award, disability insurance payments, or other awards for the same illnesses or injuries, dollar-for-dollar, to the same monthly, weekly, or other stated period, as determined by IPERS.

[**ARC 8929B**, IAB 7/14/10, effective 6/21/10; **ARC 9068B**, IAB 9/8/10, effective 10/13/10; **ARC 0662C**, IAB 4/3/13, effective 5/8/13; **ARC 2402C**, IAB 2/17/16, effective 3/23/16]

These rules are intended to implement Iowa Code sections 97B.50 and 97B.50A.

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CHAPTER 14
DEATH BENEFITS AND BENEFICIARIES
[Prior to 11/24/04, see 581—Ch 21]

495—14.1(97B) Internal Revenue Code limitations. The death benefits payable under Iowa Code sections 97B.51 and 97B.52 shall not exceed the maximum amount possible under Internal Revenue Code Section 401(a)(9).

To ensure that the limit is not exceeded, a member's combined lump sum death benefit under Iowa Code sections 97B.52(1) and 97B.52(2) shall not exceed 100 times the Option 2 amount that would have been payable to the member at the member's earliest normal retirement age. If a beneficiary of a special service member is eligible for an in-the-line-of-duty death benefit, any reduction required under this rule shall be taken first from a death benefit payable under Iowa Code section 97B.52(1). The "100 times" limit shall apply to active and inactive members. The death benefits payable under this chapter for a period of reemployment for a retired reemployed member who dies during the period of reemployment shall also be subject to the limits described in this rule.

The maximum claims period for IPERS lump sum death benefits shall not exceed the period required under Internal Revenue Code Section 401(a)(9), which may be less than five years for a member who dies after the member's required beginning date, unless the beneficiary is a spouse. The claims period for all cases in which the member's death occurs during the same calendar year in which a claim must be filed under this rule shall end April 1 of the year following the year of the member's death.

A member's beneficiary or heir may file a claim for previously forfeited death benefits. Interest, if any, for periods prior to the date of the claim will only be credited through the quarter that the death benefit was required to be forfeited by law. Interest for periods following the quarter of forfeiture will accrue beginning with the quarter that the claim for reinstatement is received by IPERS. For death benefits required to be forfeited in order to satisfy Section 401(a)(9) of the federal Internal Revenue Code, in no event will the forfeiture date precede January 1, 1988. IPERS shall not be liable for any excise taxes imposed by the Internal Revenue Service on reinstated death benefits.

Effective January 14, 2004, all claims for a previously forfeited death benefit shall be processed under the procedure set forth at rule 495—14.13(97B).

The system recognizes the validity of same gender marriages executed in Iowa on or after April 27, 2009, if the domestic relations order or other assignment otherwise meets the system's minimum requirements for such orders; the system shall modify the tax treatment of distributions under such orders as required by the federal laws governing such distributions. IPERS shall adopt such rules and procedures as are deemed necessary to fully implement the provisions of this rule. The Iowa Supreme Court decision recognizing same gender marriages in Iowa specifically states that this recognition does not extend to same gender marriages of other states. The system recognizes the validity of same gender marriages based on the U.S. Supreme Court's decision in *United States v. Windsor,* 133 S.Ct. 2675 (2013) and the direction of Rev. Rul. 2013-17 and IRS Notice 2014-19. IPERS shall recognize the federal tax treatment of distributions as required by the sources listed in this paragraph.

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10; **ARC 1348C**, IAB 2/19/14, effective 3/26/14; **ARC 1887C**, IAB 2/18/15, effective 3/25/15]

495—14.2(97B) Survival into first month of entitlement. When a member who has filed an application for retirement benefits and has survived into the first month of entitlement dies prior to the issuance of the first benefit check, IPERS will pay the death benefit allowed under the retirement option elected by the member in the application for retirement benefits.

495—14.3(97B) Designation of beneficiaries.

14.3(1) *Designation of beneficiaries.* To designate a beneficiary, the member must complete an IPERS designation of beneficiary form, which must be filed with IPERS. The designation of a beneficiary by a retiring member on the application for monthly benefits revokes all prior designation of beneficiary forms. IPERS may consider as valid a designation of beneficiary form filed with the member's employer prior to the death of the member, even if that form was not forwarded to

IPERS prior to the member's death. If a retired member is reemployed in covered employment, the most recently filed beneficiary form shall govern the payment of all death benefits for all periods of employment. Notwithstanding the foregoing sentence, a reemployed IPERS Option 4 or 6 retired member may name someone other than the member's contingent annuitant as beneficiary, but only for lump sum death benefits accrued during the period of reemployment and only if the contingent annuitant has died or has been divorced from the member before or during the period of reemployment unless a qualified domestic relations order (QDRO) directs otherwise. If a reemployed IPERS Option 4 or 6 retired member dies without filing a new beneficiary form, the death benefits accrued for the period of reemployment shall be paid to the member's contingent annuitant, unless the contingent annuitant has died or been divorced from the member. If the contingent annuitant has been divorced from the member, any portion of the lump sum death benefits awarded in a QDRO shall be paid to the contingent annuitant as alternate payee, and the remainder of the lump sum death benefits shall be paid to the member's estate or, if applicable, to the member's heirs if no estate is probated.

14.3(2) *Change of beneficiary.* The beneficiary may be changed by the member by filing a new designation of beneficiary form with IPERS. The latest dated designation of beneficiary form on file shall determine the identity of the beneficiary. Payment of a refund to a terminated member cancels the designation of beneficiary on file with IPERS.
[**ARC 1887C**, IAB 2/18/15, effective 3/25/15]

495—14.4(97B) Applications for death benefits. Before death benefit payments can be made, application in writing must be submitted to IPERS with a copy of the member's death certificate, or if a death certificate cannot be obtained, IPERS may rely on such resources as it has available, including but not limited to records from the Social Security Administration, bureau of health statistics, IPERS' own internal records, or reports derived from other public records, and other departmental or governmental records to which IPERS may have access together with information establishing the claimant's right to payment. A named beneficiary must complete an IPERS application for death benefits based on the deceased member's account. If the claimant's claim is based on dissolution of marriage that revoked the IPERS beneficiary designation, the claim must be processed pursuant to rule 495—14.17(97B).
[**ARC 1887C**, IAB 2/18/15, effective 3/25/15; **ARC 2402C**, IAB 2/17/16, effective 3/23/16]

495—14.5(97B) Commuted lump sums.

14.5(1) *Designated beneficiary is an estate, trust, church, charity, or similar organization.* Where the designated beneficiary is an estate, trust, church, charity or similar organization, or is a person, such as a trustee, executor, or administrator who has been appointed to receive funds on behalf of such entities, payment of benefits shall be made in a lump sum only.

14.5(2) *Multiple beneficiaries.* Where multiple beneficiaries have been designated by the member, payment, including the payment of the remainder of a series of guaranteed annuity payments, shall be made in a lump sum only. The lump sum payment shall be paid to the multiple beneficiaries in equal shares.

14.5(3) *Guaranteed payments.* Where a member has selected Option 5 and dies before receiving all guaranteed payments, and the member's designated beneficiary also dies before all guaranteed payments are made, any remaining guaranteed payments shall be paid in a commuted lump sum.
[**ARC 8929B**, IAB 7/14/10, effective 6/21/10; **ARC 9068B**, IAB 9/8/10, effective 10/13/10]

495—14.6(97B) Payment of the death benefit when no designation of beneficiary or an invalid designation of beneficiary form is on file. When no designation of beneficiary or an invalid designation of beneficiary form is on file with IPERS, payment shall be made in one of the following ways.

14.6(1) Where the estate is open, payment shall be made to the administrator or executor where said executor or administrator shall be duly appointed and serving under Iowa Code chapter 633 or 635.

14.6(2) Where no estate is probated or the estate is closed prior to the filing with IPERS of an application for death benefits, payment will be made to the surviving spouse. The following documents shall be presented as supporting evidence:

a. Copy of the will, if any;

b. Copy of any letters of appointment; and

c. Copy of the court order closing the estate and discharging the executor or administrator.

14.6(3) Where no estate is probated or the estate is closed prior to the filing with IPERS of an application for death benefits and there is no surviving spouse, payment will be made to the heirs-at-law as determined by the intestacy laws of the state of Iowa.

14.6(4) Where a trustee has been named as designated beneficiary and is not willing to accept the death benefit or otherwise serve as trustee, IPERS may apply but is not required to apply to the applicable district court for an order to distribute the funds to the clerk of court on behalf of the beneficiaries of the member's trust. Upon the issuance of an order and the giving of such notice as the court prescribes, IPERS may deposit the death benefit with the clerk of court for distribution. IPERS shall be discharged from all liability upon deposit with the clerk of court.

495—14.7(97B) Waiver of beneficiary rights. A named beneficiary of a deceased member may waive current and future rights to payments to which the beneficiary would have been entitled. The waiver of the rights shall occur prior to the receipt of a payment from IPERS to the beneficiary. The waiver of rights shall be binding and will be executed on a form provided by IPERS. The waiver of rights may be general, in which case payment shall be divided equally among all remaining designated beneficiaries or, if there are none, to the member's estate. The waiver of rights may also expressly be made in favor of one or more of the member's designated beneficiaries or the member's estate. If the waiver of rights operates in favor of the member's estate and no estate is probated or claim made, or if the executor or administrator expressly waives payment to the estate, payment shall be paid to the member's surviving spouse unless there is no surviving spouse or the surviving spouse has waived the surviving spouse's rights. In that case, payment shall be made to the member's heirs excluding any person who waived the right to payment. Any waiver filed by an executor, administrator, or other fiduciary must be accompanied by a release acceptable to IPERS indemnifying IPERS from all liability to beneficiaries, heirs, or other claimants for any waiver executed by an executor, administrator, or other fiduciary.

495—14.8(97B) Beneficiaries under the age of 18. Payment may be made to a conservator if the beneficiary is under the age of 18 and the total dollar amount to be paid by IPERS to a single beneficiary is $25,000 or more. Payment may be made to a custodian if the total dollar amount to be paid by IPERS to a single beneficiary is less than $25,000.

495—14.9(97B) Simultaneous deaths. IPERS will apply the provisions of the Uniform Simultaneous Death Act, Iowa Code sections 633.523 et seq., in determining the proper beneficiaries of death benefits in applicable cases.

495—14.10(97B) Felonious deaths. IPERS will apply the provisions of the Felonious Death Act, Iowa Code sections 633.535 et seq., in determining the proper beneficiaries of death benefits in applicable cases.

495—14.11(97B) No interest on postretirement death benefits. Interest is only accrued on a member's death benefit if the member dies before the member's first month of entitlement (FME) or, for a retired reemployed member, before the member's reemployment FME, and is only accrued with respect to the retired or retired reemployed member's accumulated contributions account.

495—14.12(97B) Preretirement death benefits.

14.12(1) *Pre-January 1, 1999, deaths.* Where the member dies prior to the first month of entitlement, the death benefit shall include the accumulated contributions of the member plus the product of an amount equal to the highest year of covered wages of the deceased member and the number of years of membership service divided by the "applicable denominator," as provided in Iowa Code section 97B.52(1). The amount payable shall not be less than the amount that would have been payable on the death of the member on June 30, 1984. The calculation of the highest year of covered wages shall use the highest calendar year of covered wages reported to IPERS.

14.12(2) *Post-January 1, 1999, deaths—death benefits under Iowa Code section 97B.52(1).*

a. Definitions.

"Accrued benefit" means the monthly amount that would have been payable to the deceased member under IPERS Option 2 at the member's earliest normal retirement age, based on the member's covered wages and service credits at the date of death. If a deceased member's wage record consists of a combination of regular and special service credits, the monthly amount that would have been payable to the deceased member under Option 2 at the member's earliest normal retirement age shall be determined separately for regular and special service credits, and then combined.

"Beneficiary(ies)" shall, unless the context indicates otherwise, refer to both window period beneficiaries and post-window period beneficiaries.

"Implementation date" means January 1, 2001.

"Nearest age" means a member's or beneficiary's age expressed in whole years, after rounding for partial years of age. Ages shall be rounded down to the nearest whole year if less than six complete months have passed following the month of the member's or beneficiary's last birthday, and shall be rounded up if six complete months or more have passed following the month of the member's or beneficiary's last birthday.

"Post-window period beneficiary" means a beneficiary of a member who dies before the member's first month of entitlement and on or after January 1, 2001.

"Window period beneficiary" means a beneficiary of a member who dies before the member's first month of entitlement during the period January 1, 1999, through December 31, 2000.

b. Any window period beneficiary or post-window period beneficiary may elect to receive the lump sum amount available under Iowa Code section 97B.52(1). Sole beneficiaries may elect, in lieu of the foregoing lump sum amount, to receive a single life annuity that is the actuarial equivalent of such lump sum amount.

A window period beneficiary must repay any prior preretirement death benefit received as follows:

(1) If a window period beneficiary wishes to receive the larger lump sum amount, if any, the system shall pay the difference between the prior death benefit lump sum amount and the new death benefit lump sum amount.

(2) If a sole window period beneficiary wishes to receive a single life annuity under Iowa Code section 97B.52(1), the sole window period beneficiary may either:

1. Annuitize the difference between the previously paid lump sum amount and the new larger lump sum amount, if any; or

2. Annuitize the full amount of the largest of the lump sum amounts available under the revised statute, but must repay the full amount of the previously paid lump sum amount.

(3) To the extent possible, repayment costs shall be recovered from retroactive monthly payments, if any, and the balance shall be offset against current and future monthly payments until the system is repaid in full.

c. A claim for a single life annuity under this subrule must be filed as follows:

(1) A sole window period beneficiary must file a claim for a single life annuity within 12 months of the implementation date.

(2) A sole post-window period beneficiary must file a claim for a single life annuity within 12 months of the member's death.

(3) A beneficiary who is a surviving spouse must file a claim for a single life annuity within the period specified in subparagraph (1) or (2), as applicable, or by the date that the member would have attained the age of 70½, whichever period is longer.

d. Elections to receive the lump sum amount or single life annuity available under Iowa Code section 97B.52(1) and this subrule shall be irrevocable once the first payment is made. Election shall be irrevocable as of the date the first paycheck is issued, or would have been issued but for the fact that the payment is being offset against a prior preretirement death benefit payment.

e. No further benefits will be payable following the death of any beneficiary who qualifies and elects to receive the single life annuity provided under this subrule.

f. The provisions of this subrule shall not apply to members who die before January 1, 1999.

g. Procedures and assumptions to be used in calculating the lump sum present value of a member's accrued benefit are as follows:

(1) IPERS shall calculate a member's retirement benefit at earliest normal retirement age under IPERS Option 2, based on the member's covered wages and service credits at the date of death, and the retirement benefit formula in effect in the month following the date of death.

(2) For purposes of determining the "member date of death annuity factor" under the conversion tables supplied by IPERS' actuary, IPERS shall assume that "age" means the member's nearest age at the member's date of death.

(3) For purposes of determining the "member unreduced retirement annuity factor" under the conversion tables supplied by IPERS' actuary, IPERS shall assume that "age" means the member's nearest age at the member's earliest normal retirement date. If a member had already attained the member's earliest normal retirement date, IPERS shall assume that "age" means the member's nearest age at the date of death.

h. Procedures and assumptions for converting the lump sum present value of a deceased member's preretirement death benefit to a single life annuity are as follows:

(1) For purposes of determining the "age of beneficiary annuity factor" under the conversion tables supplied by IPERS' actuary, IPERS shall assume that "age" means the beneficiary's nearest age as of the beneficiary's first month of entitlement.

(2) A beneficiary's first month of entitlement is the month after the date of the member's death.

(3) Effective for claims filed after June 30, 2004, no retroactive payments of the single life annuity shall be made under this subrule.

(4) Effective for claims filed after June 30, 2004, the beneficiary whose single life annuity is less than $600 per year shall be able to receive only the lump sum payment under this rule.

i. Eligibility for favorable experience dividend (FED) payments. Any sole beneficiary who is eligible for and elects to receive a single life annuity under this subrule shall also qualify for the dividend payments authorized under rule 495—15.2(97B), subject to the requirements of that rule.

j. Retired reemployed members and aged 70 members who retire without terminating employment. Preretirement death benefits for retired reemployed members and aged 70 members who retire without terminating employment shall be calculated as follows:

(1) For beneficiaries of such members who elect IPERS Option 4 or 6 at retirement, IPERS shall recompute (for retired reemployed members) or recalculate/recompute (for aged 70 members who retired without terminating employment) the member's monthly benefits as though the member had elected to terminate employment as of the date of death, to have the member's benefits adjusted for postretirement wages, and then lived into the recomputation or recalculation/recomputation (as applicable) first month of entitlement.

(2) The recomputation provided under subparagraph (1) shall apply only to beneficiaries of members who elected IPERS Option 4 or 6, where the member's monthly benefit would have been increased by the period of reemployment, and is subject to the limitations of Iowa Code sections 97B.48A, 97B.49A, 97B.49B, 97B.49C, 97B.49D, and 97B.49G. The recalculation/recomputations provided under subparagraph (1) shall apply only to beneficiaries of members who elected IPERS Option 4 or 6, where the member's monthly benefit would have been increased by the period of employment after the initial retirement, and is subject to the limitations of Iowa Code sections 97B.49A, 97B.49B, 97B.49C, 97B.49D, and 97B.49G. In all other cases, including cases where members previously received a lump sum payment under Iowa Code section 97B.48(1) in lieu of a monthly retirement allowance, preretirement death benefits under this subparagraph shall be the lump sum amount equal to the accumulated employee and accumulated employer contributions.

(3) Beneficiaries of members who had elected IPERS Option 4 or 6 may also elect to receive the accumulated employer and accumulated employee contributions described in subparagraph 14.12(2)*"j"*(2), in lieu of the increased monthly annuity amount. Notwithstanding subparagraph (2) above, if the member elected IPERS Option 5 at retirement, the lump sum amount payable under this paragraph shall be the greater of the applicable commuted lump sum or the accumulated employee and accumulated employer contributions.

k. Inactive members with less than 16 quarters of service credit. For deaths occurring after June 30, 2004, and before July 1, 2012, preretirement death benefits shall be provided solely under Iowa Code section 97B.52(1)*"a,"* and shall only be payable in lump sum amounts for inactive members who have less than 16 quarters of service credit. For purposes of this paragraph, an inactive member is a member as defined under Iowa Code section 97B.1A(12).

l. Inactive members not vested by service. For deaths occurring after June 30, 2012, preretirement death benefits shall be provided solely under Iowa Code section 97B.52(1)*"a,"* and shall only be payable in lump sum amounts for inactive members who are not vested by service. For purposes of this paragraph, an inactive member is a member as defined under Iowa Code section 97B.1A(12).

[**ARC 0017C**, IAB 2/22/12, effective 3/28/12; **ARC 2402C**, IAB 2/17/16, effective 3/23/16]

495—14.13(97B) Payment procedures for heirs that cannot be located.

14.13(1) *Order of priority.* If a death benefit cannot be paid because heirs cannot be located, IPERS will pay a death benefit to the member's heirs according to the following procedure.

a. Children. If there is no surviving spouse, but at least one child survives, the death benefit shall be divided equally among the member's children. If there are living and deceased children, the shares that would have been payable to deceased children shall be payable in equal shares to the surviving children of each such deceased child.

b. Grandchildren. If neither the spouse nor children survive, but at least one grandchild survives, the death benefit shall be divided equally among the member's grandchildren. If there are living and deceased grandchildren, the shares that would have been payable to any deceased grandchild shall be payable in equal shares to the surviving children of such deceased grandchild.

c. Parent(s). If there is no surviving spouse, child, or grandchild, but at least one parent survives, the death benefit shall be divided equally between the member's parents.

d. Siblings. If there is no surviving spouse, child, grandchild, or parent, but at least one sibling survives, the death benefit shall be divided equally among the member's siblings. If there are living and deceased siblings, the shares that would have been payable to any deceased sibling shall be payable in equal shares to the surviving children of such deceased siblings.

e. Nephew(s) and niece(s). If no one from the above-mentioned groups survives, but there is at least one surviving niece or nephew, the death benefit shall be divided equally among the member's surviving nieces and nephews.

f. Estate. If someone other than a member of one of the groups listed above claims the member's death benefit, an estate must be opened and the death benefit shall only be payable to the administrator of that estate.

14.13(2) *Procedures for initial distribution for identified heirs.* IPERS shall distribute the death benefit to the heirs making a claim for such benefit in descending order listed in 14.13(1)*"a"* to *"f."* A claimant shall be required to submit an affidavit suitable to IPERS that verifies the claimant's share or, to the best of the claimant's knowledge, that there are no other surviving persons from the claimant's group and that there are no living persons in any lower-numbered group that would have a higher priority claim to the death benefit. IPERS shall have no responsibility to determine or search out the member's heirs at law, nor shall IPERS incur any liability for relying on a claimant's affidavits in paying the death benefit hereunder.

14.13(3) *Procedures for final distribution to heirs who have filed claims.* If a claimant has identified other persons in the claimant's group who would be entitled to a share of the member's death benefit, but such persons have not filed a claim within five years after the member's death, or by the date required under IRC Section 401(a)(9) if earlier, the remainder of the member's death benefit shall be paid in pro-rata shares to the claimants who were previously paid a share of the death benefit. In order to comply with the applicable IRS limitations, the final payments under this subrule shall be made by December 31 of the fifth year that begins after the member's date of death, or by December 31 of the year that distribution is required under IRC Section 401(a)(9), if earlier. The sole recourse of any claimant who is a member of a group receiving payments hereunder or of any lower-numbered group that should have

received all of such payments shall be against the claimants of the group that received death benefit payments.

495—14.14(97B) Procedures for deaths of certain voluntary emergency services personnel occurring in the line of duty. Effective July 1, 2006, for a member who dies while performing the functions of a voluntary emergency services provider as described under Iowa Code section 85.61 or 147A.1, benefits for deaths occurring in the line of duty shall be paid pursuant to Iowa Code section 100B.31.

495—14.15(97B) Rollovers by nonspouse beneficiaries. Effective January 1, 2007, nonspouse beneficiaries shall be permitted to request a direct rollover of such beneficiaries' death benefit payments to traditional IRA accounts established in accordance with Section 829 of the Pension Protection Act of 2006 and IRS Notice 2007-7. IPERS shall determine the amount eligible for direct rollover under IRC Section 401(a)(9), if any, and the procedural requirements for requesting such rollovers. It shall be the beneficiaries' responsibility to determine that the recipient IRAs meet the structural and operational requirements of Section 829 and Notice 2007-7. IPERS shall bear no responsibility for rollovers to IRA accounts that fail to meet such requirements.

Effective January 1, 2008, IPERS will also allow rollovers under this rule to Roth IRA accounts established in accordance with the structural and operational requirements of Section 829 and Notice 2007-7.

495—14.16(97B) Required minimum distribution (RMD) basic calculation.

14.16(1) The RMD for a member who retired under an option with a lump sum death benefit and died after the member's required beginning date (RBD) is calculated as follows:

a. Step 1. Determine the number of payments remaining for the calendar year in which the member died. The current month's payment is not used in this calculation.

b. Step 2. Multiply the number of remaining payments determined in Step 1 by the gross amount of the member's last monthly payment to get the RMD amount. If the lump sum death benefit is less than the RMD, then the RMD is the lump sum death benefit amount.

c. Step 3. Determine the total non-RMD amount by subtracting the RMD as determined in Step 2 from the lump sum death benefit.

d. The eligible rollover amount is the total non-RMD amount as determined in Step 3.

14.16(2) In order to allocate nontaxable amounts between RMD and non-RMD, the calculation is performed as follows:

a. Nontaxable amounts are allocated first to the RMD portion of the lump sum death benefit.

b. If the nontaxable amounts are greater than the RMD amount, the remaining nontaxable amounts are allocated to the non-RMD portion of the lump sum amount.

c. If the nontaxable amounts are less than the RMD amount, the remaining portion of the RMD amount is composed of taxable amounts.

[**ARC 8929B**, IAB 7/14/10, effective 6/21/10; **ARC 9068B**, IAB 9/8/10, effective 10/13/10]

495—14.17(97B) Beneficiary revocation pursuant to Iowa Code section 598.20B, dissolution of marriage. IPERS is not liable for the payment of death benefits to a beneficiary pursuant to a beneficiary designation that has been revoked or reinstated by a divorce, annulment, or remarriage before IPERS receives the written notice set forth in subrule 14.17(1). Furthermore, IPERS shall only be liable for payments made after receipt of such written notice if the written notice is received at least ten calendar days prior to the payment.

14.17(1) *Form of notice.* The written notice shall include the following information:

a. The name of the deceased member,

b. The name of the person(s) whose entitlement to IPERS death benefits is being challenged,

c. The name, address, and telephone number of the person(s) asserting an interest,

d. A statement that the decedent's divorce, annulment, or remarriage revoked the entitlement of the person(s) whose status is being challenged to the IPERS death benefits in question, and

e. A copy of the divorce decree upon which the claim is based.

In addition to the above information, if the person whose entitlement is being challenged is not the former spouse, the written notice must indicate that the person was related to the former spouse, but not the member, by blood, adoption or affinity, and state the nature of the relationship.

14.17(2) *Delivery of notice.* Written notice under this rule must be addressed to IPERS General Counsel and mailed to IPERS by registered mail or served upon IPERS in the same manner as a summons in a civil action.

14.17(3) *Administration.* Upon receipt of written notice that meets the requirements of subrules 14.17(1) and 14.17(2):

a. IPERS shall review the deceased member's account and determine if there are moneys left to be distributed from the account.

b. IPERS shall pay the amounts owed, if any, to the probate court having jurisdiction over the decedent's estate, if the deceased member has an open estate.

c. IPERS shall pay the amounts owed, if any, to the probate court that had or would have had jurisdiction over the decedent's estate, if the deceased member's estate is closed or an estate was not opened.

d. As IPERS makes applicable payments, a copy of the written notice received by IPERS shall be filed with the probate court.

If the probate court charges a filing fee for the deposit of amounts payable hereunder, IPERS shall deduct such filing fees and other court costs from the amounts payable prior to transfer. The probate court shall hold the funds and, upon its determination, shall order disbursement or transfer in accordance with the determination. Additional filing fees and court costs, if any, shall be charged upon disbursement either to the recipient or against the funds on deposit with the probate court, in the discretion of the court.

14.17(4) *Release of claims.* Payments made to a probate court under this rule shall discharge IPERS from all claims by all persons for the value of amounts paid the court.

[**ARC 8601B**, IAB 3/10/10, effective 4/14/10; **ARC 8929B**, IAB 7/14/10, effective 6/21/10; **ARC 9068B**, IAB 9/8/10, effective 10/13/10]

495—14.18(97B) Special rules for tax treatment of distributions to same gender spouse and same gender former spouse alternate payees. Rescinded **ARC 1348C**, IAB 2/19/14, effective 3/26/14.

These rules are intended to implement Iowa Code sections 97B.1A(8), 97B.1A(18), 97B.1A(19), 97B.34, 97B.34A, 97B.44, 97B.52 and 97B.53B and 2000 Iowa Acts, chapter 1077, section 75.

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CHAPTER 16
DOMESTIC RELATIONS ORDERS AND OTHER ASSIGNMENTS
[Prior to 11/24/04, see 581—Ch 21]

495—16.1(97B) Garnishments and income withholding orders.

16.1(1) For the limited purposes of this rule, the term "member" includes IPERS members, beneficiaries, contingent annuitants and any other third-party payees to whom IPERS is paying a monthly benefit or a lump sum distribution.

16.1(2) A member's right to any payment from IPERS is not transferable or assignable and is not subject to execution, levy, attachment, garnishment, or other legal process, including bankruptcy or insolvency law, except for the purpose of enforcing child, spousal, or medical support.

16.1(3) Only members receiving payment from IPERS, including monthly benefits and lump sum distributions, may be subject to garnishment, attachment, or execution against funds that are payable. Such garnishment, attachment, or execution is not valid and enforceable for members who have not applied for and have not been approved to receive funds from IPERS.

16.1(4) Upon receipt of an income withholding order issued by the Iowa department of human services or a court, IPERS shall send a copy of the withholding order to the member. If a garnishment has been issued by a court, the party pursuing the garnishment shall send a notice pursuant to Iowa law to the member against whom the garnishment is issued.

16.1(5) IPERS shall continue to withhold a portion of the member's monthly benefit as specified in the initial withholding order until instructed by the court or the Iowa department of human services issuing the order to amend or cease payment. IPERS shall continue to withhold a portion of the member's monthly benefit as specified in the garnishment until the garnishment expires or is released.

16.1(6) Funds withheld or garnished are taxable to the member. IPERS may assess a fee of $2 per payment in accordance with Iowa Code section 252D.18A(2). The fee will be deducted from the gross amount, less federal and state income tax, before a distribution is divided.

16.1(7) A garnishment, attachment or execution may not be levied upon funds which are already the subject of a levy, including a levy placed upon funds by the United States Internal Revenue Service, unless the requirements of IRC Section 6334(a)(8) are met. Multiple garnishments, attachments and executions are allowed as long as the amount levied upon does not exceed the limitations prescribed in 15 U.S.C. Section 1673(b).

16.1(8) IPERS may release information relating to entitlement to funds to a court or to the Iowa department of human services prior to receipt of a valid garnishment, attachment, execution, or income withholding order when presented with a written request stating the information requested and reasons for the request. This request must be signed by a magistrate, judge, or child support recovery unit director or the director's designee, including an attorney representing the Iowa department of human services. In addition, IPERS may release information to the Iowa department of human services through automated matches.

495—16.2(97B) Domestic relations orders. This rule shall apply only to marital property orders. All support orders shall continue to be administered under rule 495—16.1(97B).

16.2(1) *Definitions.*

"Alternate payee" means a spouse or former spouse, regardless of gender, of a member who is recognized by a domestic relations order as having a right to receive all or a portion of the benefits payable by IPERS with respect to such member.

"Benefits" means, for purposes of this rule and depending on the context, a refund, monthly allowance (including monthly allowance paid as an actuarial equivalent (AE)), or death benefit payable with respect to a member covered under IPERS. "Benefits" does not include dividends payable under Iowa Code section 97B.49 or other cost-of-living increases unless specifically provided for in a QDRO.

"Domestic relations order" means any judgment, decree, or order which relates to the provision of marital property rights to a spouse or former spouse, regardless of gender, of a member and is made pursuant to the domestic relations laws of a state.

"Member" means, for purposes of this rule, IPERS members, beneficiaries, and contingent annuitants.

"Qualified domestic relations order" or *"QDRO"* means a domestic relations order that divides the marital property of former spouses and assigns to a former spouse alternate payee the right to receive all or a portion of the benefits payable with respect to a member under IPERS and meets the requirements of this rule.

"Successor alternate payee" means a nonspouse person or persons named in a domestic relations order to receive the amounts payable to the former spouse alternate payee under the QDRO if the alternate payee dies before the member. Successor alternate payees must be named individuals, not a class of individuals, a trust or an estate.

"Trigger event" means a distribution or series of distributions of benefits made with respect to a member.

16.2(2) *Requirements.*

a. Mandatory provisions. A domestic relations order is a QDRO if such order:

(1) Clearly specifies the member's name and last-known mailing address, member identification number or social security number, and the names and last-known mailing addresses and social security numbers of alternate payees. This information shall be provided to IPERS on IPERS' Confidential Information form;

(2) Clearly specifies a fixed dollar amount or a percentage, but not both, of the member's benefits to be paid by IPERS to the alternate payee or the manner in which the fixed dollar amount or percentage is to be determined, provided that no such method shall require IPERS to perform present value calculations of the member's accrued benefit;

(3) Clearly specifies the period to which such order applies;

(4) Clearly specifies that the order applies to IPERS;

(5) Clearly specifies that the order is for purposes of making a property division;

(6) Conforms IPERS with IRS reporting requirements for distributions to non-spouse successor alternate payees. The taxable portion and basis will be prorated to each respective recipient if the payee is the alternate payee. If the payee is a successor alternate payee, the taxable portion and basis will be borne by the member, pursuant to IRC Pub. L. 99-514, 100 Stat. 2085, enacted October 22, 1986; and

(7) Is clearly signed by the judge and filed with the clerk of court. IPERS will consider an order duly signed if it carries an original signature, a stamp bearing the judge's signature, an electronic clerk-of-court stamp and judge's signature page via the electronic data management system (EDMS) or is conformed in accordance with local court rules.

b. Prohibited provisions. A domestic relations order is not a QDRO if such order:

(1) Requires IPERS to provide any type or form of benefit or any option not otherwise provided under Iowa Code chapter 97B;

(2) Requires IPERS to provide increased benefits determined on the basis of actuarial value;

(3) Requires the payment of benefits to an alternate payee which are required to be paid to another alternate payee under another order previously determined by IPERS to be a QDRO;

(4) Requires any action by IPERS that is contrary to its governing statutes or plan provisions;

(5) Awards any future benefit increases that are provided by the legislature, except as provided in subparagraph 16.2(2)*"c"*(2); or

(6) Requires the payment of benefits to an alternate payee prior to a trigger event.

c. Permitted provisions. A QDRO may also:

(1) If a trigger event has not occurred as of the date the order is received by IPERS, name an alternate payee as a designated beneficiary or contingent annuitant or require the payment of benefits under a particular benefit option, or both;

(2) Specify that the alternate payee shall be entitled to a fixed dollar amount or percentage of dividend payments, or cost-of-living increase or any other postretirement benefit increase to the member (all known as dividend payments), as follows:

1. If the court order awards a fixed dollar amount of benefits to the alternate payee, the dollar amount of dividend payments to be added or method for determining the dollar amount shall be stated in the court order or an award of a share of dividend payments shall be given no effect; and

2. If the court order awards a specified percentage of benefits to the alternate payee, IPERS shall add dividends to the alternate payee's share of the retirement allowance as necessary to keep the alternate payee's share of payments at the percentage specified in the court order;

(3) Bar a vested member from requesting a refund of the member's accumulated contributions without the alternate payee's written consent. If a member applies for a refund, a consent form will be sent to the alternate payee at the address of record at IPERS. The completed consent form must be received by IPERS within 60 days. If returned undeliverable or no response is received, the alternate payee's refund amount will be payable to the member. If returned marked "no consent," the refund will not be payable to either the member or alternate payee;

(4) Allow benefits to be paid to an alternate payee based on a period of reemployment for a retired member; and

(5) Name a successor alternate payee to receive the amounts that would have been payable to the member's former spouse alternate payee under the order, if the former spouse alternate payee dies before the member. A successor alternate payee may be an individual(s) or a trustee, so long as the relationship of the trustee is clearly defined in the order stating that payment to the trustee is to be made in the case when any of the named successor alternate payees in the order is a minor or is legally incompetent. Once a successor alternate payee reaches the age of majority, IPERS will make payment, not to the trustee, but to the successor alternate payee directly. The designation of a successor alternate payee in an order shall be void and be given no effect if IPERS does not receive confirmation of the successor's name, social security number, and last-known mailing address on IPERS' Confidential Information form. A QDRO that lists a series of default successor alternate payees by class or permits a successor alternate payee to designate additional successor alternate payees is not permitted and will be rejected. Once a QDRO is accepted by IPERS for administration, in order to change the designation of successor alternate payees, an amended order is required.

16.2(3) *Administrative provisions.*

a. IPERS uses the shared payment method for payments under a domestic relations order. IPERS will not create a separate account for the alternate payee or any successor alternate payee(s). Payment to the alternate payee (or successor alternate payee(s)) shall be in a lump sum if the member's benefits are paid in a lump sum distribution or as monthly payments if the member's benefits are paid under a retirement option. A member shall not be able to receive an actuarial equivalent (AE) under Iowa Code section 97B.48(1) unless the total benefit payable with respect to that member meets the applicable requirements. All divisions of benefits shall be based on the gross amount of monthly or lump sum benefits payable. Federal and state income taxes shall be deducted from the member's and former spouse alternate payee's respective shares and reported under their respective federal tax identification numbers. Unrecovered basis shall be allocated on a pro rata basis to the member and alternate payee. Federal and state income taxes shall be deducted from the member's gross payment when a nonspouse successor alternate payee(s) receives a payment. Federal and state income taxes shall be reported under the member's federal tax identification number. Unrecovered basis shall be allocated to the member.

b. The alternate payee shall not be entitled to any share of the member's death benefits except to the extent such entitlement is so provided in a QDRO or in a beneficiary designation filed subsequent to the dissolution.

c. Upon acceptable proof from a member that a preretirement divorce is final, a member may submit a new enrollment/beneficiary designation form to IPERS. IPERS will place the new designation in the member's record. However, if a domestic relations order is later received and qualified by IPERS, the provisions of the QDRO shall be deemed, except as revoked or modified in a subsequent QDRO, to operate as a beneficiary designation, and shall be given first priority by IPERS in the determination and payment of such member's death benefits. Death benefits remaining after payments are made as required by the QDRO, to the extent possible, shall then be made according to the terms of the member's most recent beneficiary designation. If a QDRO does not contain a form of benefit paragraph requiring the

member to select a specific IPERS option at retirement, the member is allowed to select any option at retirement, including an option that does not provide for payment of postretirement death benefits. Once a divorce is final postretirement, a member may submit a new enrollment/beneficiary designation form to IPERS if the member has retired under Option 1, 2 or 5, unless otherwise specified in a QDRO.

d. If an alternate payee has been awarded a share of the member's benefits and dies before the member, the alternate payee's entire share shall be restored to the member unless otherwise specified in the order and in the manner required under this rule. In order for the alternate payee's entire share to be restored to the member, IPERS requires proof of death of the alternate payee in the form of a death certificate. If a death certificate cannot be obtained, IPERS may rely on such resources as it has available, including but not limited to records from the Social Security Administration, bureau of health statistics, IPERS' own internal records, or reports derived from other public records, and other departmental or governmental records to which IPERS may have access.

e. An alternate payee shall not receive a share of dividends or other cost-of-living increases, unless so provided in a QDRO.

f. The CEO, or CEO's designee, shall have exclusive authority to determine whether a domestic relations order is a QDRO. A final determination by the CEO, or CEO's designee, may be appealed in the same manner as any other final agency determination under Iowa Code chapter 97B.

g. A person who attempts to make IPERS a party or requires IPERS to appear as a witness to a domestic relations action in order to determine an alternate payee's right to receive a portion of the benefits payable to a member shall be liable to IPERS for its costs and attorney's fees.

h. A domestic relations order shall not become effective until it is approved by IPERS. If a member is receiving a retirement allowance at the time a domestic relations order is received by the system, the order shall be effective only with respect to payments made after the order is determined to be a QDRO. Payment to the alternate payee will be withheld from the member's payment the month the alternate payee's application is mailed by IPERS. If the member is not receiving a retirement allowance at the time a domestic relations order is approved by IPERS and the member applies for a refund or monthly allowance, or dies, no distributions shall be made until the respective rights of the parties under the domestic relations order are determined by IPERS. If IPERS has placed a hold on the member's account following written or verbal notification from the member, member's spouse, or legal representative of either party of a pending dissolution of marriage, and no further contacts are received from either party or their representatives within the following one-year period, or IPERS has not received and qualified a domestic relations order, IPERS shall release the hold.

i. IPERS and its staff shall have no liability for making or withholding payments in accordance with the provisions of this rule.

j. IPERS has no duty or responsibility to search for alternate payees. Alternate payees must notify IPERS of any change in their mailing addresses. IPERS shall mail the alternate payee an application once an application for a distribution has been received from the member and considered a complete application by IPERS. The application mailed by IPERS to the alternate payee states that, if the alternate payee does not return the application to IPERS within 60 days after the application is mailed by IPERS, the amounts otherwise payable to the alternate payee shall be paid to the member or the member's beneficiary(ies). If the member applied for a refund, and the alternate payee's application is not received within the 60 days, the alternate payee's share of the member's lump sum refund shall be paid to the member. The alternate payee's only recourse shall be with the member. IPERS shall have no liability to the alternate payee or the member with respect to payment of the alternate payee's share to the member. If the member applies for a monthly pension payment, unless and until a valid application for the alternate payee's share of the monthly pension payments is received and accepted by IPERS, IPERS shall have no liability to the alternate payee with respect to payment of monthly amounts, nor will any retroactive payment be made if and when an application is received and accepted. All monthly payments in this case shall be prospective.

k. If a QDRO requires the member to select an option with joint and survivor provisions (Option 4 or 6) and name the alternate payee as contingent annuitant, the order must state the percentage in Option 4 or 6 to be payable to the alternate payee as contingent annuitant (the currently available percentages

under Option 4 or 6 are 25, 50, 75 and 100 percent). Acceptable birth proof for the alternate payee as the named contingent annuitant, pursuant to 495—subrule 11.1(2), must also be provided to IPERS prior to approval of the order by IPERS.

l. For both lump sum and monthly payments, the alternate payee's tax withholding and rollover elections, if eligible, must be received before the first or current month's benefit is certified for payment or IPERS will use the applicable default tax withholding elections.

m. If an order that is determined to be a QDRO divides a member's account using a service factor formula and the member's IPERS benefits are based on a number of quarters less than the member's total covered quarters, notwithstanding any terms of the order to the contrary, IPERS shall limit the number of quarters used in the numerator and the denominator of the service fraction to the number of quarters actually used in the calculation of IPERS benefits, not to exceed 120 quarters for special service members and 140 quarters for regular and hybrid members. IPERS will not accept or administer a service factor formula fraction in excess of 1.

n. Service credit that is purchased during the period when the member is married to the alternate payee shall be added to the numerator and the denominator of the service fraction when calculating the service factor pursuant to a domestic relations order. Service credit that is purchased during a period when the member is not married to the alternate payee shall only be added to the denominator of the service fraction when calculating the service factor pursuant to a domestic relations order. Under no circumstances shall the number of quarters in the denominator be more than the number of quarters used to calculate the member's benefit. Service purchase after retirement shall not increase or decrease the alternate payee's payment amount that was deducted and was payable at the time of retirement.

o. The parties or their attorneys in a dissolution action involving an IPERS member shall decide between themselves which attorney will submit a proposed domestic relations order to IPERS for review. IPERS shall not review a proposed order that has not been approved as to form by both parties or their counsel by enclosure of the Administrative Rule Compliance for QDROs form. A rejection under this paragraph shall not preclude IPERS from placing a hold on a member's account until the status of a proposed order as a QDRO is resolved or the hold is released pursuant to the terms of paragraph 16.2(3)*"h."*

p. If a member has filed for and is receiving monthly pension benefits, or wishes to file an application for retirement or a refund and has a qualified domestic relations order pending on the member's account, the parties (the member and the alternate payee or their counsel of record) may execute a waiver of the 30-day appeal period following review and qualification of the member's domestic relations order, using a form approved by the system.

q. If a member with an IPERS-approved QDRO is receiving a distribution according to a qualified benefits arrangement (QBA), the alternate payee shall share in the distribution to the member unless the order specifically states otherwise.

r. If an alternate payee's completed application is received and processed before the payroll has been processed in any given month, the alternate payee will receive a payment for that current month. If an alternate payee's completed application is received and processed in the current month, but after the payroll has been processed, the alternate payee's payment will commence with the payroll in the following month.

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These rules are intended to implement Iowa Code sections 97B.4, 97B.15, 97B.25, 97B.38 and 97B.39.

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CHAPTER 17
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

495—17.1(17A,22) Definitions. As used in this chapter:

"Confidential record" means a record which is not available as a matter of right for examination and copying by members of the public under applicable provisions of law. Confidential records include records or information as described in Iowa Code section 97B.17, and records, or information contained in records, that are specified in Iowa Code section 22.7, or by other provision of law.

"Custodian" means the CEO or designee.

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

"Personally identifiable information" means information about or pertaining to an individual in a record which identifies the individual and which is contained in a record system under the jurisdiction of the agency.

"Record" means all or part of a "public record" as defined in Iowa Code section 22.1 or 97B.17 which is owned by or in the physical possession of the agency. IPERS also defines a record as information stored or preserved regardless of physical form. Record content, not record form, determines whether or not information constitutes a record. Any information documenting official final business, whether recorded on paper, reproduced on microfilm, entered in an electronic database, documented photographically, recorded in video or audio media, or documented using any other medium, constitutes a record. A record that is not confidential or otherwise exempt by federal or state law is termed an open record.

"Record system" means any group of records under the jurisdiction of the agency from which a confidential record or information may be retrieved.

[**ARC 1887C**, IAB 2/18/15, effective 3/25/15]

495—17.2(17A,22) Statement of policy, purpose and scope. The purpose of this chapter is to facilitate public access to open records. It also seeks to facilitate agency determinations with respect to the handling of confidential records and the implementation of the fair information practices Act. This chapter implements Iowa Code section 22.11 by establishing rules, policies, and procedures for the maintenance of employee, member, and other records in the possession of and under the jurisdiction of the agency.

495—17.3(17A,22) Requests for access to records.

17.3(1) *Location of record.* A request for access to a record under the jurisdiction of the agency shall be directed to the CEO or designee, Iowa Public Employees' Retirement System (IPERS), 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117.

17.3(2) *Office hours.* Records shall be made available during all customary office hours which are from 8 a.m. to 4:30 p.m., excluding officially designated holidays.

17.3(3) *Request for access.* Requests for access to open records may be made in writing, by telephone, electronically or in person. All requests shall include the name, address, telephone number, and the E-mail address (if available) of the person requesting the information. All requests for information regarding member accounts must contain the member's identification number or social security number. Requests shall identify the particular records sought by name or other personal identifier and shall include a description in order to facilitate the location of the record. A person shall not be required to give a reason for requesting an open record. The request shall indicate the maximum search fee the requester is prepared to pay. If the maximum amount is reached before the requested records have been located and copied, the requester shall be notified and asked for further directions.

17.3(4) *Response to requests.* The custodian is authorized to grant or deny access to agency records according to the provisions of this chapter. The decision to grant or deny access may be delegated to one or more designated employees.

Access to an open record shall be provided promptly upon request, unless the size or nature of the request makes prompt access impractical. However, 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). The custodian shall inform the

requester of the reason for the delay and an estimate of the length of that delay and, upon request, shall provide a written reply.

The custodian may deny access to the record or information in the record by members of the public only on the grounds that a denial is warranted under Iowa Code section 22.8(4) or 22.10(4), or that it is a confidential record or information, or that its disclosure is prohibited by a court order. Access by members of the public to a confidential record or information is limited by law and, therefore, may generally be provided only in accordance with the provisions of rule 495—17.4(97B) and other applicable provisions of law.

17.3(5) *Security of record.* Individuals will not be given access to the area where the records are kept. All examination and copying of records shall be done under supervision. Records shall be protected from damage and disorganization.

17.3(6) *Copying.* A reasonable number of copies may be made at IPERS. If the number of copies is prohibitive or the copying equipment is not available, IPERS may arrange to have copies made elsewhere subject to costs.

17.3(7) *Fees.*

a. When charged. The agency is authorized to charge fees in connection with the retrieval, restoration, supervision, compiling and copying of records in accordance with Iowa Code section 22.3. To the extent permitted by applicable provisions of law, the payment of fees may be waived when the imposition of fees is inequitable or when a waiver is in the public interest.

b. Copying and postage costs. Price schedules for published records and for copies of records supplied by the agency shall be posted in the agency. Copies of records may be made by or for members of the public at cost, as determined by and posted in the agency. When the mailing of copies of records is requested, the actual costs of mailing may also be charged to the requester.

c. Search and supervisory fee. A fee may be charged for actual expenses in retrieval, restoration, compiling and supervising the examination and copying of requested records. The fee shall be based on the hourly rate of pay of an agency employee who ordinarily would be appropriate and suitable to perform this function and shall be posted in the agency. No fee shall be charged if the records are not made available for inspection. The requester shall be given advance notice of the hourly rate that will be charged in connection with the retrieval, restoration, supervision, compilation and copying of records.

d. Computer-stored information. A fee, as described in the paragraph above, may be charged for the actual expenses related to the retrieval, restoration and copying of information stored in electronic records. IPERS shall not create custom software to elicit information that is not readily available or accessible on the electronic systems as a normal business function.

e. Advance payments.

(1) When the estimated fee chargeable under this subrule exceeds $25, the requester shall be required to make an advance payment of the estimated fee. Upon completion of the request for records, the actual fee shall be calculated and the difference refunded or collected.

(2) When a requester has previously failed to pay a fee charged under this subrule, full advance payment of future estimated fees of any amount may be required before processing a new or pending request for access to records from that requester.

495—17.4(17A,22) Access to confidential records. Under Iowa Code sections 22.7, 97B.17 or other applicable provisions of law, the custodian may disclose certain confidential records to members of the public. Other provisions of law may authorize or require the custodian to release specified confidential records or information under certain circumstances or to particular persons. The following procedures apply to requests for the custodian to permit the examination or copying of a confidential record and are in addition to those specified for requests for access to records in rule 17.3(17A,22).

17.4(1) *Proof of identity.* A person requesting access to a confidential record shall be required to provide proof of identity satisfactory to the custodian.

17.4(2) *Requests.* A request for access to a confidential record shall be in a form acceptable to the agency. A person requesting access to a confidential record shall be required to sign a statement

enumerating the specific grounds alleged to justify access and provide any proof necessary to establish relevant facts.

17.4(3) *Notice to subject of record and opportunity to obtain injunction.* After the custodian receives a request for access to a confidential record, and before the custodian releases that record, the custodian may make reasonable efforts to notify any person who is a subject of that record, is identified in that record, and whose address, telephone number, or other personal identifier is contained in that record. The custodian shall give the subject of that confidential record to whom notification is transmitted a reasonable opportunity to seek an injunction under Iowa Code section 22.8 and indicate to the subject of that record the specified period of time during which disclosure will be delayed for that purpose.

17.4(4) *Request denied.* When the custodian denies a request for access to a confidential record, in whole or in part, the custodian shall notify the requester in writing. The denial shall include:

a. The name and title of the person responsible for the denial; and

b. A citation to the statute or other provision of law which prohibits disclosure of the record; or

c. A citation to the statute vesting discretion in the custodian to deny disclosure of the record and a brief statement of the reasons for the denial to the requester.

17.4(5) *Request granted.* When the custodian grants a request for access to a confidential record to a particular person, the custodian shall notify that person and indicate any lawful restrictions imposed by the custodian on that person's examination and copying of the record.

[**ARC 2402C**, IAB 2/17/16, effective 3/23/16]

495—17.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination. The custodian may treat a record as confidential and withhold it from examination only to the extent that the custodian is authorized to refuse to disclose the record to members of the public by Iowa Code section 22.7 or 97B.17, another applicable provision of law, or in response to a court order.

17.5(1) *Persons who may request.* Any person who would be aggrieved or adversely affected by disclosure of all or a part of a record under the jurisdiction of the agency to members of the public and who asserts that Iowa Code section 22.7 or 97B.17, another applicable provision of law, or a court order authorizes the custodian to treat the record as a confidential record, may file a request, as provided for in this rule, for its treatment as a confidential record and to withhold it from public inspection.

17.5(2) *Request.* A request for the treatment of a record as a confidential record shall be in writing and shall be filed with the custodian. The request shall include an enumeration of the specific reasons justifying confidential record treatment for all or part of that record, the specific provisions of law that authorize confidential record treatment in this instance, and the name, mailing address, telephone number and, if available, the E-mail address of the person authorized to respond to any action concerning the request. If the information is regarding an IPERS member, the member identification number or social security number of the member must be included. The person requesting treatment of a record as a confidential record may also be required to sign a certified statement or affidavit enumerating the specific reasons justifying the treatment of the record as a confidential record and to provide any proof necessary to establish relevant facts. The person filing a request shall, if possible, accompany the request with a redacted copy of the record in question for which confidential record treatment has been requested. If the original record is submitted at the same time the request is filed, the person shall indicate conspicuously on the original record which portions of it are requested to be confidential. Requests for treatment of all or portions of a record as confidential for a limited time period shall also specify the precise period of time for which confidential record treatment is requested.

17.5(3) *Failure to request.* Failure of a person to request confidential record treatment for a record or confidential information contained in a record shall not preclude the custodian from treating it as a confidential record or the confidential information contained in that record as permitted under Iowa Code section 22.7 or 97B.17. However, if a person who has submitted information does not request confidential record treatment under the provisions of Iowa Code sections 22.7(3) (trade secrets), 22.7(6) (advantage to competitors), and 22.7(18) (communications not required by law, rule, procedure or contract), the custodian of records containing that information may, but is not required to, proceed as if that person has no objection to its disclosure to members of the public.

17.5(4) *Timing of decision.* A decision by the agency with respect to the disclosure of all or part of a record under its jurisdiction to members of the public may be made when a request for its treatment as a confidential record is filed or when a request is received for access to the record by a member of the public.

17.5(5) *Request granted or deferred.* If a request for a confidential record or information is granted, or if action on a request is deferred, a copy of the record from which the material in question has been deleted and a copy of the decision to grant the request or to defer action on the request will be placed in the original file, and will be made available for public inspection. If a request is subsequently received for access to the original record, reasonable and timely efforts will be made to notify any person who has filed a request for its treatment as a confidential record.

17.5(6) *Request denied and opportunity to seek injunction.* If a request that a record be treated as a confidential record and be withheld from public inspection is denied, the custodian shall notify the requester in writing of the reasons for that determination. On application by the requester, the custodian may engage in a good-faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief under the provisions of Iowa Code section 22.8, or other applicable provision of law. However, a record shall not be withheld from public inspection for any period of time if the custodian determines that the requester had no reasonable grounds to justify the treatment of that record as a confidential record. The custodian shall notify requester in writing of the time period allowed to seek injunctive relief or the reasons for the determination that no reasonable grounds exist to justify the treatment of that record as a confidential record. The custodian may extend the period of good-faith, reasonable delay in allowing examination of the record so that the requester may seek injunctive relief only if no request for examination of that record has been received, or if a court directs the custodian to treat it as a confidential record, or to the extent permitted by another applicable provision of law, or with the consent of the person requesting access.

495—17.6(17A,22) Procedure by which a person who is the subject of a record may have additions, dissents, or objections entered into certain records. Except as otherwise provided by law, the subject of a record may file a request with the custodian to review and to have the right to have written additions, dissents, or objections entered into a record under the jurisdiction of the agency. However, this does not authorize a person who is a subject of a record to alter the original copy of the record or to expand the official record of an agency proceeding. The subject shall send the request to review a record or the written statement of additions, dissents or objections to the agency. Additions, dissents, or objections must be dated and signed by the subject, and shall include the current mailing address, telephone number and, if available, the E-mail address of the subject or the subject's representative. The subject's social security number must also be included on the addition.

495—17.7(17A,22) Consent to disclosure by the subject of a confidential record. To the extent permitted by any applicable provision of law, the subject of a confidential record under the jurisdiction of the agency may consent to disclosure to a third party of that portion of the record concerning the subject except as provided in subrule 17.12(1). The consent must be in writing and must identify the particular record or records that may be disclosed, the particular person or class of persons to whom the record may be disclosed and, where applicable, the time period during which the record or information may be disclosed. The subject and, where applicable, the person to whom the record is to be disclosed, must provide proof of identity. Appearance of legal counsel, or a duly appointed representative on behalf of a subject of a confidential record, is deemed to constitute consent for the agency to disclose records about that person to the person's representative.

495—17.8(17A,22) Notice to suppliers of information. When the agency requests a person to supply information about that person, the agency shall notify the person of the use that will be made of the information, which persons outside the agency might routinely be provided the information, which parts of the requested information are required and which are optional, and the consequences of a failure to provide the information requested. This notice may be given in rules, on the written form used to collect

the information, on a separate fact sheet or letter, in brochures, in formal agreements, in contracts, in handbooks, in manuals, verbally, or by other appropriate means.

495—17.9(17A,22) Disclosures without the consent of the subject.

17.9(1) Open records shall be routinely disclosed without the consent of the subject.

17.9(2) To the extent allowed by law, disclosure of confidential records may occur without the consent of the subject. Following are instances where disclosure, if lawful, will generally occur without notice to the subject:

a. For a routine use as defined in rule 495—17.10(97B) or in the notice for a particular record system.

b. To a recipient who has provided advance written assurance that the record will be used solely as a statistical research or reporting record, provided that the record is transferred in a form that does not identify the subject.

c. To another government agency or to an instrumentality of any government jurisdiction within or under the control of the United States for a civil or criminal law enforcement activity if the activity is authorized by law, and if the authorized representative of the government agency or instrumentality has submitted a written request to the custodian specifying the record desired and the law enforcement activity for which the record is sought.

d. To an individual following a showing of compelling circumstances affecting the health or safety of any individual if a notice of the disclosure is transmitted to the last-known mailing address of the subject.

e. To the legislative services agency.

f. In the course of employee disciplinary proceedings.

g. In response to a court order or subpoena.

495—17.10(17A,22) Routine use.

17.10(1) Defined. "Routine use" means the disclosure of a record, without the consent of the subject or subjects, for a purpose which is compatible with the purpose for which the record was collected. It includes disclosures required or permitted to be made by statute other than the public records law, Iowa Code chapter 22.

17.10(2) To the extent allowed by law, the following uses are considered routine uses of all agency records:

a. Disclosure to officers, employees and agents of the agency who have a need for the record in the performance of duties. The CEO or designee shall resolve disputes concerning what constitutes legitimate need to use confidential or exempt records.

b. Disclosure of information indicating an apparent violation of the law to appropriate law enforcement authorities for investigation and possible criminal prosecution, civil court action, or regulatory order.

c. Disclosure to the department of inspections and appeals for matters in which it is performing services or functions on behalf of an agency.

d. Transfers of information within an agency, to other state agencies, or to local units of government as appropriate to administer the program for which the information is collected.

e. Information released to staff of federal, state, or other governmental entities for audit purposes or for purposes of determining whether an agency is operating a program lawfully.

f. Any disclosure specifically authorized by the statute under which the record was collected or maintained.

g. Disclosure to officers, employees and agents of the agency who need to use the record to determine the named beneficiary when a wage earner or retiree dies; to maintain a record of wages reported and quarters worked for computation of benefits; to track benefits received; to recompute and adjust benefits; to update information for electronic deposit of benefits; to audit payroll reports; and to verify quarterly update of wages paid.

495—17.11(17A,22) Consensual disclosure of confidential records.

17.11(1) *Consent to disclosure by a subject individual.* The subject may consent in writing to disclosure of confidential records as provided in rule 495—17.7(97B).

17.11(2) *Complaints to public officials.* A letter from a subject of a confidential record to a public official which seeks the official's intervention on behalf of the subject in a matter that involves a record under the jurisdiction of the agency may be treated as an authorization to release sufficient information about the subject to the official to resolve the matter. The public official shall be required to treat the information received as confidential.

17.11(3) *Obtaining information from a third party.* The agency may be required to obtain information to coordinate benefits, verify applicant and employee information or to provide other services. Requests to third parties for this information may involve the release of confidential identifying information about individuals contained in records under the jurisdiction of the agency. Such requests are within the meaning of routine use as defined in rule 495—17.10(97B) and shall not require authorization from the subject of the record.

495—17.12(17A,22) Release to subject.

17.12(1) Records shall be released to the subject of a confidential record upon a written request from the subject. The agency need not release the following records or information to the requester:

a. The identity of a person providing information about the requester when the information is authorized to be held confidential pursuant to Iowa Code section 22.7(18).

b. Records that are the work products of an attorney or are otherwise privileged.

c. Peace officers' criminal investigative reports except as required by the Iowa Code. See Iowa Code section 22.7(5).

d. As otherwise authorized by law or covered as an investigative request required by the system.

17.12(2) Where a record has multiple persons with interest in the confidentiality of the record, reasonable steps shall be taken to protect confidential information relating to other persons in the record.

495—17.13(17A,22) Availability of records.

17.13(1) *Open records.* Records under the jurisdiction of the agency are open for public inspection and copying unless otherwise provided by these rules.

17.13(2) *Confidential records.* The following records under the jurisdiction of the agency may be withheld from public inspection. Records are listed by category, according to the legal basis for withholding them from public inspection.

a. Sealed bids received prior to the time set for public opening of bids. See Iowa Code section 72.3.

b. Procurement proposals prior to completion of the evaluation process and the issuance of a notice of intent to award a contract, provided that, if requests for proposals are canceled prior to the issuance of a notice of intent to award, all procurement proposals shall be returned in confidence to the bidders and no file copies shall be retained.

c. Tax records made available to the agency.

d. Records which are exempt from disclosure under Iowa Code sections 22.7 and 97B.17, including, but not limited to:

(1) Communications not required by rule, law, procedure or contract to the extent that the agency reasonably believes that such communications would not be made if the supplier knew the information would be made available for general public examination. These records are confidential under Iowa Code section 22.7(18).

(2) Data processing software, as defined in Iowa Code section 22.3A, which is developed by a governmental body.

(3) Log-on identification passwords, Internet protocol addresses, private keys, or other records containing information which might lead to disclosure of private keys used in a digital signature or other similar technologies as provided in Iowa Code chapter 554D.

(4) Records which if disclosed might jeopardize the security of an electronic transaction pursuant to Iowa Code chapter 554D.

e. Minutes of closed meetings of a government body under Iowa Code section 21.5(4).

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

g. Those portions of agency manuals, examination materials, instructions or other statements issued which set forth criteria or guidelines to be used in auditing, in making inspections, in settling commercial disputes or negotiating commercial contract arrangements, or in the selection or handling of cases, such as operational tactics on allowable tolerances or criteria for the defense, prosecution or settlement of cases, when disclosure of these statements would:

(1) Enable law violators to avoid detection;

(2) Facilitate disregard of requirements imposed by law; or

(3) Give a clearly improper advantage to persons who are in an adverse position to the agency.

h. Records which constitute attorney work product, attorney-client communications, or which are otherwise privileged. Attorney work product is confidential under Iowa Code sections 22.7(4) and 622.10, Iowa R.C.P. 1.503, Fed. R.Civ.P. 26(b)(3), and case law. Attorney-client communications are confidential under Iowa Code section 622.10, the rules of evidence, the Code of Professional Responsibility, and case law.

i. Any other records made confidential by law.

17.13(3) *Authority to release confidential records.* The agency, under certain circumstances, may disclose some information or confidential records which otherwise are exempt from disclosure under Iowa Code sections 22.7 and 97B.17, or other law. Any person may request permission to inspect particular records withheld from inspection as confidential records. If it is initially determined that records will be released, reasonable efforts will be made, where appropriate, to notify interested persons, and the records may be withheld from inspection for up to ten days to allow interested persons to seek injunctive relief.

495—17.14(17A,22) Personally identifiable information. This rule describes the nature and extent of personally identifiable information which is collected, maintained, and retrieved by personal identifier in record systems defined in rule 495—17.1(97B). For each record system, this rule describes the legal authority for the collection of that information and the means of storage of that information, and indicates whether a data processing system matches, collates, or permits the comparison of personally identifiable information in one record system with personally identifiable information in another record system. Record systems under the jurisdiction of the agency that are retrievable through the use of personal identifiers are described as follows:

17.14(1) *IPERS personnel files and records.* Personnel files of IPERS employees are maintained and kept under the jurisdiction of the agency and contain personal, private, and otherwise confidential records under Iowa Code section 22.7(11). It is unlikely that the personal and private information in these records can be separated from otherwise releasable information without identifying the subject or the employee's family. These records contain names, social security numbers and other identifying numbers, and are collected in the form of paper, microfilm, tape, and computer records. Data processing systems permit the comparison of personally identifiable information in one record system with that in another system.

17.14(2) *Iowa public employees' retirement system.* The retirement system possesses records that concern individual public employees who are covered by IPERS and their families. Records are collected in accordance with Iowa Code chapter 97B and are confidential records in part under Iowa Code sections 22.7 and 97B.17. These records contain names, addresses, social security numbers, and other identifying numbers, and are collected in the form of paper, microfilm, tape, and computer records. Data processing systems permit the comparison of personally identifiable information in one record system with that in another system.

17.14(3) *Vendor contracts.* These are records pertaining to facilities management, training, investment management, and other services. These records are collected in accordance with Iowa Code

chapter 97B and are confidential records in part under Iowa Code section 22.7. These records contain names, addresses, social security numbers, and other identifying numbers, and are collected in the form of paper, microfilm, tape, and computer records. Data processing systems permit the comparison of personally identifiable information in one record system with that in another system.

495—17.15(17A,22) Other groups of records routinely available for public inspection. This rule describes groups of records maintained by the agency other than those record systems retrieved by personally identifiable information as defined in rule 495—17.1(97B). These records are routinely available to the public subject to costs. However, these records may contain confidential information. In addition, the records listed in subrules 17.15(1) to 17.15(4), 17.15(6), and 17.15(9) may contain information about individuals. All records may be stored on paper, microfilm, tape or in automated data processing systems unless otherwise noted.

17.15(1) Rule-making records. Rule-making records may identify individuals making written or oral comments on proposed rules. This information is collected pursuant to Iowa Code section 17A.4. Public documents generated during the promulgation of agency rules, including notices and public comments, are available for public inspection. This information is not retrieved by individual identifier.

17.15(2) Board and committee records. Agendas, minutes, and materials presented to the board and committee within the agency are available from the agency except those records concerning closed sessions which are exempt from disclosure under Iowa Code section 21.5(4) or which are otherwise confidential by law. These records may identify individuals who participate in meetings. This information is collected pursuant to Iowa Code section 21.3. This information is not retrieved by individual identifier.

17.15(3) Publications. News releases, annual reports, final project reports, newsletters, and brochures describing various programs are available from the agency. These publications may contain information about individuals, including staff or members of the board or committee. This information is not retrieved by individual identifier.

17.15(4) Statistical reports. Periodic reports of activity for various department programs are available from the department. This information is not retrieved by individual identifier.

17.15(5) Appeal decisions and advisory opinions. All final orders, decisions and opinions are open to the public except for information that is confidential according to rule 495—17.5(97B) or subrule 17.13(2). These records, collected under the authority of Iowa Code chapters 97B and 97C, may contain confidential information about individuals.

17.15(6) Published materials. The agency uses many legal and technical publications in its work. The public may inspect these publications upon request. Some of these materials may be protected by copyright laws. This information is not retrieved by individual identifier.

17.15(7) Policy manuals. The agency's manuals containing the policies and procedures for programs administered by the agency are available at IPERS' headquarters. This information is not retrieved by individual identifier.

17.15(8) Administrative records. These are records related to the budgets of the agency, the requisition of equipment and supplies, the payment of claims, and other accounting functions as well as records kept by the investments section, including information on investment policies and portfolios. Some investment information is partially confidential under Iowa Code sections 22.7 and 97B.17.

17.15(9) All other records not exempted from disclosure by law.

495—17.16(17A,22) Comparison of data processing systems. To the extent required by law, all data processing systems used by the agency permit the comparison of personally identifiable information in one record system with personally identifiable information in another record system.

495—17.17(17A,22) Applicability. This chapter does not:

1. Make available to the general public records which contain information about individuals by that person's name or other personal identifier.

2. Make records available to the general public which would otherwise not be available under the public records law, Iowa Code chapter 22 and Iowa Code section 97B.17.

3. Govern the maintenance or disclosure of, notification of, or access to records in the possession of the agency which are under the jurisdiction of another agency.

4. Apply to grantees, including local governments or their subdivisions, administering state-funded programs unless otherwise provided by law or agreement.

5. Make available records compiled in reasonable anticipation of court litigation or formal administrative proceedings. The availability of those records to the general public or to any individual or party to litigation or proceedings shall be governed by applicable legal and constitutional principles, statutes, rules of discovery, evidentiary privileges, and applicable regulations of the agency.

6. Require the agency to create, compare or procure a record solely for the purpose of making it available.

These rules are intended to implement Iowa Code chapter 97B.

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CHAPTER 26
APPEALS AND CONTESTED CASES—PROCEEDINGS
[Prior to 1/7/04, see 581—21.9]

495—26.1(17A,97B) Scope and applicability. These rules are applicable to appeals and contested case proceedings conducted by the Iowa Public Employees' Retirement System.

495—26.2(17A,97B) Definitions. Except where otherwise specifically defined by law:

"Appeal" means a dispute, other than a disability claim under Iowa Code section 97B.52A, of an agency decision or action. An appeal shall be conducted as a contested case if IPERS has issued its final agency decision and if the aggrieved party wishes to continue in the appeal process.

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

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

"Party" means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

"Presiding officer" means an administrative law judge provided by the department of inspections and appeals.

495—26.3(17A,97B) Appeals.

26.3(1) A party who wishes to appeal a decision by IPERS, other than a disability claim pursuant to Iowa Code section 97B.50A, shall, within 30 days after notification was mailed to the party's last-known address, file with IPERS a notice of appeal in writing setting forth:

a. The name, address, and member identification number of the appellant;
b. A reference to the decision from which the appeal is being made;
c. The fact that an appeal from the decision is being made;
d. The grounds upon which the appeal is based; and
e. Any evidence necessary to support the appeal.

Upon receipt of the appeal, IPERS shall conduct an internal review of the facts and circumstances involved, in accordance with its appeal review procedure. IPERS shall issue a final agency decision which becomes final unless within 30 days of issuance the member files a request for a contested case proceeding. In determining the date that an appeal or request for a contested case proceeding is filed with IPERS, the following shall apply: An appeal or request for a contested case proceeding delivered by mail shall be deemed to be filed on the postmark date; an appeal or any other document delivered by any other means shall be deemed to be filed on the date of receipt. Upon receipt of a request for contested case proceeding, IPERS shall inform the department of inspections and appeals of the filing and of relevant information pertaining to the case in question. The department of inspections and appeals shall, after issuing proper notice, hold a hearing on the case under the contested cases procedure as described in 26.4(17A,97B) and shall affirm, modify, or reverse IPERS' decision.

26.3(2) Appeals of disability claims under Iowa Code section 97B.50A shall be filed and processed as provided under rule 495—13.2(97B) and, upon exhaustion of that appeal process, shall revert to the procedures set forth in 26.4(17A,97B).
[**ARC 2402C**, IAB 2/17/16, effective 3/23/16]

495—26.4(17A,97B) Contested case procedures. Appeals of final agency decisions by IPERS shall be conducted pursuant to the following subrules.

26.4(1) Time requirements. Time shall be computed as provided in Iowa Code section 4.1(34).

26.4(2) For good cause, the presiding officer may extend or shorten the time to take any action, except as precluded by statute or by rule that specifies a jurisdictional filing deadline. Except for good cause stated in the record, before extending or shortening the time to take any action, the presiding officer shall afford all parties an opportunity to be heard or to file written arguments.

495—26.5(17A,97B) 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 for a contested case proceeding shall:

1. State the name and address of the requester;
2. Identify the specific agency action which is disputed;
3. Where the requester is represented by an attorney, identify the provisions of law or precedent requiring or authorizing the holding of a contested case proceeding in the particular circumstances involved; and
4. Include a short and plain statement of the issues of material fact in dispute.

495—26.6(17A,97B) Notice of hearing.

26.6(1) *Delivery.* Delivery of the notice of hearing by the department of inspections and appeals constitutes the commencement of the contested case proceeding. Delivery may be executed by:

a. Personal service as provided in the Iowa Rules of Civil Procedure; or

b. Certified mail, return receipt requested; or

c. First-class mail; or

d. Publication, as provided in the Iowa Rules of Civil Procedure.

26.6(2) *Contents.* The notice of hearing shall 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 agency 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 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 agency or the state and of parties' counsel where known;

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

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

h. Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11(1) and rule 26.7(17A,97B), that the presiding officer be an administrative law judge.

495—26.7(17A,97B) Presiding officer. The presiding officer for contested cases shall be an administrative law judge employed by the department of inspections and appeals.

495—26.8(17A,97B) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the agency in its discretion may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

495—26.9(17A,97B) Telephone proceedings. The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen.

495—26.10(17A,97B) Disqualification.

26.10(1) A presiding officer shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

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

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

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

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

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

f. Has a spouse or relative within the third degree of relationship that:

(1) Is a party to the case, or an officer, CEO or designee or trustee of a party;

(2) Is an attorney or legal representative in the case;

(3) Is known to have an interest that could be substantially affected by the outcome of the case; or

(4) Is likely to be a material witness in the case; or

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

26.10(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(3) and subrules 26.10(3) and 26.24(9).

26.10(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.

26.10(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 26.10(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17. The motion must be filed as soon as practicable 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 must establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 26.26(17A,97B) and seek a stay under rule 26.30(17A,97B).

495—26.11(17A,97B) Consolidation—severance.

26.11(1) *Consolidation.* The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where: (a) the matters at issue involve common parties or common questions of fact or law; (b) consolidation would expedite and simplify consideration of the issues involved; and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

26.11(2) *Severance.* The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

495—26.12(17A,97B) Pleadings.

26.12(1) Pleadings may be required by rule, by the notice of hearing, or by order of the presiding officer.

26.12(2) Petition.

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 the petitioner and the petitioner's attorney, if any.

26.12(3) Answer. An answer 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.

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.

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

Any allegation in the 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.

26.12(4) Amendment. Any notice of hearing, petition, or other charging document 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.

495—26.13(17A,97B) Service and filing of pleadings and other papers.

26.13(1) *When service required.* Except where otherwise provided by law, 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 state or the agency, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

26.13(2) *Service—how made.* Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

26.13(3) *Filing—when required.* After the notice of hearing, all pleadings, motions, documents or other papers in a contested case proceeding shall be filed with the CEO, or designee, IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117. All pleadings, motions, documents or other papers that are required to be served upon a party shall be filed simultaneously with the agency.

26.13(4) *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the CEO, or designee, IPERS, 7401 Register Drive, P.O. Box 9117, Des Moines, Iowa 50306-9117, 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.

26.13(5) *Proof of mailing.* Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the (agency office and address) and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).
_____(Date) _____(Signature)

495—26.14(17A,97B) Discovery.

26.14(1) Discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

26.14(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 26.14(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

26.14(3) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible in that proceeding.

495—26.15(17A,97B) Subpoenas.

26.15(1) *Issuance.*

a. An agency subpoena shall be issued to a party on 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 five days before the scheduled hearing. The request shall include the name, address, and telephone number of the requesting party.

b. 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.

26.15(2) *Motion to quash or modify.* The presiding officer may quash or modify a subpoena for any lawful reason upon motion in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be set for argument promptly.

495—26.16(17A,97B) Motions.

26.16(1) No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

26.16(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 rules of the agency or the presiding officer. The presiding officer may consider a failure to respond within the required time period in ruling on a motion.

26.16(3) The presiding officer may schedule oral argument on any motion.

26.16(4) Motions pertaining to the hearing, except motions for summary judgment, must be filed and served at least ten days, or other time period designated by the agency or presiding officer, prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the agency or an order of the presiding officer.

26.16(5) Motions for summary judgment. Motions for summary judgment shall comply with the requirements of Iowa Rule of Civil Procedure 1.981 and shall be subject to disposition according to the requirements of that rule to the extent such requirements are not inconsistent with the provisions of this rule or any other provision of law governing the procedure in contested cases. Motions for summary judgment must be filed and served at least 20 days prior to the scheduled hearing date, or other time period determined by the presiding officer. Any party resisting the motion shall file and serve a resistance within 10 days, unless otherwise ordered by the presiding officer, from the date a copy of the motion was served. The time fixed for hearing or normal 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 26.29(17A,97B) and appeal pursuant to 26.28(17A,97B).

495—26.17(17A,97B) Prehearing conference.

26.17(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be scheduled not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the presiding officer to all parties. For good cause the presiding officer may permit variances from this rule.

26.17(2) Each party shall bring to the prehearing conference:

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

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

c. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

26.17(3) In addition to the requirements of subrule 26.17(2), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters which the parties intended to 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.

26.17(4) Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a telephone prehearing conference.

495—26.18(17A,97B) Continuances. Unless otherwise provided, applications for continuances shall be made to the presiding officer.

26.18(1) A written application for a continuance shall:

a. Be made at the earliest possible time and no less than seven days before the hearing except in case of unanticipated emergencies;

b. State the specific reasons for the request; and

c. Be signed by the requesting party or the party's representative.

An oral application for a continuance may be made if the presiding officer waives the requirement for a written motion. However, a party making such an oral application for a continuance must confirm that request by written application within five days after the oral request unless that requirement is waived by the presiding officer. No application for continuance shall be made or granted without notice to all parties except in an emergency where notice is not feasible. The agency or presiding officer may waive notice of such requests for a particular case or an entire class of cases.

26.18(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; and

i. Other relevant factors.

The presiding officer may require documentation of any grounds for continuance.

495—26.19(17A,97B) Withdrawals. A party requesting a contested case proceeding may withdraw that request prior to the hearing only in accordance with agency rules. A party requesting withdrawal of an appeal shall do so in writing and submit the request to the CEO or presiding officer, whichever is applicable. Unless otherwise provided, a withdrawal shall be with prejudice.

495—26.20(17A,97B) Intervention.

26.20(1) *Motion.* A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

26.20(2) *When filed.* Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. The presiding officer may deny the motion for leave to intervene if not filed timely. 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.

26.20(3) *Grounds for intervention.* The movant shall demonstrate that: (a) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (b) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (c) the interests of the movant are not adequately represented by existing parties.

26.20(4) *Effect of intervention.* If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate actively in the proceeding. 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.

495—26.21(17A,97B) Hearing procedures.

26.21(1) The presiding officer presides at the hearing and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings.

26.21(2) All objections shall be timely made and stated on the record.

26.21(3) 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. The cost of representation is the responsibility of the party.

26.21(4) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

26.21(5) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

26.21(6) Witnesses may be sequestered during the hearing.

26.21(7) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

b. The parties shall be given an opportunity to present opening statements;

c. Parties shall present their cases in the sequence determined by the presiding officer;

d. Each witness shall be sworn or affirmed by the presiding officer or the court reporter, and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

495—26.22(17A,97B) Evidence.

26.22(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

26.22(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

26.22(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, shall receive a continuance sufficient to amend pleadings and to prepare on the additional issue.

26.22(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties. All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

26.22(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

26.22(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

495—26.23(17A,97B) Default.

26.23(1) If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

26.23(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

26.23(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 26.27(17A,97B). 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.

26.23(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

26.23(5) Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to

the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

26.23(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rules of Civil Procedure 1.977.

26.23(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 26.26(17A,97B).

26.23(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

26.23(9) A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues but, unless the defaulting party has appeared, it cannot exceed the relief demanded.

26.23(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 26.30(17A,97B).

495—26.24(17A,97B) Ex parte communication.

26.24(1) Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the agency 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 26.10(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.

26.24(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

26.24(3) Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

26.24(4) To avoid prohibited ex parte communications notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 26.13(17A,97B) and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through a conference telephone call including all parties or their representatives.

26.24(5) Persons who jointly act as presiding officer or are a committee assigned to conduct a contested case may communicate with each other without notice or opportunity for parties to participate.

26.24(6) The CEO, or designee, or other persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under any provision of law and they comply with subrule 26.24(1).

26.24(7) Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 26.18(17A,97B).

26.24(8) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication while a contested case is pending 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 and disclosed to all parties having an interest in the contested case. 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.

26.24(9) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

26.24(10) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the agency. Violation of ex parte communication prohibitions by agency personnel shall be reported to the CEO or agency general counsel for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

495—26.25(17A,97B) Recording costs. Upon request, the agency shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

495—26.26(17A,97B) Interlocutory appeals. Upon written request of a party or on its own motion, the CEO, or designee, may review an interlocutory order of the presiding officer. In determining whether to do so, the CEO shall weigh the extent to which the granting of the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the agency at the time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within ten 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.

495—26.27(17A,97B) Hearing decision. Following the conclusion of a hearing of an appeal, the administrative law judge within the department of inspections and appeals shall announce the findings of fact and conclusion of law and issue a written decision. The decision shall be signed by the administrative law judge, and filed with IPERS, with a copy mailed to the appellant. This decision shall be deemed final unless, within 30 days after the issuance date of such decision, further appeal is initiated. The issuance date is the date that the decision is signed by the administrative law judge.

495—26.28(17A,97B) Appeal of the hearing decision.

26.28(1) *Notice of appeal.* An appeal of a written decision of an administrative law judge is initiated by filing a timely notice of appeal with the employment appeal board of the Iowa department of inspections and appeals. In determining the date that a notice of appeal or any other document is filed with the employment appeal board, and subject to applicable exceptions adopted by the employment appeal board, the following shall apply: an appeal or any other document delivered by mail shall be deemed to be filed as of the postmark date; an appeal or any other document delivered by any other means shall be deemed to be filed as of the date that it is received. The notice of appeal must be signed

by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

a. The parties initiating the appeal;

b. The proposed decision or order appealed from;

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

d. The relief sought;

e. The grounds for relief.

26.28(2) *Requests to present additional evidence.* A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The CEO, or a designee, may preside at the taking of additional evidence.

26.28(3) *Scheduling.* The employment appeal board shall issue a schedule for consideration of the appeal.

26.28(4) *Briefs and arguments.* Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 14 days thereafter any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs. The employment appeal board may resolve the appeal on the briefs or provide an opportunity for oral argument.

26.28(5) *Judicial review.* The employment appeal board's decision shall be final and without further review 30 days after the decision is mailed to all interested parties of record unless within 20 days a petition for rehearing is filed with the employment appeal board or within 30 days a petition for judicial review is filed in the appropriate district court. The agency, in its discretion, may also petition the district court for judicial review of questions of law involving any of its decisions. Action brought by the agency for judicial review of its decisions shall be brought in the district court of Polk County, Iowa.

495—26.29(17A,97B) Applications for rehearing.

26.29(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

26.29(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the agency decision on the existing record and whether, on the basis of the grounds enumerated in subrule 26.28(2), the applicant requests an opportunity to submit additional evidence.

26.29(3) *Time of filing.* The application shall be filed with the Iowa department of inspections and appeals within 20 days after issuance of the written decision.

26.29(4) *Notice to other parties.* A copy of the application shall be timely served by the applicant to all parties of record not joining therein.

26.29(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the appeal board grants the application within 20 days after its filing.

495—26.30(17A,97B) Stays of agency actions.

26.30(1) *When available.*

a. Any party to a contested case proceeding may petition the agency 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 CEO, or designee, may rule on the stay or authorize the presiding officer to do so.

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

26.30(2) *When granted.* In determining whether to grant a stay, the CEO, or designee, or presiding officer shall consider the factors listed in Iowa Code section 17A.19(4).

26.30(3) *When vacated.* A stay may be vacated by the issuing authority upon application of the agency's representative or any other party.

495—26.31(17A,97B) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

495—26.32(17A,97B) Emergency adjudicative proceedings.

26.32(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare and, consistent with the Constitution and other provisions of law, the agency may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the agency by emergency adjudicative order. Before issuing an emergency adjudicative order the agency shall consider factors including, but not limited to, the following:

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

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

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

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

e. Whether the specific action contemplated by the agency is necessary to avoid the immediate danger.

26.32(2) *Issuance of order.*

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

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing one or more of the following procedures:

(1) Personal delivery;

(2) Certified mail, return receipt requested, to the last address on file with the agency;

(3) Certified mail to the last address on file with the agency;

(4) First-class mail to the last address on file with the agency; or

(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that agency orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the agency shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

26.32(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the agency shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

26.32(4) *Completion of proceedings.* After the issuance of an emergency adjudicative order, the agency shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

Issuance of a written emergency adjudicative order shall include notification of the date on which agency proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further agency proceedings to a later date will be granted only in compelling circumstances upon application in writing.

These rules are intended to implement Iowa Code chapters 17A and 97B.

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NATURAL RESOURCE COMMISSION[571]

[Prior to 12/31/86, see Conservation Commission [290], renamed Natural Resource Commission[571] under the "umbrella" of Department of Natural Resources by 1986 Iowa Acts, chapter 1245]

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CHAPTER 15
GENERAL LICENSE REGULATIONS

[Prior to 12/31/86, see Conservation Commission[290] Chs 17, 66, 67, and 75]

571—15.1(483A) Scope. The purposes of this chapter are to provide rules for license sales, refunds and administration; implement the wildlife violator compact and penalties for multiple offenses; administer special licenses available for hunting and fishing; and describe and implement certification and education programs of the department of natural resources.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

DIVISION I
LICENSE SALES, REFUNDS AND ADMINISTRATION

571—15.2(483A) Definitions. For the purposes of this division, the following definitions shall apply:

"Administration fee" means the fee collected by the department to pay a portion of the cost of administering the sale of licenses through electronic means.

"Department" means the department of natural resources.

"Director" means the director of the department of natural resources.

"Immediate family member" means the spouse, a domestic partner, and all minor children of the licensee or person seeking a license.

"License" means any license or privilege issued by the department to an individual for hunting or fishing in the state of Iowa. Multiple types of licenses are described in these rules.

"License agent" means an individual, business, or governmental agency authorized to sell a license.

"Licensee" means the person who applies for and receives a license under these rules from the department.

"Nonresident" means a person who is not a resident as that term is defined in this rule.

"Principal and primary residence or domicile" means the one and only place where a person has a true, fixed, and permanent home, and to where, whenever the person is briefly and temporarily absent, the person intends to return. Relevant factors used to determine a person's principal and primary residence or domicile include the following:

1. Proof of place of employment, which must include the address of the person's place of employment or business, including the area or region where a majority of the person's work is performed.
2. Physical address, which shall be the person's 911 address(es) or the address of an immediate family member. A post office box or a forwarded address shall not be accepted by the department to verify the person's principal and primary residence or domicile.
3. Utility records, which must include the person's name and be associated with the physical address provided for as the person's principal and primary residence or domicile. The types of records that may be submitted include rental and lease documents and telephone, cellular phone, electricity, water, sewer, cable or satellite television, and any other utility records.
4. Real estate records, which include legal documents showing ownership or leasehold interests of any and all real estate related to the physical address used by the department to verify the person's principal and primary residence or domicile. These records should also provide the time period of such ownership or rental.
5. Vehicle registration(s) for any vehicles owned or leased by the person and immediate family members.
6. Portion of federal, state or local income tax returns filed during the relevant time period showing the address provided on those forms by the person.
7. Documentation of homestead tax exemption allowed to the person or immediate family member(s) for all states in which such exemption is allowed.
8. Documentation of any coinhabitants, other than the person's immediate family members, who use the same principal and primary residence or domicile.

"Resident" means a natural person who meets any of the following criteria during each year in which the person claims status as a resident:

1. Has physically resided in this state at the person's principal and primary residence or domicile for a period of not less than 90 consecutive days immediately before applying for or purchasing a resident license, tag, or permit under this chapter and has been issued an Iowa driver's license or an Iowa nonoperator's identification card. A person is not considered a resident under this rule if the person is residing in the state only for a special or temporary purpose including but not limited to engaging in hunting, fishing, or trapping.
2. Is a full-time student at either of the following:

- An accredited educational institution located in this state if the person resides in this state while attending the educational institution.
- An accredited educational institution located outside of this state, if the person is under the age of 25 and normally resides with at least one parent or legal guardian who maintains a principal and primary residence or domicile in this state.

3. Is a student who qualifies as a resident pursuant to paragraph "2," second bulleted paragraph, only for the purpose of purchasing any resident license specified in Iowa Code section 483A.1 or 484A.2.
4. Is a resident under 18 years of age whose parent is a resident of this state.
5. Is a member of the armed forces of the United States who is serving on active duty, claims residency in this state, and has filed a state individual income tax return as a resident pursuant to Iowa Code chapter 422, division II, for the preceding tax year, or is stationed in this state.

"Retail" means the sale of goods or commodities to the ultimate consumer, as opposed to the sale of goods or commodities for further distribution or processing.

"Wholesale" means the sale of goods or commodities for resale by a retailer, as opposed to the sale of goods or commodities to the ultimate consumer.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09; **ARC 9004B**, IAB 8/11/10, effective 9/15/10]

571—15.3(483A) Form of licenses. Every license shall contain a general description of the licensee. At the time of application, the applicant for a license must provide the applicant's date of birth and either a social security number or a valid Iowa driver's license number. The license shall be signed by the applicant and shall clearly indicate the privilege granted.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.4(483A) Administration fee. An administration fee of $1.50 per privilege purchased shall be collected from the purchaser at the time of purchase, except upon the issuance of free landowner deer and turkey hunting licenses, free annual hunting and fishing licenses, free annual fishing licenses, free group home fishing licenses, and boat registrations, renewals, transfers, and duplicates. An administrative fee of $3.65 will be collected from the purchaser at the time of boat registration, renewal, transfer, and duplicate purchases.

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571—15.5(483A) Electronic license sales.

15.5(1) Designation as license agent. The director may designate a retail business establishment, an office of a governmental entity, or a nonprofit corporation as an agent of electronically issued licenses in accordance with the provisions of this rule. The provisions of 571—15.6(483A) shall not apply to a license agent engaging in, or applying to engage in, the electronic sale and issuance of licenses.

15.5(2) Application. Application forms to sell electronically issued licenses may be secured by a written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. The following information must be provided on the application form:

a. The legal name, address, and telephone number of the entity applying for designation;
b. The hours open for business and general service to the public;
c. A brief statement of the nature of the business or service provided by the applicant;

d. Type of Internet connection (dial up or high speed) used for accessing the electronic licensing system; and

e. A signature by an owner, partner, authorized corporate official, or public official of the entity applying for designation.

15.5(3) Application review.

a. The director shall approve or deny the application to sell electronically issued licenses based upon the following criteria:

(1) The need for a license agent in the area;

(2) The hours open for business or general service to the public;

(3) The potential volume of license sales;

(4) The apparent financial stability and longevity of the applicant;

(5) The number of point-of-sale (POS) terminals available to the department; and

(6) Type of Internet connection (dial up or high speed) used for accessing the electronic licensing system.

b. If necessary, the department may utilize a waiting list for license agent designation. The order of priority for the waiting list will be determined by the time of submittal of a complete and correct application and receipt of the required security deposit, as outlined in the application.

15.5(4) Issuance of electronic licensing equipment. Upon the director's approval of an application under this rule and designation of a license agent for electronic license sales, the equipment necessary to conduct such sales will be issued to the license agent by the department subject to the following terms and conditions:

a. Prior to the issuance of the electronic licensing equipment, the approved license agent shall furnish to the department an equipment security deposit in an amount to be determined by the department.

b. Prior to the issuance of the electronic licensing equipment, the approved license agent shall enter into an electronic license sales agreement with the department which sets forth the terms and conditions of such sales, including the authorized amounts to be retained by the license agent.

c. Prior to the issuance of the electronic licensing equipment, the approved license agent shall furnish to the department a signed authorization agreement for electronic funds transfer pursuant to subrule 15.5(5).

d. Electronic licensing equipment and supplies must be stored in a manner to provide protection from damage, theft, and unauthorized access. Any damage to or loss of equipment or loss of moneys derived from license sales is the responsibility of the license agent.

e. Upon termination of the agreement by either party, all equipment and supplies, as outlined in the agreement, must be returned to the department. Failure to return equipment and supplies in a usable condition, excluding normal wear and tear, will result in the forfeiture of deposit in addition to any other remedies available to the department by law.

15.5(5) License fees. All moneys received from the sale of licenses, less and except the agreed-upon service fee, must be immediately deposited and held in trust for the department.

a. All license agents must furnish to the department a signed authorization agreement for electronic funds transfer authorizing access by the department to a bank account for electronic transfer of license fees received by the license agent.

b. The amount of money due for accumulated sales will be drawn electronically by the department on a weekly basis. The license agent shall be given notice of the amount to be withdrawn at least two business days before the actual transfer of funds occurs. The license agent is responsible for ensuring that enough money is in the account to cover the amount due.

c. License agents may accept or decline payment in any manner other than cash, such as personal checks or credit cards, at their discretion. Checks or credit payments must be made payable to the license agent, not to the department. The license agent shall be responsible for ensuring that the license fee is deposited in the electronic transfer account, regardless of the payment or nonpayment status of any check accepted by the license agent.

15.5(6) Upon the termination of the electronic license sales agreement pursuant to subrule 15.5(7) or 15.5(8), the department may disconnect or otherwise block the license agent's access to the electronic licensing system.

15.5(7) Equipment shut down and termination. The department reserves the right to disconnect the license agent's access to the electronic licensing system or terminate the license agent's electronic license sales agreement for cause. Cause shall include, but is not limited to, the following:

a. Failing to deposit license fees into the electronic transfer account in a sum sufficient to cover the amount due for accumulated sales;

b. Charging or collecting any fees in excess of those authorized by law;

c. Discriminating in the sale of a license in violation of state or federal law;

d. Knowingly making a false entry concerning any license sold or knowingly issuing a license to a person who is not eligible for the license issued;

e. Using license sale proceeds, other than the service fee, for personal or business purposes;

f. Disconnecting or blocking access to the electronic licensing system for a period of 30 days or more; or

g. Violating any of these rules or the terms of the electronic license sales agreement. Repeated violations of these rules may result in termination of the license agent's electronic license sales agreement.

15.5(8) Voluntary termination. A license agent may terminate its designation and the electronic license sales agreement at its discretion by providing written notice to the department. Voluntary termination shall become effective 30 days after the department's receipt of notice.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.6(483A) Paper license sales. Paper licenses shall be sold only in the event that the electronic licensing system is no longer available.

15.6(1) *Depositary designation.* The director may designate a retail business establishment, an office of a governmental entity, or a nonprofit corporation as a depositary for the sale of hunting and fishing licenses in accordance with the provisions of this rule.

15.6(2) *Application.*

a. An application form to act as a depositary may be secured by a written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. Requests for an application form may be made through department field staff or field officers. The applicant must provide the following information on the form:

(1) The name of the retail business establishment, governmental entity, or nonprofit corporation, and location(s) and telephone numbers.

(2) A general description of the type of retail business establishment, governmental entity, or nonprofit corporation.

(3) The form of ownership if a retail business establishment. If a partnership, the full names and addresses of all partners must be provided. If a corporation, the date and state of incorporation must be provided.

(4) If a governmental entity, the name and title of the responsible official.

(5) If a nonprofit corporation, the date and state of incorporation.

(6) The hours and days open to the public.

(7) The contact information of the person signing the application.

(8) The name, address, and telephone number of three credit references, including the bank used by the retail business establishment, governmental entity, or nonprofit corporation.

b. The application form contains a statement by which the applicant agrees to the terms and conditions as set forth in this rule. The application form must be signed by the owner if a sole proprietorship; by a partner if a partnership; by an authorized corporate official if a corporation; or by the elected or appointed official administratively in charge of the governmental entity. The signature must be attested to by a notary public.

15.6(3) *Security.* The applicant under this rule must provide security, either a surety bond from an association or corporation whose business is assuring the fidelity of others and which has the authority by law to do business in this state, a collateral assignment of a certificate of deposit, or a letter of credit.

a. Condition of security. A surety bond required by this rule shall generally provide that the applicant render a true account of and turn over all moneys, license blanks, and duplicates when requested to do so by the director or an authorized representative and that the applicant comply with all applicable provisions of the application, the Iowa Administrative Code, and the Iowa Code.

b. Amount of security. All forms of security required by this rule shall be in the amount of $5,000 each or a larger amount as jointly agreed to by the department and the depositary.

c. Term of bond. The bond required by this rule shall run continuously from the date the application is approved.

d. Termination of bond. The surety or principal may terminate the bond at any time by sending written notice by certified mail, return receipt requested, to the Director, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034. The termination shall become effective 30 days after the receipt of the notice by the director.

e. Collateral assignment of a certificate of deposit and letters of credit. Collateral assignments of certificates of deposit and letters of credit shall be subject to the following terms and conditions:

(1) Certificates of deposit shall be assigned, in writing, to the department, and the assignment shall be recorded on the books of the bank issuing the certificate.

(2) Banks issuing these certificates shall waive all rights of setoff or liens which they have or might have against these certificates.

(3) Certificates of deposit shall be automatically renewed unless the director approves, in writing, release of the funds. Letters of credit shall be without reservation and shall remain in effect continuously, or as otherwise agreed to by the director.

(4) The director will release the certificates of deposit or approve the cancellation of a letter of credit upon termination of a license agent agreement if all licenses and moneys have been accounted for satisfactorily or if the depositary provides a satisfactory surety bond in lieu thereof.

15.6(4) *Multiple establishment locations.* An application and security may be submitted for retail business establishments with multiple locations. For purposes of reporting and for determining the amount of the security, each application will be considered on a case-by-case basis and as mutually agreed upon by the depositary and the director.

15.6(5) *Approval of application and security.* The director will approve the application upon the receipt of a satisfactory bond, collateral assignment of deposit, or letter of credit and a determination that the credit references are satisfactory. However, the director reserves the right not to approve any application received from a party whose depositary agreement has previously been terminated by the department for cause. Upon approval by the director, the department will provide the depositary with license blanks, reporting forms, and instructions.

15.6(6) *Depositary reporting standards.* All depositaries shall comply with the following reporting standards:

a. Monthly reports. A full and complete monthly sales report, including duplicate copies of the licenses sold and a check or other monetary instrument in the amount due, shall be remitted to the department the following month on a prescheduled due date. A depositary that does not provide the monthly report to the department within 10 days after the due date shall be considered seriously delinquent. However, if the depositary's office or business is operated on a seasonal basis, a monthly report is not required for any month that the office or business is not open to the public.

b. Annual report. An annual report for all sales for the calendar year and all unused license blanks for the year shall be remitted to the department by January 31 of each year. A depositary will be considered seriously delinquent if the annual report is not received by February 15. An annual report shall also be submitted at the time a depositary agreement is terminated for any reason during the calendar year. This report must be received within 15 days after the director issues or, in the case of a voluntary termination, receives the notice of termination.

15.6(7) *Accountability.* The depositary shall be fully accountable to the state for all proceeds collected from the sale of licenses. This accountability shall not be diminished by reason of bankruptcy, fire loss, theft loss, or other similar reason.

15.6(8) *Probation.*

a. A depositary shall be placed on probation under any of the following circumstances:

(1) The depositary is seriously delinquent for the second time during any consecutive six-month period.

(2) The depositary fails to correct a serious delinquency within ten days.

(3) A check is returned by the bank due to insufficient funds.

b. Notice of probation shall be sent to the depositary by certified mail, return receipt requested.

c. The probation will be automatically canceled after six months of satisfactory performance by the depositary.

15.6(9) *Termination of depositary agreement.* A depositary may terminate the agreement at any time by notifying the director by certified mail, return receipt requested. The termination shall be effective 30 days after the receipt of the notice by the director and after the depositary has fully accounted for all moneys and unused license blanks. The director may terminate the depositary agreement and require an immediate and full accounting of all moneys and unused license blanks under any of the following circumstances:

a. The occurrence of a third serious delinquency during any consecutive six-month period.

b. When an insufficient funds check is received by the department, not correcting the deficiency within 10 days after proper notice by the director.

c. Failing to correct a serious delinquency within 15 calendar days.

d. Knowingly placing a date, other than the correct date, on any license.

e. Knowingly selling a resident license to a nonresident or selling a license to a person not qualified for such license.

f. Charging more than the statutory writing fee.

g. Refusing to sell a license to any individual by reason of creed, sexual orientation, gender identity, religion, pregnancy or public accommodation.

h. Canceling a bond, certificate of deposit, or letter of credit or allowing one to expire.

i. Failing to make a full and complete monthly sales report and monthly remittance.

j. Knowingly making a false entry on any license being sold or knowingly issuing any license to a person to whom issuance of that license is improper.

15.6(10) *Forms available from the department.* Copies of the forms required for application, bond, monthly reports, and collateral as assignment may be obtained by written or in-person request to the Licensing Section, Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.7(483A) Lost or destroyed license blanks.

15.7(1) *Accountability for license blanks.* Whenever a depositary or county recorder requests to be relieved from accountability for license blanks that have been lost or destroyed, the depositary or county recorder (recorder) shall file a bond for the face value of such lost or destroyed license blanks and provide an explanation to the director.

15.7(2) *Explanation.*

a. The depositary or recorder shall submit a written statement in the form of an affidavit regarding the facts and circumstances surrounding the alleged loss or destruction. Pictures, drawings, or other pertinent information may be attached and referenced in the statement. The loss or destruction must relate to one or a combination of the following reasons:

(1) Loss or destruction by fire.

(2) Loss from theft.

(3) Loss while in transit.

(4) Loss from natural causes, including but not limited to floods, tornadoes, and severe storms.

(5) Loss or accidental destruction during the course of normal business operations or facility maintenance and repair.

b. The statement must also include a specific description of the precautions and procedures normally utilized by the recorder or depositary to prevent or to guard against the loss or destruction described, and a further statement as to why the precautions or procedures failed in this particular instance.

c. The director shall consider the written explanation as provided. The director shall also consider the past record of the depositary or recorder regarding losses and destructions and the past record of the depositary or recorder regarding prompt and accurate reporting. The director may direct department staff to further investigate the circumstances and facts.

(1) If the director determines that the depositary or recorder exercised reasonable and prudent care, the director shall relieve the depositary or recorder of accountability upon the filing of a bond.

(2) If the director determines that there was gross negligence by the depositary or recorder and holds the depositary or recorder accountable, the depositary or recorder may file a request for a contested case proceeding as provided in 571—Chapter 7 of the Iowa Administrative Code.

15.7(3) *Bond.* The depositary or recorder shall provide a bond in the amount of the face value of the lost or destroyed licenses. The bond shall be on a bond form provided by the department. The bond shall be conditioned to the effect that the depositary or recorder agrees to surrender the subject licenses to the department in the event that they are located at any future time; or in the event of proof showing that any or all of the subject licenses have been issued, the depositary, recorder, or sureties jointly and severally agree to pay the state the face value of all licenses covered by the bond.

a. For a face amount of $500 or less, the personal bond of the depositary or recorder is sufficient. One additional personal surety is required for a face amount up to $1,000; and two personal sureties, in addition to the depositary or recorder, are required if the face amount is more than $1,000.

b. A corporate surety authorized to do business in Iowa may be provided in lieu of the personal sureties required, in addition to the depositary or recorder.

c. The value assigned to a lost or destroyed blank license form shall be $25. This amount will be paid by the depositary to the department, except as relief from such payment is provided according to this rule.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.8(483A) Refund or change requests for special deer and turkey hunting licenses and general licenses.

15.8(1) *Invalid applications.* Deer and turkey hunting license applications that are received after the closing date for acceptance of applications and applications that are invalid on their face will be returned unopened to the applicant. Any license fee related to an application determined invalid by a computer analysis or other analysis after the application has been processed will be refunded to the applicant, less a $10 invalid application fee to compensate for the additional processing cost related to an invalid application.

15.8(2) *Death of licensee.* The fee for a deer or turkey hunting license will be refunded to the licensee's estate when the licensee's death predates the season for which the license was issued and a written request from the licensee's spouse, executor or estate administrator is received by the department within 90 days of the last date of the season for which the license was issued.

15.8(3) *National or state emergency.* The fee for a deer or turkey hunting license will be refunded if the licensee is a member of the National Guard or a reserve unit and is activated for a national or state emergency which occurs during the season for which the license was issued. A written refund request must be received by the department within 90 days of the last date of the season for which the license was issued.

15.8(4) *License changes.* The department will attempt to change an applicant's choice of season or type of license if a written or telephonic request is received by the licensing section in sufficient time (usually 20 days) before the license is printed and if the requested change does not result in disadvantage to another applicant. A change request made by telephone must be verified in writing by the requester

before the change request will be honored. The department's ability to accommodate requests to change the season or license type is dependent on workload and processing considerations. If the department cannot accommodate a request to change a season or license type, the license will be issued as originally requested by the applicant. No refund will be allowed. The department will not change the name on the license from that submitted on the application.

15.8(5) *Duplicate purchases of general hunting and fishing licenses.* Upon a showing of sufficient documentation (usually a photocopy of the licenses) that more than one hunting or fishing license was purchased by or for a single person, the department will refund the amount related to the duplicate purchase. A written request for refund, with supporting documentation, must be received by the licensing section within 90 days of the date on the face of the duplicate licenses.

15.8(6) *Other refund requests.* Except as previously described in this rule, the department will not issue refunds for any licenses as defined in 571—15.2(483A).

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.9(483A) Proof of residency required. The department shall have the authority to require persons applying for or who have received resident licenses to provide additional information to determine the person's principal and primary residence or domicile and residency status. Whether a person was issued resident or nonresident licenses by the department in previous years shall not be a determining factor of residency. Persons required to provide additional information under this rule shall be notified in writing by the department and shall have 60 days to submit all required information to the department.

[**ARC 9004B**, IAB 8/11/10, effective 9/15/10]

571—15.10(483A) Residency status determination. Upon receipt of information requested from the person, the department may determine whether the person is a resident or a nonresident for purposes of these rules and Iowa Code chapter 483A. The department shall provide the person with written notice of the finding.

[**ARC 9004B**, IAB 8/11/10, effective 9/15/10]

571—15.11(483A) Suspension or revocation of licenses when nonresidents obtain resident licenses.

15.11(1) *Suspension or revocation of license.* If the department finds that a nonresident has obtained a resident license, the department shall provide written notice of intent to revoke and suspend hunting, fishing, or trapping licenses as provided in 571—Chapter 7. If the person requests a hearing, it shall be conducted in accordance with 571—Chapter 7. If the department finds that a nonresident has obtained a resident license fraudulently or through intentional misrepresentation, the person shall be guilty of a simple misdemeanor, punishable as a scheduled violation under Iowa Code section 805.8B.

15.11(2) *Dates of suspension or revocation.* The suspension or revocation shall be effective upon failure of the person to request a hearing within 30 days of the notice described in rule 571—15.10(483A) or upon issuance of an order affirming the department's intent to suspend or revoke the license after the hearing. The person shall immediately surrender all licenses and shall not apply for or obtain new licenses for the full term of the suspension or revocation.

15.11(3) *Magistrate authority.* Nothing in this chapter shall limit the magistrate's authority as described in Iowa Code section 483A.21 to suspend or revoke licenses.

[**ARC 9004B**, IAB 8/11/10, effective 9/15/10]

571—15.12 to **15.15** Reserved.

DIVISION II
MULTIPLE OFFENDER AND WILDLIFE VIOLATOR COMPACT

571—15.16(481A,481B,482,483A,484A,484B) Multiple offenders—revocation and suspension of hunting, fishing, and trapping privileges from those persons who are determined to be multiple offenders.

15.16(1) *Definitions.* For the purpose of this rule, the following definitions shall apply:

"Department" means the Department of Natural Resources, Wallace State Office Building, 502 East 9th Street, Des Moines, Iowa 50319-0034.

"License" means any paid or free license, permit, or certificate to hunt, fish, or trap listed in Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716, including the authorization to hunt, fish, or trap pursuant to any reciprocity agreements with neighboring states.

"Licensee" means the holder of any license.

"Multiple offender" means any person who has equaled or exceeded five points for convictions in Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716 during a consecutive three-year period as provided in 15.16(3).

"Revocation" means the taking or cancellation of an existing license.

"Suspension" means to bar or exclude one from applying for or acquiring licenses for future seasons.

15.16(2) *Record-keeping procedures.* For the purpose of administering this rule, it shall be the responsibility of the clerk of district court for each county to deliver, on a weekly basis, disposition reports of each charge filed under Iowa Code chapters 481A, 481B, 482, 483A, 484A, 484B, and 716 to the department. Dispositions and orders of the court of all cases filed on the chapters listed in this subrule shall be sent to the department regardless of the jurisdiction or the department of the initiating officer.

a. License suspensions. In the event of a license suspension pursuant to Iowa Code section 481A.133, the clerk of court shall immediately notify the department.

b. Entering information. Upon receipt of the disposition information from the clerks of court, the department will, on a monthly basis, enter this information into a computerized system that is directly accessible by the department of public safety communications system for use by the department's licensing section, and all state and local law enforcement officers. Direct access through the department of public safety communications system will be available as soon as practical and is dependent on the development of appropriate computer linkage by the department of public safety.

c. Disposition report information. Information from the disposition report that will be entered into a computerized system which includes but may not be limited to the following:

County of violation, name of defendant, address of defendant, social security or driver's license number, date of birth, race, sex, height, weight, date and time of violation, charge and Iowa Code section, officer name/C-number who filed charge, and date of conviction.

15.16(3) *Point values assigned to convictions.* For the purposes of defining a multiple offender, the person shall be classified as a multiple offender when the person equals or exceeds a total of five points during a consecutive three-year period using the values attached to the following offenses. Multiple citations and convictions of the same offense will be added as separate convictions:

a. Convictions of the following offenses shall have a point value of three attached to them:

(1) Illegal sale of birds, game, fish, or bait.
(2) More than the possession or bag limit for any species of game or fish.
(3) Hunting, trapping, or fishing during the closed season.
(4) Hunting by artificial light.
(5) Hunting from aircraft, snowmobiles, all-terrain vehicles or motor vehicle.
(6) Any violation involving threatened or endangered species.
(7) Any violations of Iowa Code chapter 482, except sections 482.6 and 482.14.
(8) Any violation of nonresident license requirements.
(9) No fur dealer license (resident or nonresident).
(10) Illegal taking or possession of protected nongame species.
(11) The taking of any fish, game, or fur-bearing animal by illegal methods.
(12) Illegal taking, possession, or transporting of a raptor.
(13) Hunting, fishing, or trapping while under license suspension or revocation.
(14) Illegal removal of fish, minnows, frogs, or other aquatic wildlife from a state fish hatchery.
(15) Any fur dealer violations except failure to submit a timely annual report.
(16) Any resident or nonresident making false claims to obtain a license.
(17) Illegal taking or possession of hen pheasant.

(18) Applying for or acquiring a license while under suspension or revocation.
(19) For a repeat offense of acquiring a hunting license without hunter safety certification.
(20) Taking game from the wild—see Iowa Code section 481A.61.
(21) Violation of Iowa Code section 483A.27(7).
(22) Any violation of Iowa Code Supplement section 716.8 as amended by 2008 Iowa Acts, House File 2612, section 21, while hunting deer.

b. Convictions of the following offenses shall have a point value of two attached to them:
(1) Hunting, fishing, or trapping on a refuge.
(2) Illegal possession of fur, fish, or game.
(3) Chasing wildlife from or disturbing dens.
(4) Trapping within 200 yards of an occupied building or private drive.
(5) Possession of undersized or oversized fish.
(6) Snagging of game fish.
(7) Shooting within 200 yards of occupied building or feedlot.
(8) No valid resident license relating to deer or turkey.
(9) Illegal importation of fur, fish, or game.
(10) Failure to exhibit catch to an officer.
(11) Trapping or poisoning game birds, or poisoning game animals.
(12) Violations pertaining to private fish hatcheries and aquaculture.
(13) Violations of the fur dealers reporting requirements.
(14) Violation of Iowa Code section 481A.126 pertaining to taxidermy.
(15) Loaded gun in a vehicle.
(16) Attempting to take any fish, game, or fur-bearing animals by illegal methods.
(17) Attempting to take game before or after legal shooting hours.
(18) Wanton waste of fish, game or fur-bearing animals.
(19) Illegal discharge of a firearm pursuant to Iowa Code section 481A.54.
(20) Any violation of Iowa Code section 482.14 pertaining to commercial fishing.
(21) Failure to tag deer or turkey.
(22) Applying for or obtaining more than the legal number of licenses allowed for deer or turkey.
(23) Illegal transportation of game, fish or furbearers.
(24) Violation of Iowa Code section 483A.27, except subsection (7).

c. All other convictions of provisions in Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B shall have a point value of one attached to them.

15.16(4) *Length of suspension or revocation.*

a. The term of license suspension or revocation shall be determined by the total points accumulated during any consecutive three-year period, according to the following: 5 points through 8 points is one year, 9 points through 12 points is two years, and 13 points or over is three years.

b. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(2) shall have an additional suspension of one year. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(3) shall have an additional suspension of two years. Any person convicted of a violation of any provision of Iowa Code chapters 481A, 481B, 482, 483A, 484A, and 484B under the circumstances described in Iowa Code subsection 481A.135(4) shall have an additional suspension of three years. The foregoing provisions apply whether or not a person has been found guilty of a simple misdemeanor, serious misdemeanor or aggravated misdemeanor pursuant to Iowa Code subsections 481A.135(2), 481A.135(3) and 481A.135(4). If a magistrate suspends the privilege of a defendant to procure another license and the conviction contributes to the accumulation of a point total that requires the department to initiate a suspension, the term of suspension shall run consecutively up to a maximum of five years. After a five-year suspension, remaining time will be calculated at a concurrent rate.

15.16(5) *Points applicable toward suspension or revocation.* If a person pleads guilty or is found guilty of an offense for which points have been established by this rule but is given a suspended sentence

or deferred sentence by the court as defined in Iowa Code section 907.1, the assigned points will become part of that person's violation record and apply toward a department suspension or revocation.

15.16(6) *Notification of intent to suspend and revoke license.* If a person reaches a total of five or more points, the department shall provide written notice of intent to revoke and suspend hunting, fishing, or trapping licenses as provided in 571—Chapter 7. If the person requests a hearing, it shall be conducted in accordance with 571—Chapter 7.

15.16(7) *Dates of suspension or revocation.* The suspension or revocation shall be effective upon failure of the person to request a hearing within 30 days of the notice described in 15.16(6) or upon issuance of an order affirming the department's intent to suspend or revoke the license after the hearing. The person shall immediately surrender all licenses and shall not apply for or obtain new licenses for the full term of the suspension or revocation.

15.16(8) *Magistrate authority.* This chapter does not limit the magistrate authority as described in Iowa Code section 483A.21.

15.16(9) *Suspension for failure to comply with a child support order.* The department is required to suspend or deny all licenses of an individual upon receipt of a certificate of noncompliance with child support obligation from the Iowa child support recovery unit pursuant to Iowa Code section 252J.8(4).

a. The receipt by the department of the certificate of noncompliance shall be conclusive evidence. Pursuant to Iowa Code section 252J.8(4), the person does not have a right to a hearing before the department to contest the denial or suspension action taken due to the department's receipt of a certificate of noncompliance with a child support obligation but may seek a hearing in district court in accordance with Iowa Code section 252J.9.

b. Suspensions for noncompliance with a child support obligation shall continue until the department receives a withdrawal of the certificate of noncompliance from the Iowa child support recovery unit.

c. After the department receives a withdrawal of the certificate of noncompliance, an individual may obtain a new license upon application and the payment of all applicable fees.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.17(456A) Wildlife violator compact. The department has entered into the wildlife violator compact (the compact) with other states for the uniform enforcement of license suspensions. The compact, a copy of which may be obtained by contacting the department's law enforcement bureau, is adopted herein by reference. The procedures set forth in this rule shall apply to license suspensions pursuant to the wildlife violator compact.

15.17(1) *Definitions.* For purposes of this rule, the following definitions shall apply:

"Compliance" with respect to a citation means the act of answering a citation through an appearance in a court or through the payment of all fines, costs, and surcharges, if any.

"Department" means the Iowa department of natural resources.

"Home state" means the state of primary residence of a person.

"Issuing state" means a participating state that issues a fish or wildlife citation to a person.

"License" means any license, permit, or other public document which conveys to the person to whom it was issued the privilege of pursuing, possessing, or taking any fish or wildlife regulated by statute, law, regulation, ordinance, or administrative rule of a participating state.

"Participating state" means any state which enacts legislation to become a member of the wildlife violator compact. Iowa is a participating state pursuant to Iowa Code section 456A.24(14).

15.17(2) *Suspension of licenses for noncompliance.* Upon the receipt of a valid notice of failure to comply, as defined in the compact, the department shall issue a notice of suspension to the Iowa resident. The notice of suspension shall:

a. Indicate that all department-issued hunting (including furbearer) or fishing licenses shall be suspended, effective 30 days from the receipt of the notice, unless the department receives proof of compliance.

b. Inform the violator of the facts behind the suspension with special emphasis on the procedures to be followed in resolving the matter with the court in the issuing state. Accurate information in regard to the court (name, address, telephone number) must be provided in the notice of suspension.

c. Notify the license holder of the right to appeal the notice of suspension within 30 days of receipt. Said appeal shall be conducted pursuant to 571—Chapter 7 but shall be limited to the issues of whether the person so notified has a pending charge in the issuing state, whether the person has previously received notice of the violation from the issuing state, and whether the pending charge is subject to a license suspension for failure to comply pursuant to the terms of the compact.

d. Notify the license holder that, prior to the effective date of suspension, a person may avoid suspension through an appearance in the court with jurisdiction over the underlying violations or through the payment of all fines, costs, and surcharges associated with the violations.

e. Indicate that, once a suspension has become effective, the suspension may only be lifted upon the final resolution of the underlying violations.

15.17(3) *Reinstatement of licenses.* Any license suspended pursuant to this rule may be reinstated upon the receipt of an acknowledgement of compliance from the issuing state, a copy of a court judgment, or a certificate from the court with jurisdiction over the underlying violations and the payment of applicable Iowa license fees.

15.17(4) *Issuance of notice of failure to comply.* When a nonresident is issued a citation by the state of Iowa for violations of any provisions under the jurisdiction of the natural resource commission which is covered by the suspension procedures of the compact and fails to timely resolve said citation by payment of applicable fines or by properly contesting the citation through the courts, the department shall issue a notice of failure to comply.

a. The notice of failure to comply shall be delivered to the violator by certified mail, return receipt requested, or by personal service.

b. The notice of failure to comply shall provide the violator with 14 days to comply with the terms of the citation. The violator may avoid the imposition of the suspension by answering a citation through an appearance in a court or through the payment of all fines, costs, and surcharges, if any.

c. If the violator fails to achieve compliance, as defined in this rule, within 14 days of receipt of the notice of failure to comply, the department shall forward a copy of the notice of failure to comply to the home state of the violator.

15.17(5) *Issuance of acknowledgement of compliance.* When a person who has previously been issued a notice of failure to comply achieves compliance, as defined in this rule, the department shall issue an acknowledgement of compliance to the person who was issued the notice of failure to comply.

15.17(6) *Reciprocal recognition of suspensions.* Upon receipt of notification from a state that is a member of the wildlife violator compact that the state has suspended or revoked any person's hunting or fishing license privileges, the department shall:

a. Enter the person's identifying information into the records of the department.

b. Deny all applications for licenses to the person for the term of the suspension or until the department is notified by the suspending state that the suspension has been lifted.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.18 to **15.20** Reserved.

DIVISION III
SPECIAL LICENSES

571—15.21(483A) Fishing license exemption for patients of substance abuse facilities.

15.21(1) *Definition.* For the purpose of this rule, the definition of "substance abuse facility" is identical to the definition of "facility" in Iowa Code subsection 125.2(9).

15.21(2) *Procedure.* Each substance abuse facility may apply to the department of natural resources for a license exempting patients from the fishing license requirement while fishing as a supervised group as follows:

a. Application shall be made on a form provided by the department and shall include the name, address and telephone number of the substance abuse facility including the name of the contact person. A general description of the type of services or care offered by the facility must be included as well as the expected number of participants in the fishing program and the water bodies to be fished.

b. A license will be issued to qualifying substance abuse facilities and will be valid for all patients under the care of that facility.

c. Patients of the substance abuse facility must be supervised by an employee of the facility while fishing without a license pursuant to this rule. An employee of the substance abuse facility must have the license in possession while supervising the fishing activity of patients.

d. Notwithstanding the provisions of this rule, each employee of the substance abuse facility must possess a valid fishing license while participating in fishing.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.22(481A) Authorization to use a crossbow for deer and turkey hunting during the bow season by handicapped individuals.

15.22(1) *Definitions.* For the purpose of this rule:

"Bow and arrow" means a compound, recurve, or longbow.

"Crossbow" means a weapon consisting of a bow mounted transversely on a stock or frame and designed to fire a bolt, arrow, or quarrel by the release of the bow string, which is controlled by a mechanical or electric trigger and a working safety.

"Handicapped" means a person possessing a physical impairment of the upper extremities that makes a person physically incapable of shooting a bow and arrow. This includes difficulty in lifting and reaching with arms as well as difficulty in handling and fingering.

15.22(2) *Application for authorization card.* An individual requesting use of a crossbow for hunting deer or turkey must submit an application for an authorization card on forms provided by the department. The application must include a statement signed by the applicant's physician declaring that the individual is not physically capable of shooting a bow and arrow. A first-time applicant must submit the authorization card application no later than ten days before the last day of the license application period for the season the person intends to hunt.

15.22(3) *Authorization card—issuance and use.* Approved applicants will be issued a card authorizing the individual to hunt deer and turkey with a crossbow. The authorization card must be carried with the license and on the person while hunting deer and turkey and must be exhibited to a conservation officer upon request.

15.22(4) *Validity and forfeiture of authorization card.* A card authorizing the use of a crossbow for hunting deer and turkey will be valid for as long as the person is incapable of shooting a bow and arrow. If a conservation officer has probable cause to believe the person's handicapped status has improved, making it possible for the person to shoot a bow and arrow, the department may, upon the officer's request, require the person to obtain in writing a current physician's statement.

If the person is unable to obtain a current physician's statement confirming that the person is incapable of shooting a bow and arrow, the department may initiate action to revoke the authorization card pursuant to 571—Chapter 7.

15.22(5) *Restrictions.* Crossbows equipped with pistol grips and designed to be fired with one hand are illegal for taking or attempting to take deer or turkey. All projectiles used in conjunction with a crossbow for deer hunting must be equipped with a broadhead with at least three blades.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.23(483A) Free hunting and fishing license for low-income persons 65 years of age and older or low-income persons who are permanently disabled.

15.23(1) *Purpose.* Pursuant to Iowa Code subsection 483A.24(15), the department of natural resources will issue a free annual combination hunting and fishing license to low-income persons who meet the age status or permanently disabled status as defined.

15.23(2) *Definitions.*

"Age status" means a person who has achieved the sixty-fifth birthday.

"Low-income person" means a person who is a recipient of a program administered by the state department of human services for persons who meet low-income guidelines.

"Permanently disabled" means a person who meets the definition in Iowa Code section 483A.4.

15.23(3) *Procedure.* Each person shall apply to the department of natural resources for a license as follows:

a. Application shall be made on a form provided by the department and shall include the name, address, height, weight, color of eyes and hair, date of birth, and gender of the applicant. In addition, applicants shall include a copy of an official document such as a birth certificate if claiming age status, or a copy of an award letter from the Social Security Administration or private pension plan if claiming permanent disabled status. The application shall include an authorization allowing the department of human services to verify the applicant's household income if proof of income is provided through the department of human services.

b. The free annual hunting and fishing combination license will be issued by the department upon verification of program eligibility. The license issued under this rule will be valid until January 10 of the subsequent year. Proof of eligibility must be submitted each year in order to obtain a free license.

c. A person whose income falls below the federal poverty guidelines may apply for this license by providing either of the following:

(1) A current Notice of Decision letter. For purposes of this rule, a "current Notice of Decision letter" shall mean a letter from the department of human services dated in the month the application is received or dated in the five months immediately preceding the month the application is received that describes the applicant's monthly or annual household income.

(2) If a person does not have a Notice of Decision letter as described in subparagraph (1), a document shall be provided that states that the applicant's annual income does not exceed the federal poverty limit for the current year and lists income from all sources, including but not limited to any wages or compensation, social security, retirement income, dividends and interest, cash gifts, rents and royalties, or other cash income. In addition, the applicant shall provide documentation of such income by submitting a copy of the applicant's most recently filed state or federal income tax return to the department. In the event an applicant does not have a tax return that was filed within the last year because the applicant's income level does not require the filing of a tax return, the applicant shall so notify the department, shall provide to the department bank statements, social security statements or other relevant income documentation identified by the department, and shall meet with the department to verify income eligibility under this rule.

Federal poverty guidelines are published in February of each year and will be the income standard for applicants from that time until the guidelines are available in the subsequent year. The guidelines will be shown on the application and will be available upon request from the department.

15.23(4) *Revocation.* Any license issued pursuant to rule 571—15.23(483A) may be revoked, in whole or in part, by written notice, if the director determines that a license holder had provided false information to obtain a license under this chapter or has violated any provision of this chapter and that continuation of the license is not in the public interest. Such revocation shall become effective upon a date specified in the notice. The notice shall state the extent of the revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation, the license holder may file a notice of appeal, requesting a contested case hearing pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the license be reinstated.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09; **ARC 8465B**, IAB 1/13/10, effective 2/17/10]

571—15.24(483A) Free annual fishing license for persons who have severe physical or mental disabilities.

15.24(1) *Purpose.* Pursuant to Iowa Code subsection 483A.24(9), the department of natural resources will issue a free annual fishing license to Iowa residents 16 or more years of age who have severe mental or physical disabilities who meet the definition of "severe mental disability" or "severe physical disability" in 15.24(2).

15.24(2) *Definitions.* For the purposes of this rule, the following definitions apply:

"Severe mental disability" means a person who has severe, chronic conditions in all of the following areas which:

1. Are attributable to a mental impairment or combination of mental and physical impairments;
2. Result in substantial functional limitations in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency;
3. Reflect the person's need for a combination and sequence of services that are individually planned and coordinated; and
4. Requires the full-time assistance of another person to maintain a safe presence in the outdoors.

"Severe physical disability" means a disability that limits or impairs the person's mobility or use of a hand or arm and that requires the full-time assistance of another person or that makes the person dependant on a wheelchair for the person's normal life routine.

15.24(3) *Procedure.* Each person shall apply to the department of natural resources for a license as follows:

a. Application shall be made on a form provided by the department and shall include the name, home address, home telephone number, height, weight, eye and hair color, date of birth, and gender of the applicant and other information as required. The license issued under this rule will be issued by the department upon verification of program eligibility and will be valid until January 10 of the subsequent year. Proof of eligibility must be submitted each year in order to obtain the license.

b. The application shall be certified by the applicant's attending physician with an original signature and, based upon the definition of severe mental disability or severe physical disability as provided for in this rule, declare that the applicant has a severe mental or physical disability. A medical statement from the applicant's attending physician specifying the applicant's type of disability shall be on 8½" x 11" stationery of the attending physician or on paper inscribed with the attending physician's letterhead. For purposes of this rule, the attending physician must be a currently practicing doctor of medicine, doctor of osteopathy, physician's assistant or nurse practitioner.

15.24(4) *Revocation.* Any license issued pursuant to 571—15.24(483A) may be revoked, in whole or in part, by written notice, if the director determines that a license holder had provided false information to obtain a license under this chapter or has violated any provision of this chapter and that continuation of the license is not in the public interest. Such revocation shall become effective upon a date specified in the notice. The notice shall state the extent of the revocation and the reasons for the action. Within 30 days following receipt of the notice of a revocation, the license holder may file a notice of appeal, requesting a contested case hearing pursuant to 561—Chapter 7. The notice of appeal shall specify the basis for requesting that the license be reinstated.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09; **ARC 8465B**, IAB 1/13/10, effective 2/17/10]

571—15.25(483A) Transportation tags for military personnel on leave from active duty.

15.25(1) *Military transportation tags for deer and turkey.* The military transportation tag shall include the following information: name, birth date, current address of military person; species and sex of animal taken; date of kill; and weapon used. Only conservation officers of the department shall be authorized to issue military transportation tags.

15.25(2) *Annual limit for military transportation tags.* A person receiving a military transportation tag shall be limited to one military deer tag and one military turkey tag annually.

15.25(3) *Regulations apply to military personnel.* With the exception of the license requirement exemption set forth in Iowa Code section 483A.24(6), all hunting and fishing regulations shall apply to active duty military personnel.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.26(483A) Special nonresident deer and turkey licenses. The commission hereby authorizes the director to issue special nonresident deer and turkey licenses pursuant to the provisions of 561—Chapter 12.

[**ARC 2398C**, IAB 2/17/16, effective 3/23/16]

571—15.27 to **15.40** Reserved.

DIVISION IV
EDUCATION AND CERTIFICATION PROGRAMS

571—15.41(483A) Hunter safety and ethics education program. This division clarifies the term "hunting license" as used in Iowa Code section 483A.27 in relation to the hunter safety and ethics education course requirement, clarifies the need for exhibiting a hunter safety and ethics education course certificate when applying for a deer or wild turkey license, and explains the requirements for individuals who wish to demonstrate their knowledge of hunter safety and ethics to qualify for purchase of an Iowa hunting license. For the purpose of this division, a hunting license, pursuant to Iowa Code sections 483A.1 and 483A.24, includes:

1. Hunting licenses for legal residents except as otherwise provided. (Iowa Code section 483A.1(1))
2. Hunting licenses for nonresidents. (Iowa Code section 483A.1(2))
3. Hunting preserve license.
4. Free annual hunting and fishing licenses for persons who are disabled or are 65 years of age or older and qualify for low-income status as defined in Iowa Code section 483A.24.
5. Veteran's lifetime hunting and fishing license as defined in Iowa Code section 483A.24.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.42(483A) Testing procedures.

15.42(1) *General testing procedures.* Upon completion of the required curriculum, each person shall score a minimum of 75 percent on the written or oral test provided by the department and demonstrate safe handling of a firearm. Based on the results of the written or oral test and demonstrated firearm safe handling techniques as prescribed by the department, the volunteer instructor shall determine the persons who shall be issued a certificate of completion.

15.42(2) *Special testing out provisions.* Any person born after January 1, 1972, who does not complete the required ten-hour hunter safety and ethics course (as described in Iowa Code section 483A.27, subsection (1)), must meet the following requirements to be eligible to purchase an Iowa hunting license:

a. To comply with Iowa Code section 483A.27, subsection (5), an individual must pass a written examination compiled by the department of natural resources under the direct supervision of a state conservation officer or certified hunter safety instructor.

b. If the applicant does not pass the examination by a score of 95 percent or more, the applicant must then wait seven days to take the examination again.

c. If the applicant does not pass the second examination with a score of 95 percent or more, the applicant must successfully complete the ten-hour safety and ethics course to obtain a certificate of completion (as described in Iowa Code section 483A.27, subsection (2)).

15.42(3) *Exemptions.* The following groups of individuals do not need hunting licenses and therefore do not need to satisfactorily complete a hunter safety and ethics education course:

a. Landowners and tenants. Owners or tenants of land and their children when hunting on the land which they own or on which they are tenants.

b. Residents under 16. Residents of the state under 16 years of age accompanied by their parent or guardian or in the company of any other competent adult if the adult accompanying said minor possesses a valid hunting license, providing, however, there is one licensed adult accompanying each person under 16 years of age.

15.42(4) *Deer and wild turkey license applications.* Individuals are not required to exhibit a certificate showing satisfactory completion of a hunter safety and ethics education course only when applying for a deer or wild turkey license.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.43(321G,462A,483A) Volunteer bow and fur harvester education instructors, snowmobile and all-terrain vehicle (ATV) safety instructors, boating safety instructors and hunter education instructors.

15.43(1) *Purpose.* Pursuant to Iowa Code sections 321G.23(2), 462A.3 and 483A.27(4), the department will certify volunteer instructors to teach bow, fur harvester, snowmobile, ATV, boating and hunter education courses.

15.43(2) *Definitions.* For the purpose of this rule:

"Certified instructor" means a person who has met all criteria in this rule for one or more of the above-named courses.

"Course" means the department's bow, fur harvester, snowmobile, ATV, boating and hunter education and ethics courses.

"Department" means the department of natural resources.

"Instructor applicant" means a person who has applied to become a certified volunteer instructor for one of the above-named courses.

15.43(3) *Minimum qualifications.* The following conditions must be satisfied before any person can become a certified instructor. Failure to meet these conditions will result in the denial of the application. An applicant may be disqualified if the applicant has accumulated any habitual offender points pursuant to rule 571—15.16(481A,481B,482,483A,484A,484B), or other license suspension by the court or department. The instructor applicant will be notified of the denial by the recreational safety coordinator. An instructor applicant shall:

a. Submit an application as provided by the department to the local conservation officer or recreational safety officer.

b. Be at least 18 years of age.

c. Have experience in handling equipment, such as firearms, bows and arrows, furbearer traps, snowmobiles, ATVs and various navigational vessels, that is necessary for the various prescribed courses.

d. Have completed the course as defined in subrule 15.43(2).

e. Attend and pass an instructor's training and certification course administered by the department.

f. Submit to a background check. This check will include, but not be limited to, a criminal history check as provided by the department of public safety. A record of a felony conviction will disqualify the applicant. A record of serious or aggravated misdemeanors may disqualify the applicant based on type of offense and year committed.

g. Successfully complete the apprenticeship as required in subrule 15.43(4).

15.43(4) *Instructor applicant apprenticeship.* In addition to subrule 15.43(3), the following conditions must be satisfied to complete the instructor applicant apprenticeship:

a. Participate in one course.

b. Apprentice with a certified instructor.

The recreational safety officer may make the determination as to which certified instructor will be supervising the instructor applicant during the apprenticeship.

15.43(5) *Certified education instructor responsibilities.* A certified instructor has the following responsibilities:

a. To complete all prerequisites to becoming an instructor as provided in subrules 15.43(3) and 15.43(4).

b. To follow all policies and procedures as set forth in the current "Instructor Procedures Manual."

c. To assist in the recruitment and training of additional volunteer instructors.

d. To recruit and train students in the applied-for prescribed course program.

e. To actively promote the program in the instructor's county and to arrange for publicity for each new class.

f. To maintain order and discipline in the classroom and outdoor classroom at all times.

g. To accurately fill out required forms and reports for each class and mail that material to the recreational safety coordinator within 15 days after completion of the course.

h. To teach the course as prescribed by the department.

i. To maintain a file on all students that the instructor teaches.

j. To actively participate in one course every two years. If this requirement is not met, the instructor's certification may be terminated after notification by letter by the recreational safety coordinator. The person may reapply to become a volunteer safety education instructor pursuant to subrule 15.43(3).

k. To attend a minimum of one continuing education instructor workshop every three years for hunter education as provided by the department.

15.43(6) *Grounds for revocation of instructor certification.* The department may, at any time, seek to revoke the instructor certification of any person who:

a. Fails to meet the instructor responsibilities as outlined in subrules 15.43(4) and 15.43(5).

b. Fails to follow the policies and procedures as set forth in the current "Instructor Procedures Manual."

c. Falsifies any information as may be required by the department.

d. Handles any equipment in an unsafe manner, or allows any student or other instructor to handle equipment in a reckless or unsafe manner.

e. Is convicted of or forfeits bond for any fish and game, snowmobile, ATV or navigation violation of this state or any other state.

f. Uses abusive or foul language while conducting a course.

g. Participates in a course while under the influence of alcohol or any illegal drug.

h. Has substantiated complaints filed against the instructor by the public, department personnel or other certified instructor(s).

i. Fails to meet the requirements in subrule 15.43(5), paragraphs *"j"* and *"k."*

j. Is convicted of a felony or an aggravated or serious misdemeanor as defined in the statutes of this state. This would also include any felonies or comparable misdemeanors of any other state.

k. Receives compensation directly or indirectly from students for time spent preparing for or participating in a course.

15.43(7) *Termination of certification.* Any certified instructor has the right, at any time, to voluntarily terminate certification. If an instructor voluntarily terminates certification or certification is terminated by the department, the instructor must return to the department the certification card and all materials that were provided.

15.43(8) *Compensation for instructors.* Instructor applicants and certified instructors shall not receive any compensation for their time either directly or indirectly from students while preparing for or participating in a course. However, instructor applicants and certified instructors may require students to pay for actual course-related expenses involving facilities, meals or materials other than those provided by the department.

15.43(9) *Hearing rights.* If the department seeks to revoke an instructor certification pursuant to subrule 15.43(6), the department shall provide written notice of intent to revoke the certification as provided in 571—Chapter 7. If the certified instructor requests a hearing, it shall be conducted in accordance with 571—Chapter 7.

[**ARC 7852B**, IAB 6/17/09, effective 7/22/09]

571—15.44 to **15.50** Reserved.

DIVISION V
LICENSE REVOCATION, SUSPENSION, AND MODIFICATION DUE TO LIABILITIES OWED TO THE STATE

571—15.51(272D) Purpose and use. This rule is intended to help collect liabilities of the state or a state agency. This rule shall apply to all licenses issued, renewed or otherwise authorized by the department.

[**ARC 8465B**, IAB 1/13/10, effective 2/17/10]

571—15.52(272D) Definitions. For purposes of this chapter, the following definitions shall apply:

"Certificate of noncompliance" means a document provided by the unit certifying the named person has outstanding liability placed with the unit and has not entered into an approved payment plan to pay the liability.

"Department" means the department of natural resources.

"Liability" means a debt or obligation placed with the unit for collection that is greater than $1,000. For purposes of this chapter, "liability" does not include child support payments collected pursuant to Iowa Code chapter 252J.

"License" means a license, certification, registration, permit, approval, renewal or other similar authorization issued to a person by the department which evidences the admission to, or granting of authority to engage in, a profession, occupation, business, industry, or recreation, including those authorizations set out in Iowa Code chapters 321G, 321I, 455B, 455C, 455D, 456A, 459, 459A, 461A, 462A, 481A, 481B, 481C, 482, 483A, 484B and 484C.

"Licensee" means a person to whom a license has been issued by the department or who is seeking the issuance of a license from the department.

"Notice of intent" means a notice sent to a licensee indicating the department's intent to suspend, revoke, or deny renewal or issuance of a license.

"Obligor" means a person with a liability placed with the unit.

"Unit" means the centralized collection unit of the department of revenue or the college student aid commission.

"Withdrawal of a certificate of noncompliance" means a document provided by the unit certifying that the certificate of noncompliance is withdrawn and that the department may proceed with issuance, reinstatement, or renewal of a person's license.

[**ARC 8465B**, IAB 1/13/10, effective 2/17/10; **ARC 9005B**, IAB 8/11/10, effective 9/15/10]

571—15.53(272D) Requirements of the department.

15.53(1) *Records.* The department shall collect and maintain records of its licensees that must include, at a minimum, the following:

a. The licensee's first and last names.

b. The licensee's current known address.

c. The licensee's social security number.

The records shall be made available to the unit so that the unit may match to the records the names of persons with any liabilities placed with the unit for collections. The records must be submitted in an electronic format and updated on a quarterly basis.

15.53(2) *Certificate of noncompliance.* Upon receipt of a certificate of noncompliance from the unit, the department shall initiate its existing rules and procedures for the suspension, revocation, or denial of issuance or renewal of a person's license.

15.53(3) *Notice of intent.* The department shall provide a notice of intent to a person of its intent to suspend, revoke or deny issuance or renewal of a license in accordance with Iowa Code chapter 272D or section 261.126, whichever is appropriate. The suspension, revocation, or denial shall be effective no sooner than 30 days following the issuance of the notice of intent to the person. The notice shall include all of the following:

a. That the department has received a certificate of noncompliance from the unit and intends to suspend, revoke or deny issuance or renewal of a person's license;

b. That the person must contact the unit to schedule a conference or to otherwise obtain a withdrawal of a certificate of noncompliance;

c. That the department will revoke, suspend or deny the person's license unless a withdrawal of a certificate of noncompliance is received from the unit within 30 days from the date of the notice;

d. That, in the event the department's rules and procedures conflict with the additional rules and procedures under this action, the rules and procedures of this action shall apply;

e. That mistakes of fact in the amount of the liability owed and the person's identity may not be contested to the department; and

f. That the person may request a district court hearing as outlined in rule 701—153.14(272D).

15.53(4) *Withdrawal.* Upon receipt of a withdrawal of a certificate of noncompliance from the unit, the department shall immediately reinstate, renew, or issue a license if the person is otherwise in compliance with the department's requirements.
[**ARC 8465B**, IAB 1/13/10, effective 2/17/10; **ARC 9005B**, IAB 8/11/10, effective 9/15/10]

571—15.54(272D) No administrative appeal of the department's action. Pursuant to Iowa Code sections 261.126 and 272D.8, a person does not have a right to a hearing before the department to contest the department's action under this rule, but may request a court hearing pursuant to rule 571—15.55(272D).
[**ARC 8465B**, IAB 1/13/10, effective 2/17/10; **ARC 9005B**, IAB 8/11/10, effective 9/15/10]

571—15.55(272D) District court hearing. A person may seek review of the actions listed in rule 701—153.14(272D) and request a hearing before the district court by filing an application with the district court in the county in which the majority of the liability was incurred. The person must send a copy of the application to the unit by regular mail. The application must be filed no later than 30 days after the department issues its notice of intent.

15.55(1) *Scheduling.* The clerk of the district court shall schedule a hearing and mail a copy of the scheduling order to the person, the unit, and the department.

15.55(2) *Certification.* The unit shall certify a copy of its written decision and certificate of noncompliance, indicating the date of issuance, and the department shall certify a copy of the notice issued pursuant to subrule 15.53(3) to the court prior to the hearing.

15.55(3) *Stay.* Upon receipt from the clerk of court of a copy of a scheduling order and prior to the hearing, the department shall stay any action contemplated on the person's license pursuant to the notice of intent.

15.55(4) *Hearing.* The hearing on the person's application shall be scheduled and held within 30 days of the application being filed. However, if the person fails to appear at the scheduled hearing, the stay shall be lifted and the department shall continue its procedures pursuant to the notice of intent.

15.55(5) *Scope of review.* The district court's review shall be limited to demonstration of the amount of the liability owed or the identity of the person.

15.55(6) *Findings.* If the court finds the unit was in error either in issuing a certificate of noncompliance or in its failure to issue a withdrawal of a certificate of noncompliance, the unit shall issue a withdrawal of a certificate of noncompliance to the department. If the court finds the unit was justified in issuing a certificate of noncompliance or in not issuing a withdrawal of a certificate of noncompliance, a stay imposed under subrule 15.55(3) shall be lifted and the department shall proceed with the action as outlined in its notice of intent.
[**ARC 8465B**, IAB 1/13/10, effective 2/17/10]

These rules are intended to implement Iowa Code chapters 272D, 321G, 456A, 462A, 481A, 481B, 482, 483A, 484A, and 484B and Iowa Code section 261.126.

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CHAPTER 327
PRACTICE OF PHYSICIAN ASSISTANTS

[Prior to 8/7/02, see 645—325.6(148C) to 645—325.9(148C) and 645—325.18(148C)]

645—327.1(148C) Duties.

327.1(1) The medical services to be provided by the physician assistant are those delegated by a supervising physician. The ultimate role of the physician assistant cannot be rigidly defined because of the variations in practice requirements due to geographic, economic, and sociologic factors. The high degree of responsibility a physician assistant may assume requires that, at the conclusion of the formal education, the physician assistant possess the knowledge, skills and abilities necessary to provide those services appropriate to the practice setting. The physician assistant's services may be utilized in any clinical settings including, but not limited to, the office, the ambulatory clinic, the hospital, the patient's home, extended care facilities and nursing homes. Diagnostic and therapeutic medical tasks for which the supervising physician has sufficient training or experience may be delegated to the physician assistant after a supervising physician determines the physician assistant's proficiency and competence. The medical services to be provided by the physician assistant include, but are not limited to, the following:

a. The initial approach to a patient of any age group in any setting to elicit a medical history and perform a physical examination.

b. Assessment, diagnosis and treatment of medical or surgical problems and recording the findings.

c. Order, interpret, or perform laboratory tests, X-rays or other medical procedures or studies.

d. Performance of therapeutic procedures such as injections, immunizations, suturing and care of wounds, removal of foreign bodies, ear and eye irrigation and other clinical procedures.

e. Performance of office surgical procedures including, but not limited to, skin biopsy, mole or wart removal, toenail removal, removal of a foreign body, arthrocentesis, incision and drainage of abscesses.

f. Assisting in surgery.

g. Prenatal and postnatal care and assisting a physician in obstetrical care.

h. Care of orthopedic problems.

i. Performing and screening the results of special medical examinations including, but not limited to, electrocardiogram or Holter monitoring, radiography, audiometric and vision screening, tonometry, and pulmonary function screening tests.

j. Instruction and counseling of patients regarding physical and mental health on matters such as diets, disease, therapy, and normal growth and development.

k. Function in the hospital setting by performing medical histories and physical examinations, making patient rounds, recording patient progress notes and other appropriate medical records, assisting in surgery, performing or assisting with medical procedures, providing emergency medical services and issuing, transmitting and executing patient care orders as delegated by the supervising physician.

l. Providing services to patients requiring continuing care (i.e., home, nursing home, extended care facilities).

m. Referring patients to specialty or subspecialty physicians, medical facilities or social agencies as indicated by the patients' problems.

n. Immediate evaluation, treatment and institution of procedures essential to providing an appropriate response to emergency medical problems.

o. Order drugs and supplies in the office, and assist in keeping records and in the upkeep of equipment.

p. Admit patients to a hospital or health care facility.

q. Order diets, physical therapy, inhalation therapy, or other rehabilitative services as indicated by the patient's problems.

r. Administer any drug (a single dose).

s. Prescribe drugs and medical devices under the following conditions:

(1) The physician assistant shall have passed the national certifying examination conducted by the National Commission on the Certification of Physician Assistants or its successor examination approved by the board. Physician assistants with a temporary license may order drugs and medical devices only with the prior approval and direction of a supervising physician. Prior approval may include discussion of the specific medical problems with a supervising physician prior to the patient's being seen by the physician assistant.

(2) The physician assistant may not prescribe Schedule II controlled substances which are listed as depressants in Iowa Code chapter 124. The physician assistant may order Schedule II controlled substances which are listed as depressants in Iowa Code chapter 124 only with the prior approval and direction of a physician. Prior approval may include discussion of the specific medical problems with a supervising physician prior to the patient's being seen by the physician assistant.

(3) The physician assistant shall inform the board of any limitation on the prescriptive authority of the physician assistant in addition to the limitations set out in 327.1(1)*"s"*(2).

(4) A physician assistant shall not prescribe substances that the supervising physician does not have the authority to prescribe except as allowed in 327.1(1)*"n."*

(5) The physician assistant may prescribe, supply and administer drugs and medical devices in all settings including, but not limited to, hospitals, health care facilities, health care institutions, clinics, offices, health maintenance organizations, and outpatient and emergency care settings except as limited by 327.1(1)*"s"*(2).

(6) A physician assistant who is an authorized prescriber may request, receive, and supply sample drugs and medical devices except as limited by 327.1(1)*"s"*(2).

(7) The board of physician assistants shall be the only board to regulate the practice of physician assistants relating to prescribing and supplying prescription drugs, controlled substances and medical devices.

t. Supply properly packaged and labeled prescription drugs, controlled substances or medical devices when pharmacist services are not reasonably available or when it is in the best interests of the patient as delegated by a supervising physician.

(1) When the physician assistant is the prescriber of the medications under 327.1(1)*"s,"* these medications shall be supplied for the purpose of accommodating the patient and shall not be sold for more than the cost of the drug and reasonable overhead costs as they relate to supplying prescription drugs to the patient and not at a profit to the physician or physician assistant.

(2) When a physician assistant supplies medication on the direct order of a physician, subparagraph (1) does not apply.

(3) A nurse or staff assistant may assist the physician assistant in supplying medications when prescriptive drug supplying authority is delegated by a supervising physician to the physician assistant under 327.1(1)*"s."*

u. When a physician assistant supplies medications as delegated by a supervising physician in a remote site, the physician assistant shall secure the regular advice and consultation of a pharmacist regarding the distribution, storage and appropriate use of presciption drugs, controlled substances, and medical devices.

v. May, at the request of the peace officer, withdraw a specimen of blood from a patient for the purpose of determining the alcohol concentration or the presence of drugs.

w. Direct medical personnel, health professionals and others involved in caring for patients in the execution of patient care.

x. May authenticate medical forms by signing the form and including a supervising physician's name.

y. Perform other duties appropriate to a physician's practice.

z. Health care providers shall consider the instructions of the physician assistant to be instructions of a supervising physician if the instructions concern duties delegated to the physician assistant by the supervising physician.

327.1(2) Emergency medicine duties.

a. A physician assistant may be a member of the staff of an ambulance or rescue squad pursuant to Iowa Code chapter 147A.

b. A physician assistant shall document skills, training and education equivalent to that required of a certified advanced emergency medical technician or a paramedic.

c. A physician assistant must apply for approval of advanced care training equivalency on forms supplied by the board of physician assistants.

d. Exceptions to this subrule include:

(1) A physician assistant who accompanies and is responsible for a transfer patient;

(2) A physician assistant who serves on a basic ambulance or rescue squad service; and

(3) A physician assistant who renders aid within the physician assistant's skills during an emergency.

645—327.2(148C) Prohibition. No physician assistant shall be permitted to prescribe lenses, prisms or contact lenses for the aid, relief or correction of human vision. No physician assistant shall be permitted to measure the visual power and visual efficiency of the human eye, as distinguished from routine visual screening, except in the personal presence of a supervising physician at the place where these services are rendered.

645—327.3(148C) Free medical clinic. Rescinded IAB 9/15/04, effective 8/25/04.

645—327.4(148C) Remote medical site.

327.4(1) A physician assistant may provide medical services in a remote medical site if one of the following three conditions is met:

a. The physician assistant has a permanent license and at least one year of practice as a physician assistant; or

b. The physician assistant with less than one year of practice has a permanent license and meets the following criteria:

(1) The physician assistant has practiced as a physician assistant for at least six months; and

(2) The physician assistant and supervising physician have worked together at the same location for a period of at least three months; and

(3) The supervising physician reviews patient care provided by the physician assistant at least weekly; and

(4) The supervising physician signs all patient charts unless the medical record documents that direct consultation with the supervising physician occurred; or

c. The physician assistant and supervising physician provide a written statement sent directly to the board that the physician assistant is qualified to provide the needed medical services and that the medical care will be unavailable at the remote site unless the physician assistant is allowed to practice there. In addition, for three months the supervising physician must review patient care provided by the physician assistant at least weekly and must sign all patient charts unless the medical record documents that direct consultation with the supervising physician occurred.

327.4(2) A supervising physician must provide medical direction and consultation in accordance with the requirements in 645—subrule 326.8(4) and subrule 327.1(1).

[**ARC 1909C**, IAB 3/18/15, effective 4/22/15; see Delay note at end of chapter]

645—327.5(147) Identification as a physician assistant. The physician assistant shall be identified as a physician assistant to patients and to the public.

645—327.6(147) Prescription requirements.

327.6(1) Each written outpatient prescription drug order issued by a physician assistant shall contain the following:

a. The date of issuance.

b. The name and address of the patient for whom the drug is prescribed.

c. The name, strength, and quantity of the drug, medicine, or device prescribed and directions for use.

d. When delegated prescribing occurs, the supervising physician's name shall be used, recorded, or otherwise indicated in connection with each individual prescription so that the individual who dispenses or administers the prescription knows under whose delegated authority the physician assistant is prescribing. Notification may include, but is not limited to, including the physician's name on the prescription, including the physician's name in the memo section of an electronic prescription, or providing the physician's name by telephone or other electronic means. If, in an electronic prescription record, the record does not include a dedicated field for the name of the supervising physician, a memo or comment field may be used to record the supervising physician's name by entering the code "SP01" and then the supervising physician's name prior to any other comment in the memo or comment field.

e. The physician assistant's name and the practice address.

f. The signature of the physician assistant followed by the initials "PA."

g. The Drug Enforcement Administration (DEA) number of the physician assistant if the prescription is for a controlled substance.

All other prescriptions shall comply with paragraph *"d."*

327.6(2) Each oral prescription drug order issued by a physician assistant shall include the same information required for a written prescription, except for the written signature of the physician assistant and the address of the practitioners.

[**ARC 9217B**, IAB 11/3/10, effective 12/8/10; **ARC 9844B**, IAB 11/16/11, effective 12/21/11]

645—327.7(147) Supplying—requirements for containers, labeling, and records.

327.7(1) *Containers.* A prescription drug shall be supplied in a container which meets the requirements of the Poison Prevention Packaging Act of 1970, 15 U.S.C. §§1471-1476 (1976), which relate to childproof closure, unless otherwise requested by the patient. The containers must also meet the requirements of Section 502G of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §§301 et seq. (1976), which pertain to light resistance and moisture resistance needs of the drug supplied.

327.7(2) *Labeling.* A label bearing the following information shall be affixed to a container in which a prescription drug is supplied:

a. The name and practice address of the supervising physician and physician assistant.

b. The name of the patient.

c. The date supplied.

d. The directions for administering the prescription drug and any cautionary statement deemed appropriate by the physician assistant.

e. The name, strength and quantity of the prescription drug in the container.

f. When supplying Schedule II, III, or IV controlled substances, the federal transfer warning statement must appear on the label as follows: "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed."

327.7(3) *Samples.* Prescription sample drugs will be provided without additional charge to the patient. Prescription sample drugs supplied in the original container or package shall be deemed to conform to labeling and packaging requirements.

327.7(4) *Records.* A record of prescription drugs supplied by the physician assistant to a patient shall be kept which contains the label information required by paragraphs 327.7(2)*"b"* to *"e."* Noting such information on the patient's chart or record is sufficient.

These rules are intended to implement Iowa Code section 147.107 and chapters 148C and 272C.

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[2] April 22, 2015, effective date of ARC 1909C [327.4(2)] delayed until the adjournment of the 2016 General Assembly by the Administrative Rules Review Committee at a special meeting held April 20, 2015. At its meeting held February 5, 2016, the Committee extended the delay 70 days beyond the adjournment of the 2016 General Assembly.

PHARMACY BOARD[657]

[Prior to 2/10/88, see Pharmacy Examiners, Board of [620], renamed Pharmacy Examiners Board[657] under the "umbrella" of Public Health Department by 1986 Iowa Acts, ch 1245; renamed by 2007 Iowa Acts, Senate File 74]

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CHAPTER 4
PHARMACIST-INTERNS
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 3]

657—4.1(155A) Definitions.

"Board" means the Iowa board of pharmacy.

"Pharmacist-intern" or *"intern"* means a person enrolled in a college of pharmacy or actively pursuing a pharmacy degree, or as otherwise provided by the board, who is registered with the board for the purpose of obtaining instruction in the practice of pharmacy from a preceptor pursuant to Iowa Code section 155A.6. "Pharmacist-intern" includes a graduate of an approved college of pharmacy, or a foreign graduate who has established educational equivalency pursuant to the requirements of rule 657—4.7(155A), who is registered with the board for the purpose of obtaining practical experience as a requirement for licensure as a pharmacist in Iowa. "Pharmacist-intern" may include an individual participating in a residency or fellowship program in Iowa, whether or not the individual is licensed as a pharmacist in another state.

"Pharmacist preceptor" or *"preceptor"* means a pharmacist licensed to practice pharmacy whose license is current and in good standing. Preceptors shall meet the conditions and requirements of rule 657—4.9(155A). No pharmacist shall serve as a preceptor while the pharmacist's license to practice pharmacy is the subject of disciplinary sanction by a pharmacist licensing authority.

[**ARC 9784B**, IAB 10/5/11, effective 11/9/11; **ARC 1406C**, IAB 4/2/14, effective 5/7/14]

657—4.2(155A) Goal and objectives of internship.

4.2(1) *Goal.* The goal of internship is for the pharmacist-intern, over a period of time, to attain and build upon the knowledge, skills, responsibilities, and ability to safely, efficiently, and effectively practice pharmacy under the laws and rules of the state of Iowa.

4.2(2) *Objectives.* The objectives of internship are as follows:

a. Managing drug therapy to optimize patient outcomes. The pharmacist-intern shall evaluate the patient and patient information to determine the presence of a disease or medical condition, to determine the need for treatment or referral, and to identify patient-specific factors that affect health, pharmacotherapy, or disease management; ensure the appropriateness of the patient's specific pharmacotherapeutic agents, dosing regimens, dosage forms, routes of administration, and delivery systems; and monitor the patient and patient information and manage the drug regimen to promote health and ensure safe and effective pharmacotherapy.

b. Ensuring the safe and accurate preparation and dispensing of medications. The pharmacist-intern shall perform calculations required to compound, dispense, and administer medication; select and dispense medications; and prepare and compound extemporaneous preparations and sterile products.

c. Providing drug information and promoting public health. The pharmacist-intern shall access, evaluate, and apply information to promote optimal health care; educate patients and health care professionals regarding prescription medications, nonprescription medications, and medical devices; and educate patients and the public regarding wellness, disease states, and medical conditions.

d. Adhering to professional and ethical standards. The pharmacist-intern shall comply with professional, legal, moral, and ethical standards relating to the practice of pharmacy and the operation of the pharmacy.

e. Understanding the management of pharmacy operations. The pharmacist-intern shall develop a general understanding of the business procedures of a pharmacy and develop knowledge concerning the employment and supervision of pharmacy employees.

657—4.3(155A) 1500-hour requirements. Internship credit may be obtained only after internship registration with the board and commencement of the first professional year in a college of pharmacy. Internship shall consist of a minimum of 1500 hours, all of which may be a college-based clinical program approved or accepted by the board. Programs shall be structured to provide experience in community, institutional, and clinical pharmacy practices. A pharmacist-intern may acquire additional

hours under the supervision of one or more preceptors in a traditional licensed general or hospital pharmacy, at a rate of no more than 48 hours per week, where the goal and objectives of internship in rule 657—4.2(155A) apply. Credit toward any additional hours will be allowed, at a rate not to exceed 10 hours per week, for an internship served concurrent with academic training and outside a college-based clinical program. "Concurrent time" means internship experience acquired while the person is a full-time student carrying, in a given school term, at least 75 percent of the average number of credit hours per term needed to graduate and receive an entry-level degree in pharmacy. Recognized academic holiday periods, such as spring break and winter break, shall not be considered "concurrent time." The competencies in subrule 4.2(2) and the concurrent time limitations of this rule shall not apply to college-based clinical programs.
[**ARC 1406C**, IAB 4/2/14, effective 5/7/14]

657—4.4(155A) Iowa colleges of pharmacy clinical internship programs. The board shall periodically review the clinical component of internship programs of the colleges of pharmacy located in Iowa. The board reserves the right to set conditions relating to the approval of such programs.

657—4.5(155A) Out-of-state internship programs. Candidates enrolled in out-of-state colleges of pharmacy who complete the internship requirements of that state shall be deemed to have satisfied Iowa's internship requirements. Candidates shall submit documentation from the out-of-state internship program certifying completion of that state's requirements. Candidates enrolled in colleges of pharmacy located in states with no formal internship training program shall submit documentation from that state's board of pharmacy or college of pharmacy certifying that the candidate has completed all prelicensure training requirements.

657—4.6(155A) Registration, reporting, and authorized functions. Every person shall register with the board before beginning the person's internship experience, whether or not for the purpose of fulfilling the requirements of rule 657—4.3(155A). Registration is required of all students enrolled in Iowa colleges of pharmacy upon commencement of the first professional year in the college of pharmacy. Colleges of pharmacy located in Iowa shall annually certify to the board the names of students who are enrolled in the first professional year in the college of pharmacy. Colleges of pharmacy located in Iowa shall, within two weeks of any change, certify to the board the names of students who have withdrawn from the college of pharmacy.

4.6(1) *Application for registration—required information.* Application for registration as a pharmacist-intern shall be on forms provided by the board, and all requested information shall be provided on or with such application. The application shall require that the applicant provide, at a minimum, the following: name; address; telephone number; date of birth; social security number or individual tax identification number (ITIN); and name and location of college of pharmacy and anticipated month and year of graduation. The college of pharmacy shall certify the applicant's eligibility to practice as a pharmacist-intern.

4.6(2) *Supervision and authorized functions.* A licensed pharmacist shall be on duty in the pharmacy and shall be responsible for the actions of a pharmacist-intern during all periods of internship training. At the discretion of the supervising pharmacist, the following judgmental functions, usually restricted to a pharmacist, may be delegated to pharmacist-interns registered by the board:

a. Verification of the accuracy, validity, and appropriateness of the filled prescription or medication order;

b. Review and assessment of patient records for purposes identified in rule 657—8.21(155A);

c. Patient counseling;

d. Administration of vaccines pursuant to rule 657—8.33(155A).

4.6(3) *Term of registration.* Registration shall remain in effect as long as the board is satisfied that the intern is pursuing a degree in pharmacy in good faith and with reasonable diligence. A pharmacist-intern may request that the intern's registration be extended beyond the automatic termination of the registration pursuant to the procedures and requirements of 657—Chapter 34. Except as provided by the definition

of pharmacist-intern in rule 657—4.1(155A), registration shall automatically terminate upon the earliest of any of the following:

a. Licensure to practice pharmacy in any state;

b. Lapse in the pursuit of a degree in pharmacy; or

c. One year following graduation from the college of pharmacy.

4.6(4) *Identification, reports, and notifications.* Credit for internship time will not be granted unless registration and other required records or affidavits are completed.

a. The pharmacist-intern shall be so designated in all relationships with the public and health professionals. While on duty in the pharmacy, the intern shall wear visible to the public a name badge including the designation "pharmacist-intern" or "pharmacy student."

b. Registered interns shall notify the board office within ten days of a change of name or address.

c. Notarized affidavits of experience in non-college-sponsored programs shall be filed with the board office after the successful completion of the internship. These affidavits shall certify only the number of hours and dates of training obtained outside a college-based clinical program as provided in rule 657—4.3(155A). An individual registered as a pharmacist-intern while participating in an Iowa residency or fellowship program shall not be required to file affidavits of experience.

4.6(5) *No credit prior to registration.* Credit will not be given for internship experience obtained prior to the individual's registration as a pharmacist-intern. Credit for Iowa college-based clinical programs will not be granted unless registration is issued before the student begins the program.

4.6(6) *Nontraditional internship.* Internship training at any site which is not licensed as a general or hospital pharmacy is considered nontraditional internship.

a. Application. Prior to beginning a period of nontraditional internship, the intern shall submit a written application, on forms provided by the board, for approval of the objectives of the nontraditional internship. The application shall identify objectives consistent with the unique learning experiences of the intern and consistent with the goal and objectives of internship in rule 657—4.2(155A).

b. Preceptor. A preceptor supervising a pharmacist-intern in a nontraditional internship shall be a currently licensed pharmacist in the state where the internship is served, and the requirements of rule 657—4.9(155A) shall apply to all preceptors.

c. Certification, not credit. Hours obtained in nontraditional internship shall not be credited toward the total 1500 hours required pursuant to rule 657—4.3(155A) prior to licensure to practice pharmacy in Iowa. The board may, however, certify hours obtained in one or more approved nontraditional internships in recognition of the pharmacist-intern's training outside the scope of traditional pharmacy practice. Certification shall not be granted for experience obtained in a nontraditional internship unless the board, prior to the intern's beginning the period of internship, approved the objectives of the internship.

[**ARC 9784B**, IAB 10/5/11, effective 11/9/11; **ARC 1406C**, IAB 4/2/14, effective 5/7/14; **ARC 1786C**, IAB 12/10/14, effective 1/14/15; **ARC 2405C**, IAB 2/17/16, effective 3/23/16]

657—4.7(155A) Foreign pharmacy graduates. Foreign pharmacy graduates who are candidates for licensure in Iowa will be required to obtain a minimum of 1500 hours of internship in a licensed pharmacy or other board-approved location.

4.7(1) *Registration.* Candidates shall register with the board as provided in rule 657—4.6(155A). Internship credit will not be granted until the candidate has been issued an intern registration. Applications for registration shall be accompanied by certification from the Foreign Pharmacy Graduate Examination Committee (FPGEC) as provided in 657—subrule 2.10(1).

4.7(2) *Certification of hours.* Following completion of any period of internship, internship hours shall be certified to the board by submission of notarized affidavits of experience as provided in paragraph 4.6(4)*"c."*

4.7(3) *Credit for foreign pharmacy practice.* The board may grant credit to a foreign pharmacy graduate, based on the candidate's experience in the practice of pharmacy, for all or any portion of the required 1500 hours of internship training. The candidate shall provide detailed information regarding the candidate's experience in the practice of pharmacy. The board shall determine, on a case-by-case

basis, whether and to what extent the candidate's experience meets the goals and objectives established in rule 657—4.2(155A).
[**ARC 1406C**, IAB 4/2/14, effective 5/7/14]

657—4.8(155A) Fees. The fee for registration as a pharmacist-intern is $30, plus applicable surcharge pursuant to 657—30.8(155A), which shall be payable with the application.

657—4.9(155A) Preceptor requirements.

4.9(1) *Licensed pharmacist.* A preceptor shall be a licensed pharmacist in good standing in the state where the internship is to be served pursuant to the definition of pharmacist preceptor in rule 657—4.1(155A).

4.9(2) *Affidavits.* A preceptor shall be responsible for completing the affidavit certifying the number of hours and the dates of each internship training period under the supervision of the preceptor for any period of internship completed outside a college-based clinical program.

4.9(3) *Number of interns.* A preceptor may supervise no more than two pharmacist-interns concurrently.

4.9(4) *Responsibility.* A preceptor shall be responsible for all functions performed by a pharmacist-intern.
[**ARC 1406C**, IAB 4/2/14, effective 5/7/14]

657—4.10(155A) Denial of pharmacist-intern registration. The board may deny an application for registration as a pharmacist-intern for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs, or for any violation of Iowa Code chapter 124, 124A, 124B, 126, 147, 155A or 205, or any rule of the board.

657—4.11(155A) Discipline of pharmacist-interns.

4.11(1) *Grounds for discipline.* The board may impose discipline for any violation of the laws of this state, another state, or the United States relating to prescription drugs, controlled substances, or nonprescription drugs or for any violation of Iowa Code chapter 124, 124A, 124B, 126, 147, 155A, or 205, or any rule of the board.

4.11(2) *Sanctions.* The board may impose the following disciplinary sanctions:

a. Revocation of a pharmacist-intern registration.

b. Suspension of a pharmacist-intern registration until further order of the board or for a specified period.

c. Prohibit permanently, until further order of the board, or for a specified period, the engaging in specified procedures, methods, or acts.

d. Such other sanctions allowed by law as may be appropriate.

These rules are intended to implement Iowa Code section 155A.6.

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CHAPTER 6
GENERAL PHARMACY PRACTICE
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 2]

657—6.1(155A) Purpose and scope. A general pharmacy is a location where a pharmacist provides pharmaceutical services or dispenses pharmaceutical products to patients in accordance with pharmacy laws. This chapter does not apply to a hospital pharmacy as defined in 657—Chapter 7. The requirements of these rules for general pharmacy practice are in addition to the requirements of 657—Chapter 8 and other rules of the board relating to services provided by the pharmacy.

657—6.2(155A) Pharmacist in charge. One professionally competent, legally qualified pharmacist in charge in each pharmacy shall be responsible for, at a minimum, the responsibilities identified in rule 657—8.3(155A).
[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 0501C**, IAB 12/12/12, effective 1/16/13; **ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—6.3(155A) Reference library. References may be printed or computer-accessed. A reference library shall be maintained which includes, at a minimum, one current reference from each of the following categories, including access to current periodic updates.

1. A reference including all pertinent Iowa laws, rules, and regulations that impact the pharmacy's practice.
2. A patient information reference that includes or provides patient information in compliance with rule 657—6.14(155A).
3. A reference on drug interactions.
4. A general information reference.
5. A drug equivalency reference.
6. A reference on natural or herbal medicines.
7. The readily accessible telephone number of a poison control center that serves the area.
8. Additional references as may be necessary for the pharmacist to adequately meet the needs of the patients served.

[**ARC 2196C**, IAB 10/14/15, effective 11/18/15]

657—6.4(155A) Exemption from duplicate requirements. A pharmacy established in the same location as another licensed pharmacy and with direct and immediate access to required references, patient counseling area, refrigerator, or sink with hot and cold running water may utilize the references, counseling area, refrigerator, or sink of the other pharmacy to satisfy the requirements of rule 657—6.3(155A), subrule 6.14(3), or rule 657—8.5(155A), paragraphs "1" and "2."

657—6.5 and **6.6** Reserved.

657—6.7(124,155A) Security. While on duty, each pharmacist shall be responsible for the security of the prescription department and of the provisions for effective control against theft of, diversion of, or unauthorized access to prescription drugs, including those collected through an authorized collection program, records for such drugs and authorized collection program activities, and patient records as provided in 657—Chapters 10 and 21 and federal regulations for authorized controlled substance collection programs, which can be found at http://deadiversion.usdoj.gov/drug_disposal/.

6.7(1) *Department locked.* The prescription department shall be locked by key or combination so as to prevent access when a pharmacist is not on site except as provided in subrule 6.7(2).

6.7(2) *Temporary absence of pharmacist.* In the temporary absence of the pharmacist, only the pharmacist in charge may designate pharmacy technicians or pharmacy support persons who may be present in the prescription department to perform technical or nontechnical functions, respectively, designated by the pharmacist in charge. Activities identified in subrule 6.7(3) may not be performed during such temporary absence of the pharmacist. A temporary absence is an absence of short duration not to exceed two hours.

a. In the absence of the pharmacist, the pharmacy shall be secured from public access and the pharmacy shall notify the public that the pharmacist is temporarily absent and that no prescriptions will be dispensed until the pharmacist returns. If the pharmacist in charge has authorized the presence in the pharmacy of a pharmacy technician or a pharmacy support person to perform designated functions when the pharmacy is closed, the pharmacy technician or the pharmacy support person may not dispense or deliver any drug, chemical, device, or prepared prescription to a patient or patient's agent.

b. A pharmacy technician or a pharmacy support person who is present in the pharmacy when the pharmacy is closed shall prepare and maintain in the pharmacy a log identifying each period of time that the pharmacy technician or pharmacy support person worked in the pharmacy while the pharmacy was closed and identifying each activity performed during that time period. Each entry shall be dated, and each daily record shall be signed by the pharmacy technician or pharmacy support person who prepared the record. The log shall be periodically reviewed by the pharmacist in charge.

6.7(3) *Activities prohibited in absence of pharmacist.* Activities which shall not be designated and shall not be performed during the temporary absence of the pharmacist include:

a. Dispensing or distributing any prescription drugs or devices to patients or others.

b. Providing the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order.

c. Conducting prospective drug use review or evaluating a patient's medication record for purposes identified in rule 657—8.21(155A).

d. Providing patient counseling, consultation, or drug information.

e. Making decisions that require a pharmacist's professional judgment such as interpreting or applying information.

f. Transferring prescriptions to or from other pharmacies.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 1308C**, IAB 2/5/14, effective 3/12/14; **ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—6.8(124,155A) Prescription processing documentation. All prescriptions shall be dated and assigned a unique identification number that shall be recorded on the original prescription. The original prescription, whether transmitted orally, electronically, or in writing, shall be retained by the pharmacy filling the prescription. Refill documentation shall include date of refill and the initials or other unique identification of the pharmacist. The name, strength, and either the manufacturer's name or the National Drug Code (NDC) of the actual drug product dispensed shall be maintained and be readily retrievable.

657—6.9(124,155A) Transfer of prescription. The transmission of a prescription drug order from a pharmacy to a pharmacy engaged in centralized prescription filling or processing on behalf of the originating pharmacy pursuant to the requirements of 657—Chapter 18 shall not constitute the transfer of a prescription. Upon the request of a patient or the patient's caregiver, a pharmacy shall transfer original prescription drug order information and prescription refill information to a pharmacy designated by the patient or the patient's caregiver, central fill or processing pharmacies excepted, subject to the following requirements:

6.9(1) *Schedule III, IV, or V prescriptions.* The transfer of original prescription drug order information for controlled substances listed in Schedule III, IV, or V is permissible between pharmacies on a one-time basis except as provided in subrule 6.9(9).

6.9(2) *Noncontrolled substances prescriptions.* The transfer of original prescription drug order information for noncontrolled prescription drugs between pharmacies is permissible as long as the number of transfers does not exceed the number of originally authorized refills and the original prescription is still valid.

6.9(3) *Communication.* The transfer is communicated directly between pharmacists, directly between pharmacist-interns under the direct supervision of pharmacists at the respective pharmacies, directly between a pharmacist and a pharmacist-intern under the direct supervision of a pharmacist, or as authorized in subrule 6.9(9). Following direct communication between authorized individuals as provided herein, the transferring pharmacist or pharmacist-intern may transmit the prescription and transfer information required under subrule 6.9(5) from the transferring pharmacy via facsimile. The

receiving pharmacist or pharmacist-intern shall ensure the prescription transfer record maintained in the receiving pharmacy contains all of the information required under subrule 6.9(8).

6.9(4) *Prescriptions maintained.* Both the original and the transferred prescription drug orders are maintained for a period of two years from the date of last refill.

6.9(5) *Record of transfer out.* The pharmacist or pharmacist-intern transferring the prescription drug order information shall:

a. Invalidate the prescription drug order;

b. Record on or with the invalidated prescription drug order the following information:

(1) The name, address, and, for a controlled substance, the DEA registration number of the pharmacy to which such prescription is transferred;

(2) The name of the pharmacist or pharmacist-intern receiving the prescription drug order information;

(3) The name of the pharmacist or pharmacist-intern transferring the prescription drug order information; and

(4) The date of the transfer.

6.9(6) *Original prescription status.* The original prescription drug order shall be invalidated in the data processing system for purposes of filling or refilling, but shall be maintained in the data processing system for refill history purposes.

6.9(7) *Controlled substance prescription status.* The data processing system shall have a mechanism to prohibit the transfer or refilling of controlled substance prescription drug orders that have been previously transferred.

6.9(8) *Record of transfer received.* The pharmacist or pharmacist-intern receiving the transferred prescription drug order information shall:

a. Indicate that the prescription drug order has been transferred;

b. Record on or with the transferred prescription drug order the following information:

(1) Original date of issuance and date of dispensing, if different from date of issuance;

(2) Original prescription number;

(3) Number of valid refills remaining, the date of last refill, and, for a controlled substance, the dates and locations of all previous refills;

(4) Name, address, and, for a controlled substance, the DEA registration number of the pharmacy from which such prescription drug order information is transferred;

(5) The date of the transfer;

(6) Name of the pharmacist or pharmacist-intern receiving the prescription drug order information;

(7) Name of the pharmacist or pharmacist-intern transferring the prescription drug order information; and

(8) If transferring a controlled substance prescription from a pharmacy utilizing a shared electronic database system as described in subrule 6.9(9) to a pharmacy outside that shared system, the pharmacy name, location, DEA registration number, and prescription number from which the prescription was originally filled.

6.9(9) *Electronic transfer between pharmacies.* Pharmacies electronically accessing the same prescription drug order records via a real-time, on-line database may electronically transfer prescription information, including controlled substance prescription information, up to the maximum refills permitted by law and the prescriber's authorization, if the following requirements are met.

a. The data processing system shall have a mechanism to send the transferring pharmacy a message containing the following information:

(1) The fact that the prescription drug order was transferred;

(2) The unique identification number of the prescription drug order transferred;

(3) The name, address, and DEA registration number of the pharmacy to which the prescription drug order was transferred and the name of the pharmacist or pharmacist-intern receiving the prescription information; and

(4) The date and time of transfer.

b. A pharmacist or pharmacist-intern under the direct supervision of a pharmacist in the transferring pharmacy shall review the message and document the review by signing and dating a hard copy of the message or logbook containing the information required on the message, or by a notation in the electronic message that includes the unique identification of the pharmacist or pharmacist-intern and the date of review, as soon as practical, but in no event more than 72 hours from the time of such transfer.

c. For transfers of controlled substance prescriptions, all information requirements included in subrules 6.9(1) and 6.9(3) through 6.9(8) shall be satisfied in the electronic system. Transfers of controlled substance prescriptions shall also identify the pharmacy name, address, DEA registration number, and prescription number from which the prescription was originally filled.

[**ARC 7634B**, IAB 3/11/09, effective 4/15/09; **ARC 8169B**, IAB 9/23/09, effective 10/28/09; **ARC 0343C**, IAB 10/3/12, effective 11/7/12]

657—6.10(126,155A) Prescription label requirements.

6.10(1) *Required information.* The label affixed to or on the dispensing container of any prescription drug or device dispensed by a pharmacy pursuant to a prescription drug order shall bear the following:

a. Serial number (a unique identification number of the prescription);

b. The name, telephone number, and address of the pharmacy;

c. Except as provided in 657—subrule 8.19(7) for epinephrine auto-injectors, the name of the patient or, if such drug is prescribed for an animal, the species of the animal and the name of its owner;

d. The name of the prescribing practitioner;

e. The date the prescription is dispensed;

f. The directions or instructions for use, including precautions to be observed;

g. Unless otherwise directed by the prescriber, the label shall bear the name, strength, and quantity of the drug dispensed.

(1) If a pharmacist selects an equivalent drug product for a brand name drug product prescribed by a practitioner, the prescription container label shall identify the generic drug and may identify the brand name drug for which the selection is made, such as "(generic name) Generic for (brand name product)."

(2) If a pharmacist selects a brand name drug product for a generic drug product prescribed by a practitioner, the prescription container label shall identify the brand name drug product dispensed and may identify the generic drug product ordered by the prescriber, such as "(brand name product) for (generic name)";

h. The initials or other unique identification of the dispensing pharmacist.

6.10(2) *Exceptions.* The requirements of subrule 6.10(1) do not apply to unit dose dispensing systems, 657—22.1(155A), and patient med paks, 657—22.5(126,155A).

[**ARC 2194C**, IAB 10/14/15, effective 11/18/15; **ARC 2414C**, IAB 2/17/16, effective 3/23/16]

657—6.11 and **6.12** Reserved.

657—6.13(155A) Patient record system.

6.13(1) *Information required.* A patient record system shall be maintained by all pharmacies for patients for whom prescription drug orders are dispensed. The patient record system shall provide for the immediate retrieval of information necessary for the dispensing pharmacist to identify previously dispensed drugs at the time a prescription drug order is presented for dispensing. The pharmacist shall be responsible for obtaining, recording, and maintaining the following information:

a. Full name of the patient for whom the drug is intended;

b. Address and telephone number of the patient;

c. Patient's age or date of birth;

d. Patient's gender;

e. Known allergies;

f. Significant patient information including a list of all prescription drug orders dispensed by the pharmacy during the two years immediately preceding the most recent entry showing the name of the

drug or device, prescription number, name and strength of the drug, the quantity and date received, and the name of the prescriber; and

g. Pharmacist comments relevant to the individual's drug therapy, including:

(1) Known drug reactions,

(2) Identified idiosyncrasies,

(3) Known chronic conditions or disease states of the patient,

(4) The identity of any other drugs, over-the-counter drugs, herbals, other alternative medications, or devices currently being used by the patient that may relate to prospective drug review.

6.13(2) *Record retained.* A patient record shall be maintained for a period of not less than two years from the date of the last entry in the patient record. This record may be a hard copy or a computerized form.

6.13(3) *Confidential.* Information in the patient record shall be deemed to be confidential and may be released only as provided in rule 657—8.16(124,155A).

657—6.14(155A) Patient counseling and instruction. Every general pharmacy located in Iowa shall post in every prescription pickup area, including in every drive-through prescription pickup lane, in a manner clearly visible to patients, a notice that Iowa law requires the pharmacist to discuss with the patient any new prescriptions dispensed to the patient. The board shall provide a general pharmacy with the required signage. A pharmacy that provides no direct patient access to the pharmacy department, commonly referred to as a "closed-door pharmacy," shall not be required to post the counseling notice.

6.14(1) *Counseling required.* Upon receipt of a new prescription drug order, or upon receipt of a change in drug therapy including but not limited to a change of dose, directions, or drug formulation, and following a prospective drug use review pursuant to 657—8.21(155A), a pharmacist shall counsel each patient or patient's caregiver. An offer to counsel shall not fulfill the requirements of this rule. Patient counseling shall be on matters which, in the pharmacist's professional judgment, will enhance or optimize drug therapy. Appropriate elements of patient counseling may include:

a. The name and description of the drug;

b. The dosage form, dose, route of administration, and duration of drug therapy;

c. Intended use of the drug, if known, and expected action;

d. Special directions and precautions for preparation, administration, and use by the patient;

e. Common severe side effects or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur;

f. Techniques for self-monitoring drug therapy;

g. Proper storage;

h. Prescription refill information;

i. Action to be taken in the event of a missed dose;

j. Pharmacist comments relevant to the individual's drug therapy including any other information peculiar to the specific patient or drug.

6.14(2) *Instruction.* A pharmacist may instruct patients and demonstrate procedures for self-monitoring of medical conditions and for self-administration of drugs.

6.14(3) *Counseling area.* A pharmacy shall contain an area which is suitable for confidential patient counseling. Such area shall:

a. Be easily accessible to both patient and pharmacists and not allow patient access to prescription drugs;

b. Be designed to maintain the confidentiality and privacy of the pharmacist/patient communication.

6.14(4) *Oral counseling not practicable.* If in the pharmacist's professional judgment oral counseling is not practicable, the pharmacist may use alternative forms of patient information. "Not practicable" refers to patient variables including, but not limited to, the absence of the patient or patient's caregiver, the patient's or caregiver's hearing impairment, or a language barrier. "Not practicable" does not include pharmacy variables such as inadequate staffing, technology failure, or high prescription volume. Alternative forms of patient information may include written information leaflets, pictogram

labels, video programs, or information generated by electronic data processing equipment. When used in place of oral counseling, alternative forms of patient information shall advise the patient or caregiver that the pharmacist may be contacted for consultation in person at the pharmacy by toll-free telephone or collect telephone call. A combination of oral counseling and alternative forms of counseling is encouraged.

6.14(5) *Exception.* Patient counseling, as described above, shall not be required for inpatients of an institution where other licensed health care professionals are authorized to administer the drugs.

6.14(6) *Refusal of consultation.* A pharmacist shall not be required to counsel a patient or caregiver when the patient or caregiver refuses such consultation. A patient's or caregiver's refusal of consultation shall be documented by the pharmacist. The absence of any record of a refusal of the pharmacist's attempt to counsel shall be presumed to signify that the offer was accepted and that counseling was provided.

[**ARC 8540B**, IAB 2/24/10, effective 4/1/10; **ARC 9910B**, IAB 12/14/11, effective 1/18/12]

657—6.15(124,126) Return of drugs and other items. For the protection of the public health and safety, prescription drugs and devices, controlled substances, and items of personal contact nature may be returned to the pharmacy for reuse or resale only as herein provided:

6.15(1) *Integrity maintained.* Prescription drugs and devices may be returned, exchanged, or resold only if, in the professional judgment of the pharmacist, the integrity of the prescription drug has not in any way been compromised.

6.15(2) *Controlled substances.* Under no circumstances shall pharmacy personnel accept from a patient or a patient's agent any controlled substances for return, exchange, or resale except to the same patient.

6.15(3) *Unit dose returns.* Prescription drugs dispensed in unit dose packaging, excluding controlled substances, may be returned and reused as authorized in 657—subrule 22.1(6).

6.15(4) *Personal contact items.* Pharmacy personnel shall not accept for reuse or resale any items of personal contact nature that have been removed from the original package or container after sale.

657—6.16(124,155A) Records. Every inventory or other record required to be kept under Iowa Code chapters 124 and 155A or rules of the board shall be kept by the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of the inventory or record except as specifically identified by law or rule. Controlled substances records shall be maintained in a readily retrievable manner in accordance with federal requirements and 657—Chapter 10. Original hard-copy prescription and other pharmacy records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department unless such remote storage is prohibited under federal law. A remote storage area shall be located within the same physical structure containing the licensed pharmacy department.

6.16(1) *Combined records.* If controlled substances, prescription drugs, or nonprescription drug items are listed on the same record, the controlled substances shall be asterisked, red-lined, or in some other manner made readily identifiable from all other items appearing on the records.

6.16(2) *Prescriptions maintained.* The original prescription drug order shall be maintained for a period of two years following the date of last activity on the prescription.

6.16(3) *Number imprinted.* The original hard-copy prescription shall be imprinted with the prescription or control number assigned to the prescription drug order.

6.16(4) *Alternative data retention system.* Records, except when specifically required to be maintained in original or hard-copy form, may be maintained in an alternative data retention system, such as a data processing system or direct imaging system provided:

a. The records maintained in the alternative system contain all of the information required on the manual record;

b. The data processing system is capable of producing a hard copy of the record, within two business days, upon the request of the board, its representative, or other authorized local, state, or federal law enforcement or regulatory agencies; and

c. The information maintained in the alternative system is not obscured or rendered illegible due to security features of the original hard-copy record.

[**ARC 7636B**, IAB 3/11/09, effective 4/15/09; **ARC 8539B**, IAB 2/24/10, effective 4/1/10]

These rules are intended to implement Iowa Code sections 124.301, 124.303, 124.306, 126.10, 126.11, 155A.6, 155A.13, 155A.27, 155A.28, 155A.31, and 155A.33 through 155A.36.

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◊ Two or more ARCs

CHAPTER 7
HOSPITAL PHARMACY PRACTICE
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 12]

657—7.1(155A) Purpose and scope. Hospital pharmacy means and includes a pharmacy licensed by the board and located within any hospital, health system, institution, or establishment which maintains and operates organized facilities for the diagnosis, care, and treatment of illnesses to which patients may or may not be admitted for overnight stay at the facility. A hospital is a facility licensed pursuant to Iowa Code chapter 135B. This chapter does not apply to a pharmacy located within such a facility for the purpose of providing outpatient prescriptions. A pharmacy providing outpatient prescriptions is and shall be licensed as a general pharmacy subject to the requirements of 657—Chapter 6. The requirements of these rules for hospital pharmacy practice apply to all hospitals, regardless of size or type, and are in addition to the requirements of 657—Chapter 8 and other rules of the board relating to services provided by the pharmacy.
[**ARC 9911B**, IAB 12/14/11, effective 1/18/12]

657—7.2(155A) Pharmacist in charge. One professionally competent, legally qualified pharmacist in charge in each pharmacy shall be responsible for, at a minimum, the responsibilities identified in rule 657—8.3(155A). Where 24-hour operation of the pharmacy is not feasible, a pharmacist shall be available on an "on call" basis.
[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—7.3(155A) Reference library. References may be printed or computer-accessed. A reference library shall be maintained which includes, at a minimum, one current reference from each of the following categories, including access to current periodic updates.

1. A reference including all pertinent Iowa laws, rules, and regulations that impact the pharmacy's practice.
2. A patient information reference that includes or provides patient information in compliance with rule 657—6.14(155A).
3. A reference on drug interactions.
4. A general information reference.
5. A drug equivalency reference.
6. An injectable-drug compatibility reference.
7. A drug identification reference to enable identification of drugs brought into the facility by patients.
8. The readily accessible telephone number of a poison control center that serves the area.
9. Additional references as may be necessary for the pharmacist to adequately meet the needs of the patients served. For example, the treatment of pediatric patients and oncology patients would require additional references unique to those specialties.

[**ARC 2196C**, IAB 10/14/15, effective 11/18/15]

657—7.4 and **7.5** Reserved.

657—7.6(124,155A) Security. The pharmacy shall be located in an area or areas that facilitate the provision of services to patients and shall be integrated with the facility's communication and transportation systems. The following conditions must be met to ensure appropriate control over drugs and chemicals in and under the control of the pharmacy:

7.6(1) *Pharmacist responsibility.* Each pharmacist, while on duty, shall be responsible for the security of the pharmacy area, including provisions for effective control against theft of, diversion of, or unauthorized access to drugs or devices, controlled substances, records for such drugs, and patient records as provided in 657—Chapter 21. Policies and procedures shall identify the minimum amount of time that a pharmacist is available at the hospital pharmacy.

7.6(2) *Access when pharmacist absent.* When the pharmacist is absent from the facility, the pharmacy is closed and shall be secured from public access. Policies and procedures shall be established

that identify who will have access to the pharmacy when the pharmacy is closed and the procedures to be followed for obtaining drugs, devices, and chemicals to fill an emergent need during the pharmacist's absence.

a. The pharmacist in charge may designate pharmacy technicians or pharmacy support persons who may be present in the pharmacy to perform technical or nontechnical functions, respectively, designated by the pharmacist in charge. Activities identified in paragraph *"d"* of this subrule may not be performed when the pharmacy is closed.

b. If the pharmacist in charge has authorized the presence in the pharmacy of a pharmacy technician or a pharmacy support person to perform designated functions when the pharmacy is closed, only a certified pharmacy technician may assist another authorized, licensed health care professional to locate a drug or device pursuant to an emergent need. The pharmacy technician or the pharmacy support person may not dispense or deliver the drug, chemical, or device to the licensed health care professional. The licensed health care professional shall comply with established policies and procedures for obtaining drugs, devices, and chemicals when the pharmacy is closed. The licensed health care professional shall not ask or expect the pharmacy technician or the pharmacy support person to verify that the appropriate drug, chemical, or device has been obtained from the pharmacy.

c. A pharmacy technician or a pharmacy support person who is present in the pharmacy when the pharmacy is closed shall prepare and maintain in the pharmacy a log identifying each period of time that the pharmacy technician or pharmacy support person worked in the pharmacy while the pharmacy was closed and identifying each activity performed during that time period. Each entry shall be dated and each daily record shall be signed by the pharmacy technician or pharmacy support person who prepared the record. The log shall be periodically reviewed by the pharmacist in charge.

d. Activities which shall not be performed by a pharmacy technician or a pharmacy support person when the pharmacist is absent from the facility include:

(1) Dispensing, delivering, or distributing any prescription drugs or devices to patients or others, including health care professionals, prior to pharmacist verification. Verification by a nurse or other licensed health care professional shall not supplant verification by a pharmacist.

(2) Providing the final verification for the accuracy, validity, completeness, or appropriateness of a filled prescription or medication order.

(3) Conducting prospective drug use review or evaluating a patient's medication record for purposes identified in rule 657—8.21(155A).

(4) Providing patient counseling, consultation, or drug information.

(5) Making decisions that require a pharmacist's professional judgment such as interpreting or applying information.

(6) Preparing compounded drug products for immediate administration by other hospital staff or health care professionals without verification by a pharmacist.

7.6(3) *Locked areas.* All pharmacy areas where drugs or devices are maintained or stored and where a pharmacist is not continually present shall be locked.

7.6(4) *Verification by pharmacist.* When the pharmacy is open, patient-specific drugs or devices shall not be distributed prior to the pharmacist's final verification and approval.

7.6(5) *Drugs or devices in patient care areas.* Drugs or devices maintained or stored in patient care areas shall be in locked storage unless the patient care unit is staffed by health care personnel and the medication area is visible to staff at all times.

7.6(6) *Authorized collection program.* Receptacles that are located in the hospital for the authorized collection of controlled substances shall be secured pursuant to 657—Chapter 10 and federal regulations for disposal of controlled substances. Federal regulations regarding disposal of controlled substances can be found at http://deadiversion.usdoj.gov/drug_disposal/.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 9408B**, IAB 3/9/11, effective 4/13/11; **ARC 1308C**, IAB 2/5/14, effective 3/12/14; **ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—7.7(155A) Verification by remote pharmacist. A hospital pharmacy may contract with another pharmacy for remote pharmacist preview and verification of patient-specific drugs or devices ordered for

a patient. Contracted services may include pharmacist order entry pursuant to subrule 7.8(3). Pharmacies entering into a contract or agreement pursuant to this rule shall comply with the following requirements:

7.7(1) *Nonsupplanting service.* A contract or agreement for remote pharmacist services shall not relieve the hospital pharmacy from employing or contracting with a pharmacist to provide routine pharmacy services within the facility. The activities authorized by this rule are intended to supplement on-site hospital pharmacy services and are not intended to eliminate the need for an on-site hospital pharmacy or pharmacist. The activities authorized by this rule are intended to increase the availability of the pharmacist for involvement in cognitive and patient care activities when the pharmacy is open. The hospital pharmacy shall maintain records that demonstrate the directing of pharmacist activities to additional cognitive and patient care activities, and those records shall be available for inspection by the board or an agent of the board.

7.7(2) *Hospital-staff pharmacist.* Nothing in this rule shall prohibit a pharmacist employed by or contracting with a hospital pharmacy for on-site services from also providing remote preview and verification of patient-specific drugs or devices ordered for a patient when the hospital pharmacy is closed. A pharmacist previewing and verifying drug or device orders from a remote location shall have access to patient information pursuant to subrule 7.7(4) or 7.7(5), shall have access to the prescriber as provided in subrule 7.7(6), and shall be identified on the drug or device order as provided in subrule 7.7(7).

7.7(3) *Licenses required.* A pharmacy contracting with a hospital pharmacy to provide services pursuant to this rule shall maintain with the board a current Iowa pharmacy license. A remote pharmacist providing pharmacy services as an employee or agent of a contracting pharmacy pursuant to this rule shall be licensed to practice pharmacy in Iowa.

7.7(4) *Electronic access to patient information.* The remote pharmacist shall have secure electronic access to the hospital pharmacy's patient information system and to all other electronic systems that the on-site pharmacist has access to when the pharmacy is open. The remote pharmacist shall receive training in the use of the hospital's electronic systems.

7.7(5) *Nonelectronic patient information.* If a hospital's patient information is not maintained in an electronic data system or if the hospital pharmacy is not able to provide remote electronic access to the patient information system, the hospital pharmacy may petition for a waiver of subrule 7.7(4) pursuant to 657—Chapter 34 and this subrule. In addition to the information required pursuant to 657—Chapter 34, the petition for waiver shall identify the hospital pharmacy's alternative to the electronic sharing of patient information, shall explain in detail how the alternative method will ensure timely provision of patient information necessary for the remote pharmacist to effectively review the patient's drug regimen and history, and shall detail the processes involved in the alternative proposal including identification of all individuals involved in each of those processes.

7.7(6) *Access to prescriber.* The remote pharmacist shall be able to contact the prescriber to discuss any concerns identified during the pharmacist's review of the patient's information.

7.7(7) *Pharmacist identified.* The record of each patient-specific drug or device order processed pursuant to this rule shall identify, by name or other unique identifier, each pharmacist involved in the preview and verification of the order. The record of each patient-specific drug or device visually verified pursuant to this rule shall identify, by name or other unique identifier, each pharmacist involved in the visual verification of the product.

[**ARC 9408B**, IAB 3/9/11, effective 4/13/11; **ARC 0502C**, IAB 12/12/12, effective 1/16/13]

657—7.8(124,126,155A) Drug distribution and control. Policies and procedures governing drug distribution and control shall be established pursuant to rule 657—8.3(155A) with input from other involved hospital staff such as physicians and nurses, from committees such as the pharmacy and therapeutics committee or its equivalent, and from any related patient care committee. It is essential that the pharmacist in charge or designee routinely be available to or on all patient care areas to establish rapport with the personnel and to become familiar with and contribute to medical and nursing procedures relating to drugs.

7.8(1) *Drug preparation.* Control and adequate quality assurance procedures needed to ensure that patients receive the correct drugs at the proper times shall be established pursuant to rule 657—8.3(155A).

a. Hospitals shall utilize a unit dose dispensing system pursuant to rule 657—22.1(155A). All drugs dispensed by the pharmacy for administration to patients shall be in single unit or unit dose packages if practicable unless the dosage form or drug delivery device makes it impracticable to package the drug in a unit dose or single unit package.

(1) Established policies and procedures shall identify situations when drugs may be dispensed in other than unit dose or single unit packages outside the unit dose dispensing system.

(2) The need for nurses to manipulate drugs prior to their administration shall be minimized.

b. Pharmacy personnel shall, except as specified in policies and procedures, prepare all sterile products in conformance with 657—Chapter 20.

c. Pharmacy personnel shall compound or prepare drug formulations, strengths, dosage forms, and packages useful in the care of patients.

7.8(2) *Drug formulary.* Established policies and procedures shall include a current formulary of drug products approved for use in the institution and shall include specifications for those drug products.

7.8(3) *Medication orders.* Except as provided in subrule 7.8(14) or this subrule, a pharmacist shall receive a copy of an original written medication order for review except when the prescriber directly enters the medication order into an electronic medical record system or when the prescriber issues a verbal medication order directly to a registered nurse or pharmacist who then enters the order into an electronic medical record system.

a. Verbal order. The use of verbal orders shall be minimized. All verbal orders shall be read back to the prescriber, and the read back shall be documented with or on the order.

b. Written order not entered by prescriber. If an individual other than the prescriber enters a medication order into an electronic medical record system from an original written medication order, the pharmacist shall review and verify the entry against the original written order before the drug is dispensed except for emergency use, when the pharmacy is closed, or as provided in rule 657—7.7(155A).

c. Order entered when pharmacy closed. When the pharmacy is closed, a registered nurse or pharmacist may enter a medication order into an electronic medical record system for the purpose of creating an electronic medication administration record and a pharmacist shall verify the entry against the original written medication order, if such written order exists, as soon as practicable.

d. System security. Hospitalwide and pharmacy stand-alone computer systems shall be secure against unauthorized entry. System login or access credentials issued to an authorized system user shall not be shared or disclosed to any other individual.

e. Abbreviations and chemical symbols on orders. The use of abbreviations and chemical symbols on medication orders shall be discouraged but, if used, shall be limited to abbreviations and chemical symbols approved by the appropriate patient care committee.

7.8(4) *Stop order.* A written policy or other system concerning stop orders shall be established to ensure that medication orders are not inappropriately continued.

7.8(5) *Emergency drug supplies and floor stock.* Supplies of drugs for use in medical emergencies shall be immediately available at each nursing unit or service area as specified in policies and procedures. Authorized stocks shall be periodically reviewed in a multidisciplinary manner. All drug storage areas within the hospital shall be routinely inspected to ensure that no outdated or unusable items are present and that all stock items are properly labeled and stored.

7.8(6) *Disaster services.* The pharmacy shall be prepared to provide drugs and pharmaceutical services in the event of a disaster affecting the availability of drugs or internal access to drugs or access to the pharmacy.

7.8(7) *Drugs brought into the institution.* Established policies and procedures shall determine those circumstances when patient-owned drugs brought into the institution may be administered to a hospital patient and shall identify procedures governing the use and security of drugs brought into the institution. Procedures shall address identification of the drug and methods for ensuring the integrity of the product

prior to permitting its use by the patient. The use of patient-owned drugs shall be minimized to the greatest extent possible.

7.8(8) *Samples.* The use of drug samples within the institution shall be eliminated to the extent possible. Sample use is prohibited for hospital inpatient use. If the use of drug samples is permitted for hospital outpatients, that use of samples shall be controlled and the samples shall be distributed through the pharmacy or through a process developed in cooperation with the pharmacy and the institution's appropriate patient care committee, subject to oversight by the pharmacy.

7.8(9) *Investigational drugs.* If investigational drugs are used in the institution:

a. A pharmacist shall be a member of the institutional review board.

b. The pharmacy shall be responsible, in cooperation with the principal investigator, for providing information about investigational drugs used in the institution and for the distribution and control of those drugs.

7.8(10) *Hazardous drugs and chemicals.* Policies and procedures for handling drugs and chemicals that are known occupational hazards shall be established pursuant to rule 657—8.3(155A). The procedures shall maintain the integrity of the drug or chemical and protect hospital personnel.

7.8(11) *Leave meds.* Labeling of prescription drugs for a patient on leave from the facility for a period in excess of 24 hours shall comply with 657—subrule 6.10(1). The dispensing pharmacist shall be responsible for packaging and labeling leave meds in compliance with this subrule.

7.8(12) *Discharge meds.* Drugs authorized for a patient being discharged from the facility shall be labeled in compliance with 657—subrule 6.10(1) before the patient removes those drugs from the facility premises. The dispensing pharmacist shall be responsible for packaging and labeling discharge meds in compliance with this subrule.

7.8(13) *Own-use outpatient prescriptions.* If the hospital pharmacy dispenses own-use outpatient prescriptions, the pharmacist shall comply with all requirements of 657—Chapter 6 except rule 657—6.1(155A).

7.8(14) *Influenza and pneumococcal vaccines.* As authorized by federal law, a written or verbal patient-specific medication administration order shall not be required prior to administration to an adult patient of influenza and pneumococcal vaccines pursuant to physician-approved hospital policy and after the patient has been assessed for contraindications. Administration shall be recorded in the patient's medical record.

[**ARC 8170B**, IAB 9/23/09, effective 10/28/09; **ARC 9911B**, IAB 12/14/11, effective 1/18/12; **ARC 1961C**, IAB 4/15/15, effective 5/20/15; **ARC 2194C**, IAB 10/14/15, effective 11/18/15; **ARC 2197C**, IAB 10/14/15, effective 11/18/15]

657—7.9(124,155A) Drug information. Established policies and procedures shall include the provision to the institution's staff and patients of accurate, comprehensive information about drugs and their use. The pharmacy shall serve as the institution's center for drug information.

7.9(1) *Staff education.* The pharmacist shall keep the institution's staff well informed about the drugs used in the institution and their various dosage forms and packagings.

7.9(2) *Patient education.* The pharmacist shall help ensure that all patients are given adequate information about the drugs that they receive. This is particularly important for ambulatory, home care, and discharged patients. These patient education activities shall be coordinated with the nursing and medical staffs and patient education department, if any.

[**ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—7.10(124,155A) Ensuring rational drug therapy. An important aspect of pharmaceutical services is that of maximizing rational drug use. Policies and procedures for ensuring the quality of drug therapy shall be established pursuant to rule 657—8.3(155A).

7.10(1) *Patient profile.* Sufficient patient information shall be collected, maintained, and reviewed by the pharmacist to ensure meaningful and effective participation in patient care. This requires that a drug profile be maintained for each patient receiving care at the hospital. A pharmacist-conducted drug history from patients may be useful in this regard.

a. Appropriate clinical information about patients shall be available and accessible to the pharmacist for use in daily practice.

b. The pharmacist shall review each patient's current drug regimen and directly communicate any suggested changes to the prescriber.

7.10(2) *Adverse drug events.* Established policies and procedures shall include a mechanism for the reporting and review, by the committee or other appropriate medical group, of adverse drug events. The pharmacist shall be informed of all reported adverse drug events occurring in the facility. Adverse drug events include but need not be limited to adverse drug reactions and medication errors.
[**ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—7.11(124,126,155A) Outpatient services. No prescription drugs shall be dispensed to patients in a hospital outpatient setting. If a need is established for the dispensing of a prescription drug to an outpatient, a prescription drug order shall be provided to the patient to be filled at a pharmacy of the patient's choice.

7.11(1) *Definitions.* For the purposes of this rule, the following definitions shall apply:

"Emergency department patient" means an individual who is examined and evaluated in the emergency department.

"Outpatient" means an individual examined and evaluated by a prescriber who determined the individual's need for the administration of a drug or device, which individual presents to the hospital outpatient setting with a prescription or order for administration of a drug or device. "Outpatient" does not include an emergency department patient.

"Outpatient medication order" means a written order from a prescriber or an oral or electronic order from a prescriber or the prescriber's authorized agent for administration of a drug or device. An outpatient medication order may authorize continued or periodic administration of a drug or device for a period of time and frequency determined by the prescriber or by hospital policy, not to exceed legal limits for the refilling of a prescription drug order.

7.11(2) *Administration in the outpatient setting.* Drugs shall be administered only to outpatients who have been examined and evaluated by a prescriber who determined the patient's need for the drug therapy ordered.

a. Accountability. Established policies and procedures shall include a system of drug control and accountability in the outpatient setting. The system shall ensure accountability of drugs incidental to outpatient nonemergency therapy or treatment. Drugs shall be administered only in accordance with the system.

b. Controlled substances. Controlled substances maintained in the outpatient setting are kept for use by or at the direction of prescribers for the nonemergency therapy or treatment of outpatients. In order to receive a controlled substance, a patient shall be examined in the outpatient setting or in an alternate practice setting or office by a prescriber who shall determine the patient's need for the drug. If the patient is examined in a setting outside the outpatient setting, the prescriber shall provide the patient with a written prescription or order to be presented at the hospital outpatient setting.

c. Outpatient medication orders. A prescriber may authorize, by outpatient medication order, the periodic administration of a drug to an outpatient.

(1) Schedule II controlled substance. An outpatient medication order for administration of a Schedule II controlled substance shall be written and, except as provided in rule 657—10.25(124) regarding the issuance of multiple Schedule II prescriptions, may authorize the administration of an appropriate amount of the prescribed substance for a period not to exceed 90 days from the date ordered.

(2) Schedule III, IV, or V controlled substance. An outpatient medication order for administration of a Schedule III, IV, or V controlled substance shall be written and may be authorized for a period not to exceed six months from the date ordered.

(3) Noncontrolled substance. An outpatient medication order for administration of a noncontrolled prescription drug may be authorized for a period not to exceed 18 months from the date ordered.
[**ARC 8909B**, IAB 6/30/10, effective 8/4/10; **ARC 0243C**, IAB 8/8/12, effective 9/12/12; **ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—7.12(124,126,155A) Drugs in the emergency department. Drugs maintained in the emergency department are kept for use by or at the direction of prescribers in the emergency department. Drugs shall be administered or dispensed only to emergency department patients. For the purposes of this rule,

"emergency department patient" means an individual who is examined and evaluated in the emergency department.

7.12(1) *Accountability.* Established policies and procedures shall include a system of drug control and accountability in the emergency department. The system shall identify drugs of the nature and type to meet the immediate needs of emergency department patients. Drugs shall be administered or dispensed only in accordance with the system.

7.12(2) *Controlled substances.* Controlled substances maintained in the emergency department are kept for use by or at the direction of prescribers in the emergency department.

a. In order to receive a controlled substance, a patient shall be examined in the emergency department by a prescriber who shall determine the need for the drug. It is not permissible under state and federal regulations for a prescriber to see a patient outside the emergency department setting, or talk to the patient on the telephone, and then proceed to call the emergency department and order the administration of a stocked controlled substance upon the patient's arrival at the emergency department except as provided in paragraph 7.12(2)*"c"* or *"d."*

b. A prescriber may authorize, without again examining the patient, the administration of additional doses of a previously authorized drug to a patient presenting to the emergency department within 24 hours of the patient's examination and treatment in the emergency department.

c. In an emergency situation when a health care practitioner authorized to prescribe controlled substances is not available on site, and regardless of the provisions of paragraph 7.12(2)*"a,"* the emergency department nurse may examine the patient in the emergency department and contact the on-call prescriber. The on-call prescriber may then authorize the nurse to administer a controlled substance to the patient pending the arrival of the prescriber at the emergency department. As soon as possible, the prescriber shall examine the patient in the emergency department and determine the patient's further treatment needs.

d. In an emergency situation when a health care practitioner authorized to prescribe controlled substances examines a patient in the prescriber's office and determines a need for the administration of a controlled substance, and regardless of the provisions of paragraph 7.12(2)*"a,"* the prescriber may direct the patient to present to the emergency department, with a valid written prescription or order for the administration of the controlled substance. As soon as possible, the prescriber shall examine the patient in the emergency department and determine the patient's further treatment needs.

7.12(3) *Drug dispensing.* In those facilities with 24-hour pharmacy services, only a pharmacist or prescriber may dispense any drugs to an emergency department patient. In those facilities located in an area of the state where 24-hour outpatient or 24-hour on-call pharmacy services are not available within 15 miles of the hospital, and which facilities are without 24-hour outpatient pharmacy services, the provisions of this rule shall apply.

a. Responsibility. Pursuant to rule 657—8.3(155A), the accuracy and labeling of prepackaged drugs shall be ensured and accurate records of dispensing of drugs from the emergency department shall be maintained.

(1) Prepackaging. Except as provided in subrule 7.12(4), drugs dispensed to an emergency department patient in greater than a 24-hour supply may be dispensed only in prepackaged quantities not to exceed a 72-hour supply or the minimum prepackaged quantity in suitable containers, except that a seven-day supply of doxycycline provided through the department of public health pursuant to the crime victim compensation program of the Iowa department of justice may be dispensed for the treatment of a victim of sexual assault. Prepackaged drugs shall be prepared pursuant to the requirements of rule 657—22.3(126).

(2) Labeling. Drugs dispensed pursuant to this paragraph shall be appropriately labeled as required in paragraph 7.12(3)*"b,"* including necessary auxiliary labels.

b. Prescriber responsibility. Except as provided in subrule 7.12(4), a prescriber who authorizes dispensing of a prescription drug to an emergency department patient is responsible for the accuracy of the dispensed drug and for the accurate completion of label information pursuant to this paragraph.

(1) Labeling. Except as provided in subrule 7.12(4), at the time of delivery of the drug the prescriber shall appropriately complete the label such that the dispensing container bears a label with at least the following information:

1. Name and address of the hospital;
2. Date dispensed;
3. Name of prescriber;
4. Name of patient;
5. Directions for use;
6. Name and strength of drug.

(2) Delivery of drug to patient. Except as provided in subrule 7.12(4), the prescriber, or a licensed nurse under the supervision of the prescriber, shall give the appropriately labeled, prepackaged drug to the patient or patient's caregiver. The prescriber, or a licensed nurse under the supervision of the prescriber, shall explain the correct use of the drug and shall explain to the patient that the dispensing is for an emergency or starter supply of the drug. If additional quantities of the drug are required to complete the needed course of treatment, the prescriber shall provide the patient with a prescription for the additional quantities.

7.12(4) *Use of InstyMeds dispensing system.* A hospital located in an area of the state where 24-hour outpatient pharmacy services are not available within 15 miles of the hospital may implement the InstyMeds dispensing system in the hospital emergency department only as provided by this subrule.

a. Persons with access to the dispensing machine for the purposes of stocking, inventory, and monitoring shall be limited to pharmacists, pharmacy technicians, and pharmacist-interns.

b. The InstyMeds dispensing system shall be used only in the hospital emergency department for the benefit of patients examined or treated in the emergency department.

c. The dispensing machine shall be located in a secure and professionally appropriate environment.

d. The stock of drugs maintained and dispensed utilizing the InstyMeds dispensing system shall be limited to acute care drugs provided in appropriate quantities for a 72-hour supply or the minimum commercially available package size, except that antimicrobials may be dispensed in a quantity to provide the full course of therapy.

e. Drugs dispensed utilizing the InstyMeds dispensing system shall be appropriately labeled as provided in 657—subrule 6.10(1), paragraphs *"a"* through *"g."*

f. Prior to authorizing the dispensing of a drug utilizing the InstyMeds dispensing system, the prescriber shall offer the patient the option of being provided a prescription that may be filled at the pharmacy of the patient's choice.

g. When appropriate for an acute condition, the prescriber shall provide to the patient or the patient's caregiver a prescription for the remainder of drug therapy beyond the supply available utilizing the InstyMeds dispensing system. During consultation with the patient or the patient's caregiver, the prescriber shall clearly explain the appropriate use of the drug supplied, the need to have a prescription for any additional supply of the drug filled at a pharmacy of the patient's choice, and the need to complete the full course of drug therapy.

h. The pharmacy shall, in conjunction with the hospital emergency department, implement policies and procedures to ensure that a patient utilizing the InstyMeds dispensing system has been positively identified.

i. The hospital pharmacist shall review the printout of drugs provided utilizing the InstyMeds dispensing system within 24 hours unless the pharmacy is closed, in which case the printout shall be reviewed during the first day the pharmacy is open following the provision of the drugs. The purpose of the review is to identify any dispensing errors, to determine dosage appropriateness, and to complete a retrospective drug use review of any antimicrobials dispensed in a quantity greater than a 72-hour supply. Any discrepancies found shall be addressed by the pharmacy's continuous quality improvement program.

[**ARC 8909B**, IAB 6/30/10, effective 8/4/10; **ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—7.13(124,155A) Records. Every inventory or other record required to be kept under this chapter or other board rules or under Iowa Code chapters 124 and 155A shall be kept by the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record unless a longer retention period is specified for the particular inventory or record.

7.13(1) *Medication order information.* Each original medication order contained in inpatient records shall bear the following information:

a. Patient name and identification number;

b. Drug name, strength, and dosage form;

c. Directions for use;

d. Date ordered;

e. Practitioner's signature or electronic signature or that of the practitioner's authorized agent.

7.13(2) *Medication order maintained.* The original medication order shall be maintained with the medication administration record in the medical records of the patient following discharge.

7.13(3) *Documentation of drug administration.* Each dose of medication administered shall be properly recorded in the patient's medical record.

These rules are intended to implement Iowa Code sections 124.301, 124.303, 124.306, 126.10, 126.11, 155A.6, 155A.13, 155A.27, 155A.28, 155A.31, and 155A.33 through 155A.36.

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◊ Two or more ARCs

CHAPTER 8
UNIVERSAL PRACTICE STANDARDS
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 6]

657—8.1(155A) Purpose and scope. The requirements of these rules apply to all Iowa-licensed pharmacists and to all pharmacies providing the services addressed in this chapter to patients in Iowa and are in addition to rules of the board relating to specific types of pharmacy licenses issued by the board.

657—8.2(155A) Pharmaceutical care. Pharmaceutical care is a comprehensive, patient-centered, outcomes-oriented pharmacy practice in which the pharmacist accepts responsibility for assisting the prescriber and the patient in optimizing the patient's drug therapy plan and works to promote health, to prevent disease, and to optimize drug therapy. Pharmaceutical care does not include the prescribing of drugs without the consent of the prescribing practitioner.

8.2(1) *Drug therapy problems.* In providing pharmaceutical care, the pharmacist shall strive to identify, resolve, and prevent drug therapy problems.

8.2(2) *Drug therapy plan.* In providing pharmaceutical care, the pharmacist shall access and evaluate patient-specific information, identify drug therapy problems, and utilize that information in a documented plan of therapy that assists the patient or the patient's caregiver in achieving optimal drug therapy. In concert with the patient, the patient's prescribing practitioner, and the patient's other health care providers, the pharmacist shall assess, monitor, and suggest modifications of the plan as appropriate.

8.2(3) *Eligibility.* Any Iowa-licensed pharmacist may practice pharmaceutical care.

657—8.3(155A) Responsible parties.

8.3(1) *Pharmacist in charge.* One professionally competent, legally qualified pharmacist in charge in each pharmacy shall work cooperatively with the pharmacy, by and through its owner or license holder, and with all staff pharmacists to ensure the legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, and regulations governing the practice of pharmacy. A part-time pharmacist in charge has the same obligations and responsibilities as a full-time pharmacist in charge.

8.3(2) *Pharmacy.* Each pharmacy, by and through its owner or license holder, shall work cooperatively with the pharmacist in charge and with all staff pharmacists to ensure the legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, and regulations governing the practice of pharmacy. The pharmacy, by and through its owner or license holder, shall be responsible for employing a professionally competent, legally qualified pharmacist in charge.

8.3(3) *Pharmacy and pharmacist in charge.* The pharmacist in charge and the pharmacy, by and through its owner or license holder, shall share responsibility for, at a minimum, the following:

a. Ensuring that the pharmacy employs an adequate number of qualified personnel commensurate with the size and scope of services provided by the pharmacy.

b. Ensuring the availability of any equipment and references necessary for the particular practice of pharmacy.

c. Ensuring that there is adequate space within the prescription department or a locked room not accessible to the public for the storage of prescription drugs, including controlled substances, devices, and pharmacy records, and to support the operations of the pharmacy.

8.3(4) *Pharmacist in charge and staff pharmacists.* The pharmacist in charge and staff pharmacists shall share responsibility for, at a minimum, the following:

a. Ensuring that a pharmacist performs prospective drug use review as specified in rule 657—8.21(155A).

b. Ensuring that a pharmacist provides patient counseling as specified in rule 657—6.14(155A).

c. Dispensing drugs to patients, including the packaging, preparation, compounding, and labeling functions performed by pharmacy personnel.

d. Delivering drugs to the patient or the patient's agent.

e. Ensuring that patient medication records are maintained as specified in rule 657—6.13(155A).

f. Training and supervising pharmacist-interns, pharmacy technicians, pharmacy support persons, and other pharmacy employees.

g. Procuring and storing prescription drugs and devices and other products dispensed from the pharmacy.

h. Distributing and disposing of drugs from the pharmacy.

i. Maintaining records of all transactions of the pharmacy necessary to maintain accurate control over and accountability for all drugs as required by applicable state and federal laws, rules, and regulations.

j. Ensuring the legal operation of the pharmacy, including meeting all inspection and other requirements of state and federal laws, rules, and regulations governing the practice of pharmacy.

8.3(5) *Pharmacy, pharmacist in charge, and staff pharmacists.* The pharmacy, by and through its owner or license holder, the pharmacist in charge, and all staff pharmacists shall share responsibility for, at a minimum, the following:

a. Establishing and periodically reviewing (by the pharmacy and the pharmacist in charge), implementing (by the pharmacist in charge), and complying (by the pharmacist in charge and staff pharmacists) with policies and procedures for all operations of the pharmacy. The policies and procedures shall identify the frequency of review.

b. Establishing and maintaining effective controls against the theft or diversion of prescription drugs, including controlled substances, and records for such drugs.

c. Establishing (by the pharmacy and the pharmacist in charge), implementing (by the pharmacist in charge), and utilizing (by the pharmacist in charge and staff pharmacists) an ongoing, systematic program of continuous quality improvement for achieving performance enhancement and ensuring the quality of pharmaceutical services.

8.3(6) *Practice functions.* The pharmacist is responsible for all functions performed in the practice of pharmacy. The pharmacist maintains responsibility for any and all delegated functions including functions delegated to pharmacist-interns, pharmacy technicians, and pharmacy support persons.

8.3(7) *Pharmacist-documented verification.* The pharmacist shall provide, document, and retain a record of the final verification for the accuracy, validity, completeness, and appropriateness of the patient's prescription or medication order prior to the delivery of the medication to the patient or the patient's representative.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 1576C**, IAB 8/20/14, effective 9/24/14; **ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—8.4(155A) Pharmacist identification and staff logs.

8.4(1) *Display of pharmacist license.* During any period the pharmacist is working in a pharmacy, each pharmacist shall display, in a position visible to the public, an original license to practice pharmacy. A current license renewal certificate, which may be a photocopy of an original renewal certificate, shall be displayed with the original license.

8.4(2) *Identification codes.* A permanent log of the initials or identification codes identifying by name each dispensing pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person shall be maintained for a minimum of two years and shall be available for inspection and copying by the board or its representative. The initials or identification code shall be unique to the individual to ensure that each pharmacist, pharmacist-intern, pharmacy technician, and pharmacy support person can be identified.

8.4(3) *Temporary or intermittent pharmacy staff.* The pharmacy shall maintain a log of all pharmacists, pharmacist-interns, pharmacy technicians, and pharmacy support persons who have worked at that pharmacy and who are not regularly staffed at that pharmacy. Such log shall include the dates and shifts worked by each pharmacist, pharmacist-intern, pharmacy technician, and pharmacy

support person and shall be available for inspection and copying by the board or its representative for a minimum of two years following the date of the entry.

8.4(4) *Identification badge.* A pharmacist shall wear a visible identification badge while on duty that clearly identifies the person as a pharmacist and includes at least the pharmacist's first name.
[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 9409B**, IAB 3/9/11, effective 4/13/11]

657—8.5(155A) Environment and equipment requirements. There shall be adequate space, equipment, and supplies for the professional and administrative functions of the pharmacy pursuant to rule 657—8.3(155A). Space and equipment in an amount and type to provide secure, environmentally controlled storage of drugs shall be available.

8.5(1) *Refrigeration.* The pharmacy shall maintain one or more refrigeration units. The temperature of the refrigerator shall be maintained within a range compatible with the proper storage of drugs requiring refrigeration, and a thermometer shall be maintained in the refrigerator to verify the temperature.

8.5(2) *Sink.* The pharmacy shall have a sink with hot and cold running water located within the pharmacy department and available to all pharmacy personnel; the sink shall be maintained in a sanitary condition.

8.5(3) *Secure barrier.* A pharmacy department shall be closed and secured in the absence of the pharmacist except as provided in rule 657—6.7(124,155A) or 657—7.6(124,155A). To ensure that secure closure, the pharmacy department shall be surrounded by a physical barrier capable of being securely locked to prevent entry when the department is closed. A secure barrier may be constructed of other than a solid material with a continuous surface if the openings in the material are not large enough to permit removal of items from the pharmacy department by any means. Any material used in the construction of the barrier shall be of sufficient strength and thickness that it cannot be readily or easily removed, penetrated, or bent. The plans and specifications of the barrier shall be submitted to the board for approval at least 30 days prior to the start of construction. The pharmacy may be subject to inspection as provided in subrule 8.5(4).

8.5(4) *Remodel or relocation—inspection.* A pharmacy planning to remodel or relocate a licensed pharmacy department on or within the premises currently occupied by the pharmacy department, or a pharmacy intending to remodel or install a sterile compounding facility or equipment, shall provide written notification to the board at least 30 days prior to commencement of the remodel, pharmacy relocation, or sterile compounding installation. The board may require on-site inspection of the facility, equipment, or pharmacy department prior to or during the pharmacy's remodel, relocation, or opening. The board may also require on-site inspection of a temporary pharmacy location intended to be utilized during the remodel, construction, or relocation of the pharmacy department.

8.5(5) *Orderly and clean.* The pharmacy shall be arranged in an orderly fashion and kept clean. All required equipment shall be in good operating condition and maintained in a sanitary manner. Animals shall not be allowed within a licensed pharmacy unless that pharmacy is exclusively providing services for the treatment of animals or unless the animal is a service dog or assistive animal as defined in Iowa Code subsection 216C.11(1).

8.5(6) *Light, ventilation, temperature, and humidity.* The pharmacy shall be properly lighted and ventilated. The temperature and humidity of the pharmacy shall be maintained within a range compatible with the proper storage of drugs.

8.5(7) *Other equipment.* The pharmacist in charge and the pharmacy, by and through its owner or license holder, shall share the responsibility for ensuring the availability of any other equipment necessary for the particular practice of pharmacy and to meet the needs of the patients served by the pharmacy.

8.5(8) *Bulk counting machines.* Unless bar-code scanning is required and utilized to verify the identity of each stock container of drugs utilized to restock a counting machine cell or bin, a pharmacist shall verify the accuracy of the drugs to be restocked prior to filling the counting machine cell or bin. A record identifying the individual who verified the drugs to be restocked, the individual who restocked the counting machine cell or bin, and the date shall be maintained. Established policies and procedures

shall include a method to calibrate and verify the accuracy of the counting device. The pharmacy shall, at least quarterly, verify the accuracy of the device and maintain a dated record identifying the individual who performed the quarterly verification.

8.5(9) *Authorized collection program.* A pharmacy that is registered with the United States Department of Justice, Drug Enforcement Administration, to administer an authorized collection program shall provide adequate space, equipment, and supplies for such collection program pursuant to 657—Chapter 10 and federal regulations for authorized collection programs, which can be found at http://deadiversion.usdoj.gov/drug_disposal/.

[**ARC 8671B**, IAB 4/7/10, effective 5/12/10; **ARC 0503C**, IAB 12/12/12, effective 1/16/13; **ARC 1961C**, IAB 4/15/15, effective 5/20/15; **ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—8.6(155A) Health of personnel. Only personnel authorized by the responsible pharmacist shall be in the immediate vicinity of the drug dispensing, preparation, compounding, or storage areas. Any person shown, either by medical examination or pharmacist determination, to have an apparent illness or open lesions that may adversely affect the quality or safety of a drug product or another individual shall be excluded from direct contact with components, bulk drug substances, drug product containers, closures, in-process materials, drug products, and patients until the condition is corrected or determined by competent medical personnel not to jeopardize the quality or safety of drug products or patients. All personnel who normally assist the pharmacist shall be instructed to report to the pharmacist any health conditions that may have an adverse effect on drug products or may pose a health or safety risk to others.

657—8.7(155A) Procurement, storage, and recall of drugs and devices.

8.7(1) *Source.* Procurement of prescription drugs and devices shall be from a drug wholesaler licensed by the board to distribute to Iowa pharmacies or, on a limited basis, from another licensed pharmacy or licensed practitioner located in the United States.

8.7(2) *Sufficient stock.* A pharmacy shall maintain sufficient stock of drugs and devices to fulfill the foreseeable needs of the patients served by the pharmacy.

8.7(3) *Manner of storage.* Drugs and devices shall be stored in a manner to protect their identity and integrity.

8.7(4) *Storage temperatures.* All drugs and devices shall be stored at the proper temperature, as defined by the following terms:

a. *"Controlled room temperature"* means temperature maintained thermostatically between 15 degrees and 30 degrees Celsius (59 degrees and 86 degrees Fahrenheit);

b. *"Cool"* means temperature between 8 degrees and 15 degrees Celsius (46 degrees and 59 degrees Fahrenheit). Drugs and devices may be stored in a refrigerator unless otherwise specified on the labeling;

c. *"Refrigerate"* means temperature maintained thermostatically between 2 degrees and 8 degrees Celsius (36 degrees and 46 degrees Fahrenheit); and

d. *"Freeze"* means temperature maintained thermostatically between -20 degrees and -10 degrees Celsius (-4 degrees and 14 degrees Fahrenheit).

8.7(5) *Product recall.* There shall be a system for removing from use, including unit dose, any drugs and devices subjected to a product recall.

657—8.8(124,155A) Out-of-date drugs or devices. Any drug or device bearing an expiration date shall not be dispensed for use beyond the expiration date of the drug or device. Outdated drugs or devices shall be removed from dispensing stock and shall be quarantined until such drugs or devices are properly disposed of.

657—8.9(124,155A) Records. Every inventory or other record required to be maintained by a pharmacy pursuant to board rules or Iowa Code chapters 124 and 155A shall be maintained and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record unless a longer retention period is specified for the particular record or inventory. Original hard-copy prescription and other pharmacy records more than 12 months old may

be maintained in a secure storage area outside the licensed pharmacy department unless such remote storage is prohibited under federal law. A remote storage area shall be located within the same physical structure containing the licensed pharmacy department. The following records shall be maintained for at least two years.

8.9(1) *Drug supplier invoices.* All pharmacies shall maintain supplier invoices of prescription drugs and controlled substances upon which the actual date of receipt of the controlled substances by the pharmacist or other responsible individual is clearly recorded.

8.9(2) *Drug supplier credits.* All pharmacies shall maintain supplier credit memos for controlled substances and prescription drugs.

[**ARC 8539B**, IAB 2/24/10, effective 4/1/10]

657—8.10 Reserved.

657—8.11(147,155A) Unethical conduct or practice. The provisions of this rule apply to licensed pharmacies, licensed pharmacists, registered pharmacy technicians, registered pharmacy support persons, and registered pharmacist-interns.

8.11(1) *Misrepresentative deeds.* A pharmacist, technician, support person, or pharmacist-intern shall not make any statement intended to deceive, misrepresent or mislead anyone, or be a party to or an accessory to any fraudulent or deceitful practice or transaction in pharmacy or in the operation or conduct of a pharmacy.

8.11(2) *Undue influence.*

a. A pharmacist shall not accept professional employment or share or receive compensation in any form arising out of, or incidental to, the pharmacist's professional activities from a prescriber of prescription drugs or any other person or corporation in which one or more such prescribers have a proprietary or beneficial interest sufficient to permit them to directly or indirectly exercise supervision or control over the pharmacist in the pharmacist's professional responsibilities and duties or over the pharmacy wherein the pharmacist practices.

b. A prescriber may employ a pharmacist to provide nondispensing, drug information, or other cognitive services.

8.11(3) *Lease agreements.* A pharmacist shall not lease space for a pharmacy under any of the following conditions:

a. From a prescriber of prescription drugs or a group, corporation, association, or organization of such prescribers on a percentage of income basis;

b. From a group, corporation, association, or organization in which prescribers have majority control or have directly or indirectly a majority beneficial or proprietary interest on a percentage of income basis; or

c. If the rent is not reasonable according to commonly accepted standards of the community in which the pharmacy will be located.

8.11(4) *Nonconformance with law.* A pharmacist, technician, support person, or pharmacist-intern shall not knowingly serve in a pharmacy which is not operated in conformance with law, or which engages in any practice which if engaged in by a pharmacist would be unethical conduct.

8.11(5) *Freedom of choice/solicitation/kickbacks/fee-splitting and imprinted prescription blanks or forms.* A pharmacist or pharmacy shall not enter into any agreement which negates a patient's freedom of choice of pharmacy services. A purchasing pharmacist or pharmacy shall not engage in any activity or include in any agreement with a selling pharmacist or pharmacy any provision that would prevent or prohibit the prior notifications required in subrule 8.35(7). A pharmacist or pharmacy shall not participate in prohibited agreements with any person in exchange for recommending, promoting, accepting, or promising to accept the professional pharmaceutical services of any pharmacist or pharmacy. "Person" includes an individual, corporation, partnership, association, firm, or other entity. "Prohibited agreements" includes an agreement or arrangement that provides premiums, "kickbacks," fee-splitting, or special charges as compensation or inducement for placement of business or solicitation of patronage with any pharmacist or pharmacy. "Kickbacks" includes, but is not limited to, the

provision of medication carts, facsimile machines, any other equipment, or preprinted forms or supplies for the exclusive use of a facility or practitioner at no charge or billed below reasonable market rate. A pharmacist shall not provide, cause to be provided, or offer to provide to any person authorized to prescribe prescription blanks or forms bearing the pharmacist's or pharmacy's name, address, or other means of identification, except that a hospital may make available to hospital staff prescribers, emergency department prescribers, and prescribers granted hospital privileges for the prescribers' use during practice at or in the hospital generic prescription blanks or forms bearing the name, address, or telephone number of the hospital pharmacy.

8.11(6) *Discrimination.* It is unethical to unlawfully discriminate between patients or groups of patients for reasons of religion, race, creed, color, gender, gender identity, sexual orientation, marital status, age, national origin, physical or mental disability, or disease state when providing pharmaceutical services.

8.11(7) *Claims of professional superiority.* A pharmacist shall not make a claim, assertion, or inference of professional superiority in the practice of pharmacy which cannot be substantiated, or claim an unusual, unsubstantiated capacity to supply a drug or professional service to the community.

8.11(8) *Unprofessional conduct or behavior.* A pharmacist shall not exhibit unprofessional behavior in connection with the practice of pharmacy or refuse to provide reasonable information or answer reasonable questions for the benefit of the patient. Unprofessional behavior shall include, but not be limited to, the following acts: verbal abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, and theft.

[**ARC 9526B**, IAB 6/1/11, effective 7/6/11]

657—8.12(126,147) Advertising. Prescription drug price and nonprice information may be provided to the public by a pharmacy so long as the information is not false or misleading and is not in violation of any federal or state laws applicable to the advertisement of such articles generally and if all of the following conditions are met:

1. All charges for services to the consumer must be stated.
2. The effective dates for the prices listed shall be stated.
3. No reference shall be made to controlled substances listed in Schedules II through V of the latest revision of the Iowa uniform controlled substances Act and the rules of the Iowa board of pharmacy.

657—8.13(135C,155A) Personnel histories. Pursuant to the requirements of Iowa Code section 135C.33, the provisions of this rule shall apply to any pharmacy employing any person to provide patient care services in a patient's home. For the purposes of this rule, "employed by the pharmacy" shall include any individual who is paid to provide treatment or services to any patient in the patient's home, whether the individual is paid by the pharmacy or by any other entity such as a corporation, a temporary staffing agency, or an independent contractor. Specifically excluded from the requirements of this rule are individuals such as delivery persons or couriers who do not enter the patient's home for the purpose of instructing the patient or the patient's caregiver in the use or maintenance of the equipment, device, or drug being delivered, or who do not enter the patient's home for the purpose of setting up or servicing the equipment, device, or drug used to treat the patient in the patient's home.

8.13(1) *Applicant acknowledgment.* The pharmacy shall ask the following question of each person seeking employment in a position that will provide in-home services: "Do you have a record of founded child or dependent adult abuse or have you ever been convicted of a crime, in this state or any other state?" The applicant shall also be informed that a criminal history and dependent adult abuse record check will be conducted. The applicant shall indicate, by signed acknowledgment, that the applicant has been informed that such record checks will be conducted.

8.13(2) *Criminal history check.* Prior to the employment of any person to provide in-home services as described by this rule, the pharmacy shall submit to the department of public safety a form specified by the department of public safety and receive the results of a criminal history check.

8.13(3) *Abuse history checks.* Prior to the employment of any person to provide in-home services as described by this rule, the pharmacy shall submit to the department of human services a form specified

by the department of human services and receive the results of a dependent adult abuse record check. The pharmacy may submit to the department of human services a form specified by the department of human services to request a child abuse history check.

a. A person who has a criminal record, founded dependent adult abuse report, or founded child abuse report shall not be employed by a pharmacy to provide in-home services unless the department of human services has evaluated the crime or founded abuse report, has concluded that the crime or founded abuse does not merit prohibition from such employment, and has notified the pharmacy that the person may be employed to provide in-home services.

b. The pharmacy shall keep copies of all record checks and evaluations for a minimum of two years following receipt of the record or for a minimum of two years after the individual is no longer employed by the pharmacy, whichever is greater.

657—8.14(155A) Training and utilization of pharmacy technicians or pharmacy support persons. Pursuant to rule 657—8.3(155A), all Iowa-licensed pharmacies utilizing pharmacy technicians or pharmacy support persons shall have written policies and procedures for the training and utilization of pharmacy technicians and pharmacy support persons appropriate to the practice of pharmacy at that licensed location. Pharmacy technician and pharmacy support person training shall be documented and maintained by the pharmacy for the duration of employment. Policies and procedures and documentation of pharmacy technician and pharmacy support person training shall be available for inspection by the board or an agent of the board.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—8.15(155A) Delivery of prescription drugs and devices. Prescription drug orders, prescription devices, and completed prescription drug containers may be delivered, in compliance with all laws, rules, and regulations relating to the practice of pharmacy, to patients at any place of business licensed as a pharmacy.

8.15(1) *Alternative methods.* A licensed pharmacy may, by means of its employee or by use of a common carrier, pick up or deliver prescriptions to the patient or the patient's caregiver as follows:

a. At the office or home of the prescriber.

b. At the residence of the patient or caregiver.

c. At the hospital or medical care facility in which a patient is confined.

d. At an outpatient medical care facility where the patient receives treatment only pursuant to the following requirements:

(1) The pharmacy shall obtain and maintain the written authorization of the patient or patient's caregiver for receipt or delivery at the outpatient medical care facility;

(2) The prescription shall be delivered directly to or received directly from the patient, the caregiver, or an authorized agent identified in the written authorization;

(3) A prescription authorized by a prescriber not treating the patient at the outpatient medical care facility may be transmitted to the pharmacy by the authorized agent via facsimile provided that the means of transmission does not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the prescription and provided that the original written prescription is delivered to the pharmacy prior to delivery of the filled prescription to the patient; and

(4) The outpatient medical care facility shall store the patient's filled prescriptions in a secure area pending delivery to the patient.

e. At the patient's or caregiver's place of employment only pursuant to the following requirements:

(1) The pharmacy shall obtain and maintain the written authorization of the patient or patient's caregiver for receipt or delivery at the place of employment;

(2) The prescription shall be delivered directly to or received directly from the patient, the caregiver, the prescriber, or an authorized agent identified in the written authorization; and

(3) The pharmacy shall ensure the security of confidential information as defined in subrule 8.16(1).

8.15(2) *Policies and procedures required.* Pursuant to rule 657—8.3(155A), every pharmacy shipping or otherwise delivering prescription drugs or devices to Iowa patients shall have policies and

procedures to ensure accountability, safe delivery, and compliance with temperature requirements as defined by subrule 8.7(4).
[**ARC 7636B**, IAB 3/11/09, effective 4/15/09; **ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—8.16(124,155A) Confidential information.

8.16(1) *Definition.* "Confidential information" means information accessed or maintained by the pharmacy in the patient's records which contains personally identifiable information that could be used to identify the patient. This includes but is not limited to patient name, address, telephone number, and social security number; prescriber name and address; and prescription and drug or device information such as therapeutic effect, diagnosis, allergies, disease state, pharmaceutical services rendered, medical information, and drug interactions, regardless of whether such information is communicated to or from the patient, is in the form of paper, is preserved on microfilm, or is stored on electronic media.

8.16(2) *Release of confidential information.* Confidential information in the patient record may be released only as follows:

a. Pursuant to the express written authorization of the patient or the order or direction of a court.

b. To the patient or the patient's authorized representative.

c. To the prescriber or other licensed practitioner then caring for the patient.

d. To another licensed pharmacist when the best interests of the patient require such release.

e. To the board or its representative or to such other persons or governmental agencies duly authorized by law to receive such information.

A pharmacist shall utilize the resources available to determine, in the professional judgment of the pharmacist, that any persons requesting confidential patient information pursuant to this rule are entitled to receive that information.

8.16(3) *Exceptions.* Nothing in this rule shall prohibit pharmacists from releasing confidential patient information as follows:

a. Transferring a prescription to another pharmacy upon the request of the patient or the patient's authorized representative.

b. Providing a copy of a nonrefillable prescription to the person for whom the prescription was issued which is clearly marked as a copy and not to be filled.

c. Providing drug therapy information to physicians or other authorized prescribers for their patients.

d. Disclosing information necessary for the processing of claims for payment of health care operations or services.

e. Transferring, subject to the provisions of subrule 8.35(7), prescription and patient records of a pharmacy that discontinues operation as a pharmacy to another licensed pharmacy that is held to the same standards of confidentiality and that agrees to act as custodian of the transferred records.

8.16(4) *System security and safeguards.* To maintain the integrity and confidentiality of patient records and prescription drug orders, any system or computer utilized shall have adequate security including system safeguards designed to prevent and detect unauthorized access, modification, or manipulation of patient records and prescription drug orders.

8.16(5) *Record disposal.* Disposal of any materials containing or including patient-specific or confidential information shall be conducted in a manner to preserve patient confidentiality.
[**ARC 9526B**, IAB 6/1/11, effective 7/6/11]

657—8.17 and **8.18** Reserved.

657—8.19(124,126,155A) Manner of issuance of a prescription drug or medication order. A prescription drug order or medication order may be transmitted from a prescriber or a prescriber's agent to a pharmacy in written form, orally including telephone voice communication, by facsimile transmission as provided in rule 657—21.9(124,155A), or by electronic transmission in accordance with applicable federal and state laws, rules, and regulations. Any prescription drug order or medication order provided to a patient in written or printed form shall include the original, handwritten signature of the prescriber except as provided in rule 657—21.7(124,155A).

8.19(1) *Requirements for a prescription.* A valid prescription drug order shall be based on a valid patient-prescriber relationship except as provided in subrule 8.19(7) for epinephrine auto-injectors.

a. Written, electronic, or facsimile prescription. In addition to the electronic prescription application and pharmacy prescription application requirements of this rule, a written, electronic, or facsimile prescription shall include:

(1) The date issued.

(2) The name and address of the patient except as provided in subrule 8.19(7) for epinephrine auto-injectors.

(3) The name, strength, and quantity of the drug or device prescribed.

(4) The name and address of the prescriber and, if the prescription is for a controlled substance, the prescriber's DEA registration number.

(5) The written or electronic signature of the prescriber.

b. Written prescription. In addition to the requirements of paragraph 8.19(1)*"a,"* a written prescription shall be manually signed, with ink or indelible pencil, by the prescriber. The requirement for manual signature shall not apply when an electronically prepared and signed prescription for a noncontrolled substance is printed on security paper as provided in 657—paragraph 21.7(3)*"b."*

c. Facsimile prescription. In addition to the requirements of paragraph 8.19(1)*"a,"* a prescription transmitted via facsimile shall include:

(1) The identification number of the facsimile machine used to transmit the prescription to the pharmacy.

(2) The time and date of transmission of the prescription.

(3) The name, address, telephone number, and facsimile number of the pharmacy to which the prescription is being transmitted.

(4) If the prescription is for a controlled substance and in compliance with DEA regulations, the manual signature of the prescriber.

d. Electronic prescription. In addition to the requirements of paragraph 8.19(1)*"a,"* an electronically prepared prescription for a controlled or noncontrolled prescription drug or device that is electronically transmitted to a pharmacy shall include the prescriber's electronic signature.

(1) An electronically prepared prescription for a controlled substance that is printed out or faxed by the prescriber or the prescriber's agent shall be manually signed by the prescriber.

(2) The prescriber shall ensure that the electronic prescription application used to prepare and transmit the electronic prescription complies with applicable state and federal laws, rules, and regulations regarding electronic prescriptions.

(3) The prescriber or the prescriber's agent shall provide verbal verification of an electronic prescription upon the request of the pharmacy.

8.19(2) *Verification.* The pharmacist shall exercise professional judgment regarding the accuracy, validity, and authenticity of any prescription drug order or medication order consistent with federal and state laws, rules, and regulations. In exercising professional judgment, the prescribing practitioner and the pharmacist shall take adequate measures to guard against the diversion of prescription drugs and controlled substances through prescription forgeries.

8.19(3) *Transmitting agent.* The prescribing practitioner may authorize an agent to transmit to the pharmacy a prescription drug order or medication order orally, by facsimile transmission, or by electronic transmission provided that the first and last names and title of the transmitting agent are included in the order.

a. New order. A new written or electronically prepared and transmitted prescription drug or medication order shall be manually or electronically signed by the prescriber. If transmitted by the prescriber's agent, the first and last names and title of the transmitting agent shall be included in the order. If the prescription is for a controlled substance and is written or printed from an electronic prescription application, the prescription shall be manually signed by the prescriber prior to delivery of the prescription to the patient or prior to facsimile transmission of the prescription to the pharmacy. An electronically prepared prescription shall not be electronically transmitted to the pharmacy if the prescription has been printed prior to the electronic transmission. An electronically prepared and

electronically transmitted prescription that is printed following the electronic transmission shall be clearly labeled as a copy, not valid for dispensing.

b. Refill order or renewal order. An authorization to refill a prescription drug or medication order, or to renew or continue an existing drug therapy, may be transmitted to a pharmacist through oral communication, in writing, by facsimile transmission, or by electronic transmission initiated by or directed by the prescriber.

(1) If the transmission is completed by the prescriber's agent and the first and last names and title of the transmitting agent are included in the order, the prescriber's signature is not required on the fax or alternate electronic transmission.

(2) If the order differs in any manner from the original order, such as a change of the drug strength, dosage form, or directions for use, the prescriber shall sign the order as provided by paragraph 8.19(3)*"a."*

8.19(4) *Receiving agent.* Regardless of the means of transmission to a pharmacy, only a pharmacist, a pharmacist-intern, or a certified pharmacy technician shall be authorized to receive a new prescription drug or medication order from a practitioner or the practitioner's agent. In addition to a pharmacist, a pharmacist-intern, and a certified pharmacy technician, a technician trainee or an uncertified pharmacy technician may receive a refill or renewal order from a practitioner or the practitioner's agent if the technician's supervising pharmacist has authorized that function.

8.19(5) *Legitimate purpose.* The pharmacist shall ensure that the prescription drug or medication order, regardless of the means of transmission, has been issued for a legitimate medical purpose by an authorized practitioner acting in the usual course of the practitioner's professional practice. A pharmacist shall not dispense a prescription drug if the pharmacist knows or should have known that the prescription was issued solely on the basis of an Internet-based questionnaire, an Internet-based consultation, or a telephonic consultation and without a valid preexisting patient-practitioner relationship except as provided in subrule 8.19(7) for epinephrine auto-injectors.

8.19(6) *Refills.* A refill is one or more dispensings of a prescription drug or device that result in the patient's receipt of the quantity authorized by the prescriber for a single fill as indicated on the prescription drug order.

a. Noncontrolled prescription drug or device. A prescription for a prescription drug or device that is not a controlled substance may authorize no more than 12 refills within 18 months following the date on which the prescription is issued.

b. Controlled substance. A prescription for a Schedule III, IV, or V controlled substance may authorize no more than 5 refills within 6 months following the date on which the prescription is issued.

8.19(7) *Epinephrine auto-injector prescription issued to school or facility.* A physician, advanced registered nurse practitioner, or a physician assistant may issue a prescription for one or more epinephrine auto-injectors in the name of a facility as defined in Iowa Code subsection 135.185(1), a school district, or an accredited nonpublic school. The prescription shall comply with all requirements of subrule 8.19(1) as applicable to the form of the prescription except that the prescription shall be issued in the name and address of the facility, the school district, or the accredited nonpublic school in lieu of the name and address of a patient. Provisions requiring a preexisting patient-prescriber relationship shall not apply to a prescription issued pursuant to this subrule.

a. The pharmacy's patient profile and record of dispensing of a prescription issued pursuant to this subrule shall be maintained in the name of the facility, school district, or accredited nonpublic school to which the prescription was issued and the drug was dispensed.

b. The label affixed to an epinephrine auto-injector dispensed pursuant to this subrule shall identify the name and address of the facility, school district, or accredited nonpublic school to which the prescription is dispensed.

[**ARC 8171B**, IAB 9/23/09, effective 10/28/09; **ARC 9912B**, IAB 12/14/11, effective 1/18/12; **ARC 2414C**, IAB 2/17/16, effective 3/23/16]

657—8.20(155A) Valid prescriber/patient relationship. Prescription drug orders and medication orders shall be valid as long as a prescriber/patient relationship exists. Once the prescriber/patient

relationship is broken and the prescriber is no longer available to treat the patient or oversee the patient's use of a prescription drug, the order loses its validity and the pharmacist, on becoming aware of the situation, shall cancel the order and any remaining refills. The pharmacist shall, however, exercise prudent judgment based upon individual circumstances to ensure that the patient is able to obtain a sufficient amount of the prescribed drug to continue treatment until the patient can reasonably obtain the service of another prescriber and a new order can be issued.

657—8.21(155A) Prospective drug use review. For purposes of promoting therapeutic appropriateness and ensuring rational drug therapy, a pharmacist shall review the patient record, information obtained from the patient, and each prescription drug or medication order to identify:

1. Overutilization or underutilization;
2. Therapeutic duplication;
3. Drug-disease contraindications;
4. Drug-drug interactions;
5. Incorrect drug dosage or duration of drug treatment;
6. Drug-allergy interactions;
7. Clinical abuse/misuse;
8. Drug-prescriber contraindications.

Upon recognizing any of the above, the pharmacist shall take appropriate steps to avoid or resolve the problem and shall, if necessary, include consultation with the prescriber. The review and assessment of patient records shall not be delegated to staff assistants but may be delegated to registered pharmacist-interns under the direct supervision of the pharmacist.

657—8.22 to **8.25** Reserved.

657—8.26(155A) Continuous quality improvement program. Pursuant to rule 657—8.3(155A), each pharmacy licensed to provide pharmaceutical services to patients in Iowa shall implement or participate in a continuous quality improvement program (CQI program). The CQI program is intended to be an ongoing, systematic program of standards and procedures to detect, identify, evaluate, and prevent medication errors, thereby improving medication therapy and the quality of patient care. A pharmacy that participates as an active member of a hospital or corporate CQI program that meets the objectives of this rule shall not be required to implement a new program pursuant to this rule.

8.26(1) *Reportable program events.* For purposes of this rule, a reportable program event or program event means a preventable medication error resulting in the incorrect dispensing of a prescribed drug received by or administered to the patient and includes but is not necessarily limited to:

a. An incorrect drug;
b. An incorrect drug strength;
c. An incorrect dosage form;
d. A drug received by the wrong patient;
e. Inadequate or incorrect packaging, labeling, or directions; or
f. Any incident related to a prescription dispensed to a patient that results in or has the potential to result in serious harm to the patient.

8.26(2) *Responsibility.* The pharmacist in charge may delegate program administration and monitoring, but the pharmacist in charge maintains ultimate responsibility for the validity and consistency of program activities.

8.26(3) *Policies and procedures.* Pursuant to rule 657—8.3(155A), each pharmacy shall have written policies and procedures for the operation and management of the pharmacy's CQI program. A copy of the pharmacy's CQI program description and policies and procedures shall be maintained and readily available to all pharmacy personnel. The policies and procedures shall address, at a minimum, a planned process to:

a. Train all pharmacy personnel in relevant phases of the CQI program;
b. Identify and document reportable program events;

c. Minimize the impact of reportable program events on patients;

d. Analyze data collected to assess the causes and any contributing factors relating to reportable program events;

e. Use the findings to formulate an appropriate response and to develop pharmacy systems and workflow processes designed to prevent and reduce reportable program events; and

f. Periodically, but at least annually, meet with appropriate pharmacy personnel to review findings and inform personnel of changes that have been made to pharmacy policies, procedures, systems, or processes as a result of CQI program findings.

8.26(4) *Event discovery and notification.* As provided by the procedures of the CQI program, the pharmacist in charge or appropriate designee shall be informed of and review all reported and documented program events. All pharmacy personnel shall be trained to immediately inform the pharmacist on duty of any discovered or suspected program event. When the pharmacist on duty determines that a reportable program event has occurred, the pharmacist shall ensure that all reasonably necessary steps are taken to remedy any problems or potential problems for the patient and that those steps are documented. Necessary steps include, but are not limited to, the following:

a. Notifying the patient or the patient's caregiver and the prescriber or other members of the patient's health care team as warranted;

b. Identifying and communicating directions or processes for correcting the error; and

c. Communicating instructions for minimizing any negative impact on the patient.

8.26(5) *CQI program records.* All CQI program records shall be maintained on site at the pharmacy or shall be accessible at the pharmacy and be available for inspection and copying by the board or its representative for at least two years from the date of the record. When a reportable program event occurs or is suspected to have occurred, the program event shall be documented in a written or electronic storage record created solely for that purpose. Records of program events shall be maintained in an orderly manner and shall be filed chronologically by date of discovery.

a. The program event shall initially be documented as soon as practicable but no more than three days following discovery of the event by the staff member who discovers the event or is informed of the event.

b. Program event documentation shall include a description of the event that provides sufficient information to permit categorization and analysis of the event and shall include:

(1) The date and time the program event was discovered and the name of the staff person who discovered the event; and

(2) The names of the individuals recording and reviewing or analyzing the program event information.

8.26(6) *Program event analysis and response.* The pharmacist in charge or designee shall review each reportable program event and determine if follow-up is necessary. When appropriate, information and data collected and documented shall be analyzed, individually and collectively, to assess the cause and any factors contributing to the program event. The analysis may include, but is not limited to, the following:

a. A consideration of the effects on the quality of the pharmacy system related to workflow processes, technology utilization and support, personnel training, and both professional and technical staffing levels;

b. Any recommendations for remedial changes to pharmacy policies, procedures, systems, or processes; and

c. The development of a set of indicators that a pharmacy will utilize to measure its program standards over a designated period of time.

[**ARC 1961C**, IAB 4/15/15, effective 5/20/15; **ARC 2413C**, IAB 2/17/16, effective 3/23/16]

657—8.27 to **8.29** Reserved.

657—8.30(126,155A) Sterile products. Rescinded IAB 6/6/07, effective 7/11/07.

657—8.31 Reserved.

657—8.32(124,155A) Individuals qualified to administer. The board designates the following as qualified individuals to whom a practitioner may delegate the administration of prescription drugs. Any person specifically authorized under pertinent sections of the Iowa Code to administer prescription drugs shall construe nothing in this rule to limit that authority.

1. Persons who have successfully completed a medication administration course.
2. Licensed pharmacists.

657—8.33(155A) Vaccine administration by pharmacists. An authorized pharmacist may administer vaccines pursuant to protocols established by the CDC in compliance with the requirements of this rule. An authorized pharmacist may only delegate the administration of a vaccine to an authorized pharmacist-intern under the direct supervision of the authorized pharmacist.

8.33(1) *Definitions.* For the purposes of this rule, the following definitions shall apply:

"ACIP" means the CDC Advisory Committee on Immunization Practices.

"ACPE" means the Accreditation Council for Pharmacy Education.

"Authorized pharmacist" means an Iowa-licensed pharmacist who has met the requirements identified in subrule 8.33(2).

"Authorized pharmacist-intern" means an Iowa-registered pharmacist-intern who has met the requirements for an authorized pharmacist identified in paragraphs 8.33(2)*"a"* and *"c."*

"CDC" means the United States Centers for Disease Control and Prevention.

"Immunization" shall have the same meaning as, and shall be interchangeable with, the term "vaccine."

"Protocol" means a standing order for a vaccine to be administered by an authorized pharmacist.

"Vaccine" means a specially prepared antigen administered to a person for the purpose of providing immunity.

8.33(2) *Authorized pharmacist training and continuing education.* An authorized pharmacist shall document successful completion of the requirements in paragraph 8.33(2)*"a"* and shall maintain competency by completing and maintaining documentation of the continuing education requirements in paragraph 8.33(2)*"b."*

a. Initial qualification. An authorized pharmacist shall have successfully completed an organized course of study in a college or school of pharmacy or an ACPE-accredited continuing education program on vaccine administration that:

(1) Requires documentation by the pharmacist of current certification in the American Heart Association or the Red Cross Basic Cardiac Life Support Protocol for health care providers.

(2) Is an evidence-based course that includes study material and hands-on training and techniques for administering vaccines, requires testing with a passing score, complies with current CDC guidelines, and provides instruction and experiential training in the following content areas:

1. Standards for immunization practices;
2. Basic immunology and vaccine protection;
3. Vaccine-preventable diseases;
4. Recommended immunization schedules;
5. Vaccine storage and management;
6. Informed consent;
7. Physiology and techniques for vaccine administration;
8. Pre- and post-vaccine assessment, counseling, and identification of contraindications to the vaccine;
9. Immunization record management; and
10. Management of adverse events, including identification, appropriate response, documentation, and reporting.

b. Continuing education. During any pharmacist license renewal period, an authorized pharmacist who engages in the administration of vaccines shall complete and document at least one hour of continuing education related to vaccines.

c. Certification maintained. During any period within which the pharmacist may engage in the administration of vaccines, the pharmacist shall maintain current certification in the American Heart Association or the Red Cross basic cardiac life support protocol for health care providers.

8.33(3) *Protocol requirements.* A pharmacist may administer vaccines pursuant to CDC protocols. A protocol shall be unique to a pharmacy. The prescriber who signs a protocol shall identify within the protocol, by name or category, those pharmacists or other qualified health professionals that the prescriber is authorizing to administer vaccines pursuant to the protocol. Links to CDC protocols shall be provided on the board's Web site at www.iowa.gov/ibpe. A protocol:

a. Shall be signed by a licensed Iowa prescriber practicing in Iowa.

b. Shall expire no later than one year from the effective date of the signed protocol.

c. Shall be effective for patients who wish to receive a vaccine administered by an authorized pharmacist, who meet the CDC recommended criteria, and who have no contraindications as published by the CDC.

d. Shall require the authorized pharmacist to notify the prescriber who signed the protocol within 24 hours of a serious complication and shall submit a Vaccine Advisory Event Reporting System (VAERS) report.

e. Shall specifically indicate whether the authorizing prescriber agrees that the administration of vaccines may be delegated by the authorized pharmacist to an authorized pharmacist-intern under the direct supervision of the authorized pharmacist.

8.33(4) *Influenza and other emergency vaccines.* An authorized pharmacist shall only administer via protocol, to patients six years of age and older, influenza vaccines and other emergency vaccines in response to a public health emergency.

8.33(5) *Other adult vaccines.* An authorized pharmacist shall only administer via protocol, to patients 18 years of age and older, the following vaccines:

a. A vaccine on the ACIP-approved adult vaccination schedule.

b. A vaccine recommended by the CDC for international travel.

8.33(6) *Vaccines administered via prescription.* An authorized pharmacist may administer any vaccine pursuant to a prescription or medication order for an individual patient. In case of serious complications, the authorized pharmacist shall notify the prescriber who authorized the prescription within 24 hours and shall submit a VAERS report.

8.33(7) *Verification and reporting.* The requirements of this subrule do not apply to influenza and other emergency vaccines administered via protocol pursuant to subrule 8.33(4). An authorized pharmacist shall:

a. Prior to administering a vaccine identified in subrule 8.33(5) or subrule 8.33(6), consult the statewide immunization registry or health information network.

b. Within 30 days following administration of a vaccine identified in subrule 8.33(5) or subrule 8.33(6), report the vaccine administration to the statewide immunization registry or health information network and to the patient's primary health care provider, if known.

[**ARC 1030C**, IAB 9/18/13, effective 9/1/13; **ARC 1786C**, IAB 12/10/14, effective 1/14/15]

657—8.34(155A) Collaborative drug therapy management. An authorized pharmacist may only perform collaborative drug therapy management pursuant to protocol with a physician pursuant to the requirements of this rule. The physician retains the ultimate responsibility for the care of the patient. The pharmacist is responsible for all aspects of drug therapy management performed by the pharmacist.

8.34(1) *Definitions.*

"Authorized pharmacist" means an Iowa-licensed pharmacist whose license is in good standing and who meets the drug therapy management criteria defined in this rule.

"Board" means the board of pharmacy.

"Collaborative drug therapy management" means participation by an authorized pharmacist and a physician in the management of drug therapy pursuant to a written community practice protocol or a written hospital practice protocol.

"Collaborative practice" means that a physician may delegate aspects of drug therapy management for the physician's patients to an authorized pharmacist through a community practice protocol. "Collaborative practice" also means that a P&T committee may authorize hospital pharmacists to perform drug therapy management for inpatients and hospital clinic patients through a hospital practice protocol.

"Community practice protocol" means a written, executed agreement entered into voluntarily between an authorized pharmacist and a physician establishing drug therapy management for one or more of the pharmacist's and physician's patients residing in a community setting. A community practice protocol shall comply with the requirements of subrule 8.34(2).

"Community setting" means a location outside a hospital inpatient, acute care setting or a hospital clinic setting. A community setting may include, but is not limited to, a home, group home, assisted living facility, correctional facility, hospice, or long-term care facility.

"Drug therapy management criteria" means one or more of the following:

1. Graduation from a recognized school or college of pharmacy with a doctor of pharmacy (Pharm.D.) degree;
2. Certification by the Board of Pharmaceutical Specialties (BPS);
3. Certification by the Commission for Certification in Geriatric Pharmacy (CCGP);
4. Successful completion of a National Institute for Standards in Pharmacist Credentialing (NISPC) disease state management examination and credentialing by the NISPC;
5. Successful completion of a pharmacy residency program accredited by the American Society of Health-System Pharmacists (ASHP); or
6. Approval by the board of pharmacy.

"Hospital clinic" means an outpatient care clinic operated and affiliated with a hospital and under the direct authority of the hospital's P&T committee.

"Hospital pharmacist" means an Iowa-licensed pharmacist who meets the requirements for participating in a hospital practice protocol as determined by the hospital's P&T committee.

"Hospital practice protocol" means a written plan, policy, procedure, or agreement that authorizes drug therapy management between hospital pharmacists and physicians within a hospital and the hospital's clinics as developed and determined by the hospital's P&T committee. Such a protocol may apply to all pharmacists and physicians at a hospital or the hospital's clinics or only to those pharmacists and physicians who are specifically recognized. A hospital practice protocol shall comply with the requirements of subrule 8.34(3).

"IBM" means the Iowa board of medicine.

"P&T committee" means a committee of the hospital composed of physicians, pharmacists, and other health professionals that evaluates the clinical use of drugs within the hospital, develops policies for managing drug use and administration in the hospital, and manages the hospital drug formulary system.

"Physician" means a person who is currently licensed in Iowa to practice medicine and surgery, osteopathic medicine and surgery, or osteopathy. A physician who executes a written protocol with an authorized pharmacist shall supervise the pharmacist's activities involved in the overall management of patients receiving medications or disease management services under the protocol. The physician may delegate only drug therapies that are in areas common to the physician's practice.

"Therapeutic interchange" means an authorized exchange of therapeutic alternate drug products in accordance with a previously established and approved written protocol.

8.34(2) *Community practice protocol.*

a. An authorized pharmacist shall engage in collaborative drug therapy management with a physician only under a written protocol that has been identified by topic and has been submitted to the board or a committee authorized by the board. A protocol executed after July 1, 2008, will no longer be required to be submitted to the board; however, written protocols executed or renewed after July 1, 2008, shall be made available upon request of the board or the IBM.

b. The community practice protocol shall include:

(1) The name, signature, date, and contact information for each authorized pharmacist who is a party to the protocol and is eligible to manage the drug therapy of a patient. If more than one authorized pharmacist is a party to the agreement, the pharmacists shall work for a single licensed pharmacy and a principal authorized pharmacist shall be designated in the protocol.

(2) The name, signature, date, and contact information for each physician who may prescribe drugs and is responsible for supervising a patient's drug therapy management. The physician who initiates a protocol shall be considered the main caregiver for the patient respective to that protocol and shall be noted in the protocol as the principal physician.

(3) The name and contact information of the principal physician and the principal authorized pharmacist who are responsible for development, training, administration, and quality assurance of the protocol.

(4) A detailed written protocol pursuant to which the authorized pharmacist will base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration, and route of administration of the drug authorized by the patient's physician. The protocol shall not authorize the pharmacist to change a Schedule II drug or to initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the pharmacist to obtain or to conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions, or determine if the patient should be referred back to the patient's physician for follow-up.

4. Patient activities. The protocol may authorize the pharmacist to monitor specific patient activities.

(5) Procedures for securing the patient's written consent. If the patient's consent is not secured by the physician, the authorized pharmacist shall secure such and notify the patient's physician within 24 hours.

(6) Circumstances that shall cause the authorized pharmacist to initiate communication with the physician including but not limited to the need for new prescription orders and reports of the patient's therapeutic response or adverse reaction.

(7) A detailed statement identifying the specific drugs, laboratory tests, and physical findings upon which the authorized pharmacist shall base drug therapy management decisions.

(8) A provision for the collaborative drug therapy management protocol to be reviewed, updated, and reexecuted or discontinued at least every two years.

(9) A description of the method the pharmacist shall use to document the pharmacist's decisions or recommendations for the physician.

(10) A description of the types of reports the authorized pharmacist is to provide to the physician and the schedule by which the pharmacist is to submit these reports. The schedule shall include a time frame within which a pharmacist shall report any adverse reaction to the physician.

(11) A statement of the medication categories and the type of initiation and modification of drug therapy that the physician authorizes the pharmacist to perform.

(12) A description of the procedures or plan that the pharmacist shall follow if the pharmacist modifies a drug therapy.

(13) Procedures for record keeping, record sharing, and long-term record storage.

(14) Procedures to follow in emergency situations.

(15) A statement that prohibits the authorized pharmacist from delegating drug therapy management to anyone other than another authorized pharmacist who has signed the applicable protocol.

(16) A statement that prohibits a physician from delegating collaborative drug therapy management to any unlicensed or licensed person other than another physician or an authorized pharmacist.

(17) A description of the mechanism for the pharmacist and the physician to communicate with each other and for documentation by the pharmacist of the implementation of collaborative drug therapy.

c. Collaborative drug therapy management is valid only when initiated by a written protocol executed by at least one authorized pharmacist and at least one physician.

d. The collaborative drug therapy protocol must be filed with the board, kept on file in the pharmacy, and be made available upon request of the board or the IBM. After July 1, 2008, protocols shall no longer be filed with the board but shall be maintained in the pharmacy and made available to the board and the IBM upon request.

e. A physician may terminate or amend the collaborative drug therapy management protocol with an authorized pharmacist if the physician notifies, in writing, the pharmacist and the board. Notification shall include the name of the authorized pharmacist, the desired change, and the proposed effective date of the change. After July 1, 2008, the physician shall no longer be required to notify the board of changes in a protocol but the written notification shall be maintained in the pharmacy and made available upon request of the board or the IBM.

f. The physician or pharmacist who initiates a protocol with a patient is responsible for securing a patient's written consent to participate in drug therapy management and for transmitting a copy of the consent to the other party within 24 hours. The consent shall indicate which protocol is involved. Any variation in the protocol for a specific patient shall be communicated to the other party at the time of securing the patient's consent. The patient's physician shall maintain the patient consent in the patient's medical record.

8.34(3) *Hospital practice protocol.*

a. A hospital's P&T committee shall determine the scope and extent of collaborative drug therapy management practices that may be conducted by the hospital's pharmacists.

b. Collaborative drug therapy management within a hospital setting or the hospital's clinic setting is valid only when approved by the hospital's P&T committee.

c. The hospital practice protocol shall include:

(1) The names or groups of pharmacists and physicians who are authorized by the P&T committee to participate in collaborative drug therapy management.

(2) A plan for development, training, administration, and quality assurance of the protocol.

(3) A detailed written protocol pursuant to which the hospital pharmacist shall base drug therapy management decisions for patients. The protocol shall authorize one or more of the following:

1. Medication orders and prescription drug orders. The protocol may authorize therapeutic interchange or modification of drug dosages based on symptoms or laboratory or physical findings defined in the protocol. The protocol shall include information specific to the dosage, frequency, duration, and route of administration of the drug authorized by the physician. The protocol shall not authorize the hospital pharmacist to change a Schedule II drug or to initiate a drug not included in the established protocol.

2. Laboratory tests. The protocol may authorize the hospital pharmacist to obtain or to conduct specific laboratory tests as long as the tests relate directly to the drug therapy management.

3. Physical findings. The protocol may authorize the hospital pharmacist to check certain physical findings, e.g., vital signs, oximetry, or peak flows, that enable the pharmacist to assess and adjust the drug therapy, detect adverse drug reactions, or determine if the patient should be referred back to the physician for follow-up.

(4) Circumstances that shall cause the hospital pharmacist to initiate communication with the patient's physician including but not limited to the need for new medication orders and prescription drug orders and reports of a patient's therapeutic response or adverse reaction.

(5) A statement of the medication categories and the type of initiation and modification of drug therapy that the P&T committee authorizes the hospital pharmacist to perform.

(6) A description of the procedures or plan that the hospital pharmacist shall follow if the hospital pharmacist modifies a drug therapy.

(7) A description of the mechanism for the hospital pharmacist and the patient's physician to communicate and for the hospital pharmacist to document implementation of the collaborative drug therapy.

657—8.35(155A) Pharmacy license. A pharmacy license issued by the board is required for all sites where prescription drugs are offered for sale or dispensed under the supervision of a pharmacist. A pharmacy license issued by the board is also required for all sites where drug information or other cognitive pharmacy services, including but not limited to drug use review and patient counseling, are provided by a pharmacist. The board may issue any of the following types of pharmacy licenses: a general pharmacy license, a hospital pharmacy license, a special or limited use pharmacy license, or a nonresident pharmacy license. Nonresident pharmacy license applicants shall comply with board rules regarding nonresident pharmacy practice except when specific exemptions have been granted. Applicants for general or hospital pharmacy practice shall comply with board rules regarding general or hospital pharmacy practice except when specific exemptions have been granted. Any pharmacy located within Iowa that dispenses controlled substances must also register pursuant to 657—Chapter 10.

8.35(1) *Exemptions.* Applicants who are granted exemptions shall be issued a "general pharmacy license with exemption," a "hospital pharmacy license with exemption," a "nonresident pharmacy license with exemption," or a "limited use pharmacy license with exemption" and shall comply with the provisions set forth by that exemption. A written petition for exemption from certain licensure requirements shall be submitted pursuant to the procedures and requirements of 657—Chapter 34 and will be determined on a case-by-case basis.

8.35(2) *Limited use pharmacy license.* Limited use pharmacy license may be issued for nuclear pharmacy practice, correctional facility pharmacy practice, and veterinary pharmacy practice. Applications for limited use pharmacy license for these and other limited use practice settings shall be determined on a case-by-case basis.

8.35(3) *Application form.* Application for licensure and license renewal shall be on forms provided by the board. The application for a pharmacy license shall require an indication of the pharmacy ownership classification. If the owner is a sole proprietorship (100 percent ownership), the name and address of the owner shall be indicated. If the owner is a partnership or limited partnership, the names and addresses of all partners shall be listed or attached. If the owner is a corporation, the names and addresses of the officers and directors of the corporation shall be listed or attached. Any other pharmacy ownership classification shall be further identified and explained on the application. The application form shall require the name, signature, and license number of the pharmacist in charge. The names and license numbers of all pharmacists engaged in practice in the pharmacy, the names and registration numbers of all pharmacy technicians and pharmacy support persons working in the pharmacy, and the average number of hours worked by each pharmacist, pharmacy technician, and pharmacy support person shall be listed or attached. Additional information may be required of specific types of pharmacy license applicants. The application shall be signed by the pharmacy owner or the owner's, partnership's, or corporation's authorized representative.

8.35(4) *License expiration and renewal.* General pharmacy licenses, hospital pharmacy licenses, special or limited use pharmacy licenses, and nonresident pharmacy licenses shall be renewed before January 1 of each year. The fee for a new or renewal license shall be $135.

a. Late payment penalty. Failure to renew the pharmacy license before January 1 following expiration shall require payment of the renewal fee and a penalty fee of $135. Failure to renew the license before February 1 following expiration shall require payment of the renewal fee and a penalty fee of $225. Failure to renew the license before March 1 following expiration shall require payment of the renewal fee and a penalty fee of $315. Failure to renew the license before April 1 following expiration shall require payment of the renewal fee and a penalty fee of $405 and may require an appearance before the board. In no event shall the combined renewal fee and penalty fee for late renewal of a pharmacy license exceed $540.

b. Delinquent license. If a license is not renewed before its expiration date, the license is delinquent and the licensee may not operate or provide pharmacy services to patients in the state of Iowa

until the licensee renews the delinquent license. A pharmacy that continues to operate in Iowa without a current license may be subject to disciplinary sanctions pursuant to the provisions of 657—subrule 36.1(4).

8.35(5) *Inspection of new pharmacy location.* If the new pharmacy location within Iowa was not a licensed pharmacy immediately prior to the proposed opening of the new pharmacy, the pharmacy location shall require an on-site inspection by a pharmacy board inspector prior to the issuance of the pharmacy license. The purpose of the inspection is to determine compliance with requirements pertaining to space, library, equipment, security, temperature control, and drug storage safeguards. Inspection may be scheduled anytime following submission of necessary license and registration applications and prior to opening for business as a pharmacy. Prescription drugs, including controlled substances, may not be delivered to a new pharmacy location prior to satisfactory completion of the opening inspection.

8.35(6) *Pharmacy license changes.* When a pharmacy changes its name, location, ownership, or pharmacist in charge, a new pharmacy license application with a license fee as provided in subrule 8.35(4) shall be submitted to the board office. Upon receipt of the fee and properly completed application, the board will issue a new pharmacy license certificate. The old license certificate shall be returned to the board office within ten days of the change of name, location, ownership, or pharmacist in charge.

a. Location. A change of pharmacy location in Iowa shall require an on-site inspection of the new location as provided in subrule 8.35(5) if the new location was not a licensed pharmacy immediately prior to the relocation.

b. Ownership. A change of ownership of a currently licensed Iowa pharmacy, or a change of pharmacy location to another existing Iowa pharmacy location, shall not require on-site inspection pursuant to subrule 8.35(5). A new pharmacy license is required as provided in this subrule. A change of ownership effectively consists of a closing pharmacy, which is subject to the requirements for a closing pharmacy, and of a new pharmacy, which is subject to the requirements of a new pharmacy, with the possible exception of the on-site inspection as provided by this paragraph. In those cases in which the pharmacy is owned by a corporation, the sale or transfer of all stock of the corporation does not constitute a change of ownership provided the corporation that owns the pharmacy continues to exist and continues to own the pharmacy following the stock sale or transfer.

c. Pharmacist in charge. A change of pharmacist in charge shall require completion and submission of the application and fee for a new pharmacy license.

(1) If a permanent pharmacist in charge has not been identified by the time of the vacancy, a temporary pharmacist in charge shall be identified. Written notification identifying the temporary pharmacist in charge shall be submitted to the board by the pharmacy owner or the pharmacy owner's authorized representative and by the temporary pharmacist in charge within 10 days following the vacancy.

(2) Within 90 days following the vacancy, a permanent pharmacist in charge shall be identified, and an application for pharmacy license, including the license fee as provided in subrule 8.35(4), shall be submitted to the board office.

8.35(7) *Closing pharmacy.* A closing pharmacy shall ensure that all patient and prescription records are transferred to another pharmacy that is held to the same standards of confidentiality as the closing pharmacy and that agrees to act as custodian of the records for the appropriate retention period for each record type as required by federal or state laws, rules, or regulations. A pharmacy shall not execute a sale or closing of a pharmacy unless there exists an adequate period of time prior to the pharmacy closing for delivery of the notifications to the pharmacist in charge, the board, the Drug Enforcement Administration (DEA), and pharmacy patients as required by this subrule. However, the provisions of this subrule regarding prior notifications to the board, the DEA, and patients shall not apply in the case of a board-approved emergency or unforeseeable closure, including but not limited to emergency board action, foreclosure, fire, or natural disaster.

a. Pharmacist in charge notification. At least 40 days prior to the effective date of the sale of a pharmacy, the pharmacist in charge of the closing pharmacy, if that individual is not an owner of the closing pharmacy, shall be notified of the proposed sale. The owner of the closing pharmacy may direct the pharmacist in charge to maintain information regarding the pending closure of the pharmacy

confidential until public notifications are required 30 days prior to the pharmacy closing. The pharmacist in charge of the closing pharmacy shall provide input and direction to the pharmacy owner regarding the responsibilities of the closing pharmacy, including the notifications, deadlines, and time lines established by this subrule. The pharmacist in charge of the closing pharmacy shall prepare patient notifications pursuant to paragraph 8.35(7)*"d."* At least 30 days prior to the effective date of the sale of a pharmacy, the pharmacist in charge of the purchasing or receiving pharmacy, if that individual is not an owner of the pharmacy, shall be notified of the pending transaction.

b. Board and DEA notifications. At least 30 days prior to the closing of a pharmacy, including a closing by sale of a pharmacy, a written notice shall be sent to the board and to the Drug Enforcement Administration (DEA) notifying those agencies of the intent to discontinue business or to sell the pharmacy and including the anticipated date of closing. These prior notifications shall include the name, address, DEA registration number, Iowa pharmacy license number, and Iowa controlled substances Act (CSA) registration number of the closing pharmacy and of the pharmacy to which prescription drugs will be transferred. Notifications shall also include the name, address, DEA registration number, Iowa pharmacy license number, and CSA registration number of the location at which prescription files, patient profiles, and controlled substance receipt and disbursement records will be maintained.

c. Terms of sale or purchase. If the closing is due to the sale of the pharmacy, a copy of the sale or purchase agreement, not including information regarding the monetary terms of the transaction, shall be submitted to the board upon the request of the board. The agreement shall include a written assurance from the closing pharmacy to the purchasing pharmacy that the closing pharmacy has given or will be giving notice to its patients as required by this subrule.

d. Patient notification. At least 30 days prior to closing, a closing pharmacy shall make a reasonable effort to notify all patients who had a prescription filled by the closing pharmacy within the last 18 months that the pharmacy intends to close, including the anticipated closing date.

(1) Written notification shall identify the pharmacy that will be receiving the patient's prescriptions and records. The notification shall advise patients that if they have any questions regarding their prescriptions and records that they may contact the closing pharmacy. If the closing pharmacy receives no contact from the patient within the 30-day notification period prior to the pharmacy closing, all patient information will be transferred to the receiving pharmacy. The notification shall also advise patients that after the date of closing patients may contact the pharmacy to which the prescriptions and records have been transferred.

(2) Written notification shall be delivered to each patient at the patient's last address on file with the closing pharmacy by direct mail or personal delivery and also by public notice. Public notice refers to the display, in a location and manner clearly visible to patients, of signs in pharmacy pickup locations including drive-through prescription pickup lanes, on pharmacy or retail store entry and exit doors, or at pharmacy prescription counters. In addition, notice may be posted on the pharmacy's Web site, displayed on a marquee or electronic sign, communicated via automated message on the pharmacy's telephone system, or published in one or more local newspapers or area shopper publications.

e. Patient communication by receiving pharmacy. A pharmacy receiving the patient records of another pharmacy shall not contact the patients of the closing pharmacy until after the transfer of those patient records from the closing pharmacy to the receiving pharmacy and after the closure of the closing pharmacy.

f. Prescription drug inventory. A complete inventory of all prescription drugs being transferred shall be taken as of the close of business. The inventory shall serve as the ending inventory for the closing pharmacy as well as a record of additional or starting inventory for the pharmacy to which the drugs are transferred. A copy of the inventory shall be included in the records of each licensee.

(1) DEA Form 222 is required for transfer of Schedule II controlled substances.

(2) The inventory of controlled substances shall be completed pursuant to the requirements in 657—10.35(124,155A).

(3) The inventory of all noncontrolled prescription drugs may be estimated.

(4) The inventory shall include the name, strength, dosage form, and quantity of all prescription drugs transferred.

(5) Controlled substances requiring destruction or other disposal shall be transferred in the same manner as all other drugs. The new owner is responsible for the disposal of these substances as provided in rule 657—10.18(124).

g. Surrender of certificates and forms. The pharmacy license certificate and CSA registration certificate of the closing or selling pharmacy shall be returned to the board office within ten days of closing or sale. The DEA registration certificate and all unused DEA Forms 222 shall be returned to the DEA within ten days of closing. All authorizations to utilize the DEA's online controlled substances ordering system (CSOS) and all digital certificates issued for the purpose of ordering controlled substances for the closing pharmacy shall be canceled or revoked within ten days of closing.

h. Signs at closed pharmacy location. A location that no longer houses a licensed pharmacy shall not display any sign, placard, or other notification, visible to the public, which identifies the location as a pharmacy. A sign or other public notification that cannot feasibly be removed shall be covered so as to conceal the identification as a pharmacy. Nothing in this paragraph shall prohibit the display of a public notice to patients, as required in paragraph 8.35(7)*"d,"* for a reasonable period not to exceed six months following the pharmacy closing.

8.35(8) *Failure to complete licensure.* An application for a pharmacy license, including an application for registration pursuant to 657—Chapter 10, if applicable, will become null and void if the applicant fails to complete the licensure process within six months of receipt by the board of the required applications. The licensure process shall be complete upon the pharmacy's opening for business at the licensed location following an inspection rated as satisfactory by an agent of the board if such an inspection is required pursuant to this rule. When an applicant fails to timely complete the licensure process, fees submitted with applications will not be transferred or refunded.

[**ARC 8673B**, IAB 4/7/10, effective 6/1/10; **ARC 9526B**, IAB 6/1/11, effective 7/6/11 (See Delay note at end of chapter); **ARC 9693B**, IAB 9/7/11, effective 8/11/11; **ARC 0504C**, IAB 12/12/12, effective 1/16/13; **ARC 1962C**, IAB 4/15/15, effective 5/20/15]

657—8.36 to **8.39** Reserved.

657—8.40(155A,84GA,ch63) Pharmacy pilot or demonstration research projects. The purpose of this rule is to specify the procedures to be followed in applying for approval of a pilot or demonstration research project for innovative applications in the practice of pharmacy as authorized by 2011 Iowa Acts, chapter 63, section 36, as amended by 2012 Iowa Acts, House File 2464, section 31. In reviewing projects, the board will consider only projects that expand pharmaceutical care services that contribute to positive patient outcomes. The board will not consider any project intended only to provide a competitive advantage to a single applicant or group of applicants.

8.40(1) *Definitions.* For the purposes of this rule, the following definitions shall apply:

"Act" means Iowa Code chapter 155A, the Iowa pharmacy practice Act.

"Board" means the Iowa board of pharmacy.

"Practice of pharmacy" means the practice of pharmacy as defined in Iowa Code section 155A.3(34).

"Project" means a pilot or demonstration research project as described in this rule.

8.40(2) *Scope of project.* A project may not expand the definition of the practice of pharmacy. A project may include therapeutic substitution or substitution of medical devices used in patient care if such substitution is included under a collaborative drug therapy management protocol established pursuant to rule 657—8.34(155A).

8.40(3) *Board approval of a project.* Board approval of a project may include the grant of an exception to or a waiver of rules adopted under the Act or under any law relating to the authority of prescription verification and the ability of a pharmacist to provide enhanced patient care in the practice of pharmacy. Project approval, including exception to or waiver of board rules, shall initially be for a specified period of time not exceeding 18 months from commencement of the project. The board may approve the extension or renewal of a project following consideration of a petition that clearly identifies the project, that includes a report similar to the final project report described in paragraph 8.40(6)*"a,"* that describes and explains any proposed changes to the originally approved and implemented project, and that justifies the need for extending or renewing the term of the project.

8.40(4) *Applying for approval of a project.* A person who wishes the board to consider approval of a project shall submit to the board a petition for approval that contains at least the following information:

a. Responsible pharmacist. Name, address, telephone number, and pharmacist license number of each pharmacist responsible for overseeing the project.

b. Location of project. Name, address, and telephone number of each specific location and, if a location is a pharmacy, the pharmacy license number where the proposed project will be conducted.

c. Project summary. A detailed summary of the proposed project that includes at least the following information:

(1) The goals, hypothesis, and objectives of the proposed project.

(2) A full explanation of the project and how it will be conducted.

(3) The time frame for the project including the proposed start date and length of study. The time frame may not exceed 18 months from the proposed start date of the project.

(4) Background information or literature review to support the proposed project.

(5) The rule or rules to be waived in order to complete the project and a request to waive the rule or rules.

(6) Procedures to be used during the project to ensure that the public health and safety are not compromised as a result of the waiver.

8.40(5) *Review and approval or denial of a proposed project.*

a. Staff review. Upon receipt of a petition for approval of a project, board staff shall initially review the petition for completeness and appropriateness. If the petition is incomplete or inappropriate for board consideration, board staff shall return the petition to the requestor with a letter explaining the reason the petition is being returned. A petition that has been returned pursuant to this paragraph may be amended or supplemented as necessary and submitted for reconsideration.

b. Board review. Upon review by the board of a petition for approval of a project, the board shall either approve or deny the petition. If the board approves the petition, the approval:

(1) Shall be specific for the project requested;

(2) Shall approve the project for a specific time period; and

(3) May include conditions or qualifications applicable to the project.

c. Inspection. The project site and project documentation shall be available for inspection and review by the board or its representative at any time during the project review and the approval or denial processes and, if a project is approved, throughout the approved term of the project.

d. Documentation maintained. Project documentation shall be maintained and available for inspection, review, and copying by the board or its representative for at least two years following completion or termination of the project.

8.40(6) *Presentation of reports.* The pharmacist responsible for overseeing a project shall be responsible for submitting to the board any reports required as a condition of a project, including the final project report.

a. Final project report. The final project report shall include a written summary of the results of the project and the conclusions drawn from those results. The final project report shall be submitted to the board within three months after completion or termination of the project.

b. Board review. The board shall receive and review any report regarding the progress of a project and the final project report at a regularly scheduled meeting of the board. The report shall be an item on the open session agenda for the meeting.

[**ARC 0393C**, IAB 10/17/12, effective 11/21/12; **ARC 1032C**, IAB 9/18/13, effective 10/23/13]

These rules are intended to implement Iowa Code sections 124.101, 124.301, 124.306, 124.308, 126.10, 126.11, 126.16, 135C.33, 147.7, 147.55, 147.72, 147.74, 147.76, 155A.2 through 155A.4, 155A.6, 155A.10, 155A.12 through 155A.15, 155A.19, 155A.20, 155A.27 through 155A.29, 155A.32, and 155A.33 and 2013 Iowa Acts, Senate File 353.

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CHAPTER 10
CONTROLLED SUBSTANCES
[Prior to 2/10/88, see Pharmacy Examiners[620] Ch 8]

657—10.1(124) Purpose and definitions. Any person or business located in Iowa that manufactures, distributes, dispenses, prescribes, imports or exports, conducts research or instructional activities, or conducts chemical analysis with controlled substances in the state of Iowa, or that proposes to engage in such activities with controlled substances in the state, shall obtain and maintain a registration issued by the board unless exempt from registration pursuant to rule 657—10.6(124). A person or business required to be registered shall not engage in any activity for which registration is required until the application for registration is granted and the board has issued a certificate of registration to such person or business.

10.1(1) *Who shall register.* Manufacturers, distributors, reverse distributors, importers and exporters, individual practitioners (M.D., D.O., D.D.S., D.V.M., D.P.M., O.D., P.A., resident physician, advanced registered nurse practitioner), pharmacies, hospitals and animal shelters, care facilities, researchers and dog trainers, analytical laboratories, and teaching institutions shall register on forms provided by the board office. To be eligible to register, individual practitioners must hold a current, active license in good standing, issued by the appropriate Iowa professional licensing board, to practice their profession in Iowa.

10.1(2) *Definitions.* For the purpose of this chapter, the following definitions shall apply:

"Authorized collection program" means a program administered by a registrant that has modified its registration with DEA to collect controlled substances for the purpose of disposal. Federal regulations for such programs can be found at http://deadiversion.usdoj.gov/drug_disposal/. Modification to the registrant's Iowa Controlled Substances Act registration shall not be required.

"DEA" means the United States Department of Justice, Drug Enforcement Administration.

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657—10.2(124) Application forms. Application forms may be obtained from the Board of Pharmacy, 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688. Forms are also available on the board's Web site, www.state.ia.us/ibpe. Registration renewal forms will be mailed to each registrant approximately 60 days before the expiration date of the registration. A registrant who has not received a renewal form 45 days before the expiration date of the registration is responsible for contacting the board to request an application.

10.2(1) *Signature requirements.* Each application, attachment, or other document filed as part of an application shall be signed by the applicant as follows:

a. If the applicant is an individual practitioner, the practitioner shall sign the application and supporting documents.

b. If the applicant is a business, the application and supporting documents shall be signed by the person ultimately responsible for the security and maintenance of controlled substances at the registered location.

10.2(2) *Submission of multiple applications.* Any person or business required to obtain more than one registration may submit all applications in one package. Each application shall be complete and shall not refer to any accompanying application or any attachment to an accompanying application for required information.

657—10.3(124) Registration and renewal. For each registration or timely renewal of a registration to manufacture, distribute, dispense, prescribe, import or export, conduct research or instructional activities, or conduct chemical analysis with controlled substances listed in Schedules I through V of Iowa Code chapter 124, registrants shall pay a biennial fee of $90.

10.3(1) *Time and method of payment.* Registration and renewal fees shall be paid at the time the application for registration or renewal is submitted. Payment should be made in the form of a personal, certified, or cashier's check or a money order made payable to the Iowa Board of Pharmacy. Payments made in the form of foreign currency or third-party endorsed checks will not be accepted.

10.3(2) *Late renewal.* Any registered person or business may apply, on forms provided by the board office, for registration renewal not more than 60 days prior to the expiration of the registration. Failure to renew a registration prior to the first day of the month following expiration shall require payment of the renewal fee and a penalty fee of $90. Payment shall be made as specified in subrule 10.3(1).
[**ARC 0504C**, IAB 12/12/12, effective 1/16/13]

657—10.4(124) Exemptions—registration fee. The registration fee is waived for federal, state, and local law enforcement agencies and for the following federal and state institutions: hospitals, health care or teaching institutions, and analytical laboratories authorized to possess, manufacture, distribute, and dispense controlled substances in the course of official duties.

10.4(1) *Law enforcement officials.* In order to enable law enforcement agency laboratories to obtain and transfer controlled substances for use as standards in chemical analysis, such laboratories shall maintain a registration to conduct chemical analysis. Such laboratories shall be exempt from payment of a fee for registration.

10.4(2) *Registration and duties not exempt.* Exemption from payment of a registration or registration renewal fee as provided in this rule does not relieve the agency or institution of registration or of any other requirements or duties prescribed by law.

657—10.5(124) Separate registration for independent activities; coincident activities. The following activities are deemed to be independent of each other and shall require separate registration. Any person or business engaged in more than one of these activities shall be required to separately register for each independent activity, provided, however, that registration in an independent activity shall authorize the registrant to engage in activities identified coincident with that independent activity.

10.5(1) *Manufacturing controlled substances.* A person or business registered to manufacture controlled substances in Schedules I through V may distribute any substances for which registration to manufacture was issued. A person or business registered to manufacture controlled substances in Schedules II through V may conduct chemical analysis and preclinical research, including quality control analysis, with any substances listed in those schedules for which the person or business is registered to manufacture.

10.5(2) *Distributing controlled substances.* This independent activity includes the delivery, other than by administering or dispensing, of controlled substances listed in Schedules I through V. No coincident activities are authorized.

10.5(3) *Dispensing or instructing with controlled substances.* This independent activity includes, but is not limited to, prescribing by individual practitioners, dispensing by pharmacies and hospitals, and conducting instructional activities with controlled substances listed in Schedules II through V. A person or business registered for this independent activity may conduct research and instructional activities with those substances for which the person or business is registered to the extent authorized under state law.

10.5(4) *Conducting research with controlled substances listed in Schedule I.* A researcher may manufacture or import the substances for which registration was issued provided that such manufacture or import is permitted under the federal Drug Enforcement Administration (DEA) registration. A researcher may distribute the substances for which registration was issued to persons or businesses registered or authorized to conduct research with that class of substances or registered or authorized to conduct chemical analysis with controlled substances.

10.5(5) *Conducting research with controlled substances listed in Schedules II through V.* A researcher may conduct chemical analysis with controlled substances in those schedules for which registration was issued, may manufacture such substances if and to the extent such manufacture is permitted under the federal DEA registration, and may import such substances for research purposes. A researcher may distribute controlled substances in those schedules for which registration was issued to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances, and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3), and may conduct instructional activities with controlled substances.

10.5(6) *Conducting chemical analysis with controlled substances.* A person or business registered to conduct chemical analysis with controlled substances listed in Schedules I through V may manufacture and import controlled substances for analytical or instructional activities; may distribute such substances to persons registered or authorized to conduct chemical analysis, instructional activities, or research with such substances and to persons exempt from registration pursuant to Iowa Code subsection 124.302(3); may export such substances to persons in other countries performing chemical analysis or enforcing laws relating to controlled substances or drugs in those countries; and may conduct instructional activities with controlled substances.

10.5(7) *Importing or exporting controlled substances.* A person or business registered to import controlled substances listed in Schedules I through V may distribute any substances for which such registration was issued.

657—10.6(124) Separate registrations for separate locations; exemption from registration. A separate registration is required for each principal place of business or professional practice location where controlled substances are manufactured, distributed, imported, exported, dispensed, or collected for the purpose of disposal unless the person or business is exempt from registration pursuant to Iowa Code subsection 124.302(3), this rule, or federal regulations.

10.6(1) *Warehouse.* A warehouse where controlled substances are stored by or on behalf of a registered person or business shall be exempt from registration except as follows:

a. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to registered locations other than the registered location from which the substances were delivered to the warehouse.

b. Registration of the warehouse shall be required if such controlled substances are distributed directly from that warehouse to persons exempt from registration pursuant to Iowa Code subsection 124.302(3).

10.6(2) *Sales office.* An office used by agents of a registrant where sales of controlled substances are solicited, made, or supervised shall be exempt from registration. Such office shall not contain controlled substances, except substances used for display purposes or for lawful distribution as samples, and shall not serve as a distribution point for filling sales orders.

10.6(3) *Prescriber's office.* An office used by a prescriber who is registered at another location and where controlled substances are prescribed but where no supplies of controlled substances are maintained shall be exempt from registration. However, a prescriber who practices at more than one office location where controlled substances are administered or otherwise dispensed as a regular part of the prescriber's practice shall register at each location wherein the prescriber maintains supplies of controlled substances.

10.6(4) *Prescriber in hospital.* A prescriber who is registered at another location and who treats patients and may order the administration of controlled substances in a hospital other than the prescriber's registered practice location shall not be required to obtain a separate registration for the hospital.

10.6(5) *Affiliated interns, residents, or foreign physicians.* An individual practitioner who is an intern, resident, or foreign physician may dispense and prescribe controlled substances under the registration of the hospital or other institution which is registered and by whom the registrant is employed provided that:

a. The hospital or other institution by which the individual practitioner is employed has determined that the practitioner is permitted to dispense or prescribe drugs by the appropriate licensing board;

b. Such individual practitioner is acting only in the scope of employment in the hospital or institution;

c. The hospital or other institution authorizes the intern, resident, or foreign physician to dispense or prescribe under the hospital registration and designates a specific internal code number, letters, or combination thereof which shall be appended to the institution's DEA registration number, preceded by a hyphen (e.g., AP1234567-10 or AP1234567-12); and

d. The hospital or institution maintains a current list of internal code numbers identifying the corresponding individual practitioner, available for the purpose of verifying the authority of the prescribing individual practitioner.

[**ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—10.7 to **10.9** Reserved.

657—10.10(124,147,155A) Inspection. The board may inspect, or cause to be inspected, the establishment of an applicant or registrant. The board shall review the application for registration and other information regarding an applicant or registrant in order to determine whether the applicant or registrant has met the applicable standards of Iowa Code chapter 124 and these rules.

657—10.11(124) Modification or termination of registration. A registered individual or business may apply to modify a current registration as provided by this rule.

10.11(1) *Change of substances authorized.* Any registrant may apply to modify the substances authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, registration number, and the substances or schedules to be added to or removed from the registration and shall be signed by the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

10.11(2) *Change of address of registered location.*

a. Individual practitioner, researcher, analytical laboratory, or teaching institution. An entity registered under these classifications may apply to change the address of the registered location by submitting a written request to the board. The request shall include the registrant's name, current address, new address, telephone number, effective date of the address change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification.

b. Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter. An entity registered under these classifications shall apply to change the address of the registered location by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 657—10.3(124) shall accompany each completed application.

10.11(3) *Change of registrant's name.*

a. Individual practitioner, researcher, analytical laboratory, or teaching institution. An entity registered under these classifications may apply to change the registrant's name by submitting a written request to the board. The request shall include the registrant's current name, the new name, address, telephone number, effective date of the name change, and registration number, and shall be signed by the registered individual practitioner or the same person who signed the most recent application for registration or registration renewal. No fee shall be required for the modification. Change of name, as used in this paragraph, refers to a change of the legal name of the registrant and does not authorize the transfer of a registration issued to an individual practitioner or researcher to another individual practitioner or researcher.

b. Pharmacy, hospital, care facility, manufacturer, distributor, importer, or exporter. An entity registered under these classifications shall apply to change the registrant name by submitting a completed application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 657—10.3(124) shall accompany each completed application.

10.11(4) *Change of ownership of registered business entity.* A change of immediate ownership of a pharmacy, hospital, care facility, manufacturer, distributor, analytical laboratory, teaching institution, importer, or exporter shall require the completion of an application for registration. Applications may be obtained and shall be submitted as provided in rule 657—10.2(124). The registration fee as provided in rule 10.3(124) shall accompany each completed application.

10.11(5) *Change of responsible individual.* Any registrant, except an individual practitioner, a researcher, a hospital, or a pharmacy, may apply to change the responsible individual authorized by the registration by submitting a written request to the board. The request shall include the registrant's name, address, telephone number, the name and title of the current responsible individual and of the new responsible individual, the effective date of the change, and the registration number, and shall be signed by the new responsible individual. No fee shall be required for the modification.

a. Individual practitioners and researchers. Responsibility under a registration issued to an individual practitioner or researcher shall remain with the named individual practitioner or researcher. The responsible individual under such registration may not be changed.

b. Pharmacies and hospitals. The responsible pharmacist may execute a power of attorney for DEA order forms to change responsibility under the registration issued to the pharmacy or hospital. The power of attorney shall include the name, address, DEA registration number, and Iowa uniform controlled substances Act (CSA) registration number of the registrant. The power of attorney shall identify the current and new responsible individuals and shall authorize the new responsible individual to execute applications and official DEA order forms to requisition Schedule II controlled substances. The power of attorney shall be signed by both individuals, shall be witnessed by two adults, and shall be maintained by the registrant and available for inspection or copying by representatives of the board or other state or federal authorities.

10.11(6) *Termination of registration.* A registration issued to an individual shall terminate upon the death of the individual. A registration issued to an individual or business shall terminate when the registered individual or business ceases legal existence, discontinues business, or discontinues professional practice.

657—10.12(124) Denial, modification, suspension, or revocation of registration.

10.12(1) *Grounds for suspension or revocation.* The board may suspend or revoke any registration upon a finding that the registrant:

a. Has furnished false or fraudulent material information in any application filed under this chapter;

b. Has had the registrant's federal registration to manufacture, distribute, or dispense controlled substances suspended or revoked;

c. Has been convicted of a public offense under any state or federal law relating to any controlled substance. For the purpose of this rule only, a conviction shall include a plea of guilty, a forfeiture of bail or collateral deposited to secure a defendant's appearance in court which forfeiture has not been vacated, or a finding of guilt in a criminal action even though entry of the judgment or sentence has been withheld and the individual has been placed on probation;

d. Has committed such acts as would render the registrant's registration under Iowa Code section 124.303 inconsistent with the public interest as determined by that section; or

e. Has been subject to discipline by the registrant's respective professional licensing board and the discipline revokes, suspends, or modifies the registrant's authority regarding controlled substances (including, but not limited to, limiting or prohibiting the registrant from prescribing or handling controlled substances). A certified copy of the record of licensee discipline or a copy of the licensee's surrender of the professional license shall be conclusive evidence.

10.12(2) *Limited suspension or revocation.* If the board finds grounds to suspend or revoke a registration, the board may limit revocation or suspension of the registration to the particular controlled substance with respect to which the grounds for revocation or suspension exist. If the revocation or suspension is limited to a particular controlled substance or substances, the registrant shall be given a new certificate of registration for all substances not affected by revocation or suspension; no fee shall be required for the new certificate of registration. The registrant shall deliver the old certificate of registration to the board.

10.12(3) *Denial of registration or registration renewal.* If upon examination of an application for registration or registration renewal, including any other information the board has or receives regarding the applicant, the board determines that the issuance of the registration would be inconsistent with the

public interest, the board shall serve upon the applicant an order to show cause why the registration should not be denied.

10.12(4) *Considerations in denial of registration.* In determining the public interest, the board shall consider all of the following factors:

a. Maintenance of effective controls against diversion of controlled substances into other than legitimate medical, scientific, or industrial channels.

b. Compliance with applicable state and local law.

c. Any convictions of the applicant under any federal and state laws relating to any controlled substance.

d. Past experience in the manufacture or distribution of controlled substances, and the existence in the applicant's establishment of effective controls against diversion.

e. Furnishing by the applicant of false or fraudulent material in any application filed under this chapter.

f. Suspension or revocation of the applicant's federal registration to manufacture, distribute, or dispense controlled substances as authorized by federal law.

g. Any other factors relevant to and consistent with the public health and safety.

10.12(5) *Order to show cause.* Before denying, modifying, suspending, or revoking a registration, the board shall serve upon the applicant or registrant an order to show cause why the registration should not be denied, modified, revoked, or suspended. The order to show cause shall contain a statement of the basis therefor and shall call upon the applicant or registrant to appear before an administrative law judge or the board at a time and place not less than 30 days after the date of service of the order. The order to show cause shall also contain a statement of the legal basis for such hearing and for the denial, revocation, or suspension of registration and a summary of the matters of fact and law asserted. If the order to show cause involves the possible denial of registration renewal, the order shall be served not later than 30 days before the expiration of the registration. Proceedings to refuse renewal of registration shall not abate the existing registration, which shall remain in effect pending the outcome of the administrative hearing unless the board issues an order of immediate suspension pursuant to subrule 10.12(9).

10.12(6) *Hearing requested.* If an applicant or registrant who has received an order to show cause desires a hearing on the matter, the applicant or registrant shall file a request for a hearing within 30 days after the date of service of the order to show cause. If a hearing is requested, the board shall hold a hearing pursuant to 657—Chapter 35 at the time and place stated in the order and without regard to any criminal prosecution or other proceeding. Unless otherwise ordered by the board, an administrative law judge employed by the department of inspections and appeals shall be assigned to preside over the case and to render a proposed decision for the board's consideration.

10.12(7) *Waiver of hearing.* If an applicant or registrant entitled to a hearing on an order to show cause fails to file a request for hearing, or if the applicant or registrant requests a hearing but fails to appear at the hearing, the applicant or registrant shall be deemed to have waived the opportunity for a hearing unless the applicant or registrant shows good cause for such failure.

10.12(8) *Final board order when hearing waived.* If an applicant or registrant entitled to a hearing waives or is deemed to have waived the opportunity for a hearing, the executive director of the board may cancel the hearing and issue, on behalf of the board, the board's final order on the order to show cause.

10.12(9) *Order of immediate suspension.* The board may suspend any registration simultaneously with the service upon the registrant of an order to show cause why such registration should not be revoked or suspended if it finds there is an imminent danger to the public health or safety that warrants such action. If the board suspends a registration simultaneously with the service of the order to show cause upon the registrant, it shall serve an order of immediate suspension containing a statement of its findings regarding the danger to public health or safety upon the registrant with the order to show cause. The suspension shall continue in effect until the conclusion of the proceedings, including judicial review thereof, under the provisions of the Iowa administrative procedure Act, unless sooner withdrawn by the board or dissolved by the order of the district court or an appellate court.

10.12(10) *Disposition of controlled substances.* If the board suspends or revokes a registration, the registrant shall promptly return the certificate of registration to the board. Also, upon service of the order of the board suspending or revoking the registration, the registrant shall deliver all affected controlled substances in the registrant's possession to the board or authorized agent of the board. Upon receiving the affected controlled substances from the registrant, the board or its authorized agent shall place all such substances under seal and retain the sealed controlled substances pending final resolution of any appeals or until a court of competent jurisdiction directs otherwise. No disposition may be made of the substances under seal until the time for taking an appeal has elapsed or until all appeals have been concluded unless a court, upon application, orders the sale of perishable substances and the deposit of proceeds of the sale with the court. Upon a revocation order's becoming final, all such controlled substances may be forfeited to the state.

10.12(11) *Notifications.* The board shall promptly notify the DEA and the Iowa department of public safety of all orders suspending or revoking registration and all forfeitures of controlled substances.

657—10.13 and **10.14** Reserved.

657—10.15(124,155A) Security requirements. All applicants and registrants shall provide effective controls and procedures to guard against theft and diversion of controlled substances. In order to determine whether a person has provided effective controls against diversion, the board shall use the security requirements set forth in these rules as standards for the physical security controls and operating procedures necessary to prevent diversion.

10.15(1) *Physical security.* Physical security controls shall be commensurate with the schedules and quantity of controlled substances in the possession of the registrant in normal business operation. A registrant shall periodically review and adjust security measures based on rescheduling of substances or changes in the quantity of substances in the possession of the registrant.

a. Controlled substances listed in Schedule I shall be stored in a securely locked, substantially constructed cabinet.

b. Controlled substances listed in Schedules II through V may be stored in a securely locked, substantially constructed cabinet. However, pharmacies and hospitals may disperse these substances throughout the stock of noncontrolled substances in a manner so as to obstruct the theft or diversion of the controlled substances.

c. Controlled substances collected via an authorized collection program for the purpose of disposal shall be stored pursuant to federal regulations, which can be found at http://deadiversion.usdoj.gov/drug_disposal/.

10.15(2) *Factors in evaluating physical security systems.* In evaluating the overall security system of a registrant or applicant necessary to maintain effective controls against theft or diversion of controlled substances, the board may consider any of the following factors it deems relevant to the need for strict compliance with the requirements of this rule:

a. The type of activity conducted;

b. The type, form, and quantity of controlled substances handled;

c. The location of the premises and the relationship such location bears to security needs;

d. The type of building construction comprising the facility and the general characteristics of the building or buildings;

e. The type of vault, safe, and secure enclosures available;

f. The type of closures on vaults, safes, and secure enclosures;

g. The adequacy of key control systems or combination lock control systems;

h. The adequacy of electric detection and alarm systems, if any;

i. The adequacy of supervision over employees having access to controlled substances, to storage areas, or to manufacturing areas;

j. The extent of unsupervised public access to the facility, including the presence and characteristics of perimeter fencing, if any;

k. The procedures for handling business guests, visitors, maintenance personnel, and nonemployee service personnel;

l. The availability of local police protection or of the registrant's or applicant's security personnel; and

m. The adequacy of the registrant's or applicant's system for monitoring the receipt, manufacture, distribution, and disposition of controlled substances.

10.15(3) *Manufacturing and compounding storage areas.* Raw materials, bulk materials awaiting further processing, and finished products which are controlled substances listed in any schedule shall be stored pursuant to federal laws and regulations.

[**ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—10.16(124) Report of theft or loss. A registrant shall report to the board and the DEA any theft or significant loss of controlled substances when the loss is attributable to other than inadvertent error. Thefts or other losses of controlled substances shall be reported whether or not the controlled substances are subsequently recovered or the responsible parties are identified and action taken against them.

10.16(1) *Immediate notice to board.* If the theft was committed by a registrant or licensee of the board, or if there is reason to believe that the theft was committed by a registrant or licensee of the board, the registrant from whom the controlled substances were stolen shall notify the board immediately upon discovery of the theft and shall identify to the board the registrant or licensee suspected of the theft.

10.16(2) *Immediate notice to DEA.* A registrant shall deliver notice, immediately upon discovery of a reportable theft or loss of controlled substances, to the Des Moines DEA field office via telephone, facsimile, or a brief written message explaining the circumstances of the theft or loss.

10.16(3) *Timely report submission.* Within 14 calendar days of discovery of the theft or loss, a registrant shall submit directly to the DEA a Form 106 or alternate required form via the DEA Web site at http://www.deadiversion.usdoj.gov/. A copy of the report that was completed and submitted to the DEA shall be immediately submitted to the board via facsimile, e-mail attachment, or personal or commercial delivery.

10.16(4) *Record maintained.* A copy of the report shall be maintained in the registrant's files for a minimum of two years following the date the report was completed.

[**ARC 1787C**, IAB 12/10/14, effective 1/14/15]

657—10.17(124) Accountability of stock supply. An individual who administers a controlled substance from a non-patient-specific, stock supply in an institutional setting shall personally document on a separate readily retrievable record system each dose administered, wasted, or returned to the pharmacy. Such documentation shall not be delegated to another individual. Wastage documentation shall include the signature or unique electronic signature or identification of a witnessing licensed health care practitioner.

Distribution records for non-patient-specific, floor-stocked controlled substances shall bear the following information:

1. Patient's name;
2. Prescriber who ordered drug;
3. Name of drug, dosage form, and strength;
4. Time and date of administration to patient and quantity administered;
5. Signature or unique electronic signature of individual administering controlled substance;
6. Returns to the pharmacy;
7. Waste, which is required to be witnessed and cosigned by another licensed health care practitioner.

[**ARC 9912B**, IAB 12/14/11, effective 1/18/12]

657—10.18(124) Disposal of registrant stock. Any persons legally authorized to possess controlled substances in the course of their professional practice or the conduct of their business shall dispose of such drugs pursuant to the procedures and requirements of this rule. Disposal records shall be maintained by the registrant.

10.18(1) *Registrant stock supply.* Pharmacy personnel, registrants, and registrant staff shall remove from current inventory and dispose of controlled substances by one of the following procedures.

a. The responsible individual shall utilize the services of a DEA-registered and Iowa-licensed disposal firm.

b. The board may authorize and instruct the registrant to dispose of the controlled substances in one of the following manners:

(1) By delivery to an agent of the board or to the board office;

(2) By destruction of the drugs in the presence of a board officer, agent, inspector, or other authorized individual; or

(3) By such other means as the board may determine to ensure that drugs do not become available to unauthorized persons.

10.18(2) *Waste.* Except as otherwise specifically provided by federal or state law or rules of the board, the unused portion of a controlled substance resulting from administration to a patient from a registrant's stock or emergency supply or resulting from drug compounding operations may be destroyed or otherwise disposed of by the registrant or a pharmacist in witness of one other licensed health care provider or a registered pharmacy technician 18 years of age or older pursuant to this subrule. A written record of the wastage shall be made and maintained by the registrant for a minimum of two years following the destruction or other disposal. The record shall include the signatures of the individual destroying or otherwise disposing of the waste controlled substance and of the witnessing licensed health care provider or registered pharmacy technician and shall identify the following:

a. The controlled substance wasted;

b. The date of destruction or other disposition;

c. The quantity or estimated quantity of the wasted controlled substance;

d. The source of the controlled substance, including identification of the patient to whom the substance was administered or the drug compounding process utilizing the controlled substance; and

e. The reason for the waste.

[**ARC 0749C**, IAB 5/29/13, effective 7/3/13; **ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—10.19(124) Disposal of previously dispensed controlled substances. A registrant may not dispose of previously dispensed controlled substances unless the registrant has modified its registration with DEA to administer an authorized collection program. A registrant shall not take possession of a previously dispensed controlled substance except for reuse for the same patient.

[**ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—10.20 Reserved.

657—10.21(124,126,155A) Prescription requirements. All prescriptions for controlled substances shall be dated as of, and signed on, the day issued. Controlled substances prescriptions shall be valid for six months following date of issue. A prescription for a Schedule III, IV, or V controlled substance may include authorization to refill the prescription no more than five times within the six months following date of issue. A prescription for a Schedule II controlled substance shall not be refilled.

10.21(1) *Form of prescription.* All prescriptions shall bear the full name and address of the patient; the drug name, strength, dosage form, quantity prescribed, and directions for use; and the name, address, and DEA registration number of the prescriber. All prescriptions issued by individual prescribers shall include the legibly preprinted, typed, or hand-printed name of the prescriber as well as the prescriber's written or electronic signature. When an oral order is not permitted, or when a prescriber is unable to prepare and transmit an electronic prescription in compliance with DEA requirements for electronic prescriptions, prescriptions shall be written with ink, indelible pencil, or typed print and shall be manually signed by the prescriber. If the prescriber utilizes an electronic prescription application that meets DEA requirements for electronic prescriptions, the prescriber may electronically prepare and transmit a prescription for a controlled substance to a pharmacy that utilizes a pharmacy prescription application that meets DEA requirements for electronic prescriptions. A prescriber's agent may prepare a prescription for the review, authorization, and manual or electronic signature of the prescriber but the

prescribing practitioner is responsible for the accuracy, completeness, and validity of the prescription. An electronic prescription for a controlled substance shall not be transmitted to a pharmacy except by the prescriber in compliance with DEA regulations. A prescriber shall securely maintain the unique authentication credentials issued to the prescriber for utilization of the electronic prescription application and authentication of the prescriber's electronic signature. Unique authentication credentials issued to any individual shall not be shared with or disclosed to any other prescriber, agent, or individual. A corresponding liability rests upon the pharmacist who fills a prescription not prepared in the form prescribed by this rule.

10.21(2) *Verification by pharmacist.* The pharmacist shall verify the authenticity of the prescription with the individual prescriber or the prescriber's agent in each case when a written or oral prescription for a Schedule II controlled substance is presented for filling and neither the prescribing individual practitioner issuing the prescription nor the patient or patient's agent is known to the pharmacist. The pharmacist shall verify the authenticity of the prescription with the individual prescriber or the prescriber's agent in any case when the pharmacist questions the validity of, including the legitimate medical purpose for, the prescription. The pharmacist is required to record the manner by which the prescription was verified and include the pharmacist's name or unique identifier.

10.21(3) *Intern, resident, foreign physician.* An intern, resident, or foreign physician exempt from registration pursuant to subrule 10.6(5) shall include on all prescriptions issued the hospital's registration number and the special internal code number assigned by the hospital in lieu of the prescriber's registration number required by this rule. Each prescription shall include the stamped or legibly printed name of the intern, resident, or foreign physician as well as the prescriber's signature.

10.21(4) *Valid prescriber/patient relationship.* Once the prescriber/patient relationship is broken and the prescriber is no longer available to treat the patient or to oversee the patient's use of the controlled substance, a prescription shall lose its validity. A prescriber/patient relationship shall be deemed broken when the prescriber dies, retires, or moves out of the local service area or when the prescriber's authority to prescribe is suspended, revoked, or otherwise modified to exclude authority for the schedule in which the prescribed substance is listed. The pharmacist, upon becoming aware of the situation, shall cancel the prescription and any remaining refills. However, the pharmacist shall exercise prudent judgment based upon individual circumstances to ensure that the patient is able to obtain a sufficient amount of the drug to continue treatment until the patient can reasonably obtain the service of another prescriber and a new prescription can be issued.

10.21(5) *Schedule II prescriptions.* With appropriate verification, a pharmacist may add information provided by the patient or patient's agent, such as the patient's address, to a Schedule II controlled substance prescription. A pharmacist shall never change the patient's name, the controlled substance prescribed except for generic substitution, or the name or signature of the prescriber. After consultation with the prescriber or the prescriber's agent and documentation of such consultation, a pharmacist may change or add the following information on a Schedule II controlled substance prescription:

a. The drug strength;
b. The dosage form;
c. The drug quantity;
d. The directions for use;
e. The date the prescription was issued; and
f. The prescriber's address or DEA registration number.

[**ARC 9912B**, IAB 12/14/11, effective 1/18/12]

657—10.22(124) Schedule II emergency prescriptions.

10.22(1) *Emergency situation defined.* For the purposes of authorizing an oral or facsimile transmission of a prescription for a Schedule II controlled substance listed in Iowa Code section 124.206, the term "emergency situation" means those situations in which the prescribing practitioner determines that all of the following apply:

a. Immediate administration of the controlled substance is necessary for proper treatment of the intended ultimate user.

b. No appropriate alternative treatment is available, including administration of a drug that is not a Schedule II controlled substance.

c. It is not reasonably possible for the prescribing practitioner to provide a manually signed written prescription to be presented to the pharmacy before the pharmacy dispenses the controlled substance or the prescribing practitioner is unable to provide a DEA-compliant electronic prescription to the pharmacy before the pharmacy dispenses the controlled substance.

10.22(2) *Requirements of emergency prescription.* In the case of an emergency situation as defined in subrule 10.22(1), a pharmacist may dispense a controlled substance listed in Schedule II pursuant to a facsimile transmission or upon receiving oral authorization of a prescribing individual practitioner provided that:

a. The quantity prescribed and dispensed is limited to the smallest available quantity to meet the needs of the patient during the emergency period. Dispensing beyond the emergency period requires a written prescription manually signed by the prescribing individual practitioner or a DEA-compliant electronic prescription.

b. If the pharmacist does not know the prescribing individual practitioner, the pharmacist shall make a reasonable effort to determine that the authorization came from an authorized prescriber. The pharmacist shall record the manner by which the authorization was verified and include the pharmacist's name or unique identification.

c. The pharmacist shall prepare a temporary written record of the emergency prescription. The temporary written record shall consist of a hard copy of the facsimile transmission or a written record of the oral transmission authorizing the emergency dispensing. A written record is not required to consist of a handwritten record and may be a printed facsimile or a print of a computer-generated record of the prescription if the printed record includes all of the required elements for the prescription. If the emergency prescription is transmitted by the practitioner's agent, the record shall include the first and last names and title of the individual who transmitted the prescription.

d. If the emergency prescription is transmitted via facsimile transmission, the means of transmission shall not obscure or render the prescription information illegible due to security features of the paper utilized by the prescriber to prepare the written prescription, and the hard-copy record of the facsimile transmission shall not be obscured or rendered illegible due to such security features.

e. Within seven days after authorizing an emergency prescription, the prescribing individual practitioner shall cause a written prescription for the emergency quantity prescribed to be delivered to the dispensing pharmacist. In addition to conforming to the requirements of 657—10.21(124,126,155A), the prescription shall have written on its face "Authorization for Emergency Dispensing" and the date of the emergency order. The written prescription may be delivered to the pharmacist in person or by mail, but if delivered by mail it must be postmarked within the seven-day period. The written prescription shall be attached to and maintained with the temporary written record prepared pursuant to paragraph *"c."*

f. The pharmacist shall notify the board and the DEA if the prescribing individual fails to deliver a written prescription. Failure of the pharmacist to so notify the board and the DEA, or failure of the prescribing individual to deliver the required written prescription as herein required, shall void the authority conferred by this subrule.

[**ARC 7636B**, IAB 3/11/09, effective 4/15/09; **ARC 9410B**, IAB 3/9/11, effective 4/13/11; **ARC 9912B**, IAB 12/14/11, effective 1/18/12]

657—10.23(124) Schedule II prescriptions—partial filling. The partial filling of a prescription for a controlled substance listed in Schedule II is permitted as provided in this rule.

10.23(1) *Insufficient supply on hand.* If the pharmacist is unable to supply the full quantity called for in a prescription and makes a notation of the quantity supplied on the prescription record, a partial fill of the prescription is permitted. The remaining portion of the prescription must be filled within 72 hours of the first partial filling. If the remaining portion is not or cannot be filled within the 72-hour period, the pharmacist shall so notify the prescriber. No further quantity may be supplied beyond 72 hours without a new prescription.

10.23(2) *Long-term care or terminally ill patient.* A prescription for a Schedule II controlled substance written for a patient in a long-term care facility (LTCF) or for a patient with a medical diagnosis documenting a terminal illness may be filled in partial quantities to include individual dosage units as provided by this subrule.

a. If there is any question whether a patient may be classified as having a terminal illness, the pharmacist shall contact the practitioner prior to partially filling the prescription. Both the pharmacist and the practitioner have a corresponding responsibility to ensure that the controlled substance is for a terminally ill patient.

b. The pharmacist shall record on the prescription whether the patient is "terminally ill" or an "LTCF patient." For each partial filling, the dispensing pharmacist shall record on the back of the prescription, or on another appropriate uniformly maintained and readily retrievable record, the date of the partial filling, the quantity dispensed, the remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist.

c. The total quantity of Schedule II controlled substances dispensed in all partial fillings shall not exceed the total quantity prescribed. Schedule II prescriptions for patients in a LTCF or patients with a medical diagnosis documenting a terminal illness shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of the drug.

d. Information pertaining to current Schedule II prescriptions for patients in a LTCF or for patients with a medical diagnosis documenting a terminal illness may be maintained in a computerized system pursuant to rule 657—21.4(124,155A).

657—10.24(124) Schedule II medication order. Schedule II controlled substances may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.18(124,155A), as applicable.

657—10.25(124) Schedule II—issuing multiple prescriptions. An individual prescriber may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a Schedule II controlled substance pursuant to the provisions and limitations of this rule.

10.25(1) *Refills prohibited.* The issuance of refills for a Schedule II controlled substance is prohibited. The use of multiple prescriptions for the dispensing of Schedule II controlled substances, pursuant to this rule, ensures that the prescriptions are treated as separate dispensing authorizations and not as refills of an original prescription.

10.25(2) *Legitimate medical purpose.* Each separate prescription issued pursuant to this rule shall be issued for a legitimate medical purpose by an individual prescriber acting in the usual course of the prescriber's professional practice.

10.25(3) *Dates and instructions.* Each prescription issued pursuant to this rule shall be dated as of and manually signed by the prescriber on the day the prescription is issued. Each separate prescription, other than the first prescription if that prescription is intended to be filled immediately, shall contain written instructions indicating the earliest date on which a pharmacist may fill each prescription.

10.25(4) *Authorized fill date unalterable.* Regardless of the provisions of subrule 10.21(5), when a prescription contains instructions from the prescriber indicating that the prescription shall not be filled before a certain date, a pharmacist shall not fill the prescription before that date. The pharmacist shall not contact the prescriber for verbal authorization to fill the prescription before the fill date originally indicated by the prescriber pursuant to this rule.

10.25(5) *Number of prescriptions and authorized quantity.* An individual prescriber may issue for a patient as many separate prescriptions, to be filled sequentially pursuant to this rule, as the prescriber deems necessary to provide the patient with adequate medical care. The cumulative effect of the filling of each of these separate prescriptions shall result in the receipt by the patient of a quantity of the Schedule II controlled substance not exceeding a 90-day supply.

10.25(6) *Prescriber's discretion.* Nothing in this rule shall be construed as requiring or encouraging an individual prescriber to issue multiple prescriptions pursuant to this rule or to see the prescriber's patients only once every 90 days when prescribing Schedule II controlled substances. An individual

prescriber shall determine, based on sound medical judgment and in accordance with established medical standards, how often to see patients and whether it is appropriate to issue multiple prescriptions pursuant to this rule.
[**ARC 8172B**, IAB 9/23/09, effective 10/28/09]

657—10.26 Reserved.

657—10.27(124,155A) Facsimile transmission of a controlled substance prescription. With the exception of an authorization for emergency dispensing as provided in rule 657—10.22(124), a prescription for a controlled substance may be transmitted via facsimile from a prescriber to a pharmacy as provided in rule 657—21.9(124,155A).

10.27(1) *Schedule II prescription.* A prescription for a Schedule II controlled substance may be transmitted via facsimile to the pharmacy only as provided in rules 657—21.12(124,155A) to 657—21.16(124,155A).

10.27(2) *Schedule III, IV, or V prescription.* A prescription for a Schedule III, IV, or V controlled substance may be transmitted via facsimile to the pharmacy only as provided in rule 657—21.9(124,155A).
[**ARC 9912B**, IAB 12/14/11, effective 1/18/12]

657—10.28(124,155A) Schedule III, IV, or V refills. No prescription for a controlled substance listed in Schedule III, IV, or V shall be filled or refilled more than six months after the date on which it was issued nor be refilled more than five times.

10.28(1) *Record.* Each filling and refilling of a prescription shall be entered on the prescription or on another uniformly maintained and readily retrievable record.

a. The following information shall be retrievable by the prescription number: the name and dosage form of the controlled substance, the date filled or refilled, the quantity dispensed, the unique identification of the dispensing pharmacist for each refill, and the total number of refills authorized for that prescription.

b. If the pharmacist merely initials or affixes the pharmacist's unique identifier and dates the back of the prescription, it shall be deemed that the full face amount of the prescription has been dispensed.

10.28(2) *Oral refill authorization.* The prescribing practitioner may authorize additional refills of Schedule III, IV, or V controlled substances on the original prescription through an oral refill authorization transmitted to the pharmacist provided the following conditions are met:

a. The total quantity authorized, including the amount of the original prescription, does not exceed five refills nor extend beyond six months from the date of issuance of the original prescription.

b. The pharmacist who obtains the oral authorization records from the prescriber who issued the original prescription records on or with the original prescription the date, the quantity of each refill, the number of additional refills authorized, and the pharmacist's unique identification.

c. The quantity of each additional refill is equal to or less than the quantity authorized for the initial filling of the original prescription.

d. The prescribing practitioner must execute a new and separate prescription for any additional quantities beyond the five-refill, six-month limitation.

10.28(3) *Automated data processing record system.* An automated data processing record system may be used for the storage and retrieval of Schedule III, IV, and V controlled substance prescription fill and refill information subject to the conditions and requirements of rules 657—21.4(124,155A) and 657—21.5(124,155A).

657—10.29(124,155A) Schedule III, IV, or V partial fills. The partial filling of a prescription for a controlled substance listed in Schedule III, IV, or V is permissible provided that each partial fill is recorded in the same manner as a refill. The total quantity dispensed in all partial fills shall not exceed the total quantity prescribed. No dispensing shall occur later than six months after the date on which the prescription was issued.

657—10.30(124,155A) Schedule III, IV, and V medication order. A Schedule III, IV, or V controlled substance may be administered or dispensed to institutionalized patients pursuant to a medication order as provided in 657—subrule 7.13(1) or rule 657—23.9(124,155A), as applicable.

657—10.31(124,155A) Dispensing Schedule V controlled substances without a prescription. A controlled substance listed in Schedule V, which substance is not a prescription drug as determined under the federal Food, Drug and Cosmetic Act, and excepting products containing ephedrine, pseudoephedrine, or phenylpropanolamine, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

10.31(1) *Who may dispense.* Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit, after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

10.31(2) *Frequency and quantity.* Dispensing at retail to the same purchaser in any 48-hour period shall be limited to no more than one of the following quantities of a Schedule V controlled substance:

a. 240 cc (8 ounces) of any controlled substance containing opium.

b. 120 cc (4 ounces) of any other controlled substance.

c. 48 dosage units of any controlled substance containing opium.

d. 24 dosage units of any other controlled substance.

10.31(3) *Age of purchaser.* The purchaser shall be at least 18 years of age.

10.31(4) *Identification.* The pharmacist shall require every purchaser under this rule not known by the pharmacist to present a government-issued photo identification, including proof of age when appropriate.

10.31(5) *Record.* A bound record book (i.e., with pages sewn or glued to the spine) for dispensing of Schedule V controlled substances pursuant to this rule shall be maintained by the pharmacist. The book shall contain the name and address of each purchaser, the name and quantity of controlled substance purchased, the date of each purchase, and the name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the substance to the purchaser.

10.31(6) *Prescription not required under other laws.* No other federal or state law or regulation requires a prescription prior to distributing or dispensing a Schedule V controlled substance.

657—10.32(124,155A) Dispensing products containing ephedrine, pseudoephedrine, or phenylpropanolamine without a prescription. A product containing ephedrine, pseudoephedrine, or phenylpropanolamine, which substance is a Schedule V controlled substance and is not listed in another controlled substance schedule, may be dispensed or administered without a prescription by a pharmacist to a purchaser at retail pursuant to the conditions of this rule.

10.32(1) *Who may dispense.* Dispensing shall be by a licensed Iowa pharmacist or by a registered pharmacist-intern under the direct supervision of a pharmacist preceptor. This subrule does not prohibit, after the pharmacist has fulfilled the professional and legal responsibilities set forth in this rule and has authorized the dispensing of the substance, the completion of the actual cash or credit transaction or the delivery of the substance by a nonpharmacist.

10.32(2) *Packaging of nonliquid forms.* A nonliquid form of a product containing ephedrine, pseudoephedrine, or phenylpropanolamine includes gel caps. Nonliquid forms of these products to be sold pursuant to this rule shall be packaged either in blister packaging with each blister containing no more than two dosage units or, if blister packs are technically infeasible, in unit dose packets or pouches.

10.32(3) *Frequency and quantity.* Dispensing at retail to the same purchaser within any 30-day period shall be limited to products collectively containing no more than 7,500 mg of ephedrine, pseudoephedrine, or phenylpropanolamine; dispensing at retail to the same purchaser within a single calendar day shall not exceed 3,600 mg.

10.32(4) *Age of purchaser.* The purchaser shall be at least 18 years of age.

10.32(5) *Identification.* The pharmacist shall require every purchaser under this rule to present a current government-issued photo identification, including proof of age when appropriate. The pharmacist shall be responsible for verifying that the name on the identification matches the name provided by the purchaser and that the photo image depicts the purchaser.

10.32(6) *Record.* Purchase records shall be recorded in the real-time electronic pseudoephedrine tracking system (PTS) established and administered by the governor's office of drug control policy pursuant to 657—Chapter 100. If the real-time electronic repository is unavailable for use, the purchase record shall be recorded in an alternate format and submitted to the PTS as provided in 657—subrule 100.3(4).

a. Alternate record contents. The alternate record shall contain the following:

(1) The name, address, and signature of the purchaser.

(2) The name and quantity of the product purchased, including the total milligrams of ephedrine, pseudoephedrine, or phenylpropanolamine contained in the product.

(3) The date and time of the purchase.

(4) The name or unique identification of the pharmacist or pharmacist-intern who approved the dispensing of the product.

b. Alternate record format. The record shall be maintained using one of the following options:

(1) A hard-copy record.

(2) A record in the pharmacy's electronic prescription dispensing record-keeping system that is capable of producing a hard-copy printout of a record.

(3) A record in an electronic data collection system that captures each of the data elements required by this subrule and that is capable of producing a hard-copy printout of a record.

c. PTS records retrieval. Pursuant to 657—subrule 100.4(6), the pharmacy shall be able to produce a hard-copy printout of transactions recorded in the PTS by the pharmacy for one or more specific products for a specified period of time upon request by the board or its representative or to such other persons or governmental agencies authorized by law to receive such information.

10.32(7) *Notice required.* The pharmacy shall ensure that the following notice is provided to purchasers of ephedrine, pseudoephedrine, or phenylpropanolamine products and that the notice is displayed with or on the electronic signature device or is displayed in the dispensing area and visible to the public:

"WARNING: Section 1001 of Title 18, United States Code, states that whoever, with respect to the logbook, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any materially false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, shall be fined not more than $250,000 if an individual or $500,000 if an organization, imprisoned not more than five years, or both."

[**ARC 8892B**, IAB 6/30/10, effective 9/1/10]

657—10.33(124,155A) Schedule II perpetual inventory in pharmacy. Each pharmacy located in Iowa that dispenses Schedule II controlled substances shall maintain a perpetual inventory system for all Schedule II controlled substances pursuant to the requirements of this rule. All records relating to the perpetual inventory shall be maintained by the pharmacy and shall be available for inspection and copying by the board or its representative for a period of two years from the date of the record.

10.33(1) *Record format.* The perpetual inventory record may be maintained in a manual or an electronic record format. Any electronic record shall provide for hard-copy printout of all transactions recorded in the perpetual inventory record for any specified period of time and shall state the current inventory quantities of each drug at the time the record is printed.

10.33(2) *Information included.* The perpetual inventory record shall identify all receipts for and disbursements of Schedule II controlled substances by drug or by national drug code (NDC) number. The record shall be updated to identify each prescription filled and each shipment received. The record shall also include incident reports and reconciliation records pursuant to subrules 10.33(3) and 10.33(4).

10.33(3) *Changes to a record.* If a perpetual inventory record is able to be changed, the individual making a change to the record shall complete an incident report documenting the change. The incident report shall identify the specific information that was changed including the information before and after the change, shall identify the individual making the change, and shall include the date and the reason the record was changed. If the electronic record system documents within the perpetual inventory record all of the information that must be included in an incident report, a separate report is not required.

10.33(4) *Reconciliation.* The pharmacist in charge shall be responsible for reconciling the physical inventory of all Schedule II controlled substances with the perpetual inventory balance on a periodic basis but no less frequently than annually. In case of any discrepancies between the physical inventory and the perpetual inventory, the pharmacist in charge shall determine the need for further investigation, and significant discrepancies shall be reported to the board pursuant to rule 657—10.16(124) and to the DEA pursuant to federal DEA regulations. Periodic reconciliation records shall be maintained and available for review and copying by the board or agents of the board for a period of two years from the date of the record. The reconciliation process may be completed using either of the following procedures or a combination thereof:

a. The dispensing pharmacist verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. If controlled substances are maintained on the patient care unit, the nurse or other responsible licensed health care provider verifies that the physical inventory matches the perpetual inventory following each dispensing and documents that reconciliation in the perpetual inventory record. All discrepancies shall be reported to the pharmacist in charge. If any Schedule II controlled substances in the pharmacy's current inventory have been dispensed and verified in this manner within the year, and there are no discrepancies noted, no additional reconciliation action is required. A drug that has had no activity within the year shall be reconciled pursuant to paragraph *"b"* of this subrule.

b. A physical count of each Schedule II controlled substance stocked by the pharmacy shall be completed at least once each year, and that count shall be reconciled with the perpetual inventory record balance. The physical count and reconciliation may be completed over a period of time not to exceed one year in a manner that ensures that the perpetual inventory and the physical inventory of Schedule II controlled substances are annually reconciled. The individual performing the reconciliation shall record the date, the time, the individual's initials or unique identification, and any discrepancies between the physical inventory and the perpetual inventory. Any discrepancies between the physical inventory and the perpetual inventory shall be reported to the pharmacist in charge.

657—10.34(124,155A) Records. Every inventory or other record required to be kept under this chapter or under Iowa Code chapter 124 shall be kept by the registrant and be available for inspection and copying by the board or its representative for at least two years from the date of such inventory or record except as otherwise required in these rules. Controlled substances records shall be maintained in a readily retrievable manner that establishes the receipt and distribution of all controlled substances. Original hard-copy prescription and other pharmacy records more than 12 months old may be maintained in a secure storage area outside the licensed pharmacy department unless such remote storage is prohibited under federal law. A remote storage area shall be located within the same physical structure containing the licensed pharmacy department.

10.34(1) *Schedule I and II records.* Inventories and records of controlled substances listed in Schedules I and II shall be maintained separately from all other records of the registrant.

10.34(2) *Schedule III, IV, and V records.* Inventories and records of controlled substances listed in Schedules III, IV, and V shall be maintained either separately from all other records of the registrant or in such form that the required information is readily retrievable from the ordinary business records of the registrant.

10.34(3) *Date of record.* The date on which a controlled substance is actually received, imported, distributed, exported, disposed of, or otherwise transferred shall be used as the date of receipt, importation, distribution, exportation, disposal, or transfer.

10.34(4) *Receipt and disbursement records.* Each record of receipt or disbursement of controlled substances, unless otherwise provided in these rules or pursuant to federal law, shall include the following:

a. The name of the substance;

b. The strength and dosage form of the substance;

c. The number of units or commercial containers acquired from other registrants, including the date of receipt and the name, address, and DEA registration number of the registrant from whom the substances were acquired;

d. The number of units or commercial containers distributed to other registrants, including the date of distribution and the name, address, and DEA registration number of the registrant to whom the substances were distributed; and

e. The number of units or commercial containers disposed of in any other manner, including the date and manner of disposal and the name, address, and DEA registration number of the registrant to whom the substances were distributed for disposal, if appropriate.

10.34(5) *Dispensing records.* Each record of dispensing of controlled substances to a patient or research subject shall include the following information:

a. The name and address of the person to whom dispensed;

b. The date of dispensing;

c. The name of the substance;

d. The quantity of the substance dispensed; and

e. The name or unique identification of the individual who dispensed or administered the substance.

10.34(6) *Ordering or distributing Schedule I or II controlled substances - DEA Form 222.* Except as otherwise provided by subrule 10.34(7) and under federal law, a DEA Form 222 is required for each distribution of a Schedule I or II controlled substance. An order form may be executed only on behalf of the registrant named on the order form and only if the registrant's DEA and Iowa registrations for the substances being purchased have not expired or been revoked or suspended by the issuing agency.

a. Order forms shall be obtained, executed, and filled pursuant to DEA requirements. Each form shall be complete, legible, and properly prepared, executed, and endorsed and shall contain no alteration, erasure, or change of any kind.

b. The purchaser shall submit Copy 1 and Copy 2 of the order form to the supplier.

c. The purchaser shall maintain Copy 3 of the order form in the files of the registrant. Upon receipt of the substances from the supplier, the purchaser shall record on Copy 3 of the order form the quantity of each substance received, and the date of receipt, and shall initial each line identifying a substance received.

d. The supplier shall record on Copy 1 and Copy 2 of the order form the quantity of each substance distributed to the purchaser and the date on which the shipment is made. The supplier shall maintain Copy 1 of the order form in the files of the supplier and shall forward Copy 2 of the order form to the DEA district office.

e. Order forms shall be maintained separately from all other records of the registrant.

f. Each unaccepted, defective, or otherwise "void" order form and any attached statement or other documents relating to any order form shall be maintained in the files of the registrant.

g. If the registration of any purchaser of Schedule I or II controlled substances is terminated for any reason, or if the name or address of the registrant as shown on the registration is changed, the registrant shall return all unused order forms to the DEA district office.

10.34(7) *Ordering or distributing Schedule I or II controlled substances - electronic ordering system.* A registrant authorized to order or distribute Schedule I or II controlled substances via the DEA Controlled Substances Ordering System (CSOS) shall comply with the requirements of the DEA relating to that system, including the maintenance and security of digital certificates, signatures, and passwords and all record-keeping and reporting requirements.

a. For an electronic order to be valid, the purchaser shall sign the electronic order with a digital signature issued to the purchaser or the purchaser's agent by the DEA.

b. An electronic order may include controlled substances that are not in Schedules I and II and may also include noncontrolled substances.

c. A purchaser shall submit an order to a specific wholesale distributor appropriately licensed to distribute in Iowa.

d. Prior to filling an order, a supplier shall verify the integrity of the signature and the order, verify that the digital certificate has not expired, check the validity of the certificate, and verify the registrant's authority to order the controlled substances.

e. The supplier shall retain an electronic record of every order, including a record of the number of commercial or bulk containers furnished for each item and the date on which the supplier shipped the containers to the purchaser. The shipping record shall be linked to the electronic record of the order. Unless otherwise provided under federal law, a supplier shall ship the controlled substances to the registered location associated with the digital certificate used to sign the order.

f. If an order cannot be filled for any reason, the supplier shall notify the purchaser and provide a statement as to the reason the order cannot be filled. When a purchaser receives such a statement from a supplier, the purchaser shall electronically link the statement of nonacceptance to the original electronic order. Neither a purchaser nor a supplier may correct a defective order; the purchaser must issue a new order for the order to be filled.

g. When a purchaser receives a shipment, the purchaser shall create a record of the quantity of each item received and the date received. The record shall be electronically linked to the original order and shall identify the individual reconciling the order. A purchaser shall, for each order filled, retain the original signed order and all linked records for that order for two years. The purchaser shall also retain all copies of each unfilled or defective order and each linked statement.

h. A supplier shall retain each original order filled and all linked records for two years. A supplier shall, for each electronic order filled, forward to the DEA within two business days either a copy of the electronic order or an electronic report of the order in a format specified by the DEA.

i. Records of CSOS electronic orders and all linked records shall be maintained by a supplier and a purchaser for two years following the date of shipment or receipt, respectively. Records may be maintained electronically or in hard-copy format. Records that are maintained electronically shall be readily retrievable from all other records, shall be easily readable or easily rendered into a readable format, shall be readily retrievable at the registered location, and shall be made available to the board, to the board's agents, or to the DEA upon request. Records maintained in hard-copy format shall be maintained in the same manner as DEA Form 222.

[**ARC 8539B**, IAB 2/24/10, effective 4/1/10; **ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—10.35(124,155A) Physical count and record of inventory. Responsibility for ensuring that a required inventory is timely completed shall rest with the registrant or, in the case of a registered business, shall rest with the owner of the business. A registrant or owner of a registered business may delegate the actual taking of any inventory. The person or persons responsible for taking the inventory shall sign the completed inventory record.

10.35(1) *Record and procedure.* Each inventory record, except the periodic count and reconciliation required pursuant to subrule 10.33(4), shall comply with the requirements of this subrule and shall be maintained for a minimum of two years from the date of the inventory.

a. Each inventory shall contain a complete and accurate record of all controlled substances on hand on the date and at the time the inventory is taken.

b. Each inventory shall be maintained in a handwritten, typewritten, or electronically printed form at the registered location. An inventory of Schedule II controlled substances shall be maintained separately from an inventory of all other controlled substances.

c. Controlled substances shall be deemed to be on hand if they are in the possession of or under the control of the registrant. These shall include prescriptions prepared for dispensing to a patient but not yet delivered to the patient, substances maintained in emergency medical services programs or care facility emergency supplies, outdated or adulterated substances pending destruction, and substances stored in a warehouse on behalf of the registrant. Controlled substances obtained through an authorized collection

program for the purpose of disposal shall not be examined, inspected, counted, sorted, inventoried, or otherwise handled.

d. A separate inventory shall be made for each registered location and for each independent activity registered except as otherwise provided under federal law.

e. The inventory shall be taken either prior to opening or following the close of business on the inventory date, and the inventory record shall identify either opening or close of business.

f. The inventory record, unless otherwise provided under federal law, shall include the following information:

(1) The name of the substance;

(2) The strength and dosage form of the substance;

(3) The quantity of the substance; and

(4) Information required of authorized collection programs pursuant to federal regulations for such collection programs.

g. For all substances listed in Schedule I or II, and for all solid oral and injectable hydrocodone-containing products, the quantity shall be an exact count or measure of the substance.

h. For all substances listed in Schedule III, IV, or V, except for hydrocodone-containing products identified in paragraph *"g"* herein, the quantity may be an estimated count or measure of the substance unless the container has been opened and originally held more than 100 dosage units. If the opened commercial container originally held more than 100 dosage units, an exact count of the contents shall be made. Liquid oral hydrocodone-containing products packaged in incremented containers shall be measured to the nearest increment; products packaged in nonincremented containers may be estimated to the nearest one-fourth container.

10.35(2) *Initial inventory.* A new registrant shall take an inventory of all stocks of controlled substances on hand on the date the new registrant first engages in the manufacture, distribution, or dispensing of controlled substances. If the registrant commences business or the registered activity with no controlled substances on hand, the initial inventory shall record that fact.

10.35(3) *Annual inventory.* After the initial inventory is taken, a registrant shall take a new inventory of all stocks of controlled substances on hand at least annually. The annual inventory may be taken on any date that is within one year or seven days after the date of the previous annual inventory.

10.35(4) *Change of ownership.* Both the current owner and the prospective owner shall be responsible for ensuring that an inventory of all controlled substances is timely completed whenever there is a change of ownership of any pharmacy or drug wholesaler licensed pursuant to Iowa Code section 155A.13 or 155A.17, respectively. The inventory shall be taken following the close of business the last day under terminating ownership and prior to opening for business the first day under the new ownership. The inventory shall serve as the ending inventory for the terminating owner as well as a record of beginning inventory for the new owner.

10.35(5) *Change of pharmacist in charge (PIC).* An inventory of all controlled substances shall be completed whenever there is a change of PIC. The inventory shall be taken following the close of business the last day of the terminating PIC's employment and prior to opening for business the first day of the new PIC's employment. A single inventory shall be sufficient if there is no lapse between employment of the terminating PIC and the new PIC.

10.35(6) *Change of registered location.* A registrant shall take an inventory of all controlled substances whenever there is a change of registered location. The inventory shall be taken following the close of business the last day at the location being vacated. This inventory shall serve as the ending inventory for the location being vacated as well as a record of beginning inventory for the new location.

10.35(7) *Discontinuing registered activity.* A registrant shall take an inventory of controlled substances at the close of business the last day the registrant is engaged in registered activities. If the registrant is selling or transferring the remaining controlled substances to another registrant, this inventory shall serve as the ending inventory for the registrant discontinuing business as well as a record of additional or starting inventory for the registrant to whom the substances are transferred.

10.35(8) *Newly controlled substances.* On the effective date of the addition of a previously noncontrolled substance to any schedule of controlled substances, any registrant who possesses the

newly controlled substance shall take an inventory of all stocks of the substance on hand. That initial inventory record shall be maintained with the most recent controlled substances inventory record. Thereafter, the newly controlled substance shall be included in each inventory made by the registrant.
[**ARC 1575C**, IAB 8/20/14, effective 9/24/14; **ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—10.36(124) Samples and other complimentary packages—records. Complimentary packages and samples of controlled substances may be distributed to practitioners pursuant to federal and state law only if the person distributing the items leaves with the practitioner a specific written list of the items delivered.

10.36(1) *Distribution record.* The record form for the distribution of complimentary packages of controlled substances shall contain the following information:

a. The name, address, and DEA registration number of the supplier;

b. The name, address, and DEA registration number of the practitioner;

c. The name, strength, and quantity of the specific controlled substances delivered; and

d. The date of delivery.

10.36(2) *Reports to the board.* Any person who distributes controlled substances pursuant to this rule shall report all such distributions to the board. Reports shall:

a. Include the information identified in subrule 10.36(1). Reports may consist of copies of those distribution records or may be computer-generated listings identifying those distributions.

b. Be submitted as soon as practicable after distribution to the practitioner but no less often than once each calendar quarter.

10.36(3) *Practitioner records.* A practitioner who regularly administers or dispenses controlled substances shall keep records of the receipt and disbursement of such drugs, including complimentary packages and samples. Records shall be filed in a readily retrievable manner in accordance with federal requirements and shall be made available for inspection and copying by agents of the board or other authorized individuals for at least two years from the date of the record.

657—10.37(124,126) Revision of controlled substances schedules.

10.37(1) *Application for exception.* Any person seeking to have any compound, mixture, or preparation containing any depressant or stimulant substance listed in any of the schedules in Iowa Code chapter 124 excepted from the application of all or any part of that chapter may apply to the board for such exception.

a. An application for an exception under this rule shall provide evidence that an exception has been granted under the federal Controlled Substances Act.

b. The board shall permit any interested person to file written comments on or objections to the proposal for exception and shall designate the time during which such filings may be made. After consideration of the application and any comments on or objections to the proposal for exception, the board shall issue its findings on the application.

10.37(2) *Designation of new controlled substance.* The board may designate any new substance as a controlled substance to be included in any of the schedules in Iowa Code chapter 124 no sooner than 30 days following publication in the Federal Register of a final order so designating the substance under federal law. Designation of a new controlled substance under this subrule shall be temporary as provided in Iowa Code section 124.201, subsection 4.

10.37(3) *Objection to designation of a new controlled substance.* The board may object to the designation of any new substance as a controlled substance within 30 days following publication in the Federal Register of a final order so designating the substance under federal law. The board shall file objection to the designation of a substance as controlled, shall afford all interested parties an opportunity to be heard, and shall issue the board's decision on the new designation as provided in Iowa Code section 124.201, subsection 4.

657—10.38(124) Temporary designation of controlled substances.

10.38(1) Amend Iowa Code subsection 124.204(9) by adding the following new paragraphs *"g," "h," "i,"* and *"j"*:

g. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-(cyclohexylmethyl)-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers. Other names: AB-CHMINACA.

h. N-(1-amino-3-methyl-1-oxobutan-2-yl)-1-pentyl-1H-indazole-3-carboxamide, its optical, positional, and geometric isomers, salts, and salts of isomers. Other names: AB-PINACA.

i. [1-(5-fluoropentyl)-1H-indazol-3-yl](naphthalen-1-yl)methanone, its optical, positional, and geometric isomers, salts, and salts of isomers. Other names: THJ-2201.

j. N-(1-phenethylpiperidin-4-yl)-N-phenylacetamide, its optical, positional, and geometric isomers, salts, and salts of isomers. Other names: acetyl fentanyl.

10.38(2) Amend Iowa Code subsection 124.206(2), paragraph *"a,"* introductory paragraph, as follows:

a. Opium and opiate, and any salt, compound, derivative, or preparation of opium or opiate, excluding apomorphine, thebaine-derived butorphanol, dextrorphan, nalbuphine, nalmefene, naloxegol, naloxone, and naltrexone, and their respective salts, but including the following:

[**ARC 7906B**, IAB 7/1/09, effective 6/22/09; **ARC 8411B**, IAB 12/30/09, effective 12/1/09; **ARC 8989B**, IAB 8/11/10, effective 7/21/10; **ARC 9091B**, IAB 9/22/10, effective 8/30/10; **ARC 0893C**, IAB 8/7/13, effective 7/9/13; **ARC 1408C**, IAB 4/2/14, effective 3/13/14; **ARC 1787C**, IAB 12/10/14, effective 1/14/15; **ARC 2407C**, IAB 2/17/16, effective 3/23/16]

657—10.39(124,126) Excluded substances. The Iowa board of pharmacy hereby excludes from all schedules the current list of "Excluded Nonnarcotic Products" identified in Title 21, CFR Part 1308, Section 22. Copies of the list of excluded products may be obtained by written request to the board office at 400 S.W. Eighth Street, Suite E, Des Moines, Iowa 50309-4688.

657—10.40(124,126) Anabolic steroid defined. Anabolic steroid, as defined in Iowa Code section 126.2, paragraph 2, includes any substance identified as such in Iowa Code section 124.208, paragraph 6, or in Iowa Code section 126.2, paragraph 2.

657—10.41(124A) Designation of imitation controlled substances. Rescinded **ARC 2195C**, IAB 10/14/15, effective 11/18/15.

These rules are intended to implement Iowa Code sections 124.201, 124.301 to 124.308, 124.402, 124.403, 124.501, 126.2, 126.11, 147.88, 155A.13, 155A.17, 155A.26, 155A.37, and 205.3.

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CHAPTER 17
WHOLESALE DRUG LICENSES

657—17.1(155A) Definitions.

"Authorized collection program" means a program administered by a registrant that has modified its registration with DEA to collect controlled substances for the purpose of disposal. Federal regulations for such programs can be found at http://deadiversion.usdoj.gov/drug_disposal/. Modification to the registrant's Iowa controlled substances Act registration shall not be required.

"Blood" means whole blood collected from a single donor and processed either for transfusion or further manufacturing.

"Blood component" means that part of blood separated by physical or mechanical means.

"Board" means the Iowa board of pharmacy.

"DEA" means the United States Department of Justice, Drug Enforcement Administration.

"Distribute" means the delivery of a prescription drug or device.

"Drug sample" means a drug that is distributed without monetary consideration to a pharmacist or practitioner. "Drug sample" does not include drugs intended for patients who would otherwise not receive needed drugs due to their inability to pay.

"Manufacturer" means a person or business engaged in the production, preparation, propagation, conversion, or processing of a drug or device, either directly or indirectly, by extraction from substances of natural origin or independently by means of chemical or biological synthesis and includes packaging or repackaging of the substances or labeling or relabeling of the substances' containers.

"Prescription drug" means any of the following:

1. A substance for which federal or state law requires a prescription before it may be legally dispensed to the public.
2. A drug or device that under federal law is required, prior to being dispensed or delivered, to be labeled with one of the following statements:
   - Caution: Federal law prohibits dispensing without a prescription.
   - Caution: Federal law restricts this drug to use by or on the order of a licensed veterinarian.
   - Rx only.
3. A drug or device that is required by any applicable federal or state law or regulation to be dispensed on prescription only or is restricted to use by a practitioner only.

"Proprietary medicine" or *"over-the-counter (OTC) medicine"* means a nonnarcotic drug or device that may be sold without a prescription and that is labeled and packaged in compliance with applicable state or federal law.

"Reverse distribution" means the receipt of prescription drugs including controlled substances, whether received from Iowa locations or shipped to Iowa locations, for the purposes of destroying the drugs or returning the drugs to their original manufacturers or distributors.

"Wholesale distribution" means distribution of prescription drugs to persons other than a consumer or patient, but does not include:

1. The sale, purchase, or trade of a drug or an offer to sell, purchase or trade a drug for emergency medical reasons. For purposes of this chapter, "emergency medical reasons" includes transfers of prescription drugs by a pharmacy to another pharmacy to alleviate a temporary shortage;
2. The sale, purchase or trade of a drug, an offer to sell, purchase or trade a drug, or the dispensing of a drug pursuant to a prescription;
3. The lawful distribution of drug samples by manufacturers' representatives or wholesale salespersons;
4. The sale, purchase or trade of blood and blood components intended for transfusion; or
5. Intracompany sales.

"Wholesale distributor" or *"wholesaler"* means a person or business operating or maintaining, either within or outside this state, a manufacturing plant, wholesale distribution center, wholesale business, or any other business in which prescription drugs, medicinal chemicals, medicines, or poisons are sold, manufactured, dispensed, stocked, exposed, or offered for sale at wholesale in this

state. "Wholesaler" includes, but is not limited to, manufacturers; repackers; own-label distributors; private-label distributors; jobbers; brokers; warehouses including manufacturers' and distributors' warehouses, chain drug warehouses, and wholesale drug warehouses; independent wholesale drug traders; reverse distributors; and pharmacies that conduct wholesale distributions exceeding 5 percent of gross annual sales of prescription drugs. "Wholesaler" does not include those wholesalers who sell only OTC medicines or manufacturers' representatives lawfully distributing drug samples to authorized practitioners.

"Wholesale salesperson" or *"manufacturer's representative"* means an individual who takes purchase orders on behalf of a wholesaler for prescription drugs, medicinal chemicals, medicines, or poisons. "Manufacturer's representative" also means a person designated by a pharmaceutical manufacturer to lawfully distribute drug samples to authorized practitioners.

[**ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—17.2 Reserved.

657—17.3(155A) Wholesale drug license. Every wholesaler as defined in rule 657—17.1(155A), wherever located, that engages in wholesale distribution into, out of, or within this state must be licensed by the board in accordance with the laws and rules of Iowa before engaging in wholesale distribution of prescription drugs. Where operations are conducted at more than one location by a single wholesaler, each such location shall be separately licensed in Iowa. A wholesaler located within Iowa that engages in wholesale distribution of or collection via an authorized collection program of controlled substances shall also register pursuant to 657—Chapter 10.

17.3(1) *Application form.* Application for licensure and license renewal shall be on forms provided by the board. Application for wholesale drug licensure shall require an indication of the type of wholesale operation and the wholesaler ownership classification. If the owner is a sole proprietorship (100 percent ownership), the name and address of the owner shall be indicated. If the owner is a partnership or limited partnership, the names and addresses of all partners shall be listed or attached. If the owner is a corporation, the names and addresses of the officers and directors of the corporation shall be listed or attached. Any other wholesaler ownership classification shall be further identified and explained on the application. The name, address, and telephone numbers of at least one contact person for the licensed facility shall be identified. A list of all states in which the wholesaler is licensed and all trade or business names used by the wholesaler shall be included on or with the application. The application shall identify, if the wholesaler is located outside Iowa, applicable home state license information and DEA and FDA license or registration information. The application shall also provide information regarding any past criminal convictions or adverse actions against licenses or registrations held by the licensee or facility managers.

17.3(2) *License expiration and renewal.* A wholesale drug license shall be renewed before January 1 of each year. The fee for a new or renewal license shall be $270.

a. Late payment penalty. Failure to renew the license before January 1 shall require payment of the renewal fee and a penalty fee of $270. Failure to renew the license before February 1 following expiration shall require payment of the renewal fee and a penalty fee of $360. Failure to renew the license before March 1 following expiration shall require payment of the renewal fee and a penalty fee of $450. Failure to renew the license before April 1 following expiration shall require payment of the renewal fee and a penalty fee of $540 and may require an appearance before the board. In no event shall the combined renewal fee and penalty fee for late renewal of a wholesale drug license exceed $810.

b. Delinquent license. If a license is not renewed before its expiration date, the license is delinquent and the licensee may not operate or do business in Iowa until the licensee renews the delinquent license. A drug wholesaler who continues to do business in Iowa without a current license may be subject to disciplinary sanctions pursuant to the provisions of 657—subrule 36.1(4).

17.3(3) *Inspection of new wholesale drug distribution facility.* If a new wholesale drug distribution location within Iowa was not a licensed wholesale drug distribution site immediately prior to the proposed opening of the new wholesale facility, the location shall require an on-site inspection by

a pharmacy board inspector prior to the issuance of the wholesale drug license. The purpose of the inspection is to determine compliance with requirements pertaining to space, equipment, drug storage safeguards, and security. Inspection may be scheduled anytime following submission of necessary license and registration applications and prior to beginning wholesale drug distribution. Prescription drugs, including controlled substances, may not be delivered to a new wholesale drug distribution facility prior to satisfactory completion of the opening inspection.

17.3(4) *Wholesale drug license changes.*

a. Ownership change. When ownership of a licensed drug wholesaler changes, the licensee shall submit to the board written notification including the name, address, and license number of the wholesaler and the effective date of the change. Notification shall also identify the new ownership classification and the owners, partners, or corporate officers as indicated in subrule 17.3(1). In those cases in which the wholesaler is owned by a corporation, the sale or transfer of all stock of the corporation does not constitute a change of ownership provided the corporation that owns the wholesaler continues to exist following the stock sale or transfer. A new license shall not be required for a change of ownership.

b. Name or location change. When a licensed drug wholesaler changes its name or location, a new wholesale drug license application with a license fee as provided in 17.3(2) shall be submitted to the board office. Upon receipt of the fee and properly completed application, the board will issue a new license certificate. The old license certificate shall be returned to the board office within ten days of the change of name or location. A change of wholesaler location within Iowa, if the new location was not a licensed drug wholesaler immediately prior to the relocation, shall require an on-site inspection of the new location as provided in subrule 17.3(3).

17.3(5) *Drug wholesaler closing.* A licensee discontinuing wholesale distribution of prescription drugs in or into Iowa shall submit to the board, with the current wholesale drug license certificate, written notification indicating the effective date of closing or discontinuing business in Iowa. If the drug wholesaler had been engaged in the distribution of controlled substances in Iowa, the written notification shall identify by name, address, and appropriate license numbers the facility or facilities to which controlled substances records and any final inventory of controlled substances have been transferred.

17.3(6) *Failure to complete licensure process.* An application for a wholesale drug license, including an application for registration pursuant to 657—Chapter 10, if applicable, will become null and void if the applicant fails to complete the licensure process within six months of receipt by the board of the required applications. The licensure process shall be complete upon the wholesaler's opening for business at the licensed location following an inspection rated as satisfactory by an agent of the board if such an inspection is required pursuant to this rule. When an applicant fails to timely complete the licensure process, fees submitted with applications will not be transferred or refunded.

[**ARC 0504C**, IAB 12/12/12, effective 1/16/13; **ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—17.4(155A) Minimum qualifications. The board will consider the following factors in determining eligibility for licensure of persons or businesses that engage in the wholesale distribution of prescription drugs:

1. Any convictions of the applicant under federal, state, or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances;
2. Any felony convictions of the applicant under federal, state, or local laws;
3. The applicant's past experience in the manufacture or distribution of prescription drugs, including controlled substances;
4. The furnishing by the applicant of false or fraudulent material in any application made in connection with drug manufacturing or distribution;
5. Suspension or revocation by federal, state, or local government of any license currently or previously held by the applicant for the manufacture or distribution of any drugs, including controlled substances;
6. Compliance with licensing requirements under previously granted licenses, if any;

7. Compliance with the requirements to maintain or make available to the board, its agents or authorized personnel, or to federal, state, or local law enforcement officials those records required to be maintained by wholesalers; and

8. Any other factors or qualifications the board considers relevant to and consistent with public health and safety.

657—17.5(155A) Personnel. Licensed wholesalers shall establish and maintain lists of officers, directors, managers, and other persons in charge of wholesale drug distribution, storage, and handling, including a description of their duties and a summary of their qualifications. The wholesaler shall employ personnel with the education or experience appropriate to the responsibilities of the position held by the individual.

657—17.6(155A) Responsibility for conduct. A licensed drug wholesaler shall be held responsible for actions of the wholesaler's managerial agent when the conduct of the agent may fairly be assumed to represent the policy of the wholesaler. "Managerial agent" includes, but is not necessarily limited to, an officer or director of a corporation or an association or a partner of a partnership, and includes a person having management responsibility for submissions to the FDA regarding the development or approval of any drug product; the production, quality assurance, or quality control of any drug product; or research and development of any drug product.

17.6(1) *Misrepresentative deeds.* A managerial agent shall not make any statement intended to deceive, misrepresent, or mislead anyone, or be a party to or an accessory to any fraudulent or deceitful practice or transaction in the manufacture, distribution, or marketing of prescription drugs.

17.6(2) *Unethical conduct or behavior.* A managerial agent shall not exhibit unethical behavior in connection with the manufacture, distribution, or marketing of prescription drugs or refuse to provide reasonable information or answer reasonable questions for the benefit of a health professional or a patient. Unethical behavior shall include, but not be limited to, the following acts: verbal abuse, coercion, intimidation, harassment, sexual advances, threats, degradation of character, indecent or obscene conduct, and theft.

657—17.7(124,155A) Distribution to authorized licensees. A wholesaler shall be responsible for verifying, prior to the distribution of a prescription drug, the authority of the person or business to whom the distribution is intended. Such verification may include, but is not limited to, obtaining a copy of the license under which the person or business claims authority to possess the prescription drug or contacting the appropriate licensing authority for verification of the licensee's authority to possess the prescription drug.

657—17.8(124,155A) Written policies and procedures. Wholesalers shall establish, maintain, and adhere to written policies and procedures for the receipt, security, storage, inventory, and distribution of prescription drugs, including policies and procedures for identifying, recording, and reporting losses or thefts and for correcting all errors and inaccuracies in inventories. Wholesalers shall also include in their written policies and procedures the following:

17.8(1) *Oldest stock distributed first.* A procedure whereby the oldest approved stock of a prescription drug product is distributed first. The procedure may permit deviation from this requirement if such deviation is temporary and appropriate.

17.8(2) *Recalls and market withdrawals.* A procedure to be followed for handling recalls and withdrawals of prescription drugs. Such procedure shall be adequate to deal with recalls and withdrawals due to:

a. Any action initiated at the request of the Food and Drug Administration or other federal, state, or local law enforcement agency or other government agency, including the board;

b. Any voluntary action by the manufacturer to remove defective or potentially defective drugs from the market; or

c. Any action undertaken to promote public health and safety by replacing existing merchandise with an improved product or new package design.

17.8(3) *Emergency and disaster plan.* A procedure to ensure that wholesalers prepare for, protect against, and handle any crisis that affects security or operation of any facility in the event of strike, fire, flood, or other natural disaster, or other situations of local, state, or national emergency.

17.8(4) *Outdated drugs.* A procedure to ensure that any outdated prescription drugs shall be segregated from other drugs and either returned to the manufacturer or destroyed. This procedure shall provide for written documentation of the disposition of outdated prescription drugs.

17.8(5) *Exception.* The procedure required by subrule 17.8(1) does not apply to reverse distribution operations. All other procedures addressed in this rule are required of reverse distribution operations.

17.8(6) *Drugs supplied to salesperson/representative.* If supplying drugs to wholesale salespersons or manufacturers' representatives, a procedure directing that the security, storage, and record-keeping requirements contained in these rules shall be maintained by those wholesale salespersons or manufacturers' representatives.

657—17.9(155A) Facilities. All facilities at which prescription drugs are stored, warehoused, handled, held, offered, marketed, or displayed shall:

1. Be of suitable size and construction to facilitate cleaning, maintenance, and proper operations;
2. Have storage areas designed to provide adequate lighting, ventilation, temperature, sanitation, humidity, space, equipment, and security conditions;
3. Have a quarantine area for storage of outdated, damaged, unsafe, deteriorated, misbranded, or adulterated prescription drugs; for drugs that are in immediate or sealed outer or sealed secondary containers that have been opened; for drugs that have been identified as being defective or are believed to be defective; and for drugs that do not meet the FDA-approved criteria for the product;
4. Be maintained in a clean and orderly condition;
5. Be free from infestation by insects, rodents, birds, or vermin of any kind.

657—17.10(124,155A) Security.

17.10(1) *Secure from unauthorized entry.* All facilities used for wholesale drug distribution shall be secure from unauthorized entry.

a. Access from outside the premises shall be kept to a minimum and be well controlled.

b. The outside perimeter of the premises shall be well lighted.

c. Entry into areas where prescription drugs are held shall be limited to authorized personnel.

17.10(2) *Alarm.* All facilities shall be equipped with an alarm system to deter entry after hours.

17.10(3) *Security system.* All facilities shall be equipped with a security system that will provide suitable protection against theft and diversion. When appropriate, the security system shall provide protection against theft or diversion that is facilitated or hidden by tampering with computers or electronic records.

17.10(4) *Authorized collection program.* Licensees that are authorized to administer a controlled substances collection program shall provide security pursuant to 657—Chapter 10 and federal regulations.

[**ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—17.11(155A) Storage. All prescription drugs shall be stored at appropriate temperatures and under appropriate conditions in accordance with requirements, if any, in the labeling of such drugs or with requirements in the current edition of an official compendium.

17.11(1) *Controlled room temperature.* If no storage requirements are established for a prescription drug, the drug may be held at "controlled room temperature" to help ensure that its identity, strength, quality, and purity are not adversely affected. "Controlled room temperature" means the room temperature is maintained thermostatically between 15 degrees and 30 degrees Celsius (59 degrees and 86 degrees Fahrenheit).

17.11(2) *Documentation.* Appropriate manual, electromechanical, or electronic temperature and humidity recording equipment, devices, or logs shall be utilized to document proper storage of prescription drugs.

17.11(3) *Exception.* The storage requirements of this rule do not apply to reverse distribution operations.

657—17.12 Reserved.

657—17.13(155A) Drugs in possession of representatives. If a wholesaler is supplying samples or other forms of prescription drugs to wholesale salespersons or manufacturers' representatives, the wholesaler shall be responsible for ensuring that those representatives maintain distribution records and maintain the drugs under appropriate security and storage conditions pursuant to the requirements of these rules.

657—17.14(155A) Examination of materials.

17.14(1) *Receipt shipment.* Upon receipt, each outside shipping container shall be visually examined for identity and to prevent the acceptance of contaminated prescription drugs or prescription drugs that are otherwise unfit for distribution. This examination shall be adequate to reveal container damage that would suggest possible contamination or other damage to the contents.

17.14(2) *Outgoing shipment.* Each outgoing shipment shall be carefully inspected for identity of the prescription drug products and to ensure that there is no delivery of prescription drugs that have been damaged in storage or held under improper conditions.

17.14(3) *Type of inspection.* Examination or inspection shall be completed in a manner to ensure the stated intent of this rule. Inspection may be completed by use of electronic surveillance or personal examination.

17.14(4) *Authorized collection program.* Substances, including controlled substances, collected through an authorized collection program shall not be examined, inspected, counted, sorted, inventoried, or otherwise handled.

[**ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—17.15(155A) Returned, damaged, and outdated prescription drugs.

17.15(1) *Quarantine required.* Prescription drugs that are outdated, damaged, deteriorated, misbranded, or adulterated shall be quarantined and physically separated from other prescription drugs until they are destroyed or returned to the supplier.

17.15(2) *Seal opened.* Any prescription drugs whose immediate or sealed outer or sealed secondary containers have been opened or used shall be identified as such and shall be quarantined and physically separated from other prescription drugs until they are either destroyed or returned to the supplier.

17.15(3) *Drug safety, purity uncertain.* Unless examination, testing, or other investigation proves that a drug meets appropriate standards of safety, identity, strength, quality, and purity, a prescription drug that has been returned under conditions that cast doubt on the drug's safety, identity, strength, quality, or purity shall be destroyed or returned to the supplier. In determining whether the conditions under which a drug has been returned cast doubt on the drug's safety, identity, strength, quality, or purity, the wholesaler shall consider, among other things, the conditions under which the drug has been held, stored, or shipped before or during its return and the conditions of the drug and its container, carton, or labeling as a result of storage or shipping.

17.15(4) *Exception.* The requirements of this rule do not apply to reverse distribution operations.

657—17.16(124,155A) Record keeping. Wholesalers shall establish and maintain inventories and records of all transactions regarding the receipt and distribution or other disposition of prescription drugs, including outdated, damaged, deteriorated, misbranded, or adulterated prescription drugs.

17.16(1) *Transaction records.* Transaction records shall include the following information:

a. The source of the drugs, including the name and principal address of the seller or transferor and the address of the location from which the drugs were shipped;

b. The identity and quantity of the drugs received and distributed or disposed of;

c. The dates of receipt and distribution or other disposition of the drugs; and

d. If a distribution transaction, the recipient of the drugs, including the name and principal address of the purchaser or transferee and the address to which the drugs were shipped.

17.16(2) *Records maintained.* Inventories and records shall be made available for inspection and photocopying by any authorized official of the board or of any governmental agency charged with enforcement of these rules for a period of two years following disposition of the drugs. The annual inventory of controlled substances shall be maintained for a minimum of two years from the date of the inventory.

17.16(3) *Inspection of records.* Records described in this rule that are kept at the inspection site or that can be immediately retrieved by computer or other electronic means shall be readily available for authorized inspection during the retention period. Records kept at a central location apart from the inspection site and not electronically retrievable shall be available for inspection within two working days of a request by an authorized official of the board or of any governmental agency charged with enforcement of these rules.

17.16(4) *Confidentiality of patient information.* A wholesaler shall obtain and maintain patient-specific data only as necessary for the health and safety of the patient. Any patient-specific information in the possession of a wholesaler shall be maintained in compliance with the patient confidentiality and security requirements of rules 657—8.16(124,155A) and 657—21.2(124,155A).

17.16(5) *Authorized collection program.* A licensee that is authorized to administer a collection program shall maintain all records and inventories as required by 657—Chapter 10, this chapter, and federal regulations.

[**ARC 8669B**, IAB 4/7/10, effective 5/12/10; **ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—17.17(124,155A) Compliance with federal, state, and local laws. Wholesalers shall operate in compliance with applicable federal, state, and local laws, rules, and regulations.

17.17(1) *Access by authorized officials.* Wholesalers shall permit the board and authorized federal, state, and local law enforcement officials to enter and inspect their premises and delivery vehicles and to audit their records and written operating procedures, at reasonable times and in a reasonable manner, to the extent authorized by law. Such officials shall be required to show appropriate identification prior to being permitted access to wholesalers' premises and delivery vehicles.

17.17(2) *Controlled substance registrations.* Wholesalers that deal in controlled substances shall register with the appropriate state controlled substance authority and with the Drug Enforcement Administration (DEA) and shall comply with all applicable federal, state, and local laws, rules, and regulations.

657—17.18(155A) Discipline. Pursuant to 657—Chapters 35 and 36, the board may deny, suspend, or revoke a wholesale drug license for any violation of Iowa Code chapter 124, 124A, 124B, 126, 155A, or 205 or a rule of the board promulgated thereunder.

These rules are intended to implement Iowa Code sections 124.301 through 124.303, 124.306, 155A.4, and 155A.17.

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CHAPTER 22
UNIT DOSE, ALTERNATIVE PACKAGING, AND EMERGENCY BOXES

657—22.1(155A) Unit dose dispensing systems.

22.1(1) *Definitions.* For the purpose of this rule, the following definitions shall apply:

"Single unit package" means a package that contains one discrete pharmaceutical dosage form.

"Unit dose dispensing system" means a drug distribution system utilizing single unit, unit dose, or unit of issue packaging in a manner that helps reduce or remove traditional drug stocks from resident care areas and enables the selection and distribution of drugs to be pharmacy-based and controlled.

"Unit dose package" means a package that contains that particular dose of a drug ordered for the patient for one administration time. A unit dose package is not always a single unit package. "Unit dose package" does not include a strip pack prepared utilizing an automated medication distribution system (AMDS). A strip pack is a patient med pak subject to the requirements of rule 657—22.5(126,155A).

"Unit of issue package" means a package that provides multiple units or doses attached to each other but separated in a card or specifically designed container.

22.1(2) *General procedures.* The following will apply when a unit dose dispensing system is employed:

a. The pharmacist shall be responsible for determining the classification for containers, as set by USP General Chapter 671, used by the pharmacy to repackage nonsterile drugs into single unit, unit dose, or unit of issue packaging. This classification shall be used to determine maximum expiration dating for repackaging set forth in subrule 22.1(4).

b. Established written policies and procedures shall be available in the pharmacy for inspection by the board or its agents which specify the drug categories, specific drugs, or dosage forms which will not be dispensed under the particular unit dose dispensing system employed.

c. Those drugs not dispensed under a unit dose dispensing system shall be dispensed in accordance with the packaging requirements of the federal Food and Drug Administration (FDA).

22.1(3) *Labeling requirements.*

a. Labeling for single unit or unit dose packaging shall comply with the following:

(1) Doses packaged by the manufacturer or distributor shall be properly labeled according to federal Food and Drug Administration (FDA) requirements.

(2) Doses packaged by the pharmacy for use beyond a 24-hour period shall be labeled and packaged according to the prepackaging requirements established in subrule 22.3(2).

b. Labeling for unit of issue packages shall contain the following information:

(1) Name, strength, and expiration date of drug when the packages are utilized for floor stock in an institutional setting.

(2) Name and room or bed number of patient, the name of prescribing practitioner, the name and strength of drug, directions for use, and name and address of the dispensing pharmacy, when the packages are utilized for patients in an institutional setting. Room or bed number, the name of prescribing practitioner, and the name and address of the dispensing pharmacy are not required if this information appears on a medication administration record used by the institution.

(3) Unit of issue packages dispensed to patients on an outpatient basis or in a noninstitutional setting shall be considered prescription containers and shall be labeled in accordance with 657—subrule 6.10(1).

c. If a pharmacist selects a generically equivalent drug product for a brand name drug product prescribed by a practitioner, the label must identify the generic drug and may identify the brand name drug for which the selection is made. The dual identification allowed under this paragraph must take the form of the following statement on the label: "(generic name) Generic for (brand name product)".

d. The labeling requirements of paragraphs *"a"* and *"b"* of this subrule shall not apply to the special circumstances identified in rule 657—23.13(124,155A).

e. Those drugs not dispensed under a unit dose dispensing system shall be labeled in accordance with the requirements of subrule 22.5(5) or 657—subrule 6.10(1) as appropriate.

22.1(4) *Expiration dating.* Expiration dating for nonsterile drugs repackaged by the pharmacy into single unit, unit dose, or unit of issue packages shall meet the following conditions:

a. Not exceed 90 days from the date of repackaging except as provided in paragraph 22.1(4)*"c."*

b. Not exceed the manufacturer's original expiration date.

c. May exceed 90 days from the date of repackaging provided that each of the following conditions is met:

(1) The container is classified according to USP General Chapter 671 as being Class A or Class B for oral solid dosage forms or is a tight container for liquid dosage forms.

(2) The container is light resistant when the manufacturer has labeled the product "sensitive to light."

(3) The expiration date is not greater than 12 months.

d. Drugs or dosage forms having known stability problems are assigned an expiration date of less than 90 days or are not repackaged as determined by policies developed by the pharmacy.

22.1(5) *Packaging requirements.* Packaging for all nonsterile drugs stored and dispensed in single unit, unit dose, or unit of issue packages shall:

a. Preserve and protect the identity and integrity of the drug from the point of packaging to the point of patient administration.

b. When packaged by the manufacturer or distributor, be in accordance with federal Food and Drug Administration (FDA) requirements.

c. When in single unit and unit dose packages prepackaged by the pharmacy for use beyond 24 hours, be in accordance with rule 657—22.3(126).

d. Be clean and free of extraneous matter.

22.1(6) *Return of drugs.* Under no circumstances shall a pharmacist accept for reuse, except to the same patient, any previously dispensed controlled substances. Drugs, excluding controlled substances, dispensed in single unit, unit dose, or unit of issue packaging in compliance with subrules 22.1(2) to 22.1(5) may be returned to the pharmacy stock and reissued provided that:

a. The expiration dating information is retrievable and identifiable.

b. Drugs returned from unit of issue packaging are kept separate according to manufacturer's lot number and the repackaged expiration date assigned pursuant to subrule 22.1(4). If, however, the pharmacy's recall policy states that all lots of a drug shall be considered part of the recall due to unknown manufacturer's lot numbers, drugs returned to stock from unit of issue packaging shall be kept separate according to the pharmacy's repackaged expiration date.

c. The drugs were stored under proper storage conditions.

d. The drugs are returned to the pharmacy in the original packaging as when dispensed.

e. The pharmacy includes in written policies and procedures the manner in which returned drugs will be recorded or identified.

This rule is intended to implement Iowa Code section 155A.36.

[**ARC 1309C**, IAB 2/5/14, effective 3/12/14]

657—22.2 Reserved.

657—22.3(126) Prepackaging.

22.3(1) *Control record.* Pharmacies may prepackage and label drugs in convenient quantities for subsequent labeling and dispensing. Such drugs shall be prepackaged by or under the direct supervision of a pharmacist. The supervising pharmacist shall be responsible for the preparation and maintenance of a packaging control record containing the following information:

a. Date.

b. Identification of drug.

(1) Name of drug.

(2) Dosage form.

(3) Manufacturer.

(4) Manufacturer's lot number.

(5) Strength.

(6) Expiration date.

c. Container specification.
d. Copy of a sample label.
e. Initials or unique identification of the packager.
f. Initials or unique identification of the supervising pharmacist.
g. Quantity per container.
h. Internal control number or date.

22.3(2) *Label information.* Each prepackaged container shall bear a label containing the following information:

a. Name of drug.
b. Strength.
c. Internal control number or date.
d. Expiration date consistent with USP standards.
e. Auxiliary labels, as needed.

22.3(3) *Labeling for delivery.* Prior to the delivery of a prepackaged drug to a patient, an appropriate label shall be affixed to the drug container pursuant to the labeling requirements of the appropriate pharmacy practice rules.

This rule is intended to implement Iowa Code sections 126.10 and 126.11.

657—22.4 Reserved.

657—22.5(126,155A) Patient med paks. In lieu of dispensing prescribed drug products in conventional prescription containers, a pharmacist may, with the consent of the patient, the patient's caregiver, or the prescriber, provide a customized patient medication package (patient med pak) pursuant to the requirements of this rule.

22.5(1) *Definition.* A patient med pak is a customized patient medication package prepared for a specific patient which comprises a series of immediate containers containing prescribed solid oral dosage forms, each container being labeled with the time or the appropriate period for the patient to take its contents. A patient med pak includes but is not limited to a strip pack prepared utilizing an automated medication distribution system (AMDS).

22.5(2) *General procedures.* The following shall apply when patient med paks are employed:

a. The pharmacist shall be responsible for determining the classification, as directed by USP General Chapter 671, for containers used by the pharmacy to repackage nonsterile drugs into patient med paks.

b. Packaging for all nonsterile solid oral dosage forms stored and dispensed in patient med paks shall:

(1) Preserve and protect the identity and integrity of the drug from the point of packaging to the point of administration, and

(2) Be clean and free of extraneous matter when the drugs are placed into the package.

c. Drugs dispensed in patient med paks to patients may not be returned to the pharmacy stock and reissued except to the same patient as provided in subrule 22.5(4).

d. There is no special exemption for patient med paks from the requirements of the Poison Prevention Packaging Act. Thus, the patient med pak, if it does not meet child-resistant standards, shall be placed in an outer package that does comply, or the necessary consent of the purchaser or physician to dispense in a container not intended to be child-resistant shall be obtained.

22.5(3) *Reuse of containers.* Notwithstanding requirements that all prescription drugs be dispensed in a new container conforming with standards established in the official compendia, a pharmacist may dispense and refill a prescription for nonliquid oral products in a clean patient med pak provided:

a. A patient med pak is reused only for the same patient; and
b. No more than a one-month supply is dispensed at one time.

22.5(4) *Repackaging of patient med paks.* In the event a drug is added to or discontinued from a patient's drug regimen, the pharmacist may repackage the patient's med pak and either add to or remove from the patient's drugs packaged as ordered by the prescriber. Drugs returned by the patient

for repackaging may be reused by the pharmacist in the design of the new patient med pak, and any drug removed from the new drug regimen shall either be disposed of in compliance with board rules or returned, properly labeled, to the patient. Under no circumstances shall a drug within a container of a patient med pak be returned to the pharmacy stock or returned to an automated medication distribution system (AMDS) component unless the drug was dispensed as a single dose and was not commingled with other patient medications in a single package or container.

22.5(5) *Labeling requirements.*

a. Except as provided in subrule 22.5(6), the patient med pak shall be labeled with the following:

(1) The name of the patient;

(2) The unique identification number for the patient med pak itself and a separate unique identification number for each of the prescription drug orders for each of the drug products contained therein;

(3) The name, strength, dosage form, and total quantity of each drug product contained therein;

(4) The directions for use for each drug product contained therein;

(5) The name of the prescriber of each drug product;

(6) The date of preparation of the patient med pak and the beyond-use date assigned to the patient med pak;

(7) The name, address, and telephone number of the pharmacy; and

(8) The initials or unique identification of the responsible pharmacist.

b. The patient med pak shall be accompanied by a patient package insert, in the event that any drug contained therein is required to be dispensed with such insert as accompanying labeling. Alternatively, such required information may be incorporated into a single, overall educational insert provided by the pharmacist for the total patient med pak.

c. If the patient med pak allows for the removal or separation of the intact containers therefrom, each individual container shall bear a label identifying the patient, the unique identification number for the patient med pak, and the name and telephone number of the dispensing pharmacy.

d. If a pharmacist selects a generically equivalent drug product for a brand-name drug product prescribed by a practitioner, the label must identify the generic drug and may identify the brand-name drug for which the selection is made. The dual identification allowed under this paragraph must take the form of the following statement on the label: "(generic name) Generic for (brand-name product)".

22.5(6) *Alternate labeling.* If the patient med pak container is not of sufficient size to accommodate the label information as required in subrule 22.5(5) in a legible font, a patient package insert shall be prepared and delivered with the patient med pak. The patient package insert shall contain all label information required in subrule 22.5(5). In such case, the label affixed to the patient med pak shall minimally include:

a. The name of the patient;

b. The unique identification number for the patient med pak;

c. The beyond-use date assigned to the patient med pak;

d. A statement directing the patient or patient's caregiver to the patient package insert; and

e. The name and telephone number of the dispensing pharmacy.

22.5(7) *Expiration/beyond-use dating.* Beyond-use date or period of time shall be not longer than the shortest recommended beyond-use date for any dosage form included therein or not longer than 60 days from the date of preparation of the patient med pak, whichever is shorter. In no event shall the beyond-use date exceed the shortest expiration date on the original manufacturer's bulk containers for the dosage forms included in the patient med pak. Alternatively, the package label shall state the date of the prescriptions or the date of preparation of the patient med pak, provided the package is accompanied by a record indicating the start date and the beyond-use date.

22.5(8) *Record keeping.* The record of each patient med pak shall contain, at a minimum:

a. The name and address of the patient;

b. The unique identification number for each of the current prescription drug orders for each of the drug products contained therein;

c. A unique identification number for the patient med pak;

d. Information identifying or describing the design, characteristics, or specifications of the patient med pak sufficient to allow subsequent preparation of an identical patient med pak for the patient;

e. The date of preparation of the patient med pak and the beyond-use date that was assigned;

f. Any special labeling instructions; and

g. The name, unique identification, or initials of the responsible pharmacist.

This rule is intended to implement Iowa Code sections 126.10, 126.11, and 155A.28.

[**ARC 1309C**, IAB 2/5/14, effective 3/12/14; **ARC 2406C**, IAB 2/17/16, effective 3/23/16]

657—22.6 Reserved.

657—22.7(124,155A) Emergency/first dose drug supply. In any facility registered with the board under Iowa Code chapter 124 that does not have an institutional pharmacy, drugs may be supplied in one or more emergency/first dose drug supply containers located at the facility, provided that the emergency/first dose drug supply meets the requirements of this rule. The use of drugs from the emergency/first dose drug supply shall be limited to authorized personnel. The pharmacy supplying the emergency/first dose drug supply is responsible for verifying the qualifications of the facility.

22.7(1) *Emergency/first dose drug supplies.* Contents of the emergency/first dose drug supply shall be provided by a primary provider pharmacy designated by the facility, and the drug supply shall be available to meet the needs of all patients of the facility, without penalty or discrimination. If the primary provider pharmacy does not supply or is unable to supply all drugs and products needed for the emergency care of facility patients, a second provider pharmacy may provide an emergency/first dose drug supply consisting only of drugs and products not stocked or available from the primary provider pharmacy including, but not limited to, parenteral or compounded drug products. The provider pharmacies shall be properly registered with the federal Drug Enforcement Administration (DEA) and the board and shall be currently licensed by the board. The provider pharmacist or pharmacists, the consultant pharmacist, the director of nursing of the facility, and the medical director of the facility, or their respective designees, shall jointly determine and prepare a list of drugs necessary for prompt use in patient care that will be available in each emergency/first dose drug supply. Drugs shall be listed by identity and quantity, shall be limited to drugs necessary to meet the emergency needs of the patients served, and shall be periodically reviewed pursuant to policy. Careful patient planning should be a cooperative effort between the pharmacies and the facility to make drugs available, and emergency/first dose drug supplies shall only be used for emergency or unanticipated needs. The intent of the emergency/first dose drug supply is not to relieve a pharmacy of the responsibility for timely provision of a patient's routine drug needs and is not intended to relieve any provider pharmacy from the provider pharmacy's responsibility to provide 24-hour services to facility patients; the intent is to ensure that a supply of drugs is available to each patient in case of urgent need. The drugs in emergency/first dose drug supplies are the responsibility of the respective provider pharmacy and, therefore, shall not be used or altered in any way except as provided in this rule.

22.7(2) *Storage.* The emergency/first dose drug supply shall be stored in an area suitable to prevent unauthorized access and to ensure a proper environment for preservation of drugs contained therein as required in official compendia. The provider pharmacist is responsible for establishing procedures to maintain the security of the emergency/first dose drug supply.

22.7(3) *Labeling—exterior.* The exterior of an emergency/first dose drug supply shall be labeled clearly and shall unmistakably indicate that it is an emergency/first dose drug supply. Such label shall also contain a listing of the name, strength, and quantity of each drug contained therein and an expiration date of the supply based upon the earliest expiration date of any drug contained in the supply.

22.7(4) *Labeling—interior.* All drugs contained in the emergency/first dose drug supply shall be labeled in accordance with subrule 22.3(2) or 22.1(3), as appropriate.

22.7(5) *Removal of drugs.* A drug shall be removed from the emergency/first dose drug supply only pursuant to a valid prescription order and by authorized personnel or by the provider pharmacist. The patient's dispensing pharmacy shall be notified, prior to the administration of a second dose, that a drug was administered to a specific patient. Upon notification, the dispensing pharmacist shall perform

drug use review to assess the appropriateness of the drug therapy for the patient. If the emergency/first dose drug supply contains a multidose package of a drug product that is removed from the supply for administration of one or more doses of the product to a patient and if following that administration the package contains one or more additional doses of the drug product and if the prescriber authorizes continuation of the drug product for that patient, the provider pharmacy shall complete either of the following processes.

a. Prepare and affix to the multidose package a label in compliance with rule 657—23.11(124,155A). The label shall be prepared and affixed to the package within 24 hours of administration of the emergency dose or doses.

b. Dispense, pursuant to a valid prescription order and in compliance with rule 657—23.11(124,155A), an appropriately labeled supply of the drug for the patient. The new prescription shall be delivered to the facility within 24 hours of administration of the emergency dose or doses.

22.7(6) *Notifications.* Whenever an emergency/first dose drug supply is opened or has expired, the provider pharmacy shall be notified and the pharmacist shall be responsible for replacing the drug within 72 hours to prevent risk of harm to patients. Pursuant to rule 657—8.3(155A), established policies and procedures shall address notification, record keeping, and documentation procedures for use of the supply.

22.7(7) *Procedures.*

a. The pharmacy, in communication with the director of nursing of the facility and the medical director of the facility, or their respective designees, and as provided in rule 657—8.3(155A), shall have written policies and procedures to ensure compliance with this rule.

b. The provider pharmacy shall keep a record of each prescription drug stored in the emergency/first dose drug supply and the number of doses provided.

c. The facility shall keep a complete record of the use of prescription drugs from the emergency/first dose drug supply for two years following such use. The record shall include the patient's name, the date of use, the name of the drug used, the strength of the drug, the number of doses used, the name of the prescriber authorizing the administration, and the initials or unique identification of the person administering the dose.

d. The drugs maintained in the emergency/first dose drug supply shall be available for the emergency pharmaceutical care of all facility patients, without penalty or discrimination. If a service charge is assessed for the administration of a drug from the emergency/first dose drug supply, the same reasonable service charge shall be assessed to each patient to whom a drug from the emergency/first dose drug supply is administered, regardless of the patient's choice of pharmacy for pharmaceutical services.

This rule is intended to implement Iowa Code sections 124.301, 124.306, 155A.13, and 155A.15.
[**ARC 0749C**, IAB 5/29/13, effective 7/3/13; **ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—22.8 Reserved.

657—22.9(155A) Home health agency/hospice emergency drugs. Recognizing the emergency and unanticipated need for drugs to be available to qualified individuals authorized to administer drugs and employed by a home health agency or hospice, an Iowa-licensed pharmacy may provide an emergency drug supply pursuant to this rule. Such qualified individuals may carry the emergency drug supply. An inpatient hospice facility may have an emergency drug supply provided by an Iowa-licensed pharmacy pursuant to rule 657—22.7(124,155A), which supply may be maintained within the facility.

22.9(1) *Contract.* A written contract shall exist between the home health agency or hospice and the pharmacist in charge of the Iowa-licensed pharmacy. This contract shall be available for review by the board or its authorized agent upon request.

22.9(2) *Ownership retained.* The drugs included in this emergency supply shall remain the property of and under the responsibility of the Iowa-licensed provider pharmacy.

a. The pharmacist shall ensure that each portable container of emergency drugs is sealed in such a manner that a tamperproof seal must be broken to gain access to the drugs.

b. Each portable container of emergency drugs shall be labeled on the outside of the container with a list of the contents and the earliest expiration date.

22.9(3) *Removal of drugs.* All drugs shall be administered only on prior prescribers' order or by protocol approved by the agency's medical director or appropriate committee. Drugs administered from the emergency supply shall be replaced by submitting a prescription or medication order for the used item to the provider pharmacy within a reasonable time of administration.

22.9(4) *Records.* All records of drugs administered from the emergency supply shall be maintained as required by law. If a container of an injectable product is opened and partially used, any unused portion shall be immediately discarded and appropriately documented.

22.9(5) *Drugs included.* The provider pharmacist and the director of the home health agency or hospice, or their respective designees, shall jointly determine a list of drugs necessary for prompt use in the care of patients served by the home health agency or hospice and that will be available in the emergency drug supply. Drugs shall be listed by identity and quantity and shall be periodically reviewed in accordance with policy.

22.9(6) *Policies and procedures.* The pharmacy, pursuant to rule 657—8.3(155A) and in coordination with the home health agency or hospice, shall have policies and procedures to address storage conditions and security for drugs and kit maintenance. Outdated, expired drugs shall be properly disposed of by the pharmacy.

22.9(7) *Responsibility for compliance.* The pharmacist in charge and staff pharmacists shall share responsibility for compliance with this rule, and any abuse or misuse of the intent of this rule shall be immediately reported to the board.

This rule is intended to implement Iowa Code sections 155A.4, 155A.13, and 155A.15.

[**ARC 1961C**, IAB 4/15/15, effective 5/20/15]

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CHAPTER 23
LONG-TERM CARE PHARMACY PRACTICE

657—23.1(155A) Definitions. For the purposes of this chapter, the following definitions shall apply:

"Authorized collection program" means a program administered by a registrant that has modified its registration with DEA to collect controlled substances for the purpose of disposal. Federal regulations for such programs can be found at http://deadiversion.usdoj.gov/drug_disposal/.

"Consultant pharmacist" in a long-term care facility means a pharmacist licensed to engage in the practice of pharmacy in this state who is responsible for developing, coordinating, and supervising pharmaceutical services in a long-term care facility on a regularly scheduled basis. A consultant pharmacist:

1. Reviews the distribution and storage of drugs and devices and assists facilities in establishing the policies and procedures for the distribution and storage of drugs and devices and makes appropriate recommendations to the facility and the provider pharmacist;
2. Monitors the therapeutic response and utilization of all drugs and devices prescribed for each resident. The following shall be used as minimum guidelines supplementing the pharmacist's professional expertise:
   - Regulations and interpretive guidelines of the Centers for Medicare and Medicaid Services, if applicable;
   - Rules of the Iowa department of inspections and appeals; and
   - Other state rules and regulations;
3. Serves as a resource for pharmacy-related education services within the facility;
4. Participates in quality management of resident care in the facility;
5. Communicates with the provider pharmacist regarding areas of mutual concern and resolution thereof.

"DEA" means the United States Department of Justice, Drug Enforcement Administration.

"Long-term care facility" or *"facility"* means:

1. A facility licensed by the Iowa department of inspections and appeals under Iowa Code chapter 135C or Iowa Code chapter 135H;
2. A hospital-based long-term care unit certified under 42 CFR, Part 483, Subpart B;
3. An inpatient hospice certified under 42 CFR, Part 418;
4. A group living facility wherein health care related services are provided by the facility; or
5. A health care facility registered with the board under Iowa Code chapter 124.

"Long-term care pharmacy" or *"provider pharmacy"* means a hospital pharmacy, a general pharmacy, a limited use pharmacy, or a nonresident pharmacy in which drugs, chemicals, or poisons are prepared, compounded, dispensed, vended, distributed, or sold on a regular and recurring basis to or for the use of residents of a long-term care facility and from which related pharmacy services are delivered.

"Medication order," as used in these rules, means a written order from a practitioner or an oral order from a practitioner or the practitioner's authorized agent for administration of a drug or device. For purposes of this chapter, "medication order" includes a prescription.

"Provider pharmacist" means a pharmacist licensed to engage in the practice of pharmacy who is employed by or contracted to a long-term care pharmacy or a provider pharmacy and who is responsible for supervising the accurate dispensing and proper delivery of drugs and devices to a long-term care facility located within this state. These services shall include, at a minimum, proper medication labeling, storage, transport, record keeping, and prospective drug utilization review in compliance with all federal and state laws and regulations.

"Single unit package" means a package that contains one discrete pharmaceutical dosage form.

"Unit dose dispensing system" means a drug distribution system utilizing single unit, unit dose, or unit of issue packaging in a manner that helps reduce or remove traditional drug stocks from resident care areas and enables the selection and distribution of drugs to be pharmacy-based and controlled.

"Unit dose package" means a package that contains that particular dose of a drug ordered for a resident for one administration time. A unit dose package is not always a single unit package.

"Unit of issue package" means a package that provides multiple units or doses attached to each other but separated in a card or specifically designed container.
[**ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—23.2(124,155A) Applicability of rules. Nothing in these rules shall be deemed to constitute a waiver or abrogation of any of the provisions of board rules or other applicable provisions of state and federal laws and rules, nor should these rules be construed as authorizing or permitting any person not licensed as a pharmacist to engage in the practice of pharmacy.

657—23.3(124,155A) Freedom of choice. Pursuant to 657—subrule 8.11(5), no pharmacist or pharmacy shall participate in any agreement or plan that infringes on any resident's right to freedom of choice as to the provider of pharmacy services. A resident in a long-term care facility shall have a choice of long-term care pharmacy so long as the pharmacy's drug delivery system provides for the timely delivery of drugs compatible with the established system currently used by the facility. Determination of compatibility may consider medication administration, accessibility, and payment system.

657—23.4(124,155A) Responsibilities. The pharmacist in charge and staff pharmacists in any pharmacy providing pharmaceutical services to long-term care facility patients shall share responsibility for:

1. Providing drugs pursuant to a medication order for an individual resident, properly labeled for that resident, as addressed in rule 657—22.1(155A) or 657—23.13(124,155A).
2. Dispensing drugs for residents of long-term care facilities consistent with the drug distribution system described in the facility's policies and procedures.
3. Affixing labels to each container of drugs for residents in long-term care facilities, in compliance with rule 657—22.1(155A), 657—23.13(124,155A), or 657—23.14(124,155A).
4. Maintaining records of all transactions of the long-term care pharmacy as may be required by law and maintaining accurate control over and accountability for all drugs and prescription devices.
5. Complying with a drug recall procedure, established pursuant to rule 657—8.3(155A), that protects the health and safety of residents including immediate discontinuation of any recalled drug or device and subsequent notification of the prescriber and director of nursing of the facility.
6. Providing 24-hour emergency service either directly or by contract with another pharmacy.
7. Reviewing patient profiles to ensure the appropriateness of therapy for that resident and the compatibility of the drug and dosage for that resident when processing new medication orders.
8. Providing sufficient and accurate information to facility staff regarding the appropriate administration and use of all dispensed drugs and devices.
9. Communicating with the consultant pharmacist and the facility regarding concerns and resolution thereof.

[**ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—23.5(124,155A) Emergency drugs. A supply of emergency drugs may be provided by one or more long-term care provider pharmacies to the facility pursuant to rule 657—22.7(124,155A).

23.5(1) *Emergency medication order—pharmacist review.* When an emergency drug is provided pursuant to rule 657—22.7(124,155A), the medication order shall be reviewed by the resident's dispensing pharmacist prior to the administration of a second dose.

23.5(2) *Other emergency drugs and devices.* In addition to one or more emergency boxes or stat drug boxes, a long-term care facility staffed by one or more persons licensed to administer drugs may maintain a stock of intravenous fluids, irrigation fluids, heparin flush kits, medicinal gases, sterile water and saline, and prescription devices. Such stock shall be limited to a listing to be determined by the provider pharmacist in consultation with the consultant pharmacist and the medical director and director of nursing of the facility.
[**ARC 0749C**, IAB 5/29/13, effective 7/3/13]

657—23.6(124,155A) Space, equipment, and supplies. Pursuant to rule 657—8.3(155A), each pharmacy serving a long-term care facility shall have adequate space, equipment, and supplies for the professional and administrative functions of the pharmacy and to meet the needs of the residents served. The pharmacy shall also comply with all reference, environment, and equipment requirements contained in rules 657—6.3(155A) and 657—8.5(155A).
[**ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—23.7(124,155A) Policies and procedures. Pursuant to rule 657—8.3(155A), each pharmacy shall have policies and procedures related to all aspects of the pharmacy's packaging and dispensing responsibilities to the residents of the long-term care facility. The policies and procedures shall be maintained at the provider pharmacy and shall be available to the facility and the consultant pharmacist. Policies and procedures shall include, at a minimum:

1. Methods used to dispense and deliver drugs and devices to the facility in a timely fashion;
2. Proper notification to the facility when a drug or device is not readily available;
3. Proper labeling requirements to meet the needs of the facility and which are consistent with state and federal laws and regulations;
4. Appropriate drug destruction or return of unused drugs, or both, consistent with state and federal laws and regulations.

[**ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—23.8 Reserved.

657—23.9(124,155A) Medication orders. Drugs and prescription devices may be dispensed only upon orders of an authorized prescriber.

23.9(1) *Requirements.* New orders transmitted to the pharmacy for drugs for residents of the facility shall, at a minimum, contain resident name, drug name and strength, directions for use, date of order, and name of prescriber. Orders for Schedule II controlled substances shall comply with the requirements of rule 657—23.18(124,155A).

23.9(2) *Abbreviations.* Abbreviations or chemical symbols utilized in medication orders shall be only those abbreviations or symbols that are customarily used in the practice of medicine and pharmacy or those on a list of approved abbreviations developed by the appropriate committee or representative of the facility.

23.9(3) *Who may transmit medication orders.* An authorized prescriber or prescriber's agent or any person who is employed by a long-term care facility and who is authorized by the facility's policies and procedures may transmit to the long-term care pharmacy a medication order lawfully ordered by a practitioner authorized to prescribe drugs and devices. An order transmitted by the prescriber's agent shall include the agent's first and last names and title.

23.9(4) *Influenza and pneumococcal vaccines.* As authorized by federal law, a written or verbal patient-specific medication administration order shall not be required prior to administration to an adult patient of influenza and pneumococcal vaccines pursuant to physician-approved facility policy and after the patient has been assessed for contraindications. Administration shall be recorded in the patient's record. The facility shall submit to the provider pharmacy a listing of those residents or staff members who have been immunized utilizing vaccine from each vial supplied by the provider pharmacy.
[**ARC 9912B**, IAB 12/14/11, effective 1/18/12; **ARC 2197C**, IAB 10/14/15, effective 11/18/15]

657—23.10(124,155A) Stop orders. To ensure that drug orders are not continued inappropriately, the pharmacy's policies and procedures, established pursuant to rule 657—8.3(155A) and in consultation with the medical director and the appropriate committee or representative of the facility, shall include an automatic stop order policy. Drugs not specifically limited when ordered as to duration of therapy or number of doses shall be controlled by the automatic stop order policy in accordance with the status of the patient.
[**ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—23.11(124,155A) Drugs dispensed—general requirements.

23.11(1) *Labeling.* All prescription containers, other than those dispensed pursuant to rule 657—22.1(155A), 657—23.13(124,155A), or 657—23.14(124,155A), shall be properly labeled in accordance with 657—subrule 6.10(1).

a. If a label change is required to reflect a change in directions, the pharmacy shall be responsible for affixing the correct label to the container. Long-term care facility personnel shall not be authorized to affix such a label to the drug container.

b. Direction change labels that notify long-term care facility personnel that a change in directions for the drug has taken place may be used and affixed to the container by facility personnel so as not to deface the original label.

23.11(2) *Medication order required.* Dispensing of all drugs to the facility shall be pursuant to a medication order for an individual resident except as provided in rules 657—23.5(124,155A) and 657—23.14(124,155A) and in subrule 23.9(4).

23.11(3) *Prescription containers.* All prescription containers, including but not limited to single unit, unit dose, and unit of issue containers utilized for distribution within a long-term care facility, shall meet minimum requirements as established by the United States Pharmacopoeia. When applicable, light-resistant packaging shall be used.

23.11(4) *Floor stock.* Prescription drugs, as defined by Iowa Code section 155A.3(37), shall not be floor-stocked in a long-term care facility except as provided in this subrule or in subrule 23.5(2). Bulk supplies of nonprescription drugs may be maintained as provided in subrule 23.13(3). Any pharmacy that utilizes a floor stock distribution system pursuant to this subrule shall develop and implement procedures to accurately establish proof of use of prescription drugs and shall maintain a perpetual inventory, whether by electronic or manual means, of all prescription drugs so dispensed. A floor stock distribution system for prescription drugs may be permitted only under the following circumstances:

a. A licensed pharmacy under the direct supervision and control of a pharmacist is established in the facility; or

b. The facility and the hospital wherein the licensed pharmacy is located are both licensed under Iowa Code chapter 135B with a single hospital license.

[**ARC 2408C**, IAB 2/17/16, effective 3/23/16]

657—23.12 Reserved.

657—23.13(124,155A) Labeling drugs under special circumstances.

23.13(1) *Insulin, ophthalmics, otic preparations, biologicals, and other injectables for individual patients.* These drugs shall be dispensed with a label affixed to the immediate container showing at least the resident's name and location.

23.13(2) *Legend solutions—irrigation and infusion.* Legend irrigation solutions and infusion solutions supplied by a licensed pharmacy may be stored in the locked medication area of a long-term care facility provided that:

a. The facility uses the solution only within the confines of the facility and under the orders of an authorized prescriber;

b. Upon use, the container is identified by resident name and is used exclusively for that resident;

c. The container is dated and initialed upon opening;

d. The solution is stored appropriately after opening according to facility policy.

23.13(3) *Floor-stocked, nonprescription drug containers.* All such nonprescription drugs intended for use within the facility shall be in appropriate containers and adequately labeled to identify, at a minimum, brand name or generic name and manufacturer, strength, lot number, and expiration date. An internal code that centrally references manufacturer and lot number may be utilized.

23.13(4) *Leave meds.* Labeling of prescription drugs for residents on leave from the facility for a period in excess of 24 hours shall comply with 657—subrule 6.10(1). The dispensing pharmacist shall be responsible for packaging and labeling leave meds in compliance with this subrule.

23.13(5) *Discharge meds.* Drugs authorized for a resident being discharged from the facility shall be labeled in compliance with 657—subrule 6.10(1) before the resident removes those drugs from the facility premises. The dispensing pharmacist shall be responsible for packaging and labeling discharge meds in compliance with this subrule.
[**ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—23.14(124,155A) Labeling of biologicals and other injectables supplied to a facility. Labeling of biologicals and other injectables supplied to a facility for a health immunization or ongoing screening program, such as influenza vaccine, tuberculin skin test, or hepatitis-B, and intended for use in the facility, shall include the following information in addition to the manufacturer's label. The pharmacy label shall be affixed so as not to obscure the manufacturer's label.

1. Identification of pharmacy;
2. Name of facility;
3. Name of biological or drug;
4. Route of administration when necessary for clarification;
5. Strength of biological or drug;
6. Auxiliary labels as needed;
7. Date dispensed.

657—23.15(124,155A) Return and reuse of drugs and devices. Pharmacists and pharmacies shall not accept from residents or their agents for reuse or resale any drugs, prescribed drugs, chemicals, poisons or medical devices unless, in the professional judgment of the pharmacist, the integrity of the prescription drug has not in any way been compromised. Under no circumstances shall a pharmacist accept from a patient or patient's agent any controlled substances for return, exchange, or resale except to the same patient. Prescription drugs, excluding controlled substances, dispensed in unit dose, unit of issue, or single unit packaging pursuant to 657—22.1(155A) may, however, be returned and reused as authorized in 657—subrule 22.1(6). No items of a personal contact nature which have been removed from the original package or container after sale shall be accepted for return, exchanged, or resold by any pharmacist.

657—23.16(124,155A) Destruction of outdated and improperly labeled drugs. The pharmacy, pursuant to rule 657—8.3(155A) and in consultation with a facility representative, shall have written policies and procedures to ensure that all discontinued, outdated, deteriorated, or improperly labeled drugs and all containers with worn, illegible or missing labels are destroyed or disposed of so as to render them unusable. Drugs shall be destroyed by means that will ensure protection against unauthorized possession or use.
[**ARC 1961C**, IAB 4/15/15, effective 5/20/15]

657—23.17(124,155A) Accountability of controlled substances.

23.17(1) *Proof of use.* Documentation of use of Schedule II controlled substances shall be upon proof-of-use forms. A committee or representative of the facility may also require that Schedule III, IV, or V controlled substances or any other drugs be accounted for on proof-of-use forms. Proof-of-use forms shall specify at a minimum:

a. Name of drug;
b. Dose;
c. Name of ordering prescriber;
d. Name of resident;
e. Date and time of administration to resident;
f. Identification of individual administering;
g. Documentation of destruction, return to the pharmacy, or other disposition of all unused portions of single doses including the signatures of two individuals, at least one of whom is a licensed health care professional.

23.17(2) *Container requirement.* Any drug required to be counted and accounted for with proof-of-use forms shall be dispensed in a container that allows visual verification of quantity. Containers for solid oral doses must allow visual identification of individual doses and individual accountability.

657—23.18(124,155A) Schedule II orders. This rule shall not apply to Schedule II controlled substances orders in facilities that utilize a floor stock distribution system as provided in subrule 23.11(4). Schedule II controlled substances in all other facilities shall be dispensed only upon receipt of an electronic prescription prepared, transmitted, and received in compliance with DEA regulations for electronic prescriptions or an original written order signed by the prescribing individual practitioner or upon receipt of a facsimile transmission of an original written order signed by the prescribing individual practitioner pursuant to rule 657—21.15(124,155A). In emergency situations as defined in 657—subrule 10.22(1), Schedule II controlled substances may be dispensed in compliance with the requirements of rule 657—10.22(124) or rule 657—21.13(124,155A), as applicable. In all cases, any order for a Schedule II controlled substance shall specify the total quantity authorized by the prescriber.
[**ARC 9912B**, IAB 12/14/11, effective 1/18/12]

657—23.19(124,155A) Dispensing Schedule II controlled substances. A pharmacy that dispenses Schedule II controlled substances shall advise facility personnel that federal and state laws and regulations governing such drugs require that accurate records be kept of their administration or their ultimate disposition in compliance with rule 657—23.17(124,155A). The pharmacy shall further advise facilities that stored Schedule II substances shall be double-locked in accordance with rules of the Iowa department of inspections and appeals. The requirement for double-locking Schedule II controlled substances shall not apply to periods during which drugs are being administered to residents; however, these substances shall be secured during such administration periods.

657—23.20(124,155A) Partial filling of Schedule II controlled substances. A medication order for a Schedule II controlled substance for a resident in a long-term care facility (LTCF) may be filled in partial quantities to include individual dosage units. The pharmacist shall record on the written or electronic medication order that the patient is an "LTCF patient." A medication order that is partially filled and does not contain the notation "LTCF patient" shall be deemed to have been filled in violation of the controlled substances Act.

23.20(1) *Partial filling record.* For each partial filling, the dispensing pharmacist shall record on the back of the medication order (or on another appropriate record, uniformly maintained, and readily retrievable) the date of the partial filling, quantity dispensed, remaining quantity authorized to be dispensed, and the identification of the dispensing pharmacist.

23.20(2) *Total dispensed.* The total quantity of Schedule II controlled substances dispensed in all partial fillings shall not exceed the total quantity prescribed.

23.20(3) *Duration.* Schedule II medication orders for residents in a long-term care facility shall be valid for a period not to exceed 60 days from the issue date unless sooner terminated by the discontinuance of the drug.

23.20(4) *Requirements of computerized system.* Information pertaining to current Schedule II medication orders for residents in a long-term care facility may be maintained in a computerized system if this system has the capability to permit:

a. Output (display and printout) of the original prescription number, date of issue, identification of prescribing individual practitioner, identification of resident, address of the long-term care facility, identification of the drug authorized (to include dosage form, strength and quantity), listing of the partial fillings that have been dispensed under each medication order, and the information required in this rule.

b. Immediate (real-time) updating of the medication order record each time a partial filling of the medication order is conducted.

c. Retrieval of partially filled Schedule II medication order information as required in rule 657—21.4(124,155A).
[**ARC 9912B**, IAB 12/14/11, effective 1/18/12]

657—23.21(124,155A) Disposal of previously dispensed controlled substances. Controlled substances dispensed to a resident in a long-term care facility and subsequently requiring disposal due to discontinuance of the drug, death of the resident, or other reasons necessitating disposal shall be disposed of by one of the following methods. Controlled substances shall not be returned to a pharmacy for disposal.

23.21(1) *Disposal in the facility.* In facilities staffed by one or more persons licensed to administer drugs, a licensed health care professional (pharmacist, registered nurse, licensed practical nurse) may dispose of controlled substances in witness of one other responsible adult. The professional disposing of the drug shall prepare and maintain a readily retrievable record of the disposition which shall be clearly marked to indicate the disposition of resident drugs. The record shall include, at a minimum, the following:

a. Resident name and unique identification or number assigned by the dispensing pharmacy to the prescription;

b. The name, strength, and dosage form of the substance;

c. The quantity disposed of;

d. The date the substance is disposed of;

e. The signature or uniquely identifying initials or other unique identification of the professional and the witness;

f. The name and address of the dispensing pharmacy or the dispensing practitioner.

23.21(2) *Authorized collection program within a facility.* Registrants registered with DEA to administer an authorized collection program may install and maintain a collection receptacle in a long-term care facility for the purpose of disposal of prescription drugs, including controlled substances, pursuant to federal regulations, which can be found at http://deadiversion.usdoj.gov/drug_disposal/.

[**ARC 0749C**, IAB 5/29/13, effective 7/3/13; **ARC 2408C**, IAB 2/17/16, effective 3/23/16]

These rules are intended to implement Iowa Code sections 124.301, 124.306, 124.308, 155A.2, 155A.13, 155A.15, 155A.21, 155A.27, 155A.28, 155A.33, 155A.35, and 155A.36.

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CHAPTER 71
ADMINISTRATION OF THE CONVEYANCE SAFETY PROGRAM

875—71.1(89A) Definitions. The definitions contained in this rule shall apply to 875—Chapters 71, 72, and 73.

"Acceptance checklist" means a checklist available on the Web site of the division of labor services that includes a list of major systems and components of conveyances.

"AECO" means an elevator/escalator certification organization accredited pursuant to ASME A17.7.

"Approved" means approved by the division.

"CCD" means code compliance documentation as described in ASME A17.7, Section 2.10.

"CEI" means a person who is a certified elevator inspector or certified elevator inspector supervisor and who received the certification from a certifying organization that holds a valid document of accreditation issued by an accreditation body in accordance with ANSI/ISO/IEC 17024.

"Control" means the system governing the starting, stopping, direction of motion, acceleration, speed and deceleration of the moving member.

"Conveyance" means any elevator, escalator, dumbwaiter, wind tower lift, CPH, or other equipment governed by Iowa Code chapter 89A.

"CPH" means a construction personnel hoist.

"CPH jump" means the addition or removal of mast or tower allowing a change in the hoist service elevation of a CPH.

"Division" means the labor services division of the workforce development department.

"Elevator" means a hoisting and lowering mechanism equipped with a car or platform which moves in guides in a substantially vertical direction and which serves two or more floors of a building or structure. "Elevator" does not include a CPH.

"Elevator mechanic" means a person who meets the standard for "elevator personnel" found in ASME A17.1.

"Hoistway-unit system" means a series of hoistway-door interlocks, hoistway-door electric contacts or hoistway-door combination mechanical locks and electric contacts, or a combination thereof, the function of which is to prevent operation of the driving machine by the normal operating device unless all hoistway doors are in the closed position and, if required, locked.

"Wind tower lift" means a conveyance designed and utilized solely for movement of trained and authorized people and small loads in wind towers built for the production of electricity.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 9221B**, IAB 11/17/10, effective 12/22/10; **ARC 0168C**, IAB 6/13/12, effective 7/18/12; **ARC 0685C**, IAB 4/17/13, effective 5/22/13; **ARC 1159C**, IAB 10/30/13, effective 12/4/13]

875—71.2(89A) Registration of conveyances. The owner or authorized agent of each operable conveyance not previously registered shall register the conveyance. An application to install a new conveyance shall constitute registration. All registrations shall be submitted to the commissioner on forms available from the division of labor services and shall include all information requested by the labor commissioner.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—71.3(89A) State identification number. The commissioner shall assign an identification number to each conveyance that shall be stamped on a metal tag permanently attached to the controller, to the electrical disconnecting switch, or in a wind tower lift cage.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—71.4(89A) Responsibility for obtaining permits. The procuring of all permits and the payment of all fees required by this chapter shall be the responsibility of the owner. Failure to obtain the appropriate permit prior to installation, alteration or operation may, at the discretion of the labor commissioner, result in a referral to the attorney general for prosecution of criminal penalties as described in Iowa Code section 89A.17.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—71.5(89A) Installation permits.

71.5(1) Installation shall not begin until an installation permit has been issued by the division. A separate installation permit shall be issued for each conveyance, except that a single installation permit shall cover all identical wind tower lifts installed as the result of one construction contract in identical wind towers in a single wind farm.

71.5(2) Application for an installation permit shall be accompanied by the fee specified in rule 875—71.16(89A), shall be in the format required by the labor commissioner, and shall include the following, as applicable:

a. Sectional plan of car and hoistway.

b. Sectional plan of machine room.

c. Sectional elevation of hoistway and machine room including the pit, bottom and top clearance of car and counterweights.

d. Size and weight of rails and guide rail bracket spacing.

e. The estimated maximum vertical forces on the guide rails on application of the safety device.

f. In the case of freight elevators for class B or class C loading, the horizontal forces on the guide rail faces during loading and unloading and the estimated maximum horizontal forces in a post-wise direction on the guide rail faces on the application of the safety device.

g. The size and weight per foot of any rail reinforcements where rail reinforcements are provided.

h. Job specifications.

i. For a conveyance covered by ASME A17.7, a complete copy of the CCD with attachments and a complete copy of the Certificate of Conformance with attachments as described by ASME A17.7, Appendix I, Section 4.5.

j. For a CPH, the number of CPH jumps planned, the planned dates for each CPH jump, and the change in the number of floors anticipated with each CPH jump.

71.5(3) A CPH installation permit issued in response to an application submitted in full compliance with this subrule permits each planned CPH jump. Each CPH jump shall be considered an alteration. The fee submitted for a CPH installation permit shall be the total of the CPH installation permit fee as set forth in subrule 71.16(3) and the CPH alteration permit fee as set forth in subrule 71.16(4).

71.5(4) Issuance of an installation permit shall not be construed as a waiver or variance of any requirement of law.

71.5(5) The installation permit or a copy of the installation permit shall be conspicuously posted at the worksite. All the wind towers covered by a single installation permit shall be considered a single worksite, and posting one copy of the installation permit at the construction project office shall be sufficient compliance with this subrule.

71.5(6) Except as described in paragraphs 71.5(6)*"a"* and *"b,"* the installation permit shall expire upon the earlier of the completion of the installation as described in the permit application or one year after issuance.

a. For a CPH, the installation permit shall expire upon completion of the last CPH jump.

b. For any conveyance, during the tenth month after issuance, and upon submission to the labor commissioner of sufficient justification, the fee established by this chapter, and other required information, an extension may be granted at the discretion of the labor commissioner.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 9221B**, IAB 11/17/10, effective 12/22/10]

875—71.6(89A) Construction permits. A construction permit authorizes the temporary, limited use of an elevator for purposes relating to construction or demolition.

71.6(1) Use of the elevator shall not begin until a construction permit has been issued by the division.

71.6(2) Application for a construction permit shall be in the format required by the labor commissioner and must include all the information requested by the labor commissioner and the fee specified by this chapter.

71.6(3) Upon submission of the completed application and fee, a state inspector shall be scheduled to inspect the elevator. Construction permits shall be issued only if the following criteria are met:

a. The elevator has been successfully tested pursuant to the requirements of ASME A17.1, Section 8.11.5.13; and

b. The applicable requirements of ASME A17.1, Section 5.10, are met.

71.6(4) The construction permit or a copy of the construction permit shall be posted conspicuously in a protective sleeve in the elevator car.

71.6(5) The construction permit shall expire 120 days after issuance. However, between 90 and 110 days after issuance and upon submission to the labor commissioner of sufficient justification, the fee established by this chapter, and other required information, an extension of up to 90 days may be granted at the discretion of the labor commissioner.

71.6(6) Elevators with a construction permit but without an operating permit shall not be accessible to the general public.

71.6(7) Failure to comply with these provisions may result in the revocation of the construction permit.

71.6(8) An operating permit shall not be issued before construction and an acceptance inspection are complete.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—71.7(89A) Operating permits.

71.7(1) Operation of equipment covered by this chapter without a current operating permit is prohibited, except as authorized by rules 875—71.6(89A), 875—71.8(89A), and 875—71.20(89A). If operation of a conveyance is prohibited under this rule, the labor commissioner may post notice on the conveyance that it is not to be used. The conveyance may be returned to service only after an operating permit for the conveyance has been issued or reissued.

71.7(2) Operating permits shall not be issued prior to successful completion of an inspection pursuant to rule 875—71.11(89A) and payment of all permit and inspection fees owed to the division.

71.7(3) Current operating permits or copies of current operating permits shall be conspicuously displayed as follows:

a. The operating permit for an elevator or CPH shall be posted in the car.

b. The operating permit for an escalator, dumbwaiter, wind tower lift, moving walk, or wheelchair lift shall be posted on or near the subject conveyance.

71.7(4) An operating permit shall expire 60 days after the first permit renewal inspection following the issuance of the operating permit, unless an earlier date is dictated by this rule.

71.7(5) An operating permit is automatically suspended when an alteration begins. The operating permit automatically resumes when the elevator passes an inspection pursuant to rule 875—71.11(89A).

71.7(6) An operating permit is automatically terminated when an imminent danger notice is posted on the conveyance.

71.7(7) Notwithstanding other provisions of this rule, at the discretion of the labor commissioner, a temporary operating permit may be issued for up to 30 days provided the inspection has been completed and no code violations were identified. Issuance of a temporary operating permit does not extend the expiration date of the conveyance's operating permit.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 0318C**, IAB 9/5/12, effective 10/10/12; **ARC 0574C**, IAB 2/6/13, effective 3/13/13; **ARC 0685C**, IAB 4/17/13, effective 5/22/13]

875—71.8(89A) Controller upgrade permits. A controller upgrade permit may be issued to allow operation of an elevator while work to upgrade controls requires deactivation of the Phase I recall initiated by smoke sensing devices. Each elevator to be altered requires a separate controller upgrade permit. The duration of a controller upgrade permit shall not exceed 90 days. Each elevator in the group shall pass inspection pursuant to rule 875—71.11(89A) prior to being placed back into service.

71.8(1) A controller upgrade permit shall not be issued unless each of the following conditions is met:

a. Two or more elevators share a lobby at the level of the recall floor.

b. The project includes the installation of new elevator controllers in all of the elevators in the group.

c. Phase I fire recall initiated by a key-operated switch and all other controls shall be properly functioning for each elevator available for use.

d. There is a current alteration permit for the project.

e. A complete application for the controller upgrade permit and the fee established by this chapter have been submitted and accepted.

71.8(2) A controller upgrade permit shall not be construed to waive or excuse compliance with the requirements of any other governmental entity, including the department of public safety.

71.8(3) Upon the submission to the labor commissioner of sufficient justification, the fee established by this chapter, and other required information, an extension of the permit for up to 60 days may be granted.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—71.9(89A) Alteration permits.

71.9(1) Alteration shall not begin until an alteration permit has been issued by the division.

71.9(2) Application for an alteration permit shall be in the format required by the labor commissioner and shall include drawings and specifications of all planned changes and the fee specified by rule 875—71.16(89A).

71.9(3) Issuance of an alteration permit shall not be construed as a waiver or variance of any requirement of law.

71.9(4) The alteration permit or a copy of the alteration permit shall be conspicuously posted at the worksite.

71.9(5) If a complete installation permit application was submitted for a CPH pursuant to subrule 71.5(3), at least seven days' advance notice of each CPH jump shall be provided to the labor commissioner.

71.9(6) The alteration permit shall expire upon the earlier of the completion of the alteration as described in the permit application or one year after issuance. However, during the tenth month after issuance and upon submission to the labor commissioner of the fee set forth in this chapter, sufficient justification, and other required information, the labor commissioner may grant an extension of the alteration permit.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 9221B**, IAB 11/17/10, effective 12/22/10; **ARC 0685C**, IAB 4/17/13, effective 5/22/13; **ARC 2333C**, IAB 1/6/16, effective 2/10/16]

875—71.10(89A) Alterations.

71.10(1) Alterations or changes shall comply with rule 875—72.13(89A) or rule 875—73.8(89A), as applicable.

71.10(2) A conveyance that is relocated shall be brought into compliance with all codes that are applicable at the time of relocation.

71.10(3) Alterations of conveyances other than escalators and elevators shall require that the entire conveyance be brought into compliance with the current code.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 0168C**, IAB 6/13/12, effective 7/18/12; **ARC 0685C**, IAB 4/17/13, effective 5/22/13; **ARC 2396C**, IAB 2/17/16, effective 3/23/16]

875—71.11(89A) Inspections. Pursuant to Iowa Code section 89A.12, inspections by the labor commissioner's designee shall be permitted at reasonable times with or without prior notice.

71.11(1) *Scope of inspections.*

a. Comprehensive. Periodic inspections shall be comprehensive. Elevators being transferred from construction permits to operating permits, previously dormant conveyances being returned to service, relocated conveyances, and new conveyances shall be inspected in their entirety prior to operation.

b. Limited. The scope of an inspection after an alteration shall be determined by rule 875—72.13(89A) or 875—73.8(89A), as applicable. However, if the inspector notices a safety hazard in plain view outside the altered components, or if the periodic inspection is due, the entire conveyance shall be inspected.

71.11(2) *When inspections will occur.* When the timing of two different types of inspection on a single conveyance coincide, a state inspector may perform both inspections in one visit.

a. Periodic inspections.

(1) Each construction elevator and CPH shall be inspected at intervals not to exceed three months. All other periodic conveyance inspections by state inspectors shall be conducted annually unless the labor commissioner determines resources do not allow annual inspections. If the labor commissioner determines quarterly inspections of construction elevators and CPHs and annual inspections of other state-inspected conveyances are not feasible due to insufficient resources, the labor commissioner shall determine the inspection schedule.

(2) Conveyance inspections by special inspectors shall be conducted at least annually.

b. Acceptance inspections. A CPH shall be inspected pursuant to the schedule in ANSI A10.4 – 2007, Chapter 26. For all other conveyances, an acceptance inspection shall occur:

(1) After each relocation,

(2) After each alteration,

(3) For a new installation, not less than two business days after a completed acceptance checklist is submitted by the conveyance installation company,

(4) Before an elevator subject to a construction permit receives an operating permit, and

(5) Before a previously dormant conveyance is returned to service.

c. Other inspections. Inspections may be made when the commissioner reasonably believes that a conveyance is not in compliance with the rules. Accidents, complaints, or requests for consultative inspections may result in inspections by the labor commissioner's designee.

71.11(3) *Who may perform inspections.*

a. The labor commissioner's designee shall inspect altered conveyances, construction elevators, CPHs, previously dormant conveyances being returned to service, wind tower lifts exempted from ASME A17.1 by rule 875—72.12(89A), relocated conveyances, and new conveyances.

b. Except as noted in 71.11(3)*"c,"* annual inspections may be performed by state inspectors or special inspectors authorized by the labor commissioner pursuant to rule 875—71.12(89A).

c. An inspection report by a special inspector shall not be accepted as the required, annual inspection if the conveyance is under contract for maintenance, installation or alteration by the special inspector or the special inspector's employer, or if the property is owned or leased by the special inspector or the special inspector's employer.

71.11(4) *Inspection standards.* Inspections shall be performed in accordance with applicable safety codes or documents such as:

a. CCD;

b. ASME A17.1, Sections 8.10 and 8.11, except Section 8.11.1.1;

c. ANSI A10.4-2007;

d. Rule 875—72.12(89A) for wind tower lifts exempted from ASME A17.1 by rule 875—72.12(89A); or

e. ASME A18.1.

71.11(5) *Inspection reports.*

a. All inspectors shall file inspection reports on forms approved by the commissioner within 30 days from the date of inspection and shall provide owners of conveyances with copies of completed inspection reports. The inspection report must separately list each unsafe condition and the applicable, specific code citation. Up to 30 days shall be allowed for correction of the unsafe conditions.

b. The owner may file a petition for reconsideration of an inspection report pursuant to 875—Chapter 69. The timely and proper filing of a petition for reconsideration extends the deadline for correction of the hazards that are subject to the petition for reconsideration.

71.11(6) *Extension of time.* The owner may petition the commissioner for up to 60 additional days to make the necessary corrections. The time frames set forth in subrule 71.11(7) may be adjusted by the labor commissioner as necessary to accommodate an extension of time.

71.11(7) *Correction of unsafe conditions.* In the absence of a determination on reconsideration or appeal that correction of hazards is not required, all unsafe conditions identified in the inspection report shall be corrected. The labor commissioner shall verify correction of all unsafe conditions identified in the inspection report by sending a state inspector to reinspect the conveyance for the fee set forth in

rule 875—71.16(89A), or by reviewing appropriate documentation such as a photograph, invoice, other verifiable document, or subsequent inspection report. The time frames set forth in this subrule may be accelerated at the request of the owner.

a. Promptly upon receipt of an inspection report listing unsafe conditions, the labor commissioner will send to the owner and the special inspector, if any, an abatement order. A copy of the inspection report shall be attached to the abatement order. Unless a special inspector conducted the inspection, the order may specify a period that ends no more than 45 days after the inspection during which the owner may submit written evidence that the unsafe conditions have been corrected. The abatement order shall:

(1) Identify the equipment.

(2) Demand that the unsafe conditions be corrected within the period set forth in the inspection report.

(3) Set forth the consequences of failure to comply.

b. After the period specified on the inspection report has passed, the labor commissioner may cause a state inspector to verify correction of all unsafe conditions. If reinspection reveals no significant progress toward correcting the unsafe conditions, or the remaining unsafe conditions create significant safety concerns, the labor commissioner may serve a notice of intent to suspend, deny or revoke the operating permit.

c. The labor commissioner may issue an operating permit after receipt of the appropriate fee and verification that each unsafe condition identified in the inspection report has been corrected.

d. If written proof of correction was requested in the abatement order, but adequate proof was not received by the deadline set forth in the abatement order, the labor commissioner may send a second abatement order or cause a state inspector to inspect the conveyance. If the labor commissioner elects to send a second abatement order, it shall notify the owner that, if written proof of abatement is not received within 20 days, a state inspector may be sent to the site. Copies of the abatement order and the inspection report shall be attached to the second abatement order.

e. If a special inspector conducted the inspection, more than 45 days have passed since the deadline for correction of hazards, and an inspection report indicating the hazards are corrected has not been filed, the labor commissioner may contact the special inspector, send a second abatement order to the owner, or send a state inspector to inspect the conveyance. Copies of the abatement order and the inspection report shall be attached to a second abatement order.

f. If an inspection as described in paragraph 71.11(7)*"d"* or *"e"* reveals no significant progress toward correcting the unsafe conditions, and the remaining unsafe conditions create no significant safety concerns, the labor commissioner may extend the time for abatement of the unsafe conditions an additional 10 days or may serve a notice of intent to suspend, deny or revoke the operating permit. The labor commissioner may also post a notice prohibiting use of the conveyance pending abatement of the unsafe conditions listed in the inspection report.

g. Procedures for appeal of a notice of intent to suspend, deny or revoke an operating permit are set forth in 875—Chapter 69.

71.11(8) *Imminent danger.* If the labor commissioner determines that continued operation of a conveyance pending correction of unsafe conditions creates an imminent danger, the labor commissioner shall post notice on the conveyance that it is not to be used pending repairs. Use of a conveyance contrary to posted notice by the labor commissioner may result in additional legal proceedings pursuant to Iowa Code section 89A.10(3) or 89A.18. The conveyance may be returned to service only after the imminent danger has been corrected and the conveyance has passed a comprehensive inspection.

71.11(9) *Interference prohibited.* No person shall interfere with, delay or impede an inspector employed by the state during an inspection.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 9221B**, IAB 11/17/10, effective 12/22/10; **ARC 0168C**, IAB 6/13/12, effective 7/18/12; **ARC 0685C**, IAB 4/17/13, effective 5/22/13; **ARC 1971C**, IAB 4/29/15, effective 6/3/15]

875—71.12(89A,252J,261,272D) Special inspector commissions.

71.12(1) *Definition.* As used in this rule, "certificate of noncompliance" means:

a. A certificate of noncompliance issued by the child support recovery unit, department of human services, pursuant to Iowa Code chapter 252J;

b. A certificate of noncompliance issued by the college student aid commission pursuant to Iowa Code chapter 261; or

c. A certificate of noncompliance issued by the centralized collection unit of the department of revenue pursuant to Iowa Code chapter 272D.

71.12(2) *Qualifications.*

a. Each applicant must possess a high school diploma or general equivalency degree.

b. Each applicant shall have at least three years of full-time work experience in the construction, installation, repair or inspection of conveyances.

c. Each applicant shall be a CEI.

d. Each applicant shall satisfactorily pass a division of labor services examination on Iowa procedures, Iowa policies, and all safety standards adopted by reference.

e. Each applicant shall submit proof of insurance coverage insuring the applicant against liability for injury or death for any act or omission on the part of the applicant. The insurance policy shall be in an amount of not less than $1,000,000 for bodily injury to or death of one person in any one accident, and in an amount of not less than $5,000,000 for bodily injury to or death of two or more persons in any one accident, and in an amount of not less than $100,000 for damage to or destruction of property in any one accident. The insurance coverage of the special inspector's employer shall be considered to comply with this requirement if the coverage provides equivalent coverage for each special inspector.

71.12(3) *Application.* An applicant for a commission shall complete, sign, and submit to the division the form provided by the division with the required fee. The applicant shall include with the application proof that the applicant is a CEI.

71.12(4) *Expiration.* The commission expires when the commission is suspended or revoked by the labor commissioner or one year from issuance, whichever occurs earlier.

71.12(5) *Changes.* The special inspector shall notify the division at the time any of the information on the form or attachments changes.

71.12(6) *Denials.* The labor commissioner may refuse to issue or renew a special inspector's commission for failure of the applicant to complete an application package, if the applicant is not a CEI, or for any reason listed in subrules 71.12(8) to 71.12(10).

71.12(7) *Investigations.* The labor commissioner may investigate for any reasonable cause related to special inspectors or special inspector applicants. The labor commissioner may conduct interviews and utilize other reasonable investigatory techniques. Investigations may be conducted without prior notice at the times and in the places the labor commissioner directs. The labor commissioner may notify the organization that certified the special inspector as a CEI of the findings of an investigation.

71.12(8) *Reasons for probation.* The labor commissioner may issue a notice of commission probation when an investigation reasonably reveals that the special inspector filed inaccurate reports.

71.12(9) *Reasons for suspension.* The labor commissioner may issue a notice of commission suspension when an investigation reasonably reveals any of the following:

a. The special inspector failed to submit and report inspections on a timely basis;

b. The special inspector abused the special inspector's authority;

c. The special inspector misrepresented self as a state inspector or a state employee;

d. The special inspector used commission authority for inappropriate personal gain;

e. The special inspector failed to follow the division's rules for inspection of object repairs, alterations, construction, installation, or in-service inspection;

f. The special inspector committed numerous violations as described in subrule 71.12(8);

g. The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;

h. The special inspector is no longer a CEI;

i. The division received a certificate of noncompliance; or

j. The special inspector failed to take appropriate disciplinary actions against a subordinate special inspector who has committed repeated acts or omissions listed in paragraphs 71.12(9)*"a"* to *"h."*

71.12(10) *Reasons for revocation.* The labor commissioner may issue a notice of revocation of a special inspector's commission when an investigation reveals any of the following:

a. The special inspector filed a misleading, false or fraudulent report;

b. The special inspector failed to perform a required inspection;

c. The special inspector failed to file a report or filed a report which was not in accordance with the provisions of applicable standards;

d. The special inspector committed repeated violations as described in subrule 71.12(9);

e. The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;

f. The special inspector instructed, ordered, or otherwise encouraged a subordinate special inspector to perform the acts or omissions listed in paragraphs 71.12(10)*"a"* to *"e"*;

g. The special inspector is no longer a CEI; or

h. The division received a certificate of noncompliance.

71.12(11) *Procedures.* The following procedures shall apply except in the event of revocation or suspension due to receipt of a certificate of noncompliance. In instances involving receipt of a certificate of noncompliance, the applicable procedures of Iowa Code chapter 252J, 261, or 272D shall apply.

a. Notice of actions. The labor commissioner shall serve a notice on the special inspector by certified mail to an address listed on the commission application form or by other service as permitted by Iowa Code chapter 17A.

b. Contested cases. The special inspector shall have 20 days to file a written notice of contest with the labor commissioner. If the special inspector does not file a written contest within 20 days of receipt of the notice, the action stated in the notice shall automatically be effective.

c. Hearing procedures. The hearing procedures in 875—Chapter 1 shall govern.

d. Emergency suspension. Pursuant to Iowa Code section 17A.18A, if the labor commissioner finds that the public health, safety or welfare imperatively requires emergency action because a special inspector failed to comply with applicable laws or rules, the special inspector's commission may be summarily suspended.

e. Probation period. A special inspector may be placed on probation for a period not to exceed one year for each incident causing probation.

f. Suspension period. A special inspector's commission may be suspended up to five years for each incident causing a suspension.

g. Revocation period. A special inspector's commission that has been revoked shall not be reinstated for five years.

h. Concurrent actions. Multiple actions may proceed at the same time against any special inspector.

i. Revoked or suspended commissions. Within five business days of final agency action revoking or suspending a special inspector commission, the special inspector shall surrender the special inspector's commission card to the labor commissioner. The labor commissioner may notify the special inspector's employer and the organization that certified the special inspector as a CEI of a revocation or suspension.

[**ARC 7841B**, IAB 6/17/09, effective 7/22/09]

875—71.13(89A) State employees. Rescinded **ARC 1971C**, IAB 4/29/15, effective 6/3/15.

875—71.14(89A) Safety tests. Only safety test reports submitted on approved forms from elevator mechanics who are employed by authorized companies shall be considered to meet the requirements of this rule. The alternative test methods set forth at ASME A17.1, Rule 8.6.11.10, shall not be allowed as a substitute for a full-load safety test.

71.14(1) *When safety tests will be performed.*

a. Safety tests shall be performed on new and altered installations before they are placed in service.

b. Safety tests shall be made on all conveyances pursuant to the schedules and procedures set forth in:

(1) The maintenance control plan for wind tower lifts exempted from ASME A17.1 by rule 875—72.12(89A);

(2) The CCD for conveyances covered by ASME A17.7-2007/CSA B44-07;

(3) The columns pertaining to "periodic tests" in Table N-1 in the edition of ASME A17.1 currently adopted for new conveyances at rule 875—72.1(89A);

(4) ASME A18.1(2003), Part 10; or

(5) ANSI A10.4-2007, Section 26.4.

71.14(2) *How safety tests will be reported.* Within 30 days after completion of a safety test, the elevator mechanic shall file with the labor commissioner a report on an approved form and shall provide a copy of the form to the owner and to the witness, if applicable.

71.14(3) *How safety tests will be recorded.* The elevator mechanic shall attach a tag showing the date of the test, the elevator mechanic's name, and the type of test performed.

a. On electric traction elevators, the elevator mechanic shall attach the tag to the safety-releasing carrier.

b. On hydraulic elevators, the elevator mechanic shall attach the tag to the disconnecting switch or the controller.

c. On wheelchair lifts, the elevator mechanic shall attach the tag to the disconnecting switch.

d. On other conveyances covered by these rules, the commissioner's designee witnessing the acceptance safety test shall indicate the proper location of the tag. Subsequent test tags shall be attached in the same location.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 9221B**, IAB 11/17/10, effective 12/22/10; **ARC 0168C**, IAB 6/13/12, effective 7/18/12; **ARC 1766C**, IAB 12/10/14, effective 1/14/15]

875—71.15(89A) Authorized companies.

71.15(1) Each year, authorized companies shall train their elevator mechanics who perform safety tests on safety test procedures.

71.15(2) For each conveyance owned by an authorized company, the owner shall obtain the services of a CEI who is not employed by the authorized company or an inspector employed by the state to witness the safety test.

71.15(3) To become authorized to perform safety tests, a company shall submit a copy of its procedures for performing safety tests. The labor commissioner shall review the procedures for adequacy and shall request modifications to the procedures or grant or deny the authorization.

71.15(4) Every five years or within six months after the board adopts a new edition of ASME, whichever is earlier, authorized companies shall submit revised safety test procedures for renewal of authorization. The labor commissioner shall review the procedures for adequacy and shall request modifications to the procedures or grant or deny the authorization.

71.15(5) Investigations. Investigations shall take place at the times and in the places the labor commissioner directs. The labor commissioner may investigate for any reasonable cause. The labor commissioner may conduct interviews and utilize other reasonable investigatory techniques. Investigations may be conducted without prior notice.

71.15(6) Suspension. If the labor commissioner determines that a falsified safety test report was submitted by an elevator mechanic, the labor commissioner shall suspend the authorization of the elevator mechanic's employer for six months. During the suspension, all safety tests performed by any employee of the authorized company shall be witnessed by a state inspector or a CEI who is not employed by the suspended authorized company.

71.15(7) Suspension procedures.

a. The labor commissioner shall notify an authorized company of its suspension by certified mail or by other service as permitted by Iowa Code chapter 17A.

b. The authorized company shall have 20 days to file a written notice of contest with the labor commissioner. If the authorized company does not file a written notice of contest in a timely manner, the suspension shall automatically be effective. If the authorized company does file a written notice of contest in a timely manner, the hearing procedures in 875—Chapter 1 shall govern.

c. If the labor commissioner finds, pursuant to Iowa Code section 17A.18A, that public health, safety or welfare imperatively requires emergency action, the authorization may be summarily suspended.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—71.16(89A) Fees. Except as noted in this rule, all fees are nonrefundable and due in advance.

71.16(1) *Operating permits.* The annual operating permit fee shall be $75 per conveyance.

71.16(2) *Periodic inspections.* Fees shall be remitted to the division of labor services within 30 days of the date of inspection. The fees for periodic inspections shall be as follows:

a. Construction elevator: $200.
b. Wind tower lift: $225.
c. Hand-powered elevator: $90.
d. Television tower elevator: $500.
e. Handicapped restricted use elevator: $100.
f. Other hydraulic elevator: $100.
g. Other traction elevator: $150.
h. Escalator: $150.
i. Dumbwaiter: $90.
j. Wheelchair lift: $90.
k. CPH.
(1) Annual: $500.
(2) Quarterly: $200.
l. Moving walk: $150.

71.16(3) *Installation permits.* The fees in this subrule cover the initial print review, installation permit, initial inspection and first-year operating permit. Each print revision submitted to the division shall be subject to an additional fee of $100. The fees for new installations shall be as follows:

a. Wind tower lift: $500.
b. Hydraulic elevator: $750.
c. Traction elevator: $1000.
d. Escalator: $1000.
e. Dumbwaiter: $500.
f. Wheelchair lift: $500.
g. CPH: $500.
h. Moving walk: $500.

71.16(4) *Alteration permits.*

a. The fee for any elevator alteration permit shall be $500 and shall cover the initial print review, alteration permit, and initial inspection.

b. The fee for each CPH extension shall be $150. The total fee required for all planned CPH extensions shall be submitted with the installation permit application pursuant to subrule 71.5(3).

c. The fee for an alteration permit shall be $500 if the only alteration is the addition or replacement of an escalator skirt brush.

d. For all other conveyances, the fees for new installations shall apply to alterations.

71.16(5) *Construction permits.* The construction permit fee shall be $200 per conveyance. This fee includes the fee for initial inspection.

71.16(6) *Controller upgrade permits.* The controller upgrade permit fee shall be $250. This fee includes one inspection.

71.16(7) *Consultative inspections.* Consultative inspections may be performed at the discretion of the labor commissioner for $125 per hour, including travel time, with a minimum charge of $250.

71.16(8) *Special inspector commission.* The special inspector commission fee shall be $60 annually.

71.16(9) *Witness of safety tests.* The fee for division employees to witness safety tests shall be $125 per hour, including travel time, with a minimum charge of $250.

71.16(10) *Permit extensions.* The fee to extend an installation permit, alteration permit, or construction permit shall be $100.

71.16(11) *Inspections outside of normal business hours.* Inspections outside the normal business hours may be performed at the discretion of the labor commissioner. If the owner or contractor requests an inspection outside of normal business hours and the labor commissioner agrees to the schedule, an additional fee will be charged. The additional fee will be calculated at a rate of $200 per hour, including travel time, with a minimum charge of $400.

71.16(12) *Reinspections.* The fees for reinspections are $400 for television tower elevators and CPHs, $200 for wind tower lifts, and $300 for all other conveyances.

71.16(13) *Inspection for temporary removal from service.* The inspection fee for temporary removal from service pursuant to rule 875—71.20(89A) shall be $125 per hour, including travel time, with a minimum charge of $250.

71.16(14) *Fee waiver.*

a. When a state inspector combines in one visit two different types of inspection on a single conveyance, the commissioner may waive the lesser of the fees.

b. The fee for an alteration permit shall be waived by the commissioner if the only alterations covered by the permit application are required by rule 875—72.26(89A) or 875—73.27(89A). The fee waiver set forth in this paragraph does not eliminate the requirement to pay for an acceptance inspection or for an operating permit.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 9221B**, IAB 11/17/10, effective 12/22/10; **ARC 0318C**, IAB 9/5/12, effective 10/10/12; **ARC 0685C**, IAB 4/17/13, effective 5/22/13; **ARC 1158C**, IAB 10/30/13, effective 12/4/13; **ARC 1972C**, IAB 4/29/15, effective 6/3/15; **ARC 1971C**, IAB 4/29/15, effective 6/3/15]

875—71.17(89A) Publications available for review. Standards, codes, and publications adopted by reference in these rules are available for review in the office of the Division of Labor Services, 1000 E. Grand Avenue, Des Moines, Iowa 50319.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—71.18(89A) Other regulations affecting elevators. Regulations concerning accessibility of buildings and conveyances available to the public are found at 661—Chapter 302. Regulations governing the safety and health of employees who work in and around elevators are found at 875—Chapters 2 to 26. Iowa Code chapter 91C and 875—Chapter 150 apply to companies that alter and install conveyances. No rule in 875—Chapters 71 to 73 shall be interpreted as creating an exemption, waiver, or variance from any otherwise applicable regulation or statute.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—71.19(89A) Accidents.

71.19(1) *Reporting the accident.* The owner shall immediately notify the commissioner of each personal injury accident requiring the service of a physician or causing disability exceeding one day or causing damage to the conveyance exceeding $2,000. Notification shall be in writing and shall include the state identification number, owner, and description of accident.

71.19(2) *Securing the accident site pending investigation.* The removal of any part of the damaged conveyance or operating mechanism from the premises is forbidden until permission to do so is granted by the commissioner.

71.19(3) *Putting the conveyance back into operation.* When an accident involves the failure or destruction of any part of the conveyance or its operating mechanism, the use of the conveyance is forbidden until it has been made safe, until it has been reinspected, and until any repairs or alterations have been approved by the commissioner.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—71.20(89A) Temporary removal from service. The requirements for an annual inspection, annual inspection fee, safety test, operating permit, and operating permit fee shall be temporarily suspended for up to three years for an elevator in an unoccupied building if the requirements of this rule are met.

71.20(1) All elevator doors in unoccupied buildings shall be closed and locked. Hydraulic elevators shall be parked at the bottom of the hoistway. Traction elevators shall be parked at the top of the hoistway.

71.20(2) Upon request by the owner of an elevator in an unoccupied building, the labor commissioner shall send an inspector who is a state employee to confirm that the building is unoccupied and that the car and doors of the elevator have been properly secured. If the conditions set forth in subrule 71.20(1) are met, the inspector shall apply to the elevator a seal and a red tag marked with the words "Do Not Operate."

71.20(3) One year after the inspection, the owner must file with the labor commissioner written confirmation that the status of the elevator and building have not changed, and the owner must file again two years after the inspection. Failure to comply with this requirement shall result in termination of the temporary suspension of the requirements for safety tests, inspections, and operating permits.

71.20(4) Prior to returning the elevator to service, and upon request of the owner, the labor commissioner may allow the elevator to be operated for 30 days for the sole purpose of performing safety tests and maintenance.

71.20(5) The owner must notify the labor commissioner at least two weeks before placing an elevator back into service and must arrange for an inspector who is a state employee to witness a safety test.

71.20(6) If at the end of three years the building is still unoccupied, suspension of the requirements for safety tests, inspections, and operating permits shall end without possibility of renewal.

[**ARC 0318C**, IAB 9/5/12, effective 10/10/12]

These rules are intended to implement Iowa Code chapters 89A, 252J, 261 and 272D.

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CHAPTER 72
CONVEYANCES INSTALLED ON OR AFTER JANUARY 1, 1975

[Prior to 9/24/86, Labor, Bureau of [530]]
[Prior to 10/21/98, see 347—Ch 72]

875—72.1(89A) Purpose and scope. This chapter contains safety standards covering the design, construction, installation, operation, inspection, testing, maintenance, alteration and repair of conveyances installed on or after January 1, 1975. The rules of this chapter also apply to previously dormant conveyances that are being reactivated, and to reinstalled or moved conveyances. As used in this rule, the word "installation" refers to the date on which a conveyance contractor enters into a contractual agreement pertaining to a conveyance.

72.1(1) For installations between January 1, 1975, and December 31, 1982, ANSI A17.1 shall mean ANSI A17.1 (1971).

72.1(2) For installations between January 1, 1983, and December 31, 1992:

a. ANSI A17.1 shall mean ANSI A17.1 (1981); and

b. ANSI A117.1 shall mean ANSI A117.1 (1980).

72.1(3) For installations between January 1, 1993, and December 31, 2000:

a. ASME A17.1 shall mean ASME A17.1 (1990) and in addition shall mean the following:

(1) ASME A17.1b (1992), Rule 110.11h, for electric elevators installed between July 1, 1993, and December 31, 2000, and

(2) ASME A17.1b (1992), Rule 110.11h that is referenced by Rule 300.11, for hydraulic elevators installed between July 1, 1993, and December 31, 2000.

b. ANSI/NFPA 70 shall mean ANSI/NFPA 70 (1990); and

c. ANSI A117.1 shall mean ANSI A117.1 (1980).

72.1(4) For installations between January 1, 2001, and December 31, 2003:

a. ASME A17.1 shall mean ASME A17.1 (1996 through the 1999 addenda);

b. ASME A18.1 shall mean ASME A18.1 (1999), except Chapters 4, 5, 6, and 7;

c. ANSI A117.1 shall mean ANSI A117.1 (1998); and

d. ANSI/NFPA 70 shall mean ANSI/NFPA 70 (1999).

72.1(5) For installations between January 1, 2004, and April 4, 2006:

a. ASME A17.1 shall mean ASME A17.1 (2000 through the 2003 addenda);

b. ASME A18.1 shall mean ASME A18.1 (1999 through the 2001 addenda), except Chapters 4, 5, 6, and 7;

c. ANSI A117.1 shall mean ANSI A117.1 (1998); and

d. ANSI/NFPA 70 shall mean ANSI/NFPA 70 (2002).

72.1(6) For installations between April 5, 2006, and July 22, 2008:

a. ASME A17.1 shall mean ASME A17.1-2004, A17.1a-2005 and A17.1S-2005;

b. ASME A18.1 shall mean ASME A18.1 (2003), except Chapters 4, 5, 6, and 7;

c. ANSI A117.1 shall mean ANSI A117.1 (2003), except for Rule 407.4.6.2.2; and

d. ANSI/NFPA 70 shall mean ANSI/NFPA 70 (2005).

72.1(7) For installations between July 23, 2008, and July 18, 2012:

a. ASME A17.1 shall mean ASME A17.1-2007/CSA B44-07;

b. ASME A17.7 shall mean ASME A17.7-2007/CSA B44-07;

c. ASME A18.1 shall mean ASME A18.1 (2003), except Chapters 4, 5, 6, and 7;

d. ANSI A117.1 shall mean ANSI A117.1 (2003), except for Rule 407.4.6.2.2; and

e. ANSI/NFPA 70 shall mean ANSI/NFPA 70 (2005).

72.1(8) For installations between July 19, 2012, and January 30, 2014:

a. ASME A17.1 shall mean ASME A17.1-2010/CSA B44-10, except for Rule 2.27.1.1.6;

b. ASME A17.7 shall mean ASME A17.7-2007/CSA B44-07;

c. ASME A18.1 shall mean ASME A18.1 (2003), except Chapters 4, 5, 6, and 7;

d. ANSI A117.1 shall mean ANSI A117.1 (2003), except for Rule 407.4.6.2.2; and

e. ANSI/NFPA 70 shall mean ANSI/NFPA 70 (2008).

72.1(9) For installations between January 31, 2014, and January 14, 2015:

a. ASME A17.1 shall mean ASME A17.1-2010/CSA B44-10, except for Rule 2.27.1.1.6;

b. ASME A17.7 shall mean ASME A17.7-2007/CSA B44-07;

c. ASME A18.1 shall mean ASME A18.1 (2011), except Chapters 4, 5, 6, and 7;

d. ANSI A117.1 shall mean ANSI A117.1 (2003), except for Rule 407.4.6.2.2; and

e. ANSI/NFPA 70 shall mean ANSI/NFPA 70 (2008).

72.1(10) For installations on or after January 14, 2015:

a. ASME A17.1 shall mean ASME A17.1-2013/CSA B44-13;

b. ASME A17.7 shall mean ASME A17.7-2007/CSA B44-07;

c. ASME A18.1 shall mean ASME A18.1 (2011), except Chapters 4, 5, 6, and 7;

d. ANSI A117.1 shall mean ANSI A117.1 (2003), except for Rule 407.4.6.2.2; and

e. ANSI/NFPA 70 shall mean ANSI/NFPA 70 (2011).

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 8759B**, IAB 5/19/10, effective 6/23/10; **ARC 0168C**, IAB 6/13/12, effective 7/18/12; **ARC 1232C**, IAB 12/11/13, effective 1/31/14; **ARC 1766C**, IAB 12/10/14, effective 1/14/15; **ARC 1971C**, IAB 4/29/15, effective 6/3/15]

875—72.2(89A) Definitions. The definitions contained in ASME A17.1, ASME A18.1, ANSI A117.1, and any other standard adopted herein by reference shall be applicable as used in this chapter to the extent that the definitions do not conflict with the definitions contained in Iowa Code chapter 89A and these rules. However, the definition of "building code" in ASME A17.1 is modified to exclude the Building Construction and Safety Code (NFPA 5000) and the National Building Code of Canada (NBCC) for any installation after March 1, 2008.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—72.3(89A) Accommodating the physically disabled. All passenger elevators installed between January 1, 1975, and December 31, 1982, which are available and intended for public use shall be usable by the physically disabled. All passenger elevators shall have control buttons with identifying features for the benefit of the blind and shall allow for wheelchair traffic. All passenger elevators and wheelchair lifts installed on or after January 1, 1983, which are accessible to the general public shall comply with Accessible and Usable Buildings and Facilities ANSI A117.1, sections 407 and 408.

875—72.4(89A) Electric elevators. The provisions contained in ASME A17.1, part 2, are adopted by reference.

875—72.5(89A) Hydraulic elevators. The provisions contained in ASME A17.1, part 3, are adopted by reference.

875—72.6(89A) Power sidewalk elevators. The provisions contained in ASME A17.1, section 5.5, are adopted by reference.

875—72.7(89A) Performance-based safety code. Conveyances may comply with ASME A17.7, in whole or in part, as an alternative to ASME A17.1.

875—72.8(89A) Hand and power dumbwaiters. The provisions contained in ASME A17.1, sections 7.1, 7.2, 7.3, and 7.8, are adopted by reference.

875—72.9(89A) Escalators and moving walks. The provisions contained in ASME A17.1, part 6, are adopted by reference, except for those portions that allow an operating or safety device to reset automatically.

[**ARC 1766C**, IAB 12/10/14, effective 1/14/15]

875—72.10(89A) General requirements.

72.10(1) The provisions contained in ASME A17.1, Part 8, are adopted by reference unless specifically excluded herein.

72.10(2) Except as noted in this rule, the American Society of Mechanical Engineers Safety Code for Existing Elevators and Escalators, A17.3 (2011), is adopted by reference with an enforcement date of May 1, 2020.

a. If a code provision that is more restrictive than A17.3 (2011) applied to a conveyance when the conveyance was installed, the more restrictive provision shall remain in effect.

b. A17.3 (2011) Part X applies to handicapped restricted use elevators without regard to the scope provisions set forth in A17.3 (2011) Part X.

c. Provisions of A17.3 (2011) that require installation of a new controller to implement Phase 1 and Phase 2 fire service or car top operation are not adopted by reference and shall not be enforced in Iowa.

d. A17.3 (2011), Rule 2.3.2, is intended to prevent the accumulation of sewer gas in an elevator pit and shall not be interpreted to require the addition of a drain pipe in an existing pit. An air gap in an existing drain pipe shall be considered adequate compliance.

e. An elevator that was legally installed with guide rails made of materials other than steel shall not be required to replace the guide rails due to the adoption of A17.3 (2011).

[**ARC 1891C**, IAB 3/4/15, effective 4/8/15]

875—72.11(89A) Acceptance and periodic tests and inspections of elevators, dumbwaiters, escalators and moving walks. Rescinded IAB 6/17/09, effective 7/22/09.

875—72.12(89A) Wind tower lifts. Wind tower lifts authorized by this rule shall not be installed in grain elevators, high-rise buildings, water towers, television towers or any facility other than a wind tower built for the production of electricity. This rule applies to all wind tower lifts, whether installed before or after May 28, 2008; however, this exception shall not apply to a wind tower lift if the contract for its installation is executed after an AECO is accredited.

72.12(1) Wind tower lifts that meet the requirements of subrules 72.12(2) through 72.12(10) are exempt from the requirements of ASME A17.1. This temporary exemption shall terminate for a wind tower lift upon the occurrence of at least one of the following events:

a. Three weeks have passed since the accreditation of at least one AECO, and the manufacturer of the wind tower lift has not filed with the labor commissioner an affidavit attesting that a request for Certificate of Conformance as described by ASME A17.7 (2007) was submitted to an AECO.

b. The AECO has reviewed a request pursuant to ASME A17.7 and refused to issue a Certificate of Conformance for the model or series of lifts.

c. The AECO has determined that modifications to the wind tower lift are necessary, and the modifications have not been made with reasonable diligence.

d. The AECO has determined that modifications to the wind tower lift are necessary, and the labor commissioner determines the wind tower lift is not safe to operate prior to completion of the modifications.

e. The AECO has reviewed an application pursuant to ASME A17.7 and issued a Certificate of Conformance for the model or series of lifts.

72.12(2) A wind tower lift placed in operation on or before May 28, 2008, shall be registered by the owner with the labor commissioner no later than July 1, 2008, and shall pass an installation inspection by inspectors employed by the labor commissioner according to the schedule set by the labor commissioner. The wind tower lift shall receive a periodic inspection by the labor commissioner's inspectors annually thereafter.

72.12(3) The owner of a wind tower lift installed after May 28, 2008, shall register the wind tower lift with the labor commissioner prior to its installation. A wind tower lift installed after May 28, 2008, shall pass an installation inspection by the labor commissioner's inspectors prior to its being placed into operation. The wind tower lift shall receive a periodic inspection by the labor commissioner's inspectors annually thereafter.

72.12(4) Registration pursuant to this rule requires submission of the following information to the labor commissioner:

a. The unique identifier of the wind tower.

b. The name of the wind tower owner and contact information for the owner's representative.

c. The name of the wind tower lift manufacturer and contact information for the manufacturer's representative.

d. The location of the wind farm.

e. Three copies of the prints and design documents that are certified by a professional engineer duly licensed in the state of Iowa and that bear the professional engineer's P.E. stamp for the lifts.

f. The manufacturer's complete test procedures, inspection checklists, operating manual, service manual, and related documents as determined necessary by the labor commissioner.

72.12(5) The owner shall notify the labor commissioner within 30 days of any change in the information provided pursuant to 72.12(4)*"b"* and *"c."*

72.12(6) This subrule establishes reporting requirements in addition to the requirements of rule 875—71.3(89A). The manufacturer of a lift must notify the labor commissioner in writing within one week if one of its wind tower lifts anywhere in the world is involved in a personal injury accident requiring the service of a physician, a personal injury accident causing disability exceeding one day or death, or an incident causing property damage exceeding $2,000. The notification shall specifically identify the model number, serial number, and owner of the lift, and a description of the incident or accident. The labor commissioner shall determine and require necessary inspections, tests, changes or enhancements to prevent a similar incident or accident in this state.

72.12(7) Wind tower lifts must comply with 29 CFR 1910.

72.12(8) The manufacturer shall notify the labor commissioner within seven days of notification to the manufacturer that an AECO has:

a. Issued a Certificate of Conformance for the model or series of wind tower lifts,

b. Refused to issue a Certificate of Conformance for the model or series of wind tower lifts, or

c. Determined that modifications to the wind tower lifts are necessary.

72.12(9) Wind tower lifts shall pass an inspection covering the following criteria:

a. Ascending speed, descending speed, and emergency descending speed shall not exceed the manufacturer's recommendations.

b. Stop switch, interior lighting, cage entry door, door contact, operating controls and remote operating controls shall operate according to manufacturer's recommendations.

c. Interior floor and cage framework shall appear to be structurally sound.

d. Enclosure signage recommended by the manufacturer shall be in place.

e. Manufacturer's data plate shall be visible.

f. Hoisting mechanism shall appear to be structurally sound and intact from inside and outside the car.

g. Guide shoes shall appear to be structurally sound and undamaged.

h. Suspended power cords and strain relief devices shall reveal no visible damage.

i. Upper and lower normal and final limits shall operate according to the manufacturer's recommendations.

j. Overspeed device shall successfully pass a full-load test.

k. Overload device shall successfully pass an overload test according to the manufacturer's recommendations.

l. Wire rope, safety rope, and guide rope shall show no evidence of wear.

m. Guide rope attachments, suspension attachment beam, beam tower attachments, suspension rope attachment, suspension rope secondary attachment (if present), and guide wire rope attachments shall show no evidence of wear or fatigue.

n. The wind tower lift shall not drift when subjected to a static full load.

o. Maintenance logs, tags, and other necessary documentation shall be available in sufficient detail to establish that maintenance is occurring pursuant to the manufacturer's schedule.

p. Guide rope tension device, safety rope tension device, and suspension rope tension device shall pass a visual test for proper tension.

q. Power cord catch basket shall pass a visual inspection.

r. Safety set distance, overspeed trip speed, overload limit setting, and maximum overload allowed shall not exceed manufacturer's recommendations.

s. A communication device, if installed in the car, shall be operable.

t. Any other items on the manufacturer's recommended inspection checklist shall pass inspection.

72.12(10) The owner or owner's representative shall provide weights as needed to perform necessary tests during inspections.

875—72.13(89A) Alterations, repairs, replacements and maintenance.

72.13(1) *General.* Except as set forth in this rule, all maintenance, repairs, replacements, and alterations shall comply with the edition of ASME A17.1 currently adopted for new conveyances at rule 875—72.1(89A) or ASME A17.7-2007/CSA B44-07, as applicable. Rule 875—71.10(89A) describes alterations which require that the entire conveyance be brought into compliance with the most current codes.

72.13(2) *Exemption for button renumbering.* All maintenance, repairs and alterations to devices covered by ANSI A117.1 shall comply with ANSI A117.1 (2003), except for Rule 407.4.6.2.2.

72.13(3) *Sump pump exemption.* The provisions of ASME A17.1 that require a pit sump or drain shall not apply to an elevator alteration when all of the following criteria are met:

a. No other code or rule requires that the pit be excavated or lowered.

b. The alteration plans do not include the excavation or lowering of the pit floor for any other reason.

c. There is evidence that groundwater has not entered the pit previously.

d. The location and geology of the building indicate a likelihood that groundwater would enter the pit if the foundation or pit floor were breached to install the pit sump or drain.

e. A description of alternative means to maintain the pit in a dry condition is provided to the labor commissioner with the alteration permit application.

f. The labor commissioner approves the alternative means to maintain the pit in a dry condition.

g. The alternative means to maintain the pit in a dry condition are installed or implemented as described in the alteration permit application.

72.13(4) *Pit excavation exemption.* The full length of the platform guard set forth in ASME A17.1, Rule 2.15.9.2(a), shall not be required if all of the following criteria are met:

a. No other code or rule requires that the pit be excavated or lowered.

b. The alteration plans do not include the excavation or lowering of the pit floor for any other reason.

c. A full-length platform guard would strike the pit floor when the elevator is on its fully compressed buffer.

d. The clearance between the bottom of the platform guard and the pit floor is 2.5 centimeters (1 inch) when the elevator is on its fully compressed buffer.

72.13(5) *Sprinkler retrofits and shunt trip breakers.* When a sprinkler is added to a hoistway or machine room, the conveyance shall comply with the following:

a. The installation shall comply with the applicable version of ASME A17.1, Rule 2.8.3.3.

b. The elevator controls shall be arranged to comply with the phase I fire recall provisions of the applicable version of ASME A17.1, Rule 2.27.3.

c. The applicable version of ASME A17.1 shall be determined by reference to rule 875—72.1(89A). For purposes of rule 875—72.13(89A), the relevant subrule of 875—72.1(89A) shall apply based on the date the sprinkler is installed instead of the date the conveyance was installed.

72.13(6) *Alterations of handicapped restricted use elevators.* A component of a handicapped restricted use elevator being altered shall comply with the portions of ASME A17.1, section 5.3, applicable to the component. The edition of ASME A17.1 adopted by reference in rule 875—72.1(89A) shall be applied.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 1766C**, IAB 12/10/14, effective 1/14/15; **ARC 2396C**, IAB 2/17/16, effective 3/23/16]

875—72.14(89A) Design data and formulas. Rescinded IAB 11/26/03, effective 1/1/04.

875—72.15(89A) Power-operated special purpose elevators. The provisions contained in ASME A17.1, section 5.7, are adopted by reference.

875—72.16(89A) Inclined and vertical wheelchair lifts. The provisions contained in ASME Safety Standard for Platform Lifts and Stairway Chairlifts A18.1, sections 1, 2, 3, 8, 9, and 10, are adopted by reference for all inclined and vertical wheelchair lifts.

875—72.17(89A) Hand-powered elevators. Hand-powered elevators shall not be installed after January 1, 1983.

875—72.18(89A) Accommodating the physically disabled. Renumbered as 875—72.3(89A), IAB 11/26/03, effective 1/1/04.

875—72.19(89A) Limited-use/limited-application elevators. The provisions contained in ASME A17.1, section 5.2, are adopted by reference.

875—72.20(89A) Rack and pinion, screw-column elevators. The provisions contained in ASME A17.1, sections 4.1 and 4.2, are adopted by reference.

875—72.21(89A) Inclined elevators. The provisions contained in ASME A17.1, section 5.1, are adopted by reference.

875—72.22(89A) Material lift elevators. The provisions contained in ASME A17.1, Sections 7.4 and 7.5, are adopted by reference for Type B material lift elevators installed on or after July 23, 2008. Material lift elevators used exclusively for the movement of materials are not subject to regulation under Iowa Code chapter 89A.
[Editorial change: IAC Supplement 2/18/15; see Note 1 at end of chapter]

875—72.23(89A) Elevators used for construction. The provisions contained in ASME A17.1, section 5.10, are adopted by reference only as they pertain to elevators utilizing permanent equipment in a permanent location.

875—72.24(89A) Construction personnel hoists. The provisions of American National Standards Institute (ANSI) A10.4-2007 are adopted by reference for construction personnel hoists as defined by ANSI A10.4-2007. Notwithstanding the ANSI definition, these conveyances may be used only temporarily during construction.

875—72.25(89A) Alarm bell. An automatic passenger elevator shall be provided with an alarm bell that is activated by a switch marked "ALARM" located in or adjacent to the car operating panel. The alarm bell shall be audible inside the car and outside the hoistway.
[**ARC 0950C**, IAB 8/21/13, effective 9/25/13]

875—72.26(89A) Child safety guards. Unless the car door on a passenger elevator consists of a solid panel, the following criteria shall be met:

72.26(1) A multipoint light curtain shall be installed between the car door and the edge of the car platform.

72.26(2) A second multipoint light curtain shall be installed at the hoistway opening of each floor where a gap of more than 5 inches exists between the car light curtain and the hoistway door.

72.26(3) Each light curtain required by this rule must deactivate the elevator if the light curtain does not function or if the light curtain is obstructed by an object larger than a 4-inch ball.
[**ARC 1972C**, IAB 4/29/15, effective 6/3/15]

875—72.27(89A) Handicapped restricted use elevators. All handicapped restricted use elevators must meet ANSI A17.1 (1981), Part V. Additionally, the elevators shall comply with the following limitations:

1. The elevator shall be used only by a maximum of one disabled person and one attendant at a time. Where a disabled person cannot operate the elevator in a manner which will ensure access to all operating controls and safety features, an attendant shall accompany the disabled person.

2. The elevator shall be key-operated and shall not be capable of being called by buttons or switches but may be called by a key operator.

3. Keys to operate the elevator shall be in the control of the disabled person, the attendant or persons in positions of responsibility at the location.

4. A list shall be maintained at the location indicating the persons holding keys for the operation of the elevator.

5. Each landing and the elevator car shall be posted to indicate that the elevator is only for the use of disabled persons.

6. The travel distance of the elevator shall not exceed 50 feet.

[**ARC 1971C**, IAB 4/29/15, effective 6/3/15]

These rules are intended to implement Iowa Code chapter 89A.

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[Filed ARC 2396C (Notice ARC 2264C, IAB 11/25/15), IAB 2/17/16, effective 3/23/16]

[1] Adopted language of rule 875—72.22(89A) [ARC 6854B, 6/18/08] editorially restored IAC Supplement 2/18/15.

CHAPTER 73
CONVEYANCES INSTALLED PRIOR TO JANUARY 1, 1975

[Prior to 9/24/86, Labor, Bureau of [530]]
[Prior to 10/21/98, see 347—Ch 73]

875—73.1(89A) Scope, definitions, and schedule.

73.1(1) This chapter establishes minimum safety standards for all conveyances installed prior to January 1, 1975, except material lift elevators. Conveyances installed on or after January 1, 1975, shall conform with the requirements set forth in 875—Chapter 72. Material lift elevators installed prior to January 1, 1975, are not subject to regulation pursuant to Iowa Code section 89A.2.

73.1(2) The definitions contained in American National Standard Safety Code for Elevators, Dumbwaiters, Escalators, and Moving Walks, A17.1 (1971), shall be applicable as used in this chapter to the extent that they do not conflict with the definitions contained in Iowa Code chapter 89A or 875—Chapter 71.

73.1(3) Except as noted in this rule, the American Society of Mechanical Engineers Safety Code for Existing Elevators and Escalators, A17.3 (2011), is adopted by reference with an enforcement date of May 1, 2020.

a. If a code provision that is more restrictive than A17.3 (2011) applied to a conveyance when the conveyance was installed, the more restrictive provision shall remain in effect.

b. A17.3 (2011) Part X applies to elevators covered by rule 875—73.21(89A) without regard to the scope provisions set forth in A17.3 (2011) Part X.

c. Provisions of A17.3 (2011) that require installation of a new controller to implement Phase 1 and Phase 2 fire service or car top operation are not adopted by reference and shall not be enforced in Iowa.

d. A17.3 (2011), Rule 2.3.2, is intended to prevent the accumulation of sewer gas in an elevator pit and shall not be interpreted to require the addition of a drain pipe in an existing pit. An air gap in an existing drain pipe shall be considered adequate compliance.

e. The following shall substitute for the final sentence of A17.3 (2011) Rule 2.1.5(b): "Previously installed 60-inch chains are deemed to be in compliance."

f. An elevator that was legally installed with guide rails made of materials other than steel shall not be required to replace the guide rails due to the adoption of A17.3 (2011).

73.1(4) The American Society of Mechanical Engineers Safety Code for Elevators and Escalators, A17.1-2013/CSA B44-13 (2013), Rule 2.14.7.1.4, is adopted by reference with an effective date of May 1, 2020.

73.1(5) Rules 875—73.2(89A) to 875—73.6(89A), 875—73.9(89A) to 875—73.17(89A), 875—73.19(89A), 875—73.22(89A), and 875—73.24(89A) and subrules 73.1(2), 73.7(1) to 73.7(9), 73.7(11), 73.18(1), and 73.18(3) to 73.18(7) shall be superseded by corresponding provisions of A17.3 (2011) on May 1, 2020.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 1891C**, IAB 3/4/15, effective 4/8/15]

875—73.2(89A) Hoistways.

73.2(1) Each passenger elevator hoistway landing shall be protected with a door or gate. The door or gate shall be of solid construction and shall guard the entire entrance.

73.2(2) All automatic passenger elevators with power doors shall have nonvision panels on hoistway doors.

73.2(3) Each hoistway landing in any elevator hoistway shall be continuously provided with a properly working door or gate.

73.2(4) Where freight elevator hoistway doors or gates are of open or lattice construction, they shall be at least 6 feet high and shall come within 2 inches of the floor when closed. Gates shall be constructed to reject a ball 2 inches in diameter. Doors and gates must be able to withstand 250 pounds of pressure applied in the center of the door or gate without breaking or being forced out of their guides.

73.2(5) Manually operated biparting entrances of elevators which can be operated from the landings shall be provided with pull straps on the inside and outside of the upper panel where the lower edge of the upper panel is more than 6 feet 6 inches above the landing when the panel is in the fully opened position.

73.2(6) All freight elevators having wooden hoistway gates in an area where power loading equipment, such as fork trucks, electric mules, etc. are used shall have an acceptable means to restrain the power equipment from running through such wooden gates.

73.2(7) Each hoistway door or gate shall be provided with interlocks designed to prevent the car from moving unless the doors or gates are closed. Where doors or gates do not lock when closed they shall lock when the elevator is not more than 12 inches away from the floor. Passenger elevator hoistway doors shall be closed and locked before the car leaves the floor.

73.2(8) All hoistway-door interlocks shall function as part of a hoistway-unit system.

73.2(9) Automatic fire doors shall not lock any landing opening in the hoistway enclosure from the hoistway side nor lock any exit leading from any hoistway landing to the outside of the building.

73.2(10) Emergency keys for hoistway doors and service keys shall be kept readily accessible to authorized persons and elevator safety inspectors.

73.2(11) Access means shall be provided at one upper landing to permit access to the top of the car, and at the lowest landing if this landing is the normal point of access to the pit.

73.2(12) Each hoistway door or gate which is counterweighted shall have its weights enclosed in a box-type guide or run in metal guides. The bottom of the guides or boxes shall be so constructed as to retain the counterweight if the counterweight suspension means breaks.

73.2(13) Hoistways containing freight elevators shall be fully enclosed. Enclosures shall be unperforated to a height of 6 feet above each floor or landing and above the treads of adjacent stairways. Unperforated enclosures shall be so supported and braced as to deflect not over 1 inch when subjected to a force of 100 pounds applied horizontally to any point. Open work enclosure may be used above the 6-foot level and shall reject a ball 2 inches in diameter.

73.2(14) Hoistways containing passenger elevators shall be fully enclosed and the enclosure shall be of solid construction to its full height.

73.2(15) All elevators that have automatic leveling, inching or teasing devices and that are configured with landing sills that project into the hoistway shall be equipped with a bevel on the underside of the landing sill or the underside of projections found on the bottom section of vertically opening biparting doors. Bevels shall be constructed of smooth concrete or not less than 16-gauge metal securely fastened to the hoistway entrance. Bevels shall extend the full depth of the leveling zone plus 3 inches.

73.2(16) Every hoistway window opening seven stories or less on an outside wall above a thoroughfare and every such window three stories or less above a roof of the building or of an adjacent building shall be guarded to prevent entrance by fire or emergency rescue persons. Each such window shall be marked "hoistway" in a readily visible manner.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.3(89A) Car enclosure: Passenger.

73.3(1) Each passenger car shall be fully enclosed except on the sides used for entrance and exit. The enclosure shall be of solid construction. Grillwork at the top of the sides shall not be more than 8 inches high. If the car is provided with a solid door and there is no grillwork in the enclosure, adequate means of ventilation shall be provided.

73.3(2) Each passenger car enclosure shall have a top constructed of solid material. The top shall be capable of sustaining a load of 300 pounds on any area of 2 feet on a side and 100 pounds applied at any point. Simultaneous application of these loads is not required.

73.3(3) Passenger car enclosure tops shall have an emergency exit with cover. Opening size shall be as set forth in ANSI A17.1, 1971, Rule 204.1E. Hydraulic elevators provided with a manual lowering valve are not required to provide an emergency exit.

73.3(4) Each passenger car shall have a door or gate at each entrance. Doors or gates shall be of the horizontally sliding type. Doors shall be of solid construction. Gates shall be of the collapsible type. Gates and doors shall conform to ANSI A17.1, 1971, Rule 204.4.

73.3(5) Each passenger car door or gate shall have an electric contact to prevent the car from running with doors or gates open. EXCEPTIONS:

a. By a car-leveling or truck-zoning device.

b. By a combination hoistway access switch and operating device.

c. When a hoistway access switch is operated.

73.3(6) All automatic passenger elevators with power doors shall have reopening devices on the doors, designed to reopen doors in the event the doors should become obstructed.

73.3(7) Car door or gate closing force.

a. Where a car door or gate of an automatic or continuous-pressure operation passenger elevator is closed by power, or is of the automatically released self-closing type, and faces a manually operated or self-closing hoistway door, the closing of the car door or gate shall not be initiated unless the hoistway door is in the closed position. The closing mechanism shall be so designed that the force necessary to prevent closing of a horizontally sliding car door or gate from rest shall be not more than 30 pounds.

b. Paragraph 73.3(7)*"a"* does not apply when both of the following conditions are met:

(1) A car door or gate is closed by power through continuous pressure of a door-closing switch or the car operating device, and

(2) The release of the closing switch or operating device will cause the car door or gate to stop or to stop and reopen.

73.3(8) Each passenger car shall have lighting inside the enclosure of not less than 5 foot-candles. Bulbs and tubes shall be guarded to prevent breakage.

73.3(9) Each passenger elevator shall have a capacity plate prominently displayed in its enclosure. The capacity plate shall list its capacity in pounds.

73.3(10) All passenger elevator car floors shall be maintained so that persons are not exposed to the hazards of tripping or falling.

73.3(11) All automatic passenger elevators shall be provided with an alarm bell capable of being activated from inside the car and audible outside the hoistway. If the elevator is not equipped with a bell, a two-way conversation device to the elevator and a ready accessible point outside the hoistway may be acceptable.

73.3(12) All automatic passenger elevators shall have their door open zones adjusted so that the door shall not open unless the car has stopped within 6 inches of floor level.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.4(89A) Car enclosure: Freight.

73.4(1) Each freight elevator car shall have a solid enclosure at least 66 inches in height. The space between the solid section and the car top shall be enclosed with solid material, perforated material, or latticework. Where used, perforated material or latticework shall reject a ball 1½ inches in diameter. The portion of open-type enclosure which passes the counterweights shall be of solid construction the entire width of the counterweights plus 6 inches on either side. The enclosure top shall be provided with an emergency exit, except for hydraulic elevators with manual lowering valves.

73.4(2) Each freight car enclosure shall have doors or gates at each entrance and shall be not less than 6 feet high. Each door or gate shall be constructed in accordance with ANSI A17.1, 1971, Rule 204.4.

73.4(3) Each car door or gate on a freight elevator shall have electric contacts to prevent the car from running with doors or gates open. EXCEPTIONS:

a. By a car-leveling or truck-zoning device.

b. By a combination hoistway access switch and operating device.

c. When a hoistway access switch is operated.

73.4(4) Each freight elevator car enclosure shall be provided with a top. The top may be of solid or open-work construction and shall be of metal. The openwork shall reject a ball 2 inches in diameter.

Car tops shall be constructed to sustain a load of 200 pounds applied at any point on the car top. The top shall not have hinged or folding panels other than the emergency exit cover.

73.4(5) Each freight car enclosure shall have lighting not less than 2½ foot-candles. Bulbs or tubes shall be guarded to prevent breakage.

73.4(6) Each freight car enclosure shall have capacity plate, loading class plates, and a "No Passenger" sign conspicuously posted. Letters shall be not less than ½-inch high.

73.4(7) Freight elevators shall not be loaded to exceed the rated load as stated on their capacity plates.

73.4(8) Each freight elevator car floor shall be maintained so that personnel will not readily slip or trip. The floor shall be maintained so that it will hold its rated load without breaking through at any place in the car.

73.4(9) Freight elevators shall not be permitted to carry passengers other than the operator and persons to load and unload material.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.5(89A) Brakes.

73.5(1) Each electric elevator shall be provided with an electric brake.

73.5(2) Each brake shall be of the friction type applied by a spring or springs or gravity and released electrically. The brake shall be capable of holding the car at rest with its rated load.

875—73.6(89A) Machines.

73.6(1) Friction gearing or clutch mechanisms shall not be used for connecting the drum or sheaves to the main driving mechanism.

73.6(2) Set screw fastenings shall not be used on power elevators in lieu of keys or pins on connections subject to torque or tension.

73.6(3) Portable power-chain or cable hoist machines shall not be used to raise or lower an elevator car.

73.6(4) No belt or chain driven power machine shall be used for any elevator unless the machine is provided with a broken belt or broken chain safety switch of the electrical nonautomatic reset type. EXCEPTION: Hydraulic machines.

875—73.7(89A) Electrical protective devices.

73.7(1) All electric elevators shall have a labeled emergency stop switch. The switch shall be located on or adjacent to the operating panel.

73.7(2) All electric elevators shall have upper and lower final limit switches. Open-type switches shall not be accepted. Drum-type machines shall have final limit switches mounted on the machine and hoistway final limit switches.

73.7(3) All operating devices of car switch operations shall automatically return to the stop position and latch there when released.

73.7(4) Tiller-rope operations shall not be used unless all direction switches on controllers are mechanically operated. Contacts on direction switches shall be broken when the rope is at the centered position.

73.7(5) Except for firefighter service switches, leveling switches, and truck zone switches, no elevator shall be provided with a switch or device which makes more than one door or gate switch inoperative at any one time.

73.7(6) No person at any time shall make any required safety device or electrical protective device inoperative, except where necessary during tests, inspections or maintenance. Such devices shall be restored to their normal operating conditions as soon as all tests, inspections and maintenance have been completed. The conveyance shall not be left unattended while any of these devices are inoperative. To ensure that no jumpers are left behind, a counting system shall be utilized.

73.7(7) Each winding drum machine shall be provided with an electrical switch which shall disconnect power to the hoisting motor and brake when ropes are slackened.

73.7(8) No person shall enter an elevator pit for any reason without disconnecting power to the equipment using the pit stop switch, lockout, tagout procedures, or other appropriate means of de-energization in accordance with 875—Chapters 2 to 26.

73.7(9) Elevators having a polyphase AC power supply shall be provided with means to prevent the starting of the elevator drive motor or door motor if a reversal of phase rotation, or phase failure of the incoming polyphase AC power, will cause the elevator car or elevator door(s) to operate in the wrong direction.

73.7(10) All electrical equipment pertaining to the elevator shall conform to ANSI C1-1975 (NFPA 70-1975).

73.7(11) All electrical wiring in the machine room and hoistway shall be enclosed in metal conduit, flexible conduit or metal raceways.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 1971C**, IAB 4/29/15, effective 6/3/15]

875—73.8(89A) Maintenance, repairs and alterations.

73.8(1) *General.* Except as set forth in this rule, all maintenance, repairs and alterations shall comply with the edition of ASME A17.1 currently adopted for new conveyances at rule 875—72.1(89A) or ASME A17.7-2007/CSA B44-07, as applicable. Rule 875—71.10(89A) describes alterations which require that the entire conveyance be brought into compliance with the most current code.

73.8(2) *Exemption for button numbering.* All maintenance, repairs and alterations to devices covered by ANSI A117.1 shall comply with ANSI A117.1 (2003), except for Rule 407.4.6.2.2.

73.8(3) *Sump pump exemption.* The provisions of ASME A17.1 that require a pit sump or drain shall not apply to an elevator alteration when all of the following criteria are met:

a. No other code or rule requires that the pit be excavated or lowered.

b. The alteration plans do not include the excavation or lowering of the pit floor for any other reason.

c. There is evidence that groundwater has not entered the pit previously.

d. The location and geology of the building indicate a likelihood that groundwater would enter the pit if the foundation or pit floor were breached to install the pit sump or drain.

e. A description of alternative means to maintain the pit in a dry condition is provided to the labor commissioner with the alteration permit application.

f. The labor commissioner approves the alternative means to maintain the pit in a dry condition.

g. The alternative means to maintain the pit in a dry condition are installed or implemented as described in the alteration permit application.

73.8(4) *Pit excavation exemption.* The full length of the platform guard set forth in ASME A17.1, Rule 2.15.9.2(a), shall not be required if all of the following criteria are met:

a. No other code or rule requires that the pit be excavated or lowered.

b. The alteration plans do not include the excavation or lowering of the pit floor for any other reason.

c. A full-length platform guard would strike the pit floor when the elevator is on its fully compressed buffer.

d. The clearance between the bottom of the platform guard and the pit floor is 2.5 centimeters (1 inch) when the elevator is on its fully compressed buffer.

73.8(5) *Sprinkler retrofits and shunt trip breakers.* When a sprinkler is added to a hoistway or machine room, the conveyance shall comply with the following:

a. The installation shall comply with the applicable version of ASME A17.1, Rule 2.8.3.3.

b. The elevator controls shall be arranged to comply with the phase I fire recall provisions of the applicable version of ASME A17.1, Rule 2.27.3.

c. The applicable version of ASME A17.1 shall be determined by reference to rule 875—72.1(89A). For purposes of rule 875—73.8(89A), the relevant subrule of 875—72.1(89A) shall apply based on the date the sprinkler is installed instead of the date the conveyance was installed.

73.8(6) *Safety bulkheads.* Documentation from the manufacturer establishing that a safety bulkhead was installed shall establish compliance with ASME A17.1, Rule 8.6.5.8.

73.8(7) *Alterations of handicapped restricted use elevators.* A component of a handicapped restricted use elevator being altered shall comply with the portions of ASME A17.1, section 5.3, applicable to the component. The edition of ASME A17.1 adopted by reference in rule 875—72.1(89A) shall be applied.
[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 1766C**, IAB 12/10/14, effective 1/14/15; **ARC 2396C**, IAB 2/17/16, effective 3/23/16]

875—73.9(89A) Machine rooms.

73.9(1) All means of access to elevator machine rooms shall be of a permanent nature and shall be constructed and maintained in a clear and unobstructed manner.

73.9(2) The elevator machine and control equipment shall be located in a separate room or separated from other equipment by a substantial grill not less than 6 feet high. The grill shall be of a design that will reject a ball 2 inches in diameter. All rooms or enclosures shall have a self-closing and self-locking door.

73.9(3) All elevator machine rooms shall be provided with a floor. The floor shall cover the entire area of the machine room and hoistway.

73.9(4) Machine room floors shall be kept clean and free of grease and oil. Articles or materials not necessary for the maintenance or operation of the elevator shall not be stored therein. Storage of any equipment or materials in elevator machine rooms other than equipment directly related to elevator operation is prohibited.

73.9(5) Lighting in the machine room shall be not less than 10 foot-candles at floor level.

73.9(6) Where there is more than one machine in a room, each machine shall have a different number conspicuously marked on it. The controller, disconnecting means and relay panels for each machine shall be conspicuously numbered to correspond to the machine they control.
[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.10(89A) Pits.

73.10(1) All pits shall be kept clean and free of equipment or material not relating to the operation of the elevator. EXCEPTION: sump pumps.

73.10(2) Buffers under cars and counterweights shall be permanently fastened to the floor or their supporting beams.

73.10(3) All elevators shall have counterweight guards. Guards shall be of unperforated metal of at least the strength of or braced to the equivalent strength of number 14-gauge sheet steel. Guards shall extend from a point not more than 12 inches above the pit floor to a point not less than 7 feet above the pit floor. Where guards are not feasible, warning chains shall be installed on the bottom of the counterweights and shall extend no less than 5 feet below the counterweight. Chains shall be of a number 10 U.S. gauge wire or of equal size. EXCEPTION: When compensating chains or ropes are used, a counterweight guard is not required.

73.10(4) Buffers shall be installed where elevator pits are not provided with buffers and where the pit depth will permit. Buffers shall comply with ANSI A17.1, 1971, Section 201.

73.10(5) Where the depth of any pit is in excess of 4 feet it shall have a ladder permanently installed. The ladder shall extend not less than 30 inches above the sill of the access door, or hand grips shall be provided to the same height. Ladder shall be of noncombustible material.
[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.11(89A) Counterweights.

73.11(1) Broken or cracked sections of counterweights shall be replaced.

73.11(2) Counterweight hanger rods, tie rods or both shall firmly support and secure the counterweight sections in place.

73.11(3) Wire ropes extending through counterweights from one stack to another shall be guarded by metal sleeves attached to the wire ropes. Stacks shall not be spaced less than 8 inches apart.

875—73.12(89A) Car platforms and car slings.

73.12(1) All platforms shall be soundly constructed without cracks or breaks in stringers or frames. All floors shall be free of holes.

73.12(2) All car slings shall be soundly constructed and free of cracks or breaks.

73.12(3) Where cable sheaves are used on the crosshead, they shall be firmly attached and free of cracks or breaks.

73.12(4) All elevators shall have data plates attached to the crosshead.

73.12(5) All elevators with automatic leveling, inching or teasing devices shall have a platform guard or an apron. All other elevators shall have warning chains hung within 2 inches of the edge of the platform on the entrance sides. Chains shall be of number 10 U.S. gauge wire or of equal size. Chains shall extend not less than 5 feet below the platform and shall not be spaced more than 4 inches apart.

73.12(6) All car slings shall have guide shoes at the top and bottom of the sling. Shoes that are worn to a degree which affect the safe operation of the car shall be repaired or replaced.

875—73.13(89A) Means of suspension.

73.13(1) Suspension ropes on drum-type machines shall have not less than one turn of the rope on the drum when the car is resting on the fully compressed buffers.

73.13(2) Winding drum machines shall not be used unless they are provided with not less than two hoisting ropes. Each counterweight stack shall be provided with not less than two ropes.

73.13(3) Tiller cables on cable-operated elevators shall be kept free of breaks.

73.13(4) On tiller-cable operations, the cable shall pass through a guiding or stopping device mounted on the car. The cable shall be provided with adjustable stop balls and be provided with means to lock and hold the car at a floor. Stop balls at top and bottom shall be adjusted to automatically stop the car. The tiller cable shall be completely enclosed in the hoistway.

73.13(5) All hoisting or counterweight ropes located outside of the hoistway that are exposed shall be covered with a box-type guard. The guard shall be not less than 6 feet high from floor level.

73.13(6) Roller chains shall not be used as the suspension means for any conveyance except where specifically allowed by an applicable provision of ASME A17.1.

73.13(7) Hoisting ropes for power elevators shall not be less than 3/8 inch in diameter.

73.13(8) Hoisting rope fastening means shall be of the socket and babbitting type. Clamps shall not be used.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.14(89A) Car safeties and speed governors.

73.14(1) Each elevator suspended by ropes shall be provided with mechanically applied car safeties which shall be capable of stopping and sustaining its rated load.

73.14(2) Broken rope or slack rope safeties may be allowed if the car speed is not in excess of 50 FPM.

73.14(3) Elevators which are provided solely with broken rope or slack rope safeties shall not be used for passenger service. EXCEPTION: Handicapped restricted use elevators.

73.14(4) All safeties shall be adjusted so that clearances from the rail shall be in accordance with ANSI A17.1, 1971, Rule 1001.2.

73.14(5) All slack cable safeties shall be provided with an electrical switch which disconnects power to the elevator machine and brake when setting of the safeties occurs.

73.14(6) All safeties operated by a speed governor shall be provided with a speed switch operated by the governor when used with type B or C car safeties on elevators having a rated speed exceeding 150 FPM. A switch shall be provided on the speed governor when used with a counterweight safety for any car speed.

73.14(7) Speed governors shall have their means of speed adjustment sealed.

73.14(8) For hoistways not extending to the lowest floor and where space below the hoistway is used for a passageway or is occupied by persons, or if unoccupied but not secured against unauthorized access, the counterweights of the elevator shall be provided with safeties. Safeties shall be tripped by a

speed governor if the car speed is in excess of 150 FPM. Speed governors shall be set to trip above the car governor tripping speed but not more than 10 percent greater.

73.14(9) Access to a governor that is located inside a hoistway shall be provided in accordance with ASME A17.1-2007, Rule 2.7.6.3.4.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 8760B**, IAB 5/19/10, effective 6/23/10]

875—73.15(89A) Guide rails.

73.15(1) All guide rails and brackets whether of wood or steel shall be firmly and securely anchored or bolted in place. Where T rail is used, all fish-plate bolts shall be tight. This shall comply with ANSI A17.1, 1981, Section 200.

73.15(2) Where guide rails which are worn to such a point that proper clearance of safety jaws cannot be maintained, the worn sections shall be replaced to achieve clearances as specified in ANSI A17.1, 1971, Rule 1001.2.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.16(89A) Existing hydraulic elevators.

73.16(1) Cylinders of hydraulic-elevator machines shall be provided with a means for releasing air or other gas.

73.16(2) Each pump or group of pumps shall be equipped with a relief valve conforming to the following requirements:

a. Type and location. The relief valve shall be located between the pump and the check valve and shall be of such a type and so installed in the bypass connection that the valve cannot be shut off from the hydraulic system.

b. Setting. The relief valve shall be preset to open at a pressure not greater than that necessary to maintain 125 percent of working pressure.

c. Size. The size of the relief valve and bypass shall be sufficient to pass the maximum rated capacity of the pump without raising the pressure more than 20 percent above that at which the valve opens. Two or more relief valves may be used to obtain the required capacity.

d. Sealing. Relief valves having exposed pressure adjustments, if used, shall have their means of adjustment sealed after being set to the correct pressure.

EXCEPTION: No relief valve is required for centrifugal pumps driven by induction motors, provided the shut-off, or maximum pressure which the pump can develop, is not greater than 135 percent of the working pressure at the pump.

73.16(3) Storage and discharge tanks shall be covered and suitably vented to the atmosphere.

73.16(4) Hydraulic elevators shall be governed by the rules contained in Chapter 73 that apply to electric elevators except the following rules which are exempt: 73.5, 73.6(3), 73.7(2), 73.7(4), 73.7(7),73.9(9), 73.10(3), 73.11, 73.13, and 73.14.

73.16(5) Rescinded IAB 3/7/01, effective 4/11/01.

875—73.17(89A) Existing sidewalk elevators.

73.17(1) Hoistways shall be permanently enclosed. The enclosures shall conform to ANSI A17.1, 1971, Rule 401.1.

73.17(2) All interior landings shall have a door or gate which shall be provided with an interlock.

73.17(3) Doors opening in sidewalks or other areas exterior to the building shall be of the hinged type. Doors or covers shall be designed to hold a static load of 300 pounds per square foot. Doors shall always be closed unless elevator is at the landing.

73.17(4) Stops shall be provided to prevent the cover in the opening of the sidewalk from opening more than 90 degrees from its closed position.

73.17(5) Covers in sidewalk shall be designed to close when the car descends from the top landing.

73.17(6) Recesses or guides which will securely hold the cover in place on the car stanchions shall be provided on the underside of the cover.

73.17(7) All electrical wiring shall be enclosed in metal conduit, flexible conduit or metal raceways. If hoistway opens in the sidewalk, the wiring shall be weatherproof.

73.17(8) Operating devices and control equipment shall comply with ANSI A17.1, 1971, Rule 402.4.

73.17(9) All electric sidewalk elevators shall have upper and lower final limit switches. Open-type switches shall not be allowed.

73.17(10) Cars shall have enclosures which shall be not less than 6 feet in height provided the stanchions and bow iron are of sufficient height. The enclosure shall be provided with electric contacts to prevent the car from running with doors or gates open.

73.17(11) Cars shall have safeties. Where the speed of the elevator does not exceed 50 FPM, car safeties which operate as a result of breaking or slackening of the hoisting ropes may be used. Such safeties may be of the inertia type or approved type without governors. Governors shall not be required when car speed does not exceed 50 FPM.

73.17(12) Car enclosures and car gates shall not be required for hand-powered sidewalk elevators.

73.17(13) Rescinded IAB 3/7/01, effective 4/11/01.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.18(89A) Existing hand elevators.

73.18(1) Hand-powered elevators shall have hoistway doors. Doors shall be of the self-closing and self-locking type.

73.18(2) A sign reading "Danger—Elevator Hoistway—Keep Closed" shall be mounted on each hoistway door. The letters on the signs shall be legible, shall be at least 2 inches high, and shall contrast with the background color.

73.18(3) All hand-powered elevators shall be provided with safeties or slack cable devices. Safeties do not have to be operated by a speed governor unless the speed is in excess of 50 FPM.

73.18(4) Hand-powered elevators shall have a car enclosure which shall be constructed of metal or sound seasoned wood. The enclosure shall cover all sides which are not used for entrance or exit. The enclosure shall be secured to the car platform or frame in such a manner that it cannot work loose or become displaced in ordinary service.

73.18(5) Each hand-powered elevator shall be provided with a brake which shall be capable of stopping and sustaining the car whether loaded or unloaded.

73.18(6) Hand-powered elevators shall not be converted or changed to electric powered unless the complete conveyance is brought into conformity with 875—Chapter 72.

73.18(7) Rescinded IAB 3/7/01, effective 4/11/01.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.19(89A) Power-operated special purpose elevators.

73.19(1) Elevators complying with the following requirements may be installed in any structure where the elevator is not accessible to the general public, is used exclusively for designated operating and maintenance employees only, and where transportation of one or two persons is required to attend machinery or equipment frequently.

73.19(2) The inside platform area of the car shall not exceed 9 square feet. The rated speed shall not exceed 100 FPM. The rated load shall not exceed 650 pounds.

73.19(3) Hoistways shall be enclosed to their full width, to a height of not less than 7 feet with solid or perforated noncombustible material braced to deflect not more than 1 inch when subjected to a force of 100 pounds applied horizontally at any point. Open work enclosures shall be at least number 13 steel wire gauge or expanded metal at least number 13 U.S. gauge and shall reject a ball 2 inches in diameter. Where counterweights pass, landing and stairway side shall be of solid construction.

73.19(4) Wiring shall comply with the requirements of the National Electrical Code, ANSI C1-1975 (NFPA 70-1975).

73.19(5) Counterweights shall comply with rule 875—73.11(89A).

73.19(6) Hoistway doors shall comply with subrules 73.2(1), 73.2(7) and 73.2(11).

73.19(7) Cars shall be solidly constructed in accordance with subrules 73.12(1) and 73.12(2).

73.19(8) Car enclosure.

a. Except at the entrance, the car shall be enclosed on all sides and the top. The enclosure at the sides shall be solid or openwork. All openwork shall reject a ball 1 inch in diameter. The enclosure shall be constructed of sufficient strength that it will not deflect more than 1 inch at any one point.

b. There shall be an electric light to illuminate the car or hoistway with the switch placed on or near the operating panel.

c. There shall be no glass used in the elevator car except for the car light.

73.19(9) A car door shall be provided at each car entrance. Door or gate shall guard the complete entrance. The door or gate shall be at least 7 feet high, of metal construction with solid or open construction to reject a ball 1 inch in diameter. A contact switch shall be provided to prevent the operation of the elevator with doors or gates open. The door or gate shall be provided with interlocks.

73.19(10) Guide rails shall comply with rule 875—73.15(89A).

73.19(11) The means and methods of suspension shall comply with subrules 73.13(1), 73.13(5), 73.13(6), 73.13(7), and 73.13(8).

73.19(12) Electrical switches shall comply with subrules 73.7(2) and 73.7(9).

73.19(13) Brakes shall comply with rule 875—73.5(89A).

73.19(14) Emergency signal or communication shall comply with subrule 73.3(11).

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09]

875—73.20(89A) Inclined and vertical wheelchair lifts. All vertical and inclined wheelchair lifts shall conform to ANSI A17.1 (1981), part XX, sections 2000 and 2001.

875—73.21(89A) Handicapped restricted use elevators. All handicapped restricted use elevators must meet ANSI A17.1 (1981), Part V. Additionally, the elevators shall comply with the following limitations:

1. The elevator shall be used only by a maximum of one disabled person and one attendant at a time. Where a disabled individual cannot operate the elevator in a manner which will ensure access to all operating controls and safety features, an attendant shall accompany the disabled individual.
2. The elevator shall be key-operated and shall not be capable of being called by buttons or switches but may be called by a key operator.
3. Keys to operate the elevator shall be in the control of the disabled person, the attendant or persons in positions of responsibility at the location.
4. A list shall be maintained at the location indicating the persons holding keys for the operation of the elevator.
5. Each landing and the elevator car shall be posted to indicate that the elevator is only for the use of disabled persons.
6. The travel distance of the elevator shall not exceed 50 feet.

[**ARC 7840B**, IAB 6/17/09, effective 7/22/09; **ARC 1971C**, IAB 4/29/15, effective 6/3/15]

875—73.22(89A) Escalators.

73.22(1) Each escalator shall be provided with an electrically released mechanically applied brake capable of stopping the up and down traveling escalator with any load up to and including the rated load. The brake shall be located either on the driving machine or on the main drive shaft.

73.22(2) Starting switches shall be of the key-operated type. Starting switches shall be located on or near the escalator.

73.22(3) Emergency stop buttons or other type manually operated switches having red buttons or handles shall be accessibly located at or near the bottom and top landings. The buttons or levers shall be protected to prevent accidental operation.

73.22(4) A broken step-chain device shall be provided on each escalator that will cause interruption of power to the driving machine if a step chain breaks or if excessive sag occurs in either step chain.

73.22(5) Each escalator shall have comb plates at top and bottom landings of the escalator. Comb-plate teeth shall be meshed with and set into slots in the tread surface of the steps so that the points of the teeth are always below the upper surface of the treads.

73.22(6) Each escalator balustrade or moulding on the balustrade shall have a smooth surface. Screwheads shall set flush with the surface or be of the oval head type without any burrs or rough places on their surface.

73.22(7) The clearance on either side of the steps between the step tread and the adjacent skirt panel shall be not more than 3/16 inch.

73.22(8) Step treads shall be illuminated throughout their run. The light intensity shall be not less than 2 foot-candles.

73.22(9) An enclosed fused disconnect switch or circuit breaker arranged to disconnect the power supply to the escalator shall be in each machine room or wherever the controller is located.

73.22(10) A stop switch shall be provided in each machinery space where means of access to the space is provided. The switch when opened shall cause electric power to be removed from the escalator driving-machine motor and brake. The switch shall be of the manually opened and closed type and shall be marked "STOP".

73.22(11) Hand or finger guards shall be provided at the point where the handrail enters the balustrade.

73.22(12) Where the clearance of the upper outside edge of the balustrade and a ceiling or scaffold is less than 12 inches or where the intersection of the outside balustrade and a ceiling or soffit is less than 24 inches from the centerline of the handrail, a solid guard shall be provided in the intersection of the angle of the outside balustrade and the ceiling or soffit. The vertical front edge of the guard shall project a minimum of 14 inches horizontally from the apex of the angle. The escalator side of the vertical face of the guard shall be flush with the face of the wellway. The exposed edge of the guard shall be rounded.

This rule is intended to implement Iowa Code chapter 89A.

875—73.23(89A) Moving walks. Rescinded IAB 6/17/09, effective 7/22/09.

875—73.24(89A) Dumbwaiters. All dumbwaiters whether electric or hand powered shall conform to ANSI A17.1, 1971, section 700. Exceptions: Required rules for hoistway construction as set forth in ANSI A17.1, 1971, shall not apply to existing installations.

875—73.25(89A) Sprinkler retrofits and shunt trip breakers. Rescinded IAB 6/17/09, effective 7/22/09.

875—73.26(89A) Safety bulkheads. Rescinded IAB 6/17/09, effective 7/22/09.

875—73.27(89A) Child safety guards. Unless the car door on a passenger elevator consists of a solid panel, the following criteria shall be met:

73.27(1) A multipoint light curtain shall be installed between the car door and the edge of the car platform.

73.27(2) A second multipoint light curtain shall be installed at the hoistway opening of each floor where a gap of more than 5 inches exists between the car light curtain and the hoistway door.

73.27(3) Each light curtain required by this rule must deactivate the elevator if the light curtain does not function or if the light curtain is obstructed by an object larger than a 4-inch ball.

[**ARC 1972C**, IAB 4/29/15, effective 6/3/15]

These rules are intended to implement Iowa Code chapter 89A.

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CHAPTER 90
ADMINISTRATION OF THE BOILER AND PRESSURE VESSEL PROGRAM

[Prior to 1/14/98, see 347—Chs 41 to 49]
[Prior to 8/16/06, see 875—Chs 200, 202]

875—90.1(89) Purpose and scope. These rules institute administrative and operational procedures for implementation of Iowa Code chapter 89. An object shall not be considered "under pressure" and shall not be within the scope of Iowa Code chapter 89 when there is clear evidence that the manufacturer did not intend it to be operated at more than 3 psi and the object is operating at 3 psi or less.
[**ARC 0416C**, IAB 10/31/12, effective 12/5/12]

875—90.2(89,261,252J,272D) Definitions. To the extent they do not conflict with the definitions contained in Iowa Code chapter 89, the definitions in this rule shall be applicable to the rules contained in 875—Chapters 90 to 96.

"Alteration" means a change in a boiler or pressure vessel that substantially alters the original design requiring consideration of the effect of the change on the original design. It is not intended that the addition of nozzles smaller than an unreinforced opening size will be considered an alteration.

"ANSI/ASME CSD-1" means Control and Safety Devices for Automatically Fired Boilers.

"ASME" means the American Society of Mechanical Engineers.

"Boiler" means a vessel in which water or other liquids are heated, steam or other vapors are generated, steam or other vapors are superheated, or any combination thereof, under pressure or vacuum by the direct application of heat. "Boiler" includes all temporary boilers.

"Certificate of noncompliance" means:

1. A certificate of noncompliance issued by the child support recovery unit, department of human services, pursuant to Iowa Code chapter 252J;
2. A certificate of noncompliance issued by the college student aid commission pursuant to Iowa Code chapter 261; or
3. A certificate of noncompliance issued by the centralized collection unit of the department of revenue pursuant to Iowa Code chapter 272D.

"CFR" means Code of Federal Regulations.

"Construction or installation code" means the applicable standard for construction or installation in effect at the time of installation.

"Division" means the division of labor services, unless another meaning is clear from the context.

"Electric boilers" means a power boiler, heating boiler, high or low temperature water boiler in which the source of heat is electricity.

"External inspection" means as complete an examination as can be reasonably made of the external surfaces and safety devices while the boiler or pressure vessel is in operation.

"High temperature water boiler" means a water boiler intended for operations at pressures in excess of 160 psig or temperatures in excess of 250 degrees F.

"Hot water heating boiler" means a boiler in which no steam is generated, from which hot water is circulated for heating purposes and then returned to the boiler, and which operates at a pressure not exceeding 160 psig or a temperature of 250 degrees F at the boiler outlet.

"Hot water supply boiler" means a boiler completely filled with water that furnishes hot water to be used externally to itself at pressures not exceeding 160 psig or at temperatures not exceeding 250 degrees F.

"Institution of health and custodial care" means any of the following:

1. A health care facility as defined by Iowa Code section 135C.1;
2. An assisted living program as defined by Iowa Code section 231C.2;
3. A boarding home as defined by Iowa Code section 1350.1;
4. A hospice that offers inpatient services in an institutional setting;
5. Any institution or facility in which persons are housed to receive medical, health, or other care or treatment; or

6. Any other institution or facility in which persons are housed to receive assistance with meeting personal needs or activities of daily living.

A facility or office that provides care and services only on an outpatient basis shall not be an "institution of health and custodial care."

"Internal inspection" means as complete an examination as can be reasonably made of the internal and external surfaces of a boiler or pressure vessel while it is shut down and while manhole plates, handhole plates or other inspection opening closures are removed as required by the inspector.

"ISO" means International Standards Organization.

"Labor commissioner" means the labor commissioner or the commissioner's designee.

"Lap seam crack" means a crack found in lap seams, extending parallel to the longitudinal joint and located either between or adjacent to rivet holes.

"National Board" means the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, Ohio 43229, whose membership is composed of the chief inspectors of jurisdictions who are charged with the enforcement of the provisions of boiler codes.

"National Board Inspection Code" means the Manual for Boiler and Pressure Vessel Inspectors (ANSI/NB 23) published by the National Board. Copies of the code may be obtained from the National Board.

"Object" means a boiler or pressure vessel.

"Power boiler" means a boiler in which steam or other vapor is generated at a pressure of more than 15 pounds per square inch or a water boiler intended for operation at pressures in excess of 160 pounds per square inch or temperatures in excess of 250 degrees Fahrenheit.

"Process steam generator" means a vessel or system of vessels comprised of one or more drums and one or more heat exchange surfaces as used in waste heat or heat recovery type steam boilers.

"Psig" means pounds per square inch gage.

"Reinstallation" means the process of disconnecting an object, moving it, and reconnecting it at the same location or a new location.

"Relief valve" means an automatic pressure-relieving device actuated by a static pressure upstream of the valve that opens further with the increase in pressure over the opening pressure and that is used primarily for liquid service.

"Repair" means work necessary to return a boiler or pressure vessel to a safe operating condition.

"Rupture disk device" means a nonreclosing pressure-relief device actuated by inlet static pressure and designed to function by the bursting of a pressure-containing disk.

"Safety appliance" shall include, but not be limited to:

1. Rupture disk device;
2. Safety relief valve;
3. Safety valve;
4. Temperature limit control;
5. Pressure limit control;
6. Gas switch;
7. Air switch; or
8. Any major gas train control.

"Safety relief valve" means an automatic, pressure-actuated relieving device suitable for use as a safety or relief valve, depending on application.

"Safety valve" means an automatic, pressure-relieving device actuated by the static pressure upstream of the valve and characterized by full opening pop action. The safety valve is used for gas or vapor service.

"Special inspection" means an inspection which is not required by Iowa Code chapter 89.

"Temperature and pressure relief valve" means a valve set to relieve at a designated temperature and pressure.

"Unfired steam boiler" means a vessel or system of vessels intended for operation at a pressure in excess of 15 psig for the purpose of producing and controlling an output of thermal energy.

"Unfired steam pressure vessel" means a vessel or container used for the containment of steam pressure either internal or external in which the pressure is obtained from an external source.

"U.S. customary units" means feet, pounds, inches and degrees Fahrenheit.

"Water heater supply boiler" means a closed vessel in which water is heated by combustion of fuels, electricity or any other source and withdrawn for use external to the system at pressure not exceeding 160 psig and shall include all controls and devices necessary to prevent water temperatures from exceeding 210 degrees F.

[**ARC 8283B**, IAB 11/18/09, effective 1/1/10; **ARC 9790B**, IAB 10/5/11, effective 11/9/11; **ARC 0319C**, IAB 9/5/12, effective 10/10/12; **ARC 0739C**, IAB 5/15/13, effective 6/19/13; **ARC 1964C**, IAB 4/15/15, effective 5/20/15]

875—90.3(89) Iowa identification numbers. All objects shall be identified by an Iowa identification number. State inspectors and special inspectors shall assign identification numbers as directed by the division to all jurisdictional objects that lack numbers. Identification numbers shall be attached in plain view to the object using one of the following methods:

1. A yellow sticker 2 inches by 3 inches affixed to the object and bearing the number.
2. A metal tag 1 inch by 2½ inches affixed to the object and bearing the number.
3. Numbers at least 5/16 of an inch high and stamped directly on the object.

875—90.4(89) National Board registration. Rescinded IAB 11/18/09, effective 1/1/10.

875—90.5(89) Preinspection owner or user preparation.

90.5(1) *Preparation of objects.* Each owner or user shall ensure that each object covered by Iowa Code chapter 89 is prepared for inspection pursuant to this rule.

90.5(2) *Confined space and lockout, tagout procedures.*

a. It is the responsibility of the owner or user to assess all objects for compliance with the confined space and lockout, tagout standards pursuant to 29 CFR 1910.146 and 1910.147. If an object is a non-permit-required confined space or a permit-required confined space as defined by 29 CFR 1910.146, the owner or user must comply with all applicable requirements of 29 CFR 1910.146 and 1910.147 in preparing the object for inspection.

b. It is the duty of the owner or user to inform any inspector of the owner's or user's confined space entry and lockout, tagout procedures and supply to the inspector all information necessary to assess whether the confined space is safe for entry. It is the right of an inspector to verify any of the information supplied.

c. If the requirements of 29 CFR 1910.146 and 1910.147 are not met, the inspector shall not enter the space. If there is a breach of the procedure or the procedure is inconsistent with 29 CFR 1910.146 or 1910.147, the inspection process shall cease until the space is reassessed and determined to be safe or the procedure is rewritten in a manner consistent with the standards. No inspector shall violate the owner's or user's confined space or lockout, tagout procedures in making an inspection.

d. The owner or user shall have all objects locked and tagged, as applicable, prior to the inspector's entry for inspection or testing.

e. For entry into a permit-required confined space, the owner or user shall provide the necessary equipment such as air monitors and a qualified attendant who has received all the information relevant to the entry.

90.5(3) *Hydrostatic tests.* The owner or user shall prepare for and apply a hydrostatic test, whenever necessary, on the date specified by the inspector, which date shall be not less than seven days after the date of notification.

90.5(4) *Boilers.* A boiler shall be prepared for internal inspection in the following manner:

a. Fluid shall be drawn off and the boiler washed thoroughly.

b. Manhole and handhole plates, washout plugs and inspection plugs in water columns shall be removed as required by the inspector. The furnace and combustion chambers shall be thoroughly cooled and cleaned.

c. All grates of internally fired boilers shall be removed.

d. Brickwork shall be removed as required by the inspector in order to determine the condition of the boiler, header, furnace, supports or other parts.

e. Low-water fuel cutoff controls shall be opened or removed to allow for visual inspection.

90.5(5) *Pressure vessels.* The extent of inspection preparation for a pressure vessel will vary. If the inspection is to be external only, advance preparation is not required other than to afford reasonable access to the vessel. For combined internal and external inspections of small vessels of simple construction handling air, steam, nontoxic or nonexplosive gases or vapors, minor preparation is required, including affording reasonable means of access and removing manhole plates and inspection openings. In other cases, preparation shall include removing the internal fittings and appurtenances to permit satisfactory inspection of the interior of the vessel if required by the inspector.

90.5(6) *Removal of covering or brickwork to permit inspection.* If the object is jacketed so that the longitudinal seams of shells, drums, or domes cannot be seen, sufficient jacketing, setting wall, or other form of casing or housing shall be removed to permit reasonable inspection of the seams and so that the size of rivets, pitch of the rivets, and other data necessary to determine the safety of the object may be obtained, providing the information cannot be determined by other means. Brickwork shall be removed as required by the inspector in order to determine the condition of the boiler, header, furnace, supports or other parts.

90.5(7) *Improper preparation for inspection.* If an object has not been properly prepared for an internal inspection, or if the owner or user fails to comply with the requirements for hydrostatic tests as set forth in this chapter, the inspector may decline to make the inspection or test, and the inspection certificate shall be withheld until the owner or user complies with the requirements.

[**ARC 9082B**, IAB 9/22/10, effective 10/27/10]

875—90.6(89) Inspections.

90.6(1) *General.* All boilers and unfired steam pressure vessels covered by Iowa Code chapter 89 shall be inspected according to the requirements of the National Board Inspection Code (2015), which is hereby adopted by reference. A division inspector or special inspector must perform the inspections.

90.6(2) *Schedule.*

a. All required inspections must be performed according to the schedule set forth in Iowa Code section 89.3, unless an exception is set forth in this rule.

b. Except for inspections of unfired steam pressure vessels operating in excess of 15 pounds per square inch and low pressure steam boilers, each certificate inspection must be performed within a 60-day period prior to the expiration date of the operating certificate. Modification of this 60-day period will be permitted only upon written application showing just cause for waiver of the 60-day period.

c. Special inspections may be conducted at any time mutually agreed to by the division and the object's owner or user.

90.6(3) *Inspections conducted by special inspectors.* Special inspectors shall provide copies of the completed report to the insured and to the division within 30 days of the inspection. The reports shall list all adverse conditions and all requirements, if any. If the special inspector has not notified the division of the inspection results within 30 days of the expiration of an operating certificate, the division may conduct the inspection.

90.6(4) *Type of inspection.* The inspection shall be an internal inspection when required; otherwise, it shall be as complete an external inspection as possible. Conditions including, but not limited to, the following may also be the basis for an internal inspection:

a. Visible metal or insulation discoloration due to excessive heat.

b. Visible distortion of any part of the pressure vessel.

c. Visible leakage from any pressure-containing boundary.

d. Any operating records or verbal reports of a vessel being subjected to pressure above the nameplate rating or to a temperature above or below the nameplate design temperature.

e. A suspected or known history of internal corrosion or erosion.

f. Evidence or knowledge of a vessel having been subjected to external heat from a fire.

g. A welded repair not documented as required.

h. Evidence of an accident, incident or malfunction that could affect or may have resulted from a problem with the object's integrity.

90.6(5) *Internal inspections for unfired steam pressure vessels operating at more than 15 pounds per square inch.* The commissioner may require an internal inspection of an unfired steam pressure vessel operating in excess of 15 psi when an inspector observes any deviation from these rules, Iowa Code chapter 89, the construction code, the installation code, or the National Board Inspection Code.

90.6(6) *Inspection of inaccessible parts.* When, in the opinion of the inspector, as a result of conditions disclosed at the time of inspection, it is advisable to remove the interior or exterior lining, covering, or brickwork to expose certain parts of the vessel not normally visible, the owner or user shall remove such material to permit proper inspection and thickness measurement of any part of the vessel. Nondestructive examination is acceptable.

90.6(7) *Imminent danger.* If the labor commissioner determines that continued operation of an object constitutes an imminent danger that could seriously injure or cause death to any person, notice to immediately cease operation of that object shall be posted by the labor commissioner. Upon such notice, the owner shall immediately begin the necessary steps to cease operation of the object. The object shall not be used until the necessary repairs have been completed and the object has passed inspection. Operation of an object in violation of this subrule may result in further legal action pursuant to Iowa Code sections 89.11 and 89.13.

90.6(8) *Internal inspections on a four-year cycle based on process safety management compliance.* The owner shall demonstrate compliance with the requirements set forth in Iowa Code section 89.3(5)*"a"*(4)(b) by annually submitting to the labor commissioner a notarized affidavit. The affidavit shall be in a format approved by the labor commissioner and shall be signed by the owner or an officer of the company.

90.6(9) *Internal inspection on a four-year cycle for utility objects.* An object that meets the criteria of this subrule shall be inspected internally at least once every four years and externally every year. If at any time the object or the owner no longer meets the criteria of this subrule, internal inspections shall be performed on a two-year cycle.

a. The object is owned and operated by an electric public utility subject to rate regulation under Iowa Code chapter 476.

b. The object and the owner meet all the requirements for a two-year internal inspection interval as set forth in Iowa Code section 89.3, subsection 4.

c. If the object is shut down for a period sufficient to allow safe entry, and more than two years have passed since the last internal inspection, the owner shall notify the labor commissioner of the outage and shall schedule an internal inspection.

d. If the labor commissioner determines that an earlier inspection is necessary, the owner shall prepare the object for inspection pursuant to rule 875—90.5(89).

[**ARC 8283B**, IAB 11/18/09, effective 1/1/10; **ARC 0319C**, IAB 9/5/12, effective 10/10/12; **ARC 1189C**, IAB 11/27/13, effective 1/1/14; **ARC 1634C**, IAB 10/1/14, effective 11/5/14; **ARC 1964C**, IAB 4/15/15, effective 5/20/15; **ARC 2403C**, IAB 2/17/16, effective 4/1/16]

875—90.7(89) Fees.

90.7(1) *Special inspector commission fee.* A $55 fee shall be paid annually to the commissioner to obtain a special inspector commission pursuant to Iowa Code section 89.7.

90.7(2) *Certificate fee.* A $40 fee shall be paid for each one-year certificate, an $80 fee shall be paid for each two-year certificate, and a $160 fee shall be paid for each four-year certificate.

90.7(3) *Fees for inspection.* An inspection fee for each object inspected by a division inspector shall be paid by the appropriate party as follows:

a. A $55 fee for each water heater supply boiler.

b. A $95 fee for each boiler, other than a water heater supply boiler, having a working pressure up to and including 450 pounds per square inch or generating between 20,000 and 100,000 pounds of steam per hour.

c. A $215 fee for each boiler, other than a water heater supply boiler, having a working pressure in excess of 450 pounds per square inch and generating in excess of 100,000 pounds of steam per hour.

d. A $55 fee for each pressure vessel, such as steam stills, tanks, jacket kettles, sterilizers and all other reservoirs having a working pressure of 15 pounds or more per square inch.

e. In addition to the applicable object's inspection fee, if the division cannot follow normal practice of scheduling inspections in a cost-effective manner due to a request by an owner or user for a customized schedule, travel expenses may be charged at the discretion of the division.

f. Upon receipt of a request for a state inspector to visit or inspect for a reason not required by Iowa Code chapter 89, the labor commissioner may negotiate an appropriate fee.

g. If a boiler or pressure vessel has to be reinspected, there shall be another inspection fee as specified above.

90.7(4) *Fees for attempted inspections.* A $35 fee shall be charged for each attempt by a division inspector to conduct an inspection which is not completed through no fault of the division.

[**ARC 7863B**, IAB 6/17/09, effective 7/1/09; **ARC 8081B**, IAB 8/26/09, effective 9/30/09; **ARC 0319C**, IAB 9/5/12, effective 10/10/12; **ARC 1422C**, IAB 4/16/14, effective 5/21/14]

875—90.8(89) Certificate. No boiler or pressure vessel shall be operated without a current, valid certificate to operate. A certificate to operate shall not be issued until the boiler or pressure vessel is in compliance with the applicable rules and all fees have been paid. The current certificate to operate or a copy of the current certificate to operate shall be conspicuously posted in the room where the object is installed.

[**ARC 1964C**, IAB 4/15/15, effective 5/20/15]

875—90.9(89,252J,261) Special inspector commissions.

90.9(1) *Application.* A person applying for a commission shall complete, sign, and submit to the division with the required fee the form entitled "Application for Boiler and Pressure Vessel Special Inspector Commission" provided by the division. Additionally, the applicant shall submit a copy of the applicant's current National Board work card with each application.

90.9(2) *Expiration.* The commission is for no more than one year and ceases when the special inspector leaves employment with the insurance company, or when the commission is suspended or revoked by the labor commissioner. Each commission shall expire no later than June 30 of each year.

90.9(3) *Changes.* The special inspector shall notify the division at the time any of the information on the form or attachments changes.

90.9(4) *Denials.* The labor commissioner may refuse to issue or renew a special inspector's commission for failure to complete an application package, if the applicant or inspector does not hold a National Board commission, or for any reason listed in subrules 90.9(6) to 90.9(8).

90.9(5) *Investigations.* Investigations shall take place at the time and in the places the labor commissioner directs. The labor commissioner may investigate for any reasonable cause. The labor commissioner may conduct interviews and utilize other reasonable investigatory techniques. Investigations may be conducted without prior notice.

90.9(6) *Reasons for probation.* The labor commissioner may issue a notice of commission probation when an investigation reasonably reveals that the special inspector filed inaccurate reports.

90.9(7) *Reasons for suspension.* The labor commissioner may issue a notice of commission suspension when an investigation reasonably reveals the following:

a. The special inspector failed to submit and report inspections on a timely basis;

b. The special inspector abused the special inspector's authority;

c. The special inspector misrepresented self as a state inspector or a state employee;

d. The special inspector used commission authority for inappropriate personal gain;

e. The special inspector failed to follow the division's rules for inspection of object repairs, alterations, construction, installation, or in-service inspection;

f. The special inspector committed numerous violations as described in subrule 90.9(6);

g. The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;

h. The National Board revoked or suspended the special inspector's work card;

i. The division received a certificate of noncompliance; or

j. The special inspector failed to take appropriate disciplinary actions against a subordinate special inspector who has committed repeated acts or omissions listed in paragraphs *"a"* to *"h"* of this subrule.

90.9(8) *Reasons for revocation.* The labor commissioner may issue a notice of revocation of a special inspector's commission when an investigation reveals any of the following:

a. The special inspector filed a misleading, false or fraudulent report;

b. The special inspector failed to perform a required inspection;

c. The special inspector failed to file a report or filed a report which was not in accordance with the provisions of applicable standards;

d. The special inspector failed to notify the division in writing of any accident involving an object;

e. The special inspector committed repeated violations as described in subrule 90.9(7);

f. The special inspector used fraud or deception to obtain or retain, or to attempt to obtain or retain, a special inspector commission whether for one's self or another;

g. The special inspector instructed, ordered, or otherwise encouraged a subordinate special inspector to perform the acts or omissions listed in paragraphs *"a"* to *"f"* of this subrule;

h. The National Board revoked or suspended the special inspector's work card; or

i. The division received a certificate of noncompliance.

90.9(9) *Procedures.* The following procedures shall apply except in the event of revocation or suspension due to receipt of a certificate of noncompliance. In instances involving receipt of a certificate of noncompliance, the applicable procedures of Iowa Code chapter 252J, 261, or 272D shall apply.

a. Notice of actions. The labor commissioner shall serve a notice on the special inspector by certified mail to an address listed on the commission application form or by other service as permitted by Iowa Code chapter 17A. A copy shall be sent to the insurance company employing the special inspector.

b. Contested cases. The special inspector shall have 20 days to file a written notice of contest with the labor commissioner. If the special inspector does not file a written contest within 20 days of receipt of the notice, the action stated in the notice shall automatically be effective.

c. Hearing procedures. The hearing procedures in 875—Chapter 1 shall govern.

d. Emergency suspension. Pursuant to Iowa Code section 17A.18A, if the labor commissioner finds that public health, safety or welfare imperatively requires emergency action because a special inspector failed to comply with applicable laws or rules, the special inspector's commission may be summarily suspended.

e. Probation period. A special inspector may be placed on probation for a period not to exceed one year for each incident causing probation.

f. Suspension period. A special inspector's commission may be suspended up to five years for each incident causing a suspension.

g. Revocation period. A special inspector's commission that has been revoked shall not be reinstated for five years.

h. Concurrent actions. Multiple actions may proceed at the same time against any special inspector.

i. Revoked or suspended commissions. Within five business days of final agency action revoking or suspending a special inspector commission, the special inspector shall forfeit the special inspector's commission card to the labor commissioner.

[**ARC 8283B**, IAB 11/18/09, effective 1/1/10]

875—90.10(89) Quality reviews, surveys and audits.

90.10(1) An entity that manufactures or repairs boilers, pressure vessels or related equipment may request quality reviews, surveys or audits from certifying organizations such as the ASME or the National Board. The division is authorized to conduct the quality reviews, surveys or audits. If the division performs the service, the manufacturer or repairer shall pay all applicable expenses.

90.10(2) Quality reviews, surveys and audits for certification to the National Board or ASME standards shall be conducted only by a person or organization designated by the labor commissioner. Any person or organization seeking this designation on behalf of the division shall provide documented evidence of training, examination, experience, and certification for the type of reviews, surveys and

audits to be performed. The labor commissioner shall have final authority to determine qualifications and designations.

a. Assessing quality programs. The division recognizes the ASME and the National Board as qualified designees for conducting quality reviews, surveys and audits that lead to ASME or National Board program certification.

b. ISO 9000 assessments. The division recognizes the ASME and the National Board:

(1) To be acceptable ISO 9000 registrars of quality systems for boilers and pressure vessels and the related pressure-technology equipment industry;

(2) To certify auditors and lead auditors to the requirements of ISO 10011-2 1991(E), Annex A; and

(3) To conduct ISO 9000 assessments for the boiler, pressure vessel, and related pressure-technology equipment industry.

875—90.11(89) Notification of explosion. Owners and users of covered objects must report any object explosion by calling (515)281-3647 or (515)281-6533. If the explosion occurs during normal division operating hours, notification shall occur before close of business on that day. If the explosion occurs when the division office is closed, the notification shall occur no later than close of business on the next division business day. Division hours are 8 a.m. to 4:30 p.m., Monday through Friday, except state holidays.

875—90.12(89) Publications available for review. Pursuant to Iowa Code section 89.5, subsection 3, the standards, codes, and publications adopted by reference in these rules are available for review in the office of the Division of Labor Services, 1000 East Grand Avenue, Des Moines, Iowa.

875—90.13(89) Notice prior to installation. Written notice of intent to install objects subject to the jurisdiction of Iowa Code chapter 89 shall be provided to the labor commissioner at least ten days before installation. Written notice shall be accomplished by completing and submitting to the labor commissioner either:

1. The form designated by the labor commissioner, or
2. The National Board's Boiler Installation Report, I-1.

875—90.14(89) Temporary boilers. A certificate to operate a temporary boiler shall expire one year from the date of issuance or when the temporary boiler is disconnected. Inspections on temporary boilers that remain in one location longer than one year shall be performed according to the inspection schedule of Iowa Code section 89.3. A temporary boiler that is installed at a different location less than a year since the prior internal inspection of the boiler shall be subjected to a hydrostatic test pursuant to the National Board Inspection Code or to an internal inspection, at the discretion of the inspector.

875—90.15(89) Conversion of a power boiler to a low-pressure boiler. The following requirements apply to the conversion of a power boiler to a low-pressure boiler. The owner shall comply with the requirements of subrule 90.15(1) for each conversion. In addition, the owner shall comply with the requirements of subrule 90.15(2) if the converted object will be located outside of a place of public assembly or with the requirements of subrule 90.15(3) if the converted object will be located in a place of public assembly.

90.15(1) *General requirements.*

a. The owner shall provide to the labor commissioner written notice of intent to convert a power boiler to a low-pressure boiler prior to conversion. The required form for a notice of conversion is available at http://www.iowaworkforce.org/labor/boiler_inspection_.htm. At a minimum the notice shall contain the following:

(1) Address, uses, and owner of the building where the boiler is located.

(2) The Iowa identification number assigned to the boiler.

(3) Name and contact information for the person completing the notice.

(4) Name and contact information for the contractor or other person planning to perform the conversion.

b. Pressure controls shall not exceed 14 pounds per square inch.

c. All boiler controls shall comply with ASME CSD-1.

d. Safety valves and safety relief valves shall be manufactured in accordance with a national or international standard.

e. One or more spring-pop safety valves meeting the following requirements shall be installed on each steam boiler:

(1) The valve shall be adjusted and sealed to discharge at a pressure not to exceed 15 psig.

(2) The valve capacity shall be certified by the National Board.

f. The converted boiler shall be subject to post-conversion external inspection to ensure that the requirements of this rule are met.

90.15(2) *Boilers located outside places of public assembly.* A power boiler that was converted to a low-pressure boiler and that is located outside of a place of public assembly shall not be converted back to a power boiler unless the following requirements are met:

a. The owner shall notify the labor commissioner at least ten days prior to converting the boiler.

b. The owner shall comply with the editions of ASME Section I and CSD-1 in effect at the time of the second conversion.

c. The owner shall comply with the version of 875—Chapter 92 in effect at the time of the second conversion.

90.15(3) *Boilers located in places of public assembly.* A power boiler converted to a low-pressure boiler that is located in a place of public assembly shall comply with 875—Chapter 94.

[**ARC 9232B**, IAB 11/17/10, effective 12/22/10]

These rules are intended to implement Iowa Code chapters 17A, 89, 252J, 261, and 272D.

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◊ Two or more ARCs

1 Date corrected IAC Supp. 3/26/08

CHAPTER 91
GENERAL REQUIREMENTS FOR ALL OBJECTS

[Prior to 1/14/98, see 347—Chs 41 to 49]
[Prior to 8/16/06, see 875—Ch 203]

875—91.1(89) Codes and code cases adopted by reference.

91.1(1) *ASME boiler and pressure vessel codes adopted by reference.* The ASME Boiler and Pressure Vessel Code (2015) is adopted by reference. Regulated objects shall be designed and constructed in accordance with the ASME Boiler and Pressure Vessel Code (2015) except for objects that meet one of the following criteria:

a. An object with an ASME stamp and National Board Registration that establish compliance with an earlier version of the ASME Boiler and Pressure Vessel Code;

b. An object within the scope of 875—Chapter 95;

c. Rescinded IAB 10/5/11, effective 11/9/11.

d. A miniature boiler installed before March 31, 1967;

e. A power boiler or unfired steam pressure vessel installed before July 4, 1951; or

f. A steam heating boiler, hot water heating boiler, or hot water supply boiler installed before July 1, 1960.

91.1(2) *ASME code cases.* If the manufacturer of an object listed ASME Code Case 2529, 2568, 2571, 2571-1, 2710, or 2714 on the manufacturer's data report for the object and the object is otherwise in compliance with all applicable provisions, the object is in compliance with these rules.

91.1(3) *Inspection code adopted by reference.* The National Board Inspection Code (2015) is adopted by reference, and reinstallations, installations, alterations, and repairs after April 1, 2016, shall comply with it.

91.1(4) *Electric code adopted by reference.* The National Electrical Code (2014) is adopted by reference, and reinstallations and installations after April 1, 2016, shall comply with it.

91.1(5) *Piping codes adopted by reference.* The Power Piping Code, ASME B31.1 (2014), and the Building Services Piping Code, ASME B31.9 (2014), are adopted by reference, and reinstallations and installations after May 20, 2015, shall comply with them up to and including the first valve.

91.1(6) *Control and safety device code adopted by reference.* Controls and Safety Devices for Automatically Fired Boilers (CSD-1) (2012) is adopted by reference, and reinstallations and installations after October 31, 2013, shall comply with it.

91.1(7) *Mechanical code adopted by reference.* Excluding Section 701.1, Chapters 2 and 7 of the International Mechanical Code (IMC) (2015) are adopted by reference, and installations and reinstallations after April 1, 2016, shall comply with them.

91.1(8) *Oil burning equipment code adopted by reference.* National Fire Protection Association Standard for the Installation of Oil Burning Equipment, NFPA 31 (2011), is adopted by reference, and installations and reinstallations after October 10, 2012, shall comply with it.

91.1(9) *Fuel gas code adopted by reference.* National Fire Protection Association National Fuel Gas Code, NFPA 54 (2015), is adopted by reference, and installations and reinstallations after April 1, 2016, shall comply with it.

91.1(10) *Liquefied petroleum gas code adopted by reference.* National Fire Protection Association Liquefied Petroleum Gas Code, NFPA 58 (2014), is adopted by reference, and installations and reinstallations after April 1, 2016, shall comply with it.

91.1(11) *Boiler and combustion systems hazards code adopted by reference.* National Fire Protection Association Boiler and Combustion Systems Hazards Code, NFPA 85 (2015), is adopted by reference, and installations and reinstallations after April 1, 2016, shall comply with it.

[**ARC 8283B**, IAB 11/18/09, effective 1/1/10; **ARC 8590B**, IAB 3/10/10, effective 4/14/10; **ARC 9232B**, IAB 11/17/10, effective 12/22/10; **ARC 9790B**, IAB 10/5/11, effective 11/9/11; **ARC 0319C**, IAB 9/5/12, effective 10/10/12; **ARC 0416C**, IAB 10/31/12, effective 12/5/12; **ARC 1011C**, IAB 9/18/13, effective 10/31/13; **ARC 1964C**, IAB 4/15/15, effective 5/20/15; **ARC 2403C**, IAB 2/17/16, effective 4/1/16]

875—91.2(89) Safety appliance. No person shall remove, disable or tamper with a required safety appliance except for the purpose of repair or inspection. An object shall not be operated unless all applicable safety appliances are properly functional and operational.

875—91.3(89) Pressure-reducing valves. Where pressure-reducing valves are used, one or more relief or safety valves shall be provided on the low-pressure side of the reducing valve when the piping equipment on the low-pressure side does not meet the requirements for the full initial pressure. The relief or safety valves shall be located adjoining or as close as possible to the reducing valve. Proper protection shall be provided to prevent injury or damage caused by the escaping fluid from the discharge of relief or safety valves if vented to the atmosphere. The combined discharge capacity of the relief valves or safety valves shall be such that the pressure rating of the lowest pressure piping or equipment shall not be exceeded in case the reducing valve sticks open. If a bypass around the reducing valves is used, a safety valve is required on the low-pressure side and shall be of sufficient capacity to relieve all the fluid that can pass through the bypass without overpressuring the low-pressure side. A pressure gage shall be installed on the low-pressure side of a reducing valve.

875—91.4(89) Blowoff equipment. The blowdown from an object that enters a sanitary sewer system or blowdown that is considered a hazard to life or property shall pass through blowoff equipment that will reduce pressure and temperature. The temperature of the water leaving the blowoff equipment shall not exceed 150 degrees Fahrenheit. If the local jurisdiction has a temperature limit of less than 150 degrees Fahrenheit, the temperature of the water leaving the blowoff equipment shall comply with the limit set by the local jurisdiction. The pressure of the water leaving the blowoff equipment shall not exceed 5 psig. The blowoff piping and fittings between the object and the blowoff tank shall comply with the construction or installation code. All materials used in the fabrication of object blowoff equipment shall comply with the construction or installation code. All blowoff equipment shall be equipped with openings to facilitate cleaning and inspection.
[**ARC 8283B**, IAB 11/18/09, effective 1/1/10]

875—91.5(89) Location of discharge piping outlets. The discharge from safety valves, safety relief valves, blowoff pipes and other outlets shall be so arranged that there will be no danger of scalding personnel. When the safety valve or temperature and pressure relief valve discharge is piped away from the object to the point of discharge, provision shall be made for properly draining the piping. The size of the discharge piping shall not be reduced from the size of the relief valve.

875—91.6(89) Pipe, valve, and fitting requirements.

91.6(1) Pipes, valves, and fittings subject to the effects of galvanic action shall not be used on objects covered by these rules except where permitted in 875—Chapter 95. Dielectric fittings shall be used where dissimilar metals are joined.

91.6(2) and **91.6(3)** Rescinded IAB 11/18/09, effective 1/1/10.
[**ARC 8283B**, IAB 11/18/09, effective 1/1/10]

875—91.7(89) Electric steam generator. Rescinded **ARC 0319C**, IAB 9/5/12, effective 10/10/12.

875—91.8(89) Alterations, retrofits and repairs to objects. Rescinded **ARC 0319C**, IAB 9/5/12, effective 10/10/12.

875—91.9(89) Boiler door latches. Rescinded **ARC 0319C**, IAB 9/5/12, effective 10/10/12.

875—91.10(89) Clearance.

91.10(1) All objects installed prior to September 20, 2006, shall be so located that adequate space is provided for the proper operation, inspection, and necessary maintenance and repair of the object and its appurtenances.

91.10(2) This subrule applies to installations and reinstallations after September 20, 2006. Minimum clearance on all sides of objects shall be 24 inches, or the manufacturer's recommended

service clearances if they allow sufficient room for inspection. Where a manufacturer identifies in the installation manual or any other document that the unit requires more than 24 inches of service clearance, those dimensions shall be followed. Manholes shall have five feet of clearance between the manhole opening and any wall, ceiling or piping that would hinder entrance or exit from the object.

875—91.11(89) Fall protection. Safe access to all necessary parts of boilers over eight feet tall shall be provided by a runway platform or fall protection system consistent with the requirements below.

91.11(1) *Runway platform.* A steel runway platform in compliance with the criteria of 29 CFR 1910.23 and 1910.27 shall be installed across the tops of objects or at some other convenient level for the purpose of affording safe access. All runways shall have at least two means of exit remotely located from each other.

91.11(2) *Fall protection system.* A fall protection system shall be in compliance with the requirements of 29 CFR 1910.132.

875—91.12(89) Exit from rooms containing objects. All rooms exceeding 500 square feet of floor area and containing one or more objects having a fuel-burning capacity of 1 million Btu's shall have two means of exit remotely located from each other on each level.

875—91.13(89) Air and ventilation.

91.13(1) *Notice concerning other rules.* The division and the Iowa department of public safety both enforce requirements concerning air and ventilation. Objects that are covered by both sets of rules must comply with both sets of rules.

91.13(2) *Documentation.* Documentation of compliance with any requirement of this rule shall be maintained in the boiler room. However, it is not necessary to maintain documentation of the louvered area.

91.13(3) *National combustion air standards.*

a. Installations and reinstallations. Installations and reinstallations shall comply with the edition of NFPA 31, NFPA 54, NFPA 58, NFPA 85, or IMC currently adopted at rule 875—91.1(89) or with the Iowa combustion air standard in subrule 91.13(4). However, compliance with one of the listed NFPA codes constitutes compliance with this rule only if the object burns the fuel covered by the NFPA.

b. Existing objects. An adequate supply of combustion air shall be maintained for all objects while in operation. Compliance with the current edition of NFPA 31, NFPA 54, NFPA 58, NFPA 85, or IMC as adopted at rule 875—91.1(89) or with subrule 91.13(4) constitutes compliance with this rule. Compliance with an earlier edition of NFPA 31, NFPA 54, NFPA 58, NFPA 85, or IMC constitutes compliance with this rule. However, compliance with one of the listed NFPA codes constitutes compliance with this rule only if the object burns the fuel covered by the NFPA. Compliance with an earlier version of Iowa's combustion air rule constitutes compliance with this rule. Earlier versions of Iowa's combustion air rule are available for reference at http://www.iowaworkforce.org/labor/boiler_inspection_.htm.

91.13(4) *Iowa combustion air standard.* A permanent source of outside air shall be provided for each room to permit satisfactory combustion of fuel and ventilation if necessary under normal operations. The minimum ventilation for coal, gas, or oil burners in rooms containing objects is based on the Btu's per hour, required air, and louvered area. The minimum net louvered area shall not be less than 1 square foot. The following table shall be used to determine the net louvered area in square feet:

INPUT (Btu's per hour)	MINIMUM AIR REQUIRED (cubic feet per minute)	MINIMUM LOUVERED AREA (net square feet)
500,000	125	1.0
1,000,000	250	1.0
2,000,000	500	1.6
3,000,000	750	2.5
4,000,000	1,000	3.3

INPUT (Btu's per hour)	MINIMUM AIR REQUIRED (cubic feet per minute)	MINIMUM LOUVERED AREA (net square feet)
5,000,000	1,200	4.1
6,000,000	1,500	5.0
7,000,000	1,750	5.8
8,000,000	2,000	6.6
9,000,000	2,250	7.5
10,000,000	2,500	8.3

When mechanical ventilation is used, the supply of combustion and ventilation air to the objects and the firing device shall be interlocked with the fan so the firing device will not operate with the fan off. The velocity of the air through the ventilating fan shall not exceed 500 feet per minute, and the total air delivered shall be equal to or greater than shown above.
[**ARC 8283B**, IAB 11/18/09, effective 1/1/10]

875—91.14(89) Condensate return tank. Condensate return tanks shall be equipped with at least two vents or a vent and overflow pipe to protect against a loose float plugging a single connection.

875—91.15(89) Conditions not covered. Any condition not governed by these rules shall be governed by the construction or installation code.

875—91.16(89) Nonstandard objects. Rescinded IAB 3/12/08, effective 4/16/08.

875—91.17(89) English language and U.S. customary units required. All documentation supplied for the unit including but not limited to the manufacturers' data report, drawings, parts lists, installation manuals, and operating manuals shall be in English, and all measurements shall be in U.S. customary units. All pressure gages, thermometers and other controls and safety devices shall also be in U.S. customary units.

875—91.18(89) National Board registration. Except for cast iron boilers, cast aluminum boilers, and objects governed by 875—Chapter 95, all objects shall be registered with the National Board.
[**ARC 8283B**, IAB 11/18/09, effective 1/1/10]

875—91.19(89) ASME stamp. Except for water heaters regulated by 875—Chapter 95, all objects shall bear the appropriate ASME stamp. Objects shall not be utilized in a manner inconsistent with the stamp.
[**ARC 8283B**, IAB 11/18/09, effective 1/1/10]

875—91.20(89) CSD-1 reports and related documentation. Documentation required by this rule shall be kept on site and shall be available for inspection.

91.20(1) The requirements of this rule do not apply to:

a. An object within the scope of 875—Chapter 95;

b. An object within the scope of 875—Chapter 96;

c. A hot water supply boiler covered by ASME Section IV, Part HLW; or

d. A boiler with a fuel input rating greater than or equal to 12,500,000 Btu per hour, falling within the scope of NFPA 85, Boiler and Combustion Systems Hazards Code.

91.20(2) The installer shall complete a Manufacturer's/Installing Contractor's Report for ASME CSD-1 (CSD-1 report) for each newly installed or reinstalled object.

91.20(3) A person who installs a new burner, new gas train, or new controller on an object shall complete a CSD-1 report.

91.20(4) A person who replaces a part or component of an object shall complete the relevant portions of the CSD-1 report unless the replacement satisfies the design specifications. A copy of an invoice containing the same information as the relevant portions of the CSD-1 report is an acceptable alternative.
[**ARC 8283B**, IAB 11/18/09, effective 1/1/10; **ARC 9232B**, IAB 11/17/10, effective 12/22/10; **ARC 1964C**, IAB 4/15/15, effective 5/20/15]

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