

*State of Iowa*

**Iowa**  
**Administrative**  
**Code**  
**Supplement**

Biweekly  
March 14, 2018



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Published by the  
STATE OF IOWA  
UNDER AUTHORITY OF IOWA CODE SECTION 17A.6

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

### **Administrative Services Department[11]**

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- Replace Chapters 922 and 923

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- Replace Chapter 8

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- Replace Chapter 61
- Replace Chapter 150

TITLE V  
GENERAL SERVICES  
CHAPTER 100  
CAPITOL COMPLEX OPERATIONS  
[Prior to 9/17/03, see 401—Chapter 3]

**11—100.1(8A) Definitions.** The definitions contained in Iowa Code sections 8A.101 and 8A.301 shall be applicable to such terms when used in this chapter. In addition, the following definitions apply:

*“Assignment of office space”* means space allocated by the department to a state agency for its use.

*“Capitol complex”* means an area within the city of Des Moines in which the Iowa state capitol building is located. This area includes the state capitol building and all real property and appurtenances thereto owned by the state of Iowa within an area bounded on the north by Interstate Highway 235, on the east by East 14th Street, on the south by the northernmost railroad tracks south of Court Avenue and on the west by East 6th Street.

*“Control of assigned office space”* means the ability of an agency to modify its use of assigned space without consultation with the department as long as changes do not include relocating wiring, replacing, adding or deleting modular office components, or making other modifications that would affect the floor plan.

*“Dangerous weapon”* means any instrument or device designed primarily for use in inflicting death or injury upon a human being or animal, and which is capable of inflicting death upon a human being when used in the manner for which it was designed. Additionally, any instrument or device of any sort whatsoever which is actually used in such a manner as to indicate that the person possessing the instrument or device intends to inflict death or serious injury upon the other, and which, when so used, is capable of inflicting death upon a human being, is a dangerous weapon. Dangerous weapons include, but are not limited to, any offensive weapon as defined in Iowa Code section 724.1, pistol, revolver, or other firearm, dagger, razor, stiletto, switchblade knife, or knife having a blade exceeding five inches in length. Pistols and revolvers are exempted from the definition of “dangerous weapons” only as set forth in subrule 100.2(2).

*“Facilities”* means the capitol complex buildings, grounds, and all related property.

*“Memorandum of understanding”* or *“MOU”* means a written agreement that specifies terms, conditions and any related costs.

*“Modular office components”* means parts of a modular office system.

*“Modular office systems”* means standard cubicle furniture; generally, two-foot, three-foot and four-foot sections that have attached work surfaces and file storage space. Modular office systems are available in new, remanufactured and recycled condition.

*“Office furniture”* means any furnishing that is free standing and does not require installation with component parts. Examples are desks, chairs, file cabinets, tables, lounge seating, and computer desks.

*“Public”* means a person on the capitol complex who is not employed by the state of Iowa.

*“Recycled modular office components”* means used components that have been cleaned and have had broken parts replaced, but have not been disassembled and rebuilt.

*“Remanufactured modular office components”* means used components that have been disassembled, repainted or reupholstered, rebuilt, and have had broken parts replaced. Remanufactured components are intended to be like new.

*“Seat of government”* means office space at the capitol, other state buildings and elsewhere in the city of Des Moines for executive branch agencies, except those areas exempted by law.

*“Standard modular office systems”* means modular office systems that meet standards set by the department of administrative services, expressed by function and connectivity, for use by state agencies. These standards are for the purpose of facilitating reuse of modular office system components.

*“Waiver”* means a waiver or variance as defined in 11—Chapter 9, Iowa Administrative Code.

[ARC 3179C, IAB 7/5/17, effective 7/1/17; ARC 3287C, IAB 8/30/17, effective 10/4/17; ARC 3676C, IAB 3/14/18, effective 4/18/18]

**11—100.2(8A) Security.**

**100.2(1) *Dangerous weapons.*** No member of the public shall carry a dangerous weapon in state buildings on the capitol complex except as otherwise provided in subrule 100.2(2). This provision applies to any member of the public whether or not the individual possesses a valid Iowa permit to carry weapons. This provision does not apply to:

*a.* A peace officer as defined in Iowa Code section 801.4 or a member of the armed forces of the United States or of the national guard, when the person's duties or lawful activities require or permit possession of a dangerous weapon.

*b.* A person possessing a valid Iowa professional permit to carry a weapon whose duties require that person to carry a dangerous weapon.

*c.* A person who possesses a dangerous weapon for any purpose authorized by a state agency to further the statutory or regulatory responsibilities of that agency. An authorization issued pursuant to this paragraph shall not become effective until it has been issued in writing to the person or persons to whom it applies and until copies of the authorization have been received by the director and by the commissioner of public safety.

*d.* Members of recognized military veterans organizations performing honor guard service as provided in Iowa Code section 35A.12.

Violation of this subrule is a simple misdemeanor, pursuant to Iowa Code section 8A.322, and may result in the denial of access to a state building, filing of criminal charges or expulsion from the grounds of the capitol complex, or any combination thereof, of any individual who knowingly violates the subrule. In addition, any weapon found in possession of a member of the public in violation of this subrule may be confiscated. Charges may be filed under any other criminal statute if appropriate. Officers employed by or under the supervision of the department of public safety shall have the authority to enforce this subrule. Peace officers employed by other agencies shall have the authority to enforce this subrule at the request of the commissioner of public safety or in response to a request for assistance from an officer employed by the department of public safety.

**100.2(2) *Pistols and revolvers.*** No person, other than a peace officer, may openly carry a pistol or revolver in the capitol building and on the grounds surrounding the capitol building including state parking lots and parking garages. This provision does not preclude the lawful carrying, transportation, or possession of a pistol or revolver in the capitol building and on the grounds surrounding the capitol building including the state parking lots and parking garages by a person who displays to capitol security personnel a valid permit to carry weapons upon request.

Violation of this subrule is a simple misdemeanor, pursuant to Iowa Code section 8A.322, and may result in the denial of access to a state building, filing of criminal charges or expulsion from the grounds of the capitol complex, or any combination thereof, of any individual who knowingly violates the subrule. In addition, any weapon found in possession of a member of the public in violation of this subrule may be confiscated. Charges may be filed under any other criminal statute if appropriate. Officers employed by or under the supervision of the department of public safety shall have the authority to enforce this subrule. Peace officers employed by other agencies shall have the authority to enforce this subrule at the request of the commissioner of public safety or in response to a request for assistance from an officer employed by the department of public safety.

**100.2(3) *Building access and security.*** The department of administrative services and the department of public safety shall take reasonable and appropriate measures to ensure the safety of persons and property on the capitol complex. These measures may include, but are not limited to, the following:

*a.* Requiring any member of the public entering a state building on the capitol complex to (1) provide identification upon request; (2) allow the member of the public to be scanned with metal detecting equipment; and (3) allow any parcel, package, luggage, purse, or briefcase that the person is bringing into the building to be examined with X-ray equipment or to have the contents thereof examined, or both.

*b.* Requiring any member of the public who is inside a state building on the capitol complex outside normal business hours, other than when the building or portion of the building is open to the public during a scheduled event, to provide identification and to state the nature of the person's business in the building. A member of the public who is in a state building on the capitol complex outside normal

business hours, other than during a scheduled event, and who does not have authorization to be on the premises may be required to exit the building and be escorted from the building.

*c.* Limiting public access to state buildings on the capitol complex to selected entrances. Access to each building through at least one entrance accessible to persons with disabilities shall be maintained.

*d.* Limiting hours during which public access is allowed to state buildings on the capitol complex. Hours during which public access is allowed shall be posted at each entrance to a building through which public access is allowed.

*e.* Confiscating any container including, but not limited to, packages, bags, briefcases, or boxes that are left in public areas when the state building is not open to the public. Any confiscated container may be searched or destroyed, or both, or may be returned to the owner. Any container that is left unattended in a public area during hours in which the state building is open to the public may be examined.

Violation of this subrule is a simple misdemeanor, pursuant to Iowa Code section 8A.322, and may result in the denial of access to a state building, filing of criminal charges or expulsion from the grounds of the capitol complex, or any combination thereof, of the individual who knowingly violates the subrule. Charges may be filed under any other criminal statute if appropriate. Officers employed by or under the supervision of the department of public safety shall have the authority to enforce this subrule. Peace officers employed by other agencies shall have the authority to enforce this subrule at the request of the commissioner of public safety or in response to a request for assistance from an officer employed by the department of public safety.

**100.2(4) *Fireworks.*** No person shall use or explode consumer fireworks, display fireworks, or novelties, as those terms are defined in Iowa Code section 727.2, on the capitol complex without the director's advanced written approval.

**100.2(5) *Access barriers.*** The director may cause the temporary or permanent placement of barricades, ropes, signs, or other barriers to access certain parts of state buildings or grounds. Unauthorized persons beyond the barriers may be removed with the assistance of officers of the department of public safety or charged with a criminal offense if appropriate, or both.

[ARC 3179C, IAB 7/5/17, effective 7/1/17; ARC 3287C, IAB 8/30/17, effective 10/4/17]

### **11—100.3(142B) Smoking.**

**100.3(1)** Use of tobacco products is prohibited in all space in capitol complex buildings controlled by the executive branch including tunnels and enclosures, unless otherwise designated by appropriate signs. The department shall post signs at the entrances to capitol complex buildings to publicize this rule.

NOTE: The secretary of the senate, the clerk of the house and the court administrator are responsible for areas under their control.

**100.3(2)** Use of tobacco products is prohibited on the grounds of the capitol complex, except as permitted by the director in designated areas or structures designated for smoking. The department shall post signs at designated smoking areas.

**100.3(3)** This rule shall be enforced by peace officers of the department of public safety. Peace officers other than those employed by the department of public safety may enforce this rule at the request of the commissioner of public safety or at the request of a peace officer employed by the department of public safety.

This rule is intended to implement Iowa Code section 8A.322 and chapter 142B and Executive Order Number 68 signed November 23, 1998, by Governor Terry Branstad.

### **11—100.4(8A) Use and scheduling of capitol complex facilities.**

**100.4(1) *Scheduling conference rooms.*** Conference rooms, auditoriums and common areas within the capitol complex are for use by state agencies, boards and commissions for authorized purposes only. Arrangements may be made by contacting the agency responsible for scheduling the facility. The department of administrative services is responsible for scheduling all common areas not under control of other agencies. Questions about usage shall be resolved by the director of the responsible

agency. General questions about scheduling may be directed to the department's customer service center at (515)242-5120.

**100.4(2) *Legislative and judicial building contacts.*** The secretary of the senate, the clerk of the house and the court administrator are responsible for areas under their control. Common areas in and around the Capitol Building are under the control of the department of administrative services.

**100.4(3) *Iowa Historical Building events.*** Scheduling of events by the public as well as by state agencies, boards and commissions to be held in the Iowa Historical Building will be coordinated by the department of cultural affairs. Groups or individuals wishing to use the Iowa Historical Building for an event should contact the Facilities Coordinator, State Historical Society of Iowa, Iowa Historical Building, 600 East Locust Street, Des Moines, Iowa 50319.

**100.4(4) *Event request.*** State agencies or the general public may request use of capitol complex facilities, grounds or parking lots for public events by contacting the director and completing an application provided by the department. This shall not be interpreted as an infringement on the right of assembly and petition guaranteed by Section 20, Article I, Constitution of Iowa.

*a.* The director shall notify the applicant of approval or denial to use the requested areas. Notification of approval may take the form of a letter to the event sponsor(s) or a memorandum of understanding (MOU) signed by the director and the event sponsor(s). The MOU specifies the conditions under which the event will take place.

*b.* The director may allow events if appropriate security and supervision are provided and the director determines that granting the approval is consistent with the underlying purpose of these rules and that the public interest so demands.

*c.* Approval for the event may contain such terms and conditions as are consistent with the protection, health and safety of occupants of the buildings and visitors to the capitol complex as well as preservation of the buildings, facilities, and grounds. The approval may also contain limitations on equipment used and its location, and the time and area within which the event is allowed.

**100.4(5) *Refusal of usage.*** The director may refuse to allow use of the facilities that, in the director's judgment, would be disruptive of official state business or of the public health, safety and welfare, or is inconsistent with subrule 100.4(4). The director may consider such factors as recommendations of the department of public safety, previous experience with the requesting group or other events similar to that requested.

**100.4(6) *Liability.*** Any state agency or public group granted permission to use the capitol complex facilities shall be responsible for any damage occurring during the event.

*a.* Prior to granting approval, the director may require the requesting group to acquire liability insurance in which the "State of Iowa" is named as an additional insured to protect the state.

*b.* As a condition of granting approval of a request for an event at the capitol complex, the director may also require that a damage deposit or bond be posted by the group making the request. The director may require the filing of a bond payable to the director in an amount adequate to cover costs such as restoration, rehabilitation and cleanup of the area used, damages and other costs resulting from this event. In lieu of a bond, an event requester may elect to deposit cash equal to the amount of the required bond.

**100.4(7) *Event cleanup.*** Any state agency or public group granted permission to use the capitol complex facilities shall be responsible for a thorough cleanup after the event is concluded. All debris and animal waste shall be removed.

**100.4(8) *Alcoholic beverages at events.*** Consumption of alcoholic beverages, as defined in Iowa Code chapter 123, is not permitted on the capitol complex except for special events in the Iowa Historical Building, 600 East Locust Street, with the prior written approval of the director and the director of the department of cultural affairs.

**100.4(9) *Distribution of literature.*** Permission to distribute literature on the capitol complex grounds or in state-owned or occupied areas of leased buildings in metropolitan Des Moines must be obtained from the director. The director may designate specific locations from which literature may be distributed in order to ensure control of litter, unobstructed access to public buildings and the conduct of public business.

**100.4(10) *Private parties.*** No state-owned facilities, equipment or state personnel shall be used for such events as private parties, weddings, demonstrations, and rallies without the prior written consent of the director.

**100.4(11) *Access hours.*** Public use of state buildings is restricted to normal office hours. Hours during which public access is allowed shall be posted at each entrance to a building through which public access is allowed.

**100.4(12) *After-hours use.*** After-hours use of capitol complex buildings is restricted to use by state agencies and must directly relate to the mission of the state agency sponsoring the event.

*a.* For all buildings except the Capitol Building and the Iowa Historical Building, normal office hours are 7 a.m. to 5 p.m., Monday through Friday. Buildings are closed to the public on weekends and state-designated holidays.

*b.* For the Capitol Building, normal office hours are 6 a.m. to 6 p.m., Monday through Friday, except that if a legislative session lasts past 6 p.m., the closing hour is extended until one-half hour beyond the session's end. Weekend hours of public access shall be posted at public entrances. Inquiries regarding the hours the building is open may be directed to the information desk at (515)281-5591.

*c.* For the Iowa Historical Building, normal office hours are 8 a.m. to 4:30 p.m. every day, excluding weekends and holidays. The Iowa Historical Museum and the State Historical Library, located within the Iowa Historical Building, have different hours. Hours of public access shall be posted at public entrances. Inquiries regarding the hours the building is open may be directed to the information desk at (515)281-5111.

*d.* Hours listed above are subject to change. Changes in hours shall be posted on the main entrance doors to each affected building.

**100.4(13) *Capitol grounds hours.*** Public use of the capitol complex grounds is restricted to the hours of 6 a.m. to 11 p.m. daily. Public access hours are subject to change. Changes in hours shall be posted prominently on the capitol complex.

This rule is intended to implement 2003 Iowa Code Supplement section 8A.322.

<sup>1</sup> See 2004 Iowa Acts, HJR 2005 and SJR 2007.

## **11—100.5(8A) Solicitation.**

**100.5(1)** Canteens, cafeterias and vending machines under the control of the department for the blind, gift shops under the control of the department of cultural affairs and concessions authorized by the director pursuant to subrule 100.4(4) are authorized methods of direct sales to employees and visitors in state-owned and occupied buildings in metropolitan Des Moines.

**100.5(2)** Functions involving sales to state employees or to the public in the capitol complex or in state-owned and occupied buildings in metropolitan Des Moines must receive prior approval through the event request process in subrule 100.4(4). Sales by state employees are governed by Iowa Code chapter 68B.

**100.5(3)** Event sponsors are responsible for contracting with vendors for sales during the event. The MOU may contain terms and conditions for vendors and shall specify the responsibility of the event sponsor to ensure that all approved vendors comply with all applicable city, state and federal laws, ordinances, rules and regulations. Vendors must have all required city, state and federal permits and licenses.

**100.5(4)** For the convenience of employees and visitors, the director may enter into agreements with private vendors for providing services and products within state buildings under the jurisdiction of the department. Provision of services and products shall not interfere with the business of government or negatively affect building aesthetics. The director shall solicit competitive proposals when it is probable that more than one vendor may desire to offer a similar service or product. Agreement terms and conditions shall protect the state's interest regarding liability, reasonable compensation to the state, performance and appearance standards, and other relevant concerns.

**100.5(5)** The director reserves the right to deny or remove any vendor who does not comply with these rules and applicable laws and regulations.

This rule is intended to implement 2003 Iowa Code Supplement section 8A.322 and Iowa Code section 303.9 and chapter 216D.

**11—100.6(8A) Office space management.**

**100.6(1) Purpose.** The purpose of this rule is to standardize office space management at the seat of government in order to effectively plan and utilize office space and to promote connectivity and reuse of modular office systems. The rules outline the responsibilities of state agencies relative to use of office space assigned to them by the department of administrative services and the responsibilities of the department to manage and coordinate changes to an agency's use of its assigned space.

**100.6(2) Scope and applicability.** The department's authority for office space assignment applies to all state office space, including leased office space, at the seat of government except for buildings and grounds described in Iowa Code section 216B.3, subsection 6; section 2.43, unnumbered paragraph 1; and any buildings under the custody and control of the Iowa public employees' retirement system.

**100.6(3) Office space standards.** State agencies are required to use the following standards:

*a.* The department of administrative services has developed and shall maintain, in cooperation with state agencies, office space standards, expressed in square feet for individual offices classified by type of work, and by occupancy, expressed as the number of occupants per building floor or major unit thereof. These standards will be used to facilitate space planning, but are not intended to be applied in an exact manner to each cubicle or office. Some flexibility may be allowed in the work plan created for managing changes to use of office space to provide for unique agency needs. All office space layouts shall comply with applicable federal and state regulations and codes.

*b.* The department of administrative services has defined and shall maintain, in cooperation with state agencies and Iowa Prison Industries (IPI), modular office systems standards, expressed by function and connectivity, for use by state agencies. These standards are for the purpose of facilitating reuse of modular office system components.

The requirement to follow these standards may be waived by the director when supported by a written factual and objective business case analysis that provides clear and convincing evidence to support the waiver.

**100.6(4) Notification of intended office space or office systems modifications.** To facilitate office space planning and cost-effective space utilization, an agency shall notify the department in writing at least 45 days prior to expected completion of the work whenever an agency becomes aware of possible modifications to an agency's organization, programs or mission which may require a corresponding increase or decrease in an agency's current office space requirements; or when an agency first identifies a need to modify use of assigned office space including relocating wiring, replacing, adding or deleting modular office components, or making other floor plan modifications.

**100.6(5) Work plan.** Upon written notification of intended office space or office systems modifications, the department of administrative services and the agency will negotiate and complete a work plan including but not limited to the following items:

- a.* A description of the intended space modification result;
- b.* The tasks required to achieve the intended result, such as creating construction specifications, identifying wiring needs, selection of a space planner and a moving service, and identifying related purchases;
- c.* The party responsible for accomplishing each task; and
- d.* The scheduled time line for tasks included in the design, installation (construction and move) and completion of the project.

An agency may not proceed with office space modifications in the absence of a work plan agreed to and approved in writing by the agency and the department of administrative services. The work plan shall be modified to reflect any changes in intended results, tasks, responsibilities and time schedule.

**100.6(6) Purchase of standard modular office systems and components.** If Iowa Prison Industries (IPI) manufactures office furniture and standard modular office systems and related components, an

agency shall purchase them from IPI or obtain a written waiver in accordance with Iowa Code section 904.808, except as otherwise permitted in paragraphs “a” and “b.”

*a. Purchase from a targeted small business.* An agency may purchase standard modular office systems and related components and other furniture items from a targeted small business (TSB) without further competition when the purchase will not exceed \$10,000, as provided in Iowa Code section 8A.311(10)“a.”

*b. Procurement of standard modular office systems and components and other furniture items manufactured in Iowa.* An agency may conduct a competitive procurement for standard modular office systems and related components and other furniture items that IPI manufactures if the competitive procurement requires that the products must be manufactured in Iowa. In such procurements, IPI shall be allowed to submit a bid to provide the products. If a bidder other than IPI is the lowest bidder, the agency shall obtain written verification from the bidder that the bidder’s product is manufactured in Iowa before making the award.

The portion of the work plan for purchasing modular office systems or office furniture shall allow for the issuance of purchase orders at least 30 days prior to the desired delivery date.

Regardless of how an agency purchases or obtains modular office components, the department of administrative services shall retain responsibility for management and coordination of office space planning.

**100.6(7) Disposal of surplus office modular components, furniture and equipment.** State agencies may dispose of unfit or unnecessary office modular components, furniture and equipment by contacting the state surplus office, as identified by the department; offering items in good repair to other agencies either through the department or directly to other agencies; or trading in used items when purchasing replacements.

Any costs associated with disposal of nonstandard modular office components are the responsibility of the state agency.

[ARC 3676C, IAB 3/14/18, effective 4/18/18]

These rules are intended to implement 2003 Iowa Code Supplement sections 8A.104, 8A.321, and 8A.322 and Iowa Code section 303.9 and chapters 142B and 216D.

[Filed emergency 1/11/02—published 2/6/02, effective 1/14/02]

[Filed 4/26/02, Notice 2/6/02—published 5/15/02, effective 7/1/02]<sup>1</sup>

[Filed 1/17/03, Notice 12/11/02—published 2/5/03, effective 3/12/03]

[Filed emergency 8/29/03—published 9/17/03, effective 9/2/03]

[Filed 5/5/04, Notice 3/31/04—published 5/26/04, effective 6/30/04]

[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]

[Filed 10/3/07, Notice 8/29/07—published 10/24/07, effective 11/28/07]

[Filed Emergency ARC 3179C, IAB 7/5/17, effective 7/1/17]

[Filed ARC 3287C (Notice ARC 3177C, IAB 7/5/17), IAB 8/30/17, effective 10/4/17]

[Filed ARC 3676C (Notice ARC 3574C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

<sup>1</sup> At its meeting held June 11, 2002, the Administrative Rules Review Committee imposed a 70-day delay on the effective date of rule 401—3.4(18); the delay was lifted by the Committee at its meeting held July 9, 2002, effective July 10, 2002.



TITLE VI  
CENTRAL PROCUREMENT

CHAPTER 117

PROCUREMENT OF GOODS AND SERVICES OF GENERAL USE

[Prior to 10/29/03, see 401—Chapters 7, 8, and 9]

[Prior to 8/18/04, see 471—Chapter 13]

[Prior to 8/21/13, see 11—Chapter 105]

**11—117.1(8A) General provisions.**

**117.1(1) Applicability.**

*a. Goods and services of general use.* Under the provisions of Iowa Code chapter 8A, these rules apply to the purchase of goods and services of general use by any unit of the state executive branch including a commission, board, institution, bureau, office, agency or department, except items used by the state department of transportation, institutions under the control of the board of regents, the department for the blind, and any other agencies or instrumentalities of the state exempted by law.

*b. Services.* Procurement of services shall also meet the provisions of Iowa Administrative Code, 11—Chapters 118 and 119.

*c. Information technology.* Pursuant to Iowa Code chapter 8A, procurement of information technology devices and services by participating agencies shall also meet the requirements of rule 11—117.11(8A). Rule 11—117.11(8A) shall apply to:

(1) The process by which the department shall ensure effective and efficient compliance with standards prescribed by the department with respect to the procurement of information technology devices and services by participating agencies, and

(2) The acquisition of information technology devices and services by the department for the department or by the department for a participating agency that has requested that the department procure information technology devices or services on the agency's behalf.

**117.1(2) Funding.** The department and agencies shall follow procurement policies regardless of the funding source supporting the procurement. However, when these rules prevent the state from obtaining and using a federal grant, these rules are suspended to the extent required to comply with the federal grant requirements.

**117.1(3) Electronic processing.** Notwithstanding other administrative rules, requirements for paper transactions in the procurement of goods and services shall be waived when an alternative electronic process is available. If the vendor is unable to use the electronic process, an alternative paper process may be available.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.2(8A) Definitions.**

“Acquisition” or “acquire” is defined in the same manner as “procurement,” “procure,” or “purchase.”

“Agency” or “state agency” means a unit of state government, which is an authority, board, commission, committee, council, department, examining board, or independent agency as defined in Iowa Code section 7E.4, including but not limited to each principal central department enumerated in Iowa Code section 7E.5. However, “agency” or “state agency” does not mean any of the following:

1. The office of the governor or the office of an elective constitutional or statutory officer.
2. The general assembly, or any office or unit under its administrative authority.
3. The judicial branch, as provided in Iowa Code section 602.1102.
4. A political subdivision of the state or its offices or units, including but not limited to a county, city, or community college.

“All or none” means an award based on the total for all items included in the solicitation.

“American-based business” means an entity that has its principal place of business in the United States of America.

“American-made product” means product(s) produced or grown in the United States of America.

*“American motor vehicles”* means those vehicles manufactured in this state and those vehicles in which at least 70 percent of the value of the motor vehicle was manufactured in the United States or Canada and at least 50 percent of the motor vehicle sales of the manufacturer are in the United States or Canada.

*“Award”* means the selection of a vendor to receive a master agreement or order of a good or service.

*“Bid specification”* means the standards or qualities which must be met before a contract to purchase will be awarded and any terms which the director has set as a condition precedent to the awarding of a contract.

*“Board”* means the technology governance board established by Iowa Code section 8A.204.

*“Competent and qualified”* means an architect or engineer who, at the sole discretion of the department, has the capability in all respects to satisfactorily perform the scope of services required by the proposed contract in a timely manner.

*“Competitive bidding procedure”* means the advertisement for, solicitation of, or the procurement of bids; the manner and condition in which bids are received; and the procedure by which bids are opened, accessed, evaluated, accepted, rejected or awarded. A “competitive bidding procedure” refers to all types of competitive solicitation processes referenced in this chapter and may include a transaction accomplished in an electronic format.

*“Competitive selection documents”* means documents prepared for a competitive selection by a department or agency to purchase goods and services. Competitive selection documents may include requests for proposal, invitations to bid, or any other type of document a department or agency is authorized to use that is designed to procure a good or service for state government. A competitive selection document may be an electronic document.

*“Department”* means the department of administrative services.

*“Director”* means the director of the department of administrative services or the director’s designee.

*“Emergency”* includes, but is not limited to, a condition:

1. That threatens public health, welfare or safety; or
2. In which there is a need to protect the health, welfare or safety of persons occupying or visiting a public improvement or property located adjacent to the public improvement; or
3. In which the department or agency must act to preserve critical services or programs; or
4. In which the need is a result of events or circumstances not reasonably foreseeable.

*“Emergency procurement”* means an acquisition resulting from an emergency need.

*“Enterprise”* means most or all state agencies acting collectively, unless it is used in a manner such as “state accounting enterprise,” in which case it means the specific unit of the department of administrative services.

*“Fair and reasonable price”* means a price that is commensurate with the extent and complexity of the services to be provided and is comparable to the price paid by the department or other entities for projects of similar scope and complexity.

*“Formal competition”* means a competitive selection process that employs a request for proposals or other means of competitive selection authorized by applicable law and results in procurement of a good or service.

*“Good”* or *“goods”* means products or personal property other than money that is tangible or movable at the time of purchase, including specially manufactured goods. A contract for goods is a contract in which the predominant factor, thrust, and purpose of the contract as reasonably stated is for the acquisition of goods. When there is a contract for both goods and services and the predominant factor, thrust, and purpose of the contract as reasonably stated is for the acquisition of goods, a contract for goods exists.

*“Goods and services of general use”* means goods and services that are not unique to an agency’s program or that are needed by more than one agency. This chapter applies to the purchase of goods and services of general use.

*“Governmental entity”* means any unit of government in the executive, legislative, or judicial branch of government; an agency or political subdivision; any unit of another state government, including its

political subdivisions; any unit of the United States government; or any association or other organization whose membership consists primarily of one or more of any of the foregoing.

*“Informal competition”* means a streamlined competitive selection process in which a department or agency makes an effort to contact at least three prospective vendors identified by the department or purchasing agency as qualified to perform the work described in the scope of work to request that they provide bids or proposals for the delivery of the goods or services the department or agency is seeking.

*“Information technology device”* means equipment or associated software, including programs, languages, procedures, or associated documentation, used in operating the equipment which is designed for utilizing information stored in an electronic format. “Information technology device” includes but is not limited to computer systems, computer networks, and equipment used for input, output, processing, storage, display, scanning, and printing.

*“Information technology services”* means services designed to provide functions, maintenance, and support of information technology devices, or services including but not limited to computer systems application development and maintenance; systems integration and interoperability; operating systems maintenance and design; computer systems programming; computer systems software support; planning and security relating to information technology devices; data management consultation; information technology education and consulting; information technology planning and standards; and establishment of local area network and workstation management standards.

*“Iowa-based business”* means an entity that has its principal place of business in Iowa.

*“Iowa product”* means a product(s) produced or grown in Iowa.

*“Life cycle cost”* means the expected total cost of ownership during the life of a product, including disposal costs.

*“Limited scope”* means only a few specific services are required for a project. An example is a project for which all existing conditions and parameters are clearly evident or defined in a request for proposal, such as a project calling for development of specifications and bidding documents for replacement of an existing boiler.

*“Lowest responsible bidder”* means the responsible bidder that is fully compliant with the requirements and terms of the competitive selection document and that submits the lowest price(s) or cost(s).

*“Master agreement”* means a contract competitively bid and entered into by the department which establishes prices, terms, and conditions for the purchase of goods and services of general use. These contracts may involve the needs of one or more state agencies. Agencies may purchase from a master agreement without further competition. Master agreements (also referred to as “master contracts”) for a particular item or class of items may be awarded to a single vendor or multiple vendors. The department is the sole agency authorized to enter into master agreements for goods and services of general use.

*“Material modification”* relating to an approved IT procurement means a change in the procurement of 10 percent or \$50,000, whichever is less, or a change of sufficient importance or relevance so as to have possible significant influence on the outcome.

*“Negotiated contract”* means a master agreement for a procurement that meets the requirements of Iowa Code section 8A.207(4)“b.”

*“Newspaper of general circulation”* means a newspaper meeting the definition set forth in Iowa Code section 618.3.

*“Operational standards”* means information technology standards established by the department according to Iowa Code sections 8A.202 to 8A.207 that include but are not limited to specifications, requirements, processes, or initiatives that foster compatibility, interoperability, connectivity, and use of information technology devices and services among agencies.

*“Order”* means a direct purchase or a purchase from a state contract or master agreement.

*“Participating agency,”* applicable only to information technology purchases, means any agency other than:

1. The state board of regents and institutions operated under its authority;
2. The public broadcasting division of the department of education;
3. The department of transportation’s mobile radio network;

4. The department of public safety law enforcement communications systems and capitol complex security systems in use for the legislative branch;

5. The Iowa telecommunications and technology commission, with respect to information technology that is unique to the Iowa communications network;

6. The Iowa lottery authority; and

7. A judicial district department of correctional services established pursuant to Iowa Code section 905.2.

*“Printing”* means the reproduction of an image from a printing surface made generally by a contact impression that causes a transfer of ink, the reproduction of an impression by a photographic process, or the reproduction of an image by electronic means and shall include binding and may include material, processes, or operations necessary to produce a finished printed product, but shall not include binding, rebinding or repairs of books, journals, pamphlets, magazines and literary articles by a library of the state or any of its offices, departments, boards, and commissions held as a part of their library collection.

*“Printing equipment”* means offset presses, gravure presses, silk-screen equipment, large format ink jet printers, digital printing/copying equipment, letterpress equipment, office copiers and bindery equipment.

*“Procurement,” “procure,”* or *“purchase”* means the acquisition of goods and services through lease, lease/purchase, acceptance of, contracting for, obtaining title to, use of, or any other manner or method for acquiring an interest in a good or service.

*“Procurement authority”* means an agency authorized by statute to purchase goods and services.

*“Responsible bidder”* means a vendor that has the capability in all material respects to perform the contract requirements. In determining whether a vendor is a responsible bidder, the department may consider various factors including, but not limited to, the vendor’s competence and qualification for the type of good or service required, the vendor’s integrity and reliability, the past performance of the vendor relative to the quality of the good or service, the past experience of the department in relation to the vendor’s performance, the relative quality of the good or service, the proposed terms of delivery, and the best interest of the state.

*“Sealed”* means the submission of responses to a solicitation in a form that prevents disclosure of the contents prior to a date and time established by the department for opening the responses. Sealed responses may be received electronically.

*“Service”* or *“services”* means work performed for an agency or its clients by a service provider. A contract for services is a procurement where the predominant factor, thrust, and purpose of the contract as reasonably stated is for services. When there is a mixed contract for goods and services, if the predominant factor, thrust, and purpose of the contract as reasonably stated is for service, with goods incidentally involved, a contract for services exists.

*“Software”* means an ordered set of instructions or statements that causes information technology devices to process data and includes any program or set of programs, procedures, or routines used to employ and control capabilities of computer hardware. As used in these rules, “software” also includes, but is not limited to, an operating system; compiler; assembler; utility; library resource; maintenance routine; application; or a computer networking program’s nonmechanized and nonphysical components; arrangements; algorithms; procedures; programs; services; sequences and routines utilized to support, guide, control, direct, or monitor information technology equipment or applications; and “data processing software” as defined in Iowa Code section 22.3A(1)“e.”

*“Sole source procurement”* means a purchase of a good or service in which the department or agency selects a vendor without engaging in a competitive selection process.

*“Systems software”* means software designed to support, guide, control, direct, or monitor information technology equipment, other system software, mechanical and physical components, arrangements, procedures, programs, services or routines.

*“Targeted small business (TSB)”* means a targeted small business as defined in Iowa Code section 15.102 that is certified by the department of inspections and appeals pursuant to Iowa Code section 10A.104 and as authorized by Iowa Code chapter 73.

“*Upgrade*” means additional hardware or software enhancements, extensions, features, options, or devices to support, enhance, or extend the life or increase the usefulness of previously procured information technology devices.

“*Vendor*” means a person, firm, corporation, partnership, business or other commercial entity that provides services or offers goods for sale or lease.

“*Vendor on-line system*” means a state computer system that enables vendors to conduct business electronically with the state through an Internet location on the World Wide Web.

“*Web*” or “*website*” refers to an Internet location on the World Wide Web that provides information, communications, and the means to conduct business electronically.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.3(8A) Competitive procurement.** It is the policy of the state to obtain goods and services from the private sector for public purposes to achieve value for the taxpayer through a competitive selection process that is fair, open, and objective. Where feasible, common use items will be purchased cooperatively with state agencies having independent procurement authority to leverage economies of scale, add convenience, standardize common items, and increase efficiencies.

**117.3(1) Informal competition.** The department may use informal competition or formal competition for the purchase of any good or service or group of goods or services of general use costing less than \$50,000.

**117.3(2) Formal competition.** The department shall use formal competition for the procurement of any good or service or group of goods or services of general use costing \$50,000 or more.

**117.3(3) Construction procurement.** Formal competition shall be used for selection of a vendor for construction, erection, demolition, alteration, or repair of a public improvement when the cost of the work exceeds \$100,000 or the adjusted competitive threshold established in Iowa Code section 314.1B.

**117.3(4) Purchasing services.** Thresholds for the use of formal or informal competition for the procurement of services are governed by rule 11—118.5(8A).

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 1485C, IAB 6/11/14, effective 7/16/14]

**11—117.4(8A) Master agreements.**

**117.4(1) Use of master agreements.** The department shall enter into master agreements to procure goods and services of general use for all state agencies with the exception of those purchases made by the state department of transportation, institutions under the control of the board of regents, the department for the blind, and any other agencies exempted by law. If the department has entered into a master agreement for a good or service of general use, a state agency that is not otherwise exempt shall purchase the good or service through the master agreement, unless a comparable good or service is available from a different vendor and the quantity required or an emergency or immediate need makes it cost-effective to purchase from that vendor. If an agency or agencies routinely or on a recurring basis purchase a specific good or service not available through a master agreement, the department may establish a master agreement for that good or service in cooperation with the affected agencies.

**117.4(2) Term of master agreements.** The initial term of a master agreement shall be no more than three years. Following the initial term, a master agreement may be renewed by the department for periods of one to three years; provided, however, that a master agreement, including all optional renewals, shall not exceed a term of six years unless a waiver of this provision is granted pursuant to rule 11—117.21(8A) (goods) or rule 11—118.16(8A) (services).

**117.4(3) Master agreements available to governmental subdivisions.** Master agreements entered into by the department may be extended to and made available for the use of other governmental entities as defined in Iowa Code section 8A.101. The department shall provide a list of current master agreements to a governmental subdivision upon request. The list may be provided in an electronic format. A governmental subdivision may request a copy of a specific master agreement. The department may provide the master agreement in an electronic format and assess a copying charge when a printed copy is requested.

[ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.5(8A) Exemptions from competitive procurement.** The director or designee may exempt goods and services of general use from competitive procurement processes when the procurement meets one of the following conditions. All procurements that are exempt from competitive processes shall be recorded as such, and appropriate justification shall be maintained by the agency initiating the action. Each of the following exemptions from competitive procurement procedures require additional review and approvals.

**117.5(1) Emergency procurement.**

*a. Justification for emergency procurement.* An emergency procurement shall be limited in scope and duration to meet the emergency. When considering the scope and duration of an emergency procurement, the department or agency should consider price and availability of the good or service procured so that the department or agency obtains the best value for the funds spent under the circumstances. The department and agencies shall attempt to acquire goods and services of general use with as much competition as practicable under the circumstances.

*b. Special procedures required for emergency procurements.* Justification for the emergency purchase shall be documented and submitted to the director or designee for approval. The justification shall include the good or service that is to be or was purchased, the cost, and the reasons the purchase should be or was considered an emergency.

**117.5(2) Targeted small business (TSB) procurement.**

*a. Justification for TSB procurement.* Agencies may purchase from a TSB without competition for a purchase up to \$10,000.

*b. Special procedures for TSB procurements.* Agencies must confirm that the vendor is certified as a TSB by the department of inspections and appeals. An agency may contact the TSB directly.

**117.5(3) Iowa Prison Industries (IPI) procurement.**

*a. Justification for IPI procurement.* If IPI manufactures or formulates a product, agencies shall purchase the product from IPI or obtain a written waiver in accordance with Iowa Code section 904.808, except as otherwise permitted in paragraphs “b” and “c.”

*b. Purchase of standard modular office systems and related components.* Purchase of standard modular office systems and related components and other furniture items shall be in accordance with 11—subrule 100.6(6).

*c. Procurement of product manufactured in Iowa.* An agency may conduct a competitive procurement for a product that IPI manufactures or formulates if the competitive procurement requires that the product must be manufactured in Iowa. In such procurements, IPI shall be allowed to submit a bid to provide the product. If a vendor other than IPI is the lowest responsible bidder, the agency shall obtain written verification that the vendor’s product is manufactured in Iowa before making the award.

*d. Special procedures for IPI purchases.* An agency may contact IPI directly.

**117.5(4) Procurement based on competition managed by other governmental entities.**

*a. Justification for procurement based on competition managed by other governmental entities.* The department may utilize a current contract, agreement, or purchase order issued by a governmental entity to establish an enterprise master agreement or make a purchase without further competition. The department may join a contract or agreement let by a purchasing consortium when the department reasonably believes it is in the best interest of the enterprise and reasonably believes the contract, agreement, or order was awarded in a fair and competitive manner.

*b. Special procedures for procurement based on competition managed by other governmental entities.* The department shall notify the other governmental entity and the requesting agency of its intent to use a contract, agreement, or purchase order prior to procuring the good or service in this manner. The department may purchase goods or services from contracts let by other governmental entities provided that the vendor is in agreement and the terms and conditions of the purchase do not adversely impact the governmental entity which was the original signatory to the contract.

**117.5(5) Sole source procurement.**

*a. Justification for sole source procurement.* A sole source procurement shall be avoided unless clearly necessary and justifiable. The director or designee may exempt the purchase of a good or

service of general use from competitive selection processes when the purchase qualifies as a sole source procurement as a result of the following circumstances:

- (1) One vendor is the only one qualified or eligible or is quite obviously the most qualified or eligible to provide the good or service; or
- (2) The procurement is of such a specialized nature or related to a specific geographic location that only a single source, by virtue of experience, expertise, proximity, or ownership of intellectual property rights, could most satisfactorily provide the good or service; or
- (3) Applicable law requires, provides for, or permits use of a sole source procurement; or
- (4) The federal government or other provider of funds for the goods and services being purchased (other than the state of Iowa) has imposed clear and specific restrictions on the use of the funds in a way that restricts the procurement to only one vendor; or
- (5) The procurement is an information technology device or service that is systems software or an upgrade, or compatibility is the overriding consideration, or the procurement would prevent voidance or termination of a warranty, or the procurement would prevent default under a contract or other obligation; or
- (6) Other circumstances for services exist as outlined in rule 11—118.7(8A).

*b. Special procedures required for sole source procurement.* For exemption from competitive processes, the requesting agency shall submit to the director justification that the procurement meets the definition of sole source procurement. Use of a sole source procurement does not relieve the department or an agency from negotiating a fair and reasonable price, investigating the vendor's qualifications and any other data pertinent to the procurement, and thoroughly documenting the action. The agency initiating the procurement shall maintain in a file attached to the order the justification and response from the director. The justification, response, and order shall be available for public inspection.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15; ARC 3676C, IAB 3/14/18, effective 4/18/18]

## **11—117.6(8A) Preferred products and vendors.**

### **117.6(1) Preference to Iowa products and services.**

*a.* All requests for proposals for materials, products, supplies, provisions and other needed articles and services to be purchased at public expense shall not knowingly be written in such a way as to exclude an Iowa-based company capable of filling the needs of the purchasing entity from submitting a responsive proposal.

*b.* The department and state agencies shall make every effort to support Iowa products when making a purchase. Tied responses to solicitations, regardless of the type of solicitation, shall be decided in favor of the Iowa products. Tied bids between Iowa products shall be decided in accordance with subrule 117.13(4).

**117.6(2) Preference to Iowa-based businesses.** The department and state agencies shall make every effort to support Iowa-based businesses when making a purchase. Tied responses to solicitations, regardless of the type of solicitation, shall be decided in favor of the Iowa-based business. Tied bids between Iowa-based businesses shall be decided in accordance with subrule 117.13(4).

**117.6(3) American-made products.** The department and agencies shall make every effort to support American-made products when making a purchase. Tied responses to solicitations, regardless of the type of solicitation, shall be decided in favor of the American-made product. Tied bids between American-made products shall be decided in accordance with subrule 117.13(4).

**117.6(4) American-based businesses.** The department and agencies shall make every effort to support American-based businesses when making a purchase. Tied responses to solicitations, regardless of the type of solicitation, shall be decided in favor of the American-based business. Tied bids between American-based businesses shall be decided in accordance with subrule 117.13(4).

**117.6(5) Recycled product and content.** The department and agencies shall make every effort to protect Iowa's environment in the procurement of goods. Recycled goods and goods that include recycled content shall be acquired when those goods are available and comparable in quality, performance, and price and there are not other mitigating factors. As required by Executive Order

Number 56, the department and agencies shall whenever possible procure durable items that are readily recyclable when discarded, have minimal packaging, and are less toxic.

**117.6(6) *Products made by persons with disabilities.*** The department and agencies shall make every effort to procure those products for sale by sheltered workshops, work activity centers, and other special programs funded in whole or in part by public moneys that employ persons with mental retardation, other developmental disabilities, or mental illness if the products meet the required specifications.

**117.6(7) *Targeted small businesses.*** The department and agencies may buy from a targeted small business if a targeted small business is able to provide the good or service, pursuant to Iowa Code section 73.20. When enterprise master agreements with targeted small businesses are available, purchases shall be made through these master agreements.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

#### **11—117.7(8A) Centralized procurement authority and responsibilities.**

**117.7(1) *Centralized procurement of goods and services of general use.*** The department shall procure goods and services of general use for all state agencies with the exceptions of those purchases made by the state department of transportation, institutions under the control of the board of regents, the department for the blind, and any other agencies exempted by law.

**117.7(2) *Delegation of procurement authority.*** The department shall establish guidelines for implementation of procurement authority delegated to agencies. The department shall assist agencies in developing purchasing procedures consistent with central purchasing policy and procedures and recommended governmental procurement standards.

**117.7(3) *Planning, research, and development.*** The director may establish advisory groups and customer councils of agency representatives appointed by the respective agency directors to assist the department in procurement planning and research and to advise on policies, procedures, and financing. This advice includes, but need not be limited to, market research, product specifications, terms and conditions; purchasing rules and guidelines; purchasing system development; and equitable financing of the enterprise purchasing system. The department will provide staff support for any advisory groups and councils that are created.

The department may periodically require forecasts from state agencies and institutions regarding future procurements. When requesting forecasts, the department shall assist agencies in securing and analyzing historical information related to previous purchasing activity.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

#### **11—117.8(8A) Notice of solicitations.**

##### **117.8(1) *General notification.***

*a. Bid posting.* The department and each state agency shall provide notice of solicitations. The department and each state agency shall post notice of every formal competitive bidding opportunity and proposal to the official Internet site, [bidopportunities.iowa.gov](http://bidopportunities.iowa.gov), operated by the department of administrative services in accordance with Iowa Code sections 73.2, 8A.311, and 362.3. Instead of direct posting, the agency may add a link to [bidopportunities.iowa.gov](http://bidopportunities.iowa.gov) that connects to the website maintained by the agency on which requests for bids and proposals for that agency are posted. For the purposes of this subrule, a formal solicitation is as defined by the appropriate procurement authority. Informal competitive bidding opportunities and proposals may also be posted on or linked to the official state Internet site operated by the department of administrative services.

*b. Other forms of notice.* Notice of competitive bidding opportunities and proposals may be provided by telephone or fax, in print, or by other means that give reasonable notice to vendors, in addition to the posting or linking of formal solicitations to the official Internet site operated by the department of administrative services.

*c. Posting of requests for architectural and engineering services.* A request for proposals for architectural or engineering services may be posted electronically by a department or state agency in addition to other methods of advertisement required by law.

*d. Bids voided.* A formal competitive bidding opportunity that is not preceded by a notice that satisfies the requirements of this subrule is void and shall be rebid. This requirement shall be effective for formal competitive bidding opportunities issued on or after September 1, 2005.

**117.8(2) Targeted small business notification.** Targeted small businesses shall be notified of all solicitations at least 48 hours prior to the general release of the notice of solicitation. The notice shall be distributed to the state of Iowa's 48-hour procurement notice website for posting.

**117.8(3) Direct vendor notification.** All procurement opportunities shall be directly communicated to vendors registered through the state's electronic procurement system, Vendor Self-Serve (VSS), if the vendors have indicated an interest in the type of good or service that is the subject of the solicitation. The notice shall be sent to the email or fax or other address entered on VSS by the vendor.

**117.8(4) Advertisement of construction procurement.** Construction solicitations shall be advertised twice in a newspaper of general circulation published in the county within which the work is to be done when the cost of the work exceeds \$100,000 or the adjusted competitive threshold established in Iowa Code section 314.1B. Additional means of advertisement used shall be consistent with practices in the construction industry. The department may publish an advertisement in an electronic format as an additional method of soliciting bids.

**117.8(5) Vendor intent to participate.** In the event the department elects to conduct any procurement electronically or otherwise, it may require that vendors prequalify or otherwise indicate their intention to participate in the procurement process.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 1485C, IAB 6/11/14, effective 7/16/14; ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.9(8A) Types of solicitations.** The department may use the following solicitation methods when procuring goods and services of general use for the enterprise.

**117.9(1) Informal competition.**

*a. Description of solicitation.* The informal request for bids or proposals may be completed electronically, by telephone or fax, or by other means determined by the department.

*b. Response and evaluation.* Informal bids shall be tabulated, evaluated, documented and attached to the purchase order.

**117.9(2) Formal competition.**

*a. Description of solicitation.* A formal request for bids or proposals shall include:

- (1) Bid due date.
- (2) Time of public bid opening.
- (3) Complete description of commodity needed.
- (4) Buyer's name or code.

*b. Response and evaluation.* Bids submitted shall be sealed until the date and time of opening. All bids received prior to the date and time set forth on the solicitation will be publicly opened and announced at the designated time and place. All responses shall be documented, evaluated, tabulated and available for public inspection.

**117.9(3) Request for bids.** A request for bids shall be used to select the lowest responsible bidder from which to purchase goods and services of general use on the basis of price. Vendors may offer goods and services that equal or exceed the state's specifications. Bids that do not meet specifications shall be rejected. The state will not give weight to goods and services offered which exceed specifications. When it is feasible to do so and objective data exists to support the state's decision, the award may be made on a life cycle cost basis.

**117.9(4) Requests for proposals.**

*a. Description of solicitation.* The department shall issue a request for proposals whenever a requirement exists for a procurement and cost is not the sole evaluation criterion for selection. The request for proposals shall provide information about a requirement for technical equipment or professional services that is sufficient for the vendor to propose a solution to the requirement. Elements of a request for proposals shall include, but need not be limited to:

- (1) Purpose, intent and background of the requirement.

- (2) Key dates in the solicitation process.
- (3) Administrative requirements for submitting a proposal and format for the proposal.
- (4) Scope of work and performance requirements.
- (5) Evaluation criteria and method of proposal evaluation.
- (6) Contractual terms and conditions.
- (7) Need for a vendor conference.

*b. Response and evaluation.* Proposals submitted shall be sealed until the date and time of opening. All proposals received prior to the date and time of opening will be opened, and the name of the submitting vendor will be announced. The issuing purchasing officer will review proposals for compliance with requirements before the proposals are submitted for evaluation. A request for proposals shall be evaluated according to criteria that are developed prior to the issuance of the request for proposal document and that consist of factors relating to technical capability and the approach for meeting performance requirements; competitiveness and reasonableness of price or cost; and managerial, financial and staffing capability.

**117.9(5) Best and final offer option.**

*a. Description of solicitation.* The department reserves the right at its sole discretion to conduct a best and final offer process prior to making an award. The best and final offer process shall be conducted after the receipt of responses to a solicitation and prior to publicly releasing the responses. Any best and final offer process shall not allow material modification of the original solicitation requirements or of the evaluation criteria.

The department shall provide to affected vendors instructions that describe in specific terms how the department intends to arrive at the final order or master agreement. The instructions may include modifying the initial offer, updating pricing based on any changes the agency has made, and any added inducements that will improve the overall score in accordance with the evaluation. Other types of solicitations described in this rule may be modified to allow for a best and final offer process.

The department may enter into negotiations with the highest ranked vendor or conduct simultaneous negotiations with a number of the most highly ranked vendors whose total scores are relatively close.

*b. Response and evaluation.* A best and final offer shall arrive by the due date and time determined by the department and shall be sealed. Evaluation of best and final offers shall be conducted in the same manner as original cost proposals. Scores on the best and final offer shall replace the score achieved on the original proposal.

When negotiating with the highest ranked vendor, the department may accept the vendor's best and final offer or reject the offer and open negotiations with the next highest ranked vendor. The department shall proceed in the same manner in rank order. If the state is unable to negotiate an agreement with the highest ranked vendor, the state may negotiate a best and final offer agreement with another vendor. A best and final offer agreement accepted from a subsequent vendor must be more favorable to the state than the rejected offer or offers.

When negotiating with the highest ranked group of vendors, the department shall request the best and final offer from each. The department shall issue a notice of intent to award that is in the best interest of the enterprise.

**117.9(6) Reverse auction.**

*a. Description of solicitation.* The department may purchase goods and services through a reverse auction, a repetitive competitive bidding process that allows vendors to submit one or more bids, with each bid having a lower cost than the previous bid. Notice to vendors shall be given as described in this chapter. The notice shall include the start and ending time for the reverse auction and the method in which it will be conducted.

*b. Response and evaluation.* Vendors intending to participate shall provide to the department a notice of their intent to participate and of their agreement to provide goods or services equal to or exceeding specifications. The department may require vendors to prequalify to participate in a reverse auction. Prequalification may include a requirement to commit to a baseline price.

**117.9(7) Invitation to qualify (ITQ).** The department may prequalify vendors and make available to an agency a list of vendors that are capable of providing the requested service.

*a. Description of solicitation.* The department may prequalify vendors for certain classes of solicitations, including but not limited to:

- (1) Information technology consulting,
- (2) Architectural services, and
- (3) Engineering services.

*b. Notification of ITQ solicitation.* Following institution of a prequalification process, the department may select, in a competitive manner, a prequalified vendor without public notice and without further negotiation of general terms and conditions. A solicitation may be restricted only to prequalified vendors, in addition to the TSB notification required by subrule 117.8(2).

*c. Not an award.* Vendor prequalification is not an award and does not create an obligation on the part of the department.

*d. Purpose.* The department shall use an invitation to qualify process for the purpose of facilitating a subsequent solicitation that uses one of the other methods described in these rules. The purposes of using an invitation to qualify process include but are not limited to the following:

- (1) Standardize state terms and conditions relating to the type of procurement, thereby avoiding repetition and duplication.
- (2) Ensure that prequalified vendors are capable of performing work in a manner consistent with operational standards developed and adopted by the department.
- (3) Implement a pay-for-performance model directly linking vendor payments to defined results as required by Iowa Code section 8.47.
- (4) Consolidate records of vendor qualifications and performance in one location for reference and review.
- (5) Reduce time required for solicitation of proposals from vendors for individual procurements.

*e. Evaluation criteria.* The department shall develop criteria for vendor qualification based upon its own expertise, the recommendations of its advisors, information and research, and the needs of agencies. The department shall develop and specify evaluation criteria for each invitation to qualify. Examples of evaluation criteria may include but are not limited to the following:

- (1) Affirmative responses to a mandatory agreement questionnaire.
- (2) Ratings of at least average on a professional/technical personnel questionnaire.
- (3) Scores in a specified range for each client reference survey.
- (4) Competitive cost data by type of service.
- (5) Acceptable vendor financial information.

*f. Issuance of open invitation.*

- (1) The department shall issue invitations to qualify on an as-needed basis.
- (2) The department shall specify the period of time that the invitation to qualify will remain open and the time period for applicability.
- (3) Vendors may apply for eligibility on a continuous basis during the time period that the invitation to qualify remains open.

*g. Response and evaluation.*

- (1) Vendors seeking to qualify shall be required to meet all the criteria established by the department for a particular category or type of solicitation.
- (2) The department shall continuously evaluate vendor applications for placement on a prequalified-vendor list during the period that the invitation to qualify remains open.

*h. Acceptable performance levels.*

- (1) The department shall establish and notify prequalified vendors of minimum acceptable performance levels and institute a performance tracking mechanism on each prequalified vendor.
- (2) An approved vendor remains qualified for the period specified by the department unless the vendor does not meet minimum acceptable performance levels.
- (3) If a vendor's performance falls below the minimum acceptable level, the vendor shall be removed from the prequalified list.
- (4) A vendor that does not prequalify or that is removed from the prequalified list due to the vendor's performance has the right to appeal in accordance with rule 11—117.20(8A).

*i. Information technology purchases from a prequalified vendor.* Before a participating agency may acquire an information technology device or service from a prequalified vendor, the agency must obtain all of the required approvals from the department pursuant to rule 11—117.11(8A).

**117.9(8) Other types of solicitations.** The department may use other types of competitive solicitations not outlined in these rules if the following conditions are met:

- a.* The solicitation method has been clearly described in public notice.
- b.* The solicitation method includes fair and objective criteria for determining the award.

**117.9(9) Request for information (RFI).** A request for information (RFI) is a nonbinding method an agency may use to obtain market information from interested parties for a possible upcoming solicitation. Information may include, but is not limited to, best practices, industry standards, technology issues, and qualifications and capabilities of potential suppliers. Agencies considering the use of an RFI shall contact the department for information and guidance in using this process.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

### **11—117.10(8A) Procurement of architectural and engineering services.**

**117.10(1) Qualifications.** As part of the competitive selection process, the department shall determine whether an architect or engineer is competent and qualified. In making this determination, the department may consider the following factors:

1. Professional licensing or registration credentials,
2. Integrity and reliability,
3. Past performance relative to the quality and timeliness of service on similar projects,
4. Past experience with the state in relation to services provided,
5. Quality and timeliness of the services provided,
6. The proposed terms of delivery, and
7. The best interests of the state.

**117.10(2) Fair and reasonable price.** As part of the competitive selection process, the department may request, in addition to the architect's or engineer's qualifications, pricing information that may include a total fee for the specified services, hourly rates, or other pricing measures that will help the department establish a fair and reasonable price.

*a.* The department shall request a fee proposal(s) as part of the competitive selection process only when the services required are of limited scope, limited duration or otherwise clearly defined. An award shall not be made solely on the basis of the lowest price.

*b.* When a fee is not requested as part of the competitive selection process, other pricing factors shall be requested, and the firm deemed most qualified will be asked to negotiate a fee using the pricing factors included in the firm's proposal. If a fair and reasonable price for the work cannot be negotiated, the department shall reject the firm's proposal and begin negotiations for a fair and reasonable price with the next most qualified firm.

Examples of fair and reasonable pricing factors include:

- (1) Hourly rates and anticipated hours,
- (2) A lump sum fee,
- (3) Any other costs the department determines to be fair and reasonable.

*c.* If reimbursable expenses are included in the price proposal, rates shall not exceed those in procedure 210.245, "Travel-in-state—board, commission, advisory council, and task force member expenses," of the department of administrative services state accounting enterprise's Accounting Policy and Procedures Manual.

*d.* The fee proposal or other pricing information shall serve as a basis for contract negotiations.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.11(8A) Procurement of information technology devices and services.** This rule applies to the procurement of information technology devices and services by participating agencies.

**117.11(1) Approval of participating agency information technology procurements.**

*a.* All procurement of information technology devices and services must meet operational standards prescribed by the department.

b. With the exception of requests for proposals (RFPs) which are approved by the technology governance board, procurement of all information technology devices and services, projects and outsourcing of \$50,000 or more or a total involvement of 750 participating agency staff hours or more must receive prior approval from the office of the chief information officer (OCIO) before a participating agency issues a competitive selection document or any other procurement document or otherwise seeks to procure information technology devices or services or both through the department or on its own purchasing authority. The participating agency's approval request shall be in a form prescribed by the department.

c. Participating agencies shall notify the technology governance board in writing on a quarterly basis that technology purchases made during the previous quarter were in compliance with the technology governance board's procurement rules and information technology operational standards.

d. Participating agencies shall not break purchasing into smaller increments for the purpose of avoiding threshold requirements of this subrule.

**117.11(2) Review process for proposed procurements.**

a. With the exception of requests for proposals (RFPs) which are approved by the technology governance board, the department shall review a proposed information technology procurement of a participating agency regardless of funding source, method of procurement, or agency procurement authority.

b. The department shall review a proposed procurement for compliance with operational standards established by the department.

c. Once procurement is approved, ongoing approval by the department is not required provided that the procurement or scope of work remains consistent with the previously approved procurement or scope of work.

d. Participating agencies shall obtain the department's approval anytime a material modification of the procurement or the scope of work is completed. Review and approval by the department is required prior to implementation of a material modification to a previously approved proposed procurement by a participating agency or by the department on behalf of a participating agency.

e. After approval of the procurement is forwarded to the agency contact person and appropriate procurement authority contacts, the procurement may proceed.

f. When a procurement is not approved, the agency contact will be notified of available options, which include modification and resubmission of the request, cancellation of the request, or requesting a waiver from the director on the recommendation of the technology governance board pursuant to subrule 117.11(3).

g. The department may periodically audit procurements made by a participating agency for compliance with this rule and operational standards of the department. When the audit determines that inconsistencies with established operational standards or with this rule exist, the participating agency shall comply with technology governance board directives to remedy the noncompliance.

h. Information technology devices and services not complying with applicable operational standards shall not be procured by any participating agency unless a waiver is granted by the director on the recommendation of the technology governance board.

i. Upon request by a participating agency, the department may procure, as provided by these rules, any information technology devices or information technology services requested by or on behalf of an agency and accordingly bill the agency through the department's regular process for the information technology devices or information technology services or for the use of such devices or services.

j. The department may provide pertinent advice to a procurement authority or participating agency regarding the procurement of information technology devices or services, including opportunities for aggregation with other procurements.

**117.11(3) Waiver requests for operational standards.**

a. Waiver requests. In the event a participating agency is advised that its proposed procurement is disapproved and the participating agency seeks a waiver of operational standards, it must file its written waiver request with the department within five calendar days of the date of the disapproval. The waiver request shall be filed pursuant to rule 11—25.6(8A).

*b. Hearing.* The department may conduct a hearing with the participating agency regarding the waiver request. Additional evidence may be offered at the time of the hearing. Oral proceedings shall be recorded either by mechanized means or by a certified shorthand reporter. Parties requesting that the hearing be recorded by a certified shorthand reporter shall bear the costs. Copies of tapes of oral proceedings or transcripts recorded by certified shorthand reporters shall be paid for by the requester.

*c. Burden of proof.* The burden of proof is on the participating agency to show that good cause exists to grant a waiver to the participating agency to complete the proposed procurement.

*d. The director shall notify the participating agency in writing of the decision to grant or deny the waiver. In the event a waiver is denied, the participating agency may appeal pursuant to Iowa Code section 679A.19.*

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15; ARC 2267C, IAB 11/25/15, effective 12/30/15]

**11—117.12(8A) Specifications in solicitations.** All specifications used in solicitations shall be written in a manner that encourages competition.

**117.12(1) *Limitations on brands and models.*** Specifications shall be written in general terms without reference to a particular brand or model unless the reference is clearly identified as intending to illustrate the general characteristics of the item and not to limit competition. A specific brand or model may be procured only when necessary to maintain a standard required or authorized by law or rule or for connectivity or compatibility with existing commodities or equipment.

**117.12(2) *Recycled content and products.*** When appropriate, specifications shall include requirements for the use of recovered materials and products. The specifications shall require, at a minimum, that all responses to a solicitation include a product content statement that describes the percentage of the content of the item that is reclaimed material.

The department shall revise specifications developed by agencies if the specifications restrict the use of alternative materials, exclude recovered materials, or require performance standards that exclude products containing recovered materials unless the agency seeking the product can document that the use of recovered materials will impede the intended use of the product.

Specifications shall support the following procurements:

*a. Products containing recovered materials, including but not limited to lubricating oils, retread tires, building insulation materials, and recovered materials from waste tires.*

*b. Bio-based hydraulic fluids, greases, and other industrial lubricants manufactured from soybeans in accordance with Iowa Code section 8A.316.*

**117.12(3) *Life cycle cost and energy efficiency.*** The department and agencies shall utilize life cycle cost and energy efficiency criteria in developing standards and specifications for procuring energy-consuming products.

**117.12(4) *All or none solicitations.*** A solicitation may specify whether or not responses will be accepted on an all or none basis. Only when this statement appears on the solicitation may it be included in the response. The department may award either by item or by lot, whichever is to the advantage of the enterprise.

**117.12(5) *Financial security.*** The department may require bid, litigation, fidelity, and performance security as designated in the solicitation documents. When required, a security may be by certified check, cashier's check, certificate of deposit, irrevocable letter of credit, bond, or other security acceptable to the department.

When required, a security shall not be waived. The security provided by vendors shall be retained until all provisions of the solicitation have been met. The security will then be returned to the vendor.

**117.12(6) *Vehicle procurement.***

*a. Specifications for procurement of all non-law enforcement, light-duty vehicles, excluding those purchased and used for off-road maintenance work or to pull loaded trailers, shall be for flexible fuel vehicles (as defined by Iowa Code section 8A.362(5)) when an equivalent flexible fuel model is available.*

*b. Use of specifications for hybrid-electric or other alternative fuel vehicles (as defined by Iowa Code section 8A.362(5)) is encouraged. Procurement of hybrid-electric or other alternative fuel vehicles*

may be dependent upon whether the costs of the vehicle's life cycle are equivalent to a non-alternative fuel vehicle or non-flexible fuel vehicle (a vehicle with a gasoline E10 engine) prior to the year 2010.

*c.* The life cycle costs of American motor vehicles shall be reduced by 5 percent in order to determine if the motor vehicle is comparable to foreign-made motor vehicles. The life cycle costs of a motor vehicle shall be determined on the basis of the bid price, the resale value, and the operating costs based upon a useable life of five years or 75,000 miles, whichever occurs first.

*d.* The average fuel efficiency for new passenger vehicles and light trucks, as defined in paragraph 117.12(6) "a," that are purchased in a year shall equal or exceed the average fuel economy standard for the vehicles' model years as published by the United States Secretary of Transportation.

**117.12(7) Bulk diesel fuel procurement.** Specifications for procurement of all bulk diesel fuel shall ensure that all bulk diesel procured has at least 5 percent renewable content by 2007, 10 percent renewable content by 2008, and 20 percent renewable content by 2010, provided that fuel that meets the American Society for Testing and Materials (ASTM) D-6751 specification is available. Bulk diesel fuel that is used exclusively for emergency generation is exempt from the renewable content requirement.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.13(8A) Awards.** The department shall select a vendor on the basis of criteria contained in the competitive selection document.

**117.13(1) Intent to award.** After evaluating responses to a solicitation using formal competition, the department shall notify each vendor submitting a response to the solicitation of its intent to award to a particular vendor or vendors subject to execution of a written contract(s). Documentation of awards for solicitations using informal competition will be made available to interested parties upon request. This notice of intent to award does not constitute the formation of a contract(s) between the state and successful vendor(s). If a vendor is not registered on the vendor on-line system and does not provide an email address or fax number, the notice will be mailed.

**117.13(2) Rejection of bids.** The department reserves the right to reject any or all responses to solicitations at any time for any reason. New bids may be requested at a time deemed convenient to the department and agency involved.

**117.13(3) Minor deficiencies and informalities.** The department reserves the right to waive minor deficiencies and informalities if, in the judgment of the department, the best interest of the state of Iowa will be served.

**117.13(4) Tied bids and preferences.** If an award is based on the highest score and there is a tied score, or if the award is based on the lowest cost and there is a tied cost, the award shall be determined by a drawing. Whenever it is practical to do so, the drawing will be held in the presence of the vendors with the tied bids. Otherwise, the drawing will be held in front of at least three noninterested parties. All drawings shall be documented.

*a.* Notwithstanding the foregoing, whenever a tie involves an Iowa vendor and a vendor outside the state of Iowa, first preference will be given to the Iowa vendor. Whenever a tie involves one or more Iowa vendors and one or more vendors outside the state of Iowa, the drawing will be held among the Iowa vendors only. Tied bids involving Iowa-produced or Iowa-manufactured products and items produced or manufactured outside the state of Iowa will be resolved in favor of the Iowa product. If a tied bid does not include an Iowa vendor or Iowa-produced or Iowa-manufactured product, preference will be given to a vendor based in the United States or products produced or manufactured in the United States over a vendor based or products produced or manufactured outside the United States.

*b.* In the event of a tied bid between Iowa vendors, the department shall contact the Iowa Employer Support of the Guard and Reserve (ESGR) committee for confirmation and verification as to whether the vendors have complied with ESGR standards. Preference, in the case of a tied bid, shall be given to Iowa vendors complying with ESGR standards.

**117.13(5) Consideration of life cycle costs.** When appropriate to the procurement, life cycle costs shall be considered during the award process.

**117.13(6) Trade-ins.** When applicable and in the best interest of the state, the department may trade in devices or services to offset the cost of devices or services in a manner consistent with procurement practices to ensure accountability with the state's fixed asset inventory system.  
[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.14(8A) Agency purchasing authority and responsibilities.**

**117.14(1) Purchase of goods.** An agency may acquire goods not otherwise available from a master agreement in accordance with the procurement threshold guidelines in 11—117.15(8A).

**117.14(2) Purchase of services.** An agency may procure services unique to the agency's program or used primarily by that agency and not by other agencies. The department will assist agencies with these procurements upon request. Procurement of services by an agency shall comply with the provisions of 11—Chapters 118 and 119.

**117.14(3) Procurement of printing.**

*a.* As the first step in the printing procurement process, an agency may provide its request to state printing. State printing may produce the printing internally or procure the printing for the agency.

*b.* An agency may procure printing. Procurement of printing by an agency shall utilize formal or informal competitive selection, pursuant to 11—117.3(8A). The agency's internal procedures and controls for competitive selection of a printing vendor shall be consistent with the requirements of the department and the state auditor.

**117.14(4) Procurements requiring additional authorization.** Except where exempted by statute, the following purchases require additional approval.

*a.* Information technology devices, software and services, as required in Iowa Code sections 8A.202 and 8A.206 and rule 11—117.11(8A).

*b.* Vehicles, as prescribed in Iowa Code sections 8A.361 and 8A.362.

*c.* Architectural and engineering services, except for agencies with independent authority, as prescribed in Iowa Code sections 8A.302, 8A.311, 8A.321, 218.58, and 904.315.

*d.* Legal counsel, as prescribed in Iowa Code section 13.7.

*e.* Telecommunications equipment and services, as required by Iowa Code chapter 8D and the rules of the telecommunications and technology commission.

**117.14(5) Establishment of agency internal procedures and controls.** Agencies shall establish internal controls and procedures to initiate purchases, complete solicitations, make awards, approve purchases, and receive goods. The procedures shall address adequate public recordings of the purchases under the agency's authority consistent with law and rule. Internal controls and security procedures that are consistent with the requirements of the department and state auditor, including staff authority to initiate, execute, approve, and receive purchases, shall be in place for all phases of the procurement.

**117.14(6) Agency receipt of goods.** Agencies receiving goods shall:

*a.* Inspect or otherwise determine that the goods received meet the specifications, terms and conditions within the order or master agreement,

*b.* Initiate timely payment for goods meeting specifications, and

*c.* Document the receipt of goods electronically in a manner prescribed by the department.

All provisions of 11—117.19(8A) shall apply to agency receipt of goods.

**117.14(7) Partial orders.** Agencies may accept partial orders and await additional final receipt or may accept a partial order as a final order. The agency shall notify the vendor of its decision. An agency may pay a vendor a prorated amount for the partial order.

**117.14(8) Items not meeting specifications.** An agency shall not approve final receipt when goods appear not to meet specifications. An agency shall approve final receipt only when satisfied that the goods meet or exceed the specifications and terms and conditions of the order or master agreement. When an agency and vendor are unable to agree as to whether the specifications, terms and conditions are met, the department shall make the decision.

Agencies shall notify the department and the vendor when apparent defects are first noticed. The department will assist the agency with negotiating a satisfactory settlement with the vendor.

**117.14(9) *Payment to vendors following final receipt.*** An agency shall not unreasonably delay payment on orders for which final receipt is accepted. Except in the case of latent defects in goods, payment to the vendor by the agency signifies agreement by the agency that the goods received are satisfactory. Payment to vendors may be made by any commercially acceptable method, including a state procurement card, in accordance with state financial requirements.  
[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.15(8A) Thresholds for delegating procurement authority.**

**117.15(1) *Agency direct purchasing—basic level.*** An agency may procure non-master agreement goods costing up to \$1,500 without competition. An agency shall procure non-master agreement goods costing between \$1,501 and \$5,000 in a competitive manner, using either informal or formal competition. If an informal process is chosen, the agency shall follow the process described in the definition of “informal competition” in rule 11—117.2(8A). The agency shall document the quotes, or circumstances resulting in fewer than three quotes, in an electronic file attached to the order or in another format.

**117.15(2) *Agency direct purchasing—advanced level.*** An agency may procure non-master agreement goods up to \$50,000 per transaction in a competitive manner provided the agency personnel engaged in the purchase of goods have completed enhanced procurement training established by the director or designee.

**117.15(3) *Preference to targeted small businesses.*** Agencies shall search the TSB directory on the Web and purchase directly from the TSB source if it is reasonable and cost-effective to do so. Agencies shall comply with the TSB notification requirements in subrule 117.8(2).

**117.15(4) *Misuse of agency authority.***

*a.* Purchasing authority delegated to agencies shall not be used to avoid the use of master agreements. The agency shall not break purchasing into smaller increments for the purpose of avoiding threshold requirements in subrules 117.15(1) and 117.15(2).

*b.* As a remedy, the department may recover administrative fees appropriate to the improper execution of procurement.

*c.* This rule is not intended to prohibit agencies from aggressively seeking competitive prices. Agencies may purchase outside of master agreements under subrule 117.4(1).

*d.* The department may rescind delegated authority of an agency that misuses its authority or uses the authority to procure goods or services already available on a master agreement.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 1485C, IAB 6/11/14, effective 7/16/14; ARC 2036C, IAB 6/10/15, effective 7/15/15; ARC 2267C, IAB 11/25/15, effective 12/30/15]

**11—117.16(8A) Printing.** This rule provides guidelines for the letting of contracts for public printing by the department and by state agencies, including the enforcement by the department of contracts for printing, except as otherwise provided by law.

**117.16(1) *Competitive selection for printing.*** The department and state agencies shall procure printing by competitive selection according to the rules of this chapter except when the printing is produced by state printing, pursuant to rule 11—102.4(8A) or the procurement is otherwise exempt from competitive selection pursuant to rule 11—117.5(8A). When an agency elects to purchase printing by competitive selection rather than using the services of state printing or a TSB, state printing and TSBs shall be part of the bidding process.

**117.16(2) *Specifications for printing.***

*a.* *Preparation of written specifications.* The department or a state agency shall procure printing by preparing a competitive selection document with written specifications and issue the same to bidders. The bid specifications shall become a part of the printing contract.

*b.* *Inspection of specifications.* All specifications shall be held on file in the department’s printing division office or the office of the state agency conducting the solicitation and shall be available for inspection by prospective bidders.

**117.16(3) *Notification of solicitation for printing.*** The department or a state agency conducting the solicitation shall provide notification of the solicitation for printing to vendors.

**117.16(4) *Bid bonds for printing.***

a. *When applicable.* Security in the form of a bid bond or a certified or cashier's check may be required from printing vendors.

b. *Amount of bonds.* If a bid bond is required, each formal bid for printing must be accompanied by a certified or cashier's check for the amount stated in the specifications. An annual bid bond in an amount set by the department may be deposited with the department by the bidder to be used in lieu of a certified or cashier's check. The amount of the bond is fixed annually and bonds are dated from July 1 to June 30 of the following year.

c. *Return of bid bonds.* Checks of unsuccessful bidders will be returned when the printed item is contracted. The check of the successful bidder will be returned when the performance bond is received and accepted by the department or by the state agency conducting the solicitation.

d. *Performance bonds.* When required by the specifications, the successful bidder must deposit with the department or with the state agency conducting the solicitation a performance bond equal to 10 percent of the contract price unless otherwise stated in the specifications. The performance bond must be deposited within 21 days of the date the contract or bond paperwork is issued to the vendor by the department or agency.

e. *Forfeiture of bid bond.* Failure to enter into a contract by the successful bidder within ten days of the award may result in forfeiture of 10 percent of the bid bond or the certified or cashier's check, if a check is on deposit in lieu of a bond.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.17(8A) Vendor registration and approval.** Every vendor wishing to do business with the state shall register as a vendor. Every vendor shall register prior to submitting a response to a solicitation except in the case of an emergency procurement when the vendor shall register prior to filling an order or as soon as practicable. Only properly registered vendors are entitled to payment.

**117.17(1) Vendor on-line registration.** Vendors are encouraged to register electronically using the vendor on-line system. Vendors that are registered on the vendor on-line system are eligible for all services at the site, including receiving electronic notices of solicitations and submitting an electronic response to a solicitation.

Information from vendors completing registration through the vendor on-line system shall be protected through the use of uniquely identifying information known only to the department and the vendor to confirm the identity of the vendor for all subsequent actions, including responses to solicitations.

The department may take action to restrict or deny use of the vendor on-line system in response to inappropriate use of the site. The department may edit or delete a vendor's posting on the vendor bulletin board if the posting is not appropriate to the business of state purchasing.

**117.17(2) Alternate vendor registration.** A vendor may register by directly contacting the department or an agency initiating a procurement.

**117.17(3) Vendor registration information maintenance.** Vendors are responsible for maintaining current and accurate registration information. If registered on the vendor on-line system, the vendor shall update the vendor's account whenever information changes. If registered in an alternate manner, the vendor is responsible for notifying the department or agency of any change in information. This information includes, but is not limited to, company name or type, payment address, procurement address and other contact information.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2267C, IAB 11/25/15, effective 12/30/15]

**11—117.18(8A) Vendor performance.**

**117.18(1) Review of vendor performance.** The department, in cooperation with agencies, shall periodically, but at least directly prior to renewal of a master agreement, review the performance of vendors. Agencies are encouraged to document vendor performance throughout the duration of the contract and report any problems to the department as they are identified. Performance reviews shall be based on the specifications of the master agreement or order, and shall include, but need not be limited to:

1. Compliance with the specifications,

2. On-time delivery, and
3. Accuracy of billing.

This review will help determine whether the vendor is a responsible bidder for future projects.

**117.18(2) *Vendor suspension or debarment.*** Prior performance on a state contract may cause a vendor to be disqualified or prevent the vendor from being considered a qualified bidder. In addition, a vendor may be suspended or debarred for any of the following reasons:

- a. Failure to deliver within specified delivery dates without agreement of the department or the agency.
- b. Failure to deliver in accordance with specifications.
- c. Attempts to influence the decision of any state employee involved in the procurement process.
- d. Evidence of agreements by vendors to restrain trade or impede competitive bidding. Such activities shall in addition be reported to the attorney general for appropriate action.
- e. Determination by the civil rights commission that a vendor conducts discriminatory employment practices in violation of civil rights legislation and executive order.
- f. Evidence that a vendor has willfully filed a false certificate with the department.
- g. Debarment by the federal government.

**117.18(3) *Correcting performance.*** The department shall notify in writing any vendor considered for suspension or debarment and provide the vendor an opportunity to cure the alleged situation. If the vendor fails to remedy the situation after proper notice, the department director may suspend the vendor from eligibility for up to one year or debar the vendor from future business depending on the severity of the violation. The appeal provisions of this chapter shall apply to the decision of the director.

**117.18(4) *Remedies for failure to deliver or for delivery of nonconforming goods or services.*** If a vendor fails to remedy the situation after the opportunity to cure is provided, the department or agency may procure substitute goods or services from another source and charge the difference between the contracted price and the market price to the defaulting vendor. The attorney general shall be requested to make collection from the defaulting vendor.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

**11—117.19(8A) General instructions, terms and conditions for vendors.** The following instructions, terms and conditions shall apply to all solicitations unless otherwise stated in the solicitation.

**117.19(1) *Instructions for vendors.*** The vendor must follow all instructions in the manner prescribed and furnish all information and samples as stated in the solicitation. Minor deficiencies and informalities may be waived if, in the judgment of the department, the best interests of the state will be served.

**117.19(2) *Deadline for submission of bid or proposal.*** It is the responsibility of the vendor to submit a response to a solicitation according to time, date, and place stated in the solicitation documents. Late responses will be rejected. Unfamiliarity with a geographical location, weather events, labor stoppages, failure of a carrier to meet promised delivery schedules, mechanical failures, and similar reasons are not sufficient justifications for the department to accept a late bid or proposal. At its sole discretion, the department may accept a late response if the delay is due to a catastrophic event and acceptance by the department does not result in an advantage to a competitor.

**117.19(3) *Confidential information in a solicitation response.*** Unless material submitted in response to a solicitation is identified as proprietary or confidential by the vendor in accordance with Iowa Code section 22.7, all submissions by a vendor are public information. To facilitate a fair and objective evaluation of proposals, submissions by vendors will not be released to competitors or the public prior to issuance of the notice of intent to award. If a vendor's claim of confidentiality is challenged by a competitor or through a request by a citizen to view the proposal, it is the sole responsibility of the vendor to defend the claim of confidentiality in an appropriate venue. The department will not release the subject material while the matter is being adjudicated.

**117.19(4) *Recycled products.*** A vendor shall be required to include for all applicable procurements a product content statement providing the percentage of the content of the item that is reclaimed material.

**117.19(5) *Modifications or withdrawal of a solicitation response.*** A solicitation response may be withdrawn or modified prior to the time and date set for opening. Withdrawal or modification requests

shall be in writing. With the approval of the director or designee, a bid or proposal may be withdrawn after opening only if the vendor provides prompt notification and adequately documents the commission of an honest error that might cause undue financial loss. The department may contact a vendor to determine if an error occurred in the vendor's proposal.

**117.19(6) Security.** The department may require bid or proposal security in accordance with subrule 117.12(5). When required, security shall not be waived.

**117.19(7) Assignments.** A vendor may not assign an order or a master agreement to another party without written permission from the department.

**117.19(8) Strikes, lockouts or natural disasters.** A vendor shall notify the department promptly whenever a strike, lockout or catastrophic event prevents the vendor from fulfilling the terms of an order or contract. The department and affected agency may elect to cancel an order or master agreement at their discretion.

**117.19(9) Subcontractors or secondary suppliers.** Vendors shall be responsible for the actions of and performance of their subcontractors or secondary suppliers. Vendors shall be responsible for payment to all subcontractors or secondary suppliers. Vendors awarded a state construction contract shall disclose the names of all subcontractors within 48 hours after the award of the contract and advise the department of changes in the names of subcontractors throughout the duration of the project.

**117.19(10) Material and nonmaterial compliance.** At its sole discretion, the department reserves the right to waive technical noncompliance with instructions when such noncompliance, as viewed by a reasonable and prudent person, did not result in an advantage to the vendor submitting the apparent lowest bid or best proposal or would not result in a disadvantage to other vendors submitting competing bids or proposals.

**117.19(11) Item and pricing.** Price information shall be submitted in response to a solicitation as stated in the instructions. In the case of an error, unit price shall prevail. Unless otherwise stated, all prices shall be submitted with free-on-board (FOB) destination including freight and handling costs.

Prices for one-time purchases must be firm, and preference will be given to firm prices in multiple award contracts. If the department believes it is in the best interest of the state, an economic price adjustment clause based on an acceptable economic indicator may be included in multiple delivery contracts.

*a.* Price during testing. Items may require testing either before or after the final award is made. In these cases, the vendor must guarantee the price through the completion of testing.

*b.* Unless otherwise contained in the specifications, all items for which a vendor submits a quotation shall be new, of the latest model, crop year or manufacture and shall be at least equal in quality to those specified.

*c.* Escalator clauses. Unless specifically provided for in the solicitation document, a response containing an escalator clause that provides for an increase in price will not be considered.

*d.* Discounts. Only cash discounts that apply to payment terms of 30 days or more will be considered in determining awards. Other payment terms will not be considered. The state will attempt to earn any discounts offered and will compute the period from the latest of the following:

- (1) From date of invoice.
- (2) From the date the complete order is received.
- (3) From the date the vendor's certified invoice is received.

When additional testing of a product is required after delivery, the discount period shall not begin until testing is completed and final approval made.

**117.19(12) Notice of intent to award.** After evaluating responses to a solicitation, the department shall notify each vendor submitting a response to the solicitation of its intent to award to a particular vendor or vendors subject to execution of a written contract(s). This notice does not constitute the formation of a contract(s) between the state and the vendor(s) to which the notice of intent to award has been issued.

If a vendor is not registered on the vendor on-line system and does not provide an email address or fax number, the notice will be sent by ordinary mail.

**117.19(13) *Time of acceptance of award.*** If a time is not stated in the competitive selection document, the vendor may state the length of time that the state has to accept the vendor's offer. This period shall not be less than 10 days for informal quotations or less than 30 days for formal bids. If the vendor states no minimum time period, the offer shall be irrevocable for 90 days. The department may require a longer evaluation period for technical equipment.

**117.19(14) *Delivery.***

*a. Delivery date.* A vendor shall show in a response to a solicitation the earliest date on which delivery can be made. The department may include in a solicitation the acceptable delivery date for a commodity. The department may consider delivery dates as a factor in determining to which vendor the notice of intent to award shall be issued. Goods in transit remain the responsibility of the vendor.

*b. Notice of rejection.* The reason for any rejection of a shipment, based on apparent deficiencies that can be disclosed by ordinary methods of inspection, will be given by the receiving agency to the vendor and carrier within a reasonable time after delivery of the item with a copy of this notice provided to the purchasing section. Notice of latent deficiencies that would make items unsatisfactory for the intended purpose may be given at any time after acceptance.

*c. Disposition of rejected item.* The vendor must remove at the vendor's expense any rejected item. If the vendor fails to remove the rejected item within 30 days of notification, the department or an agency may dispose of the item by offering it for sale, deduct any accrued expense and remit the balance to the vendor.

*d. Testing after delivery.* Laboratory analysis of an item or other means of testing may be required after delivery. In such cases, vendors will be notified in writing that a special test will be made and that payment will be withheld until completion of the testing process.

*e. Risk of loss or damage.* Risk of loss or damage remains with the vendor until delivery and acceptance by the agency at the destination shown on the order.

*f. Vendor responsibility for removal of trade-ins.* Whenever the purchase of an item of equipment has been made with the trade-in of equipment, it shall be the vendor's responsibility to remove the traded equipment within 30 days of the final acceptance of the purchased equipment by the agency, if not otherwise specified in the competitive selection document. The department or agency will not assume responsibility for equipment that is not removed within this time period and may cause the equipment to be removed by and shipped to the vendor and may bill the vendor for all packing, crating and transportation charges.

**117.19(15) *Master agreement and purchase order modifications.*** When consistent with the purpose and intent of the original master agreement or order, amendments or modifications may be issued. All modifications shall be documented and approved by the department or agency and the vendor before modifications take effect. Modifications shall not be used unreasonably to avoid further competition.

**117.19(16) *Federal and state taxes.*** The state of Iowa is exempt from the payment of Iowa sales tax, motor vehicle fuel tax and any other Iowa tax that may be applied to a specified commodity or service. A vendor shall be furnished a revenue department exemption letter upon request.

[ARC 0952C, IAB 8/21/13, effective 9/25/13; ARC 2036C, IAB 6/10/15, effective 7/15/15]

**11—117.20(8A) Vendor appeals.**

**117.20(1) *Filing an appeal.*** Any vendor that filed a timely bid or proposal and that is aggrieved by an award of the department may appeal the decision by filing a written notice of appeal before the Director, Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319, within five calendar days of the date of award, exclusive of Saturdays, Sundays, and legal state holidays. The department must actually receive the notice of appeal within the specified time frame for it to be considered timely. The notice of appeal shall state the grounds upon which the vendor challenges the department's award.

**117.20(2) *Procedures for vendor appeal.*** The vendor appeal shall be a contested case proceeding and shall be conducted in accordance with the provisions of the department's administrative rules governing contested case proceedings, unless the provisions of this rule provide otherwise.

a. Notice of hearing. Upon receipt of a notice of vendor appeal, the department shall contact the department of inspections and appeals to arrange for a hearing. The department of inspections and appeals shall send a written notice of the date, time and location of the appeal hearing to the aggrieved vendor or vendors.

The presiding officer shall hold a hearing on the vendor appeal within 60 days of the date the notice of appeal was received by the department.

b. Discovery. The parties shall serve any discovery requests upon other parties at least 30 days prior to the date set for the hearing. The parties must serve responses to discovery at least 15 days prior to the date set for the hearing.

c. Witnesses and exhibits. The parties shall contact each other regarding witnesses and exhibits at least 10 days prior to the date set for the hearing. The parties must meet prior to the hearing regarding the evidence to be presented in order to avoid duplication or the submission of extraneous materials.

d. Amendments to notice of appeal. The aggrieved vendor may amend the grounds upon which the vendor challenges the department's award no later than 15 days prior to the date set for the hearing.

e. If the hearing is conducted by telephone or on the Iowa communications network, the parties must deliver all exhibits to the office of the presiding officer at least 3 days prior to the time the hearing is conducted.

f. The presiding officer shall issue a proposed decision in writing that includes findings of fact and conclusions of law stated separately. The decision shall be based on the record of the contested case and shall conform to Iowa Code chapter 17A. The presiding officer shall send the proposed decision to all parties by first-class mail.

g. The record of the contested case shall include all materials specified in Iowa Code subsection 17A.12(6).

(1) Method of recording. Oral proceedings in connection with a vendor appeal shall be recorded either by mechanized means or by certified shorthand reporters. Parties requesting that certified shorthand reporters record the hearing shall bear the costs.

(2) Transcription. A party may request that oral proceedings in connection with a hearing in a case or any portion of the oral proceedings be transcribed. A party requesting transcription shall bear the expense of the transcription.

(3) Tapes. Parties may obtain copies of tapes of oral proceedings from the presiding officer at the requester's expense.

(4) Retention time. The department shall file and retain the recording or stenographic notes of oral proceedings or the transcription for at least five years from the date of the decision.

**117.20(3) Stay of agency action for vendor appeal.**

a. *When available.*

(1) Any party appealing the issuance of a notice of award may petition for stay of the award pending its review. The petition for stay shall be filed with the notice of appeal, shall state the reasons justifying a stay, and shall be accompanied by an appeal bond equal to 120 percent of the contract value.

(2) Any party adversely affected by a final decision and order may petition the department for a stay of that decision and order pending judicial review. The petition for stay shall be filed with the director within five days of receipt of the final decision and order, and shall state the reasons justifying a stay.

b. *When granted.* In determining whether to grant a stay, the director shall consider the factors listed in Iowa Code section 17A.19(5) "c."

c. *Vacation.* A stay may be vacated by the issuing authority upon application of the department or any other party.

**117.20(4) Review of proposed decision.**

a. The proposed decision shall become the final decision of the department 15 days after mailing the proposed decision, unless prior to that time a party submits an appeal of the proposed decision in accordance with the provisions of this subrule.

b. A party appealing the proposed decision shall mail or deliver the notices of appeal to the Director, Department of Administrative Services, Hoover State Office Building, Third Floor, Des Moines, Iowa 50319. Failure to request review will preclude judicial review unless the department

reviews the proposed decision on its own motion. If the department reviews the proposed decision on its own motion, it will send notice of the review to all parties participating in the appeal.

*c.* A party appealing the proposed decision shall mail a copy of the notice of appeal to all other parties. Any party may submit to the department exceptions to and a brief in support of or in opposition to the proposed decision within 15 days after the mailing of a notice of appeal or of a request for review. The submitting party shall mail copies of any exceptions or brief it files to all other parties to the proceeding. The director shall notify the parties if the department deems oral arguments by the parties to be appropriate. The director will issue a final decision not less than 30 days after the notice of appeal is filed.

*d.* The department shall review the proposed decision based on the record and issues raised in the hearing. The department shall not take any further evidence and shall not consider issues that were not raised at the hearing. The issues for review shall be specified in the party's notice of appeal. The party appealing the proposed decision shall be responsible for transcribing any tape of the proceeding before the presiding officer and filing the transcript as part of the record for review. The party appealing the proposed decision shall bear the cost of the transcription regardless of the method used to transcribe the tape.

*e.* Each party shall have the opportunity to file exceptions to the proposed decision and present briefs in support of or in opposition to the proposed decision. The department may set a deadline for submission of briefs. When the department consents, oral arguments may be presented. A party wishing to make an oral argument shall specifically request it. The department in its sole discretion may schedule oral arguments regarding the appeal. The department shall notify all parties in advance of the scheduled time and place for oral arguments.

*f.* The director shall issue a final decision by the department. The decision shall be in writing and shall conform to the requirements of Iowa Code chapter 17A.

[ARC 0952C, IAB 8/21/13, effective 9/25/13]

#### **11—117.21(8A) Waiver procedure.**

**117.21(1) *Definition.*** For the purpose of this chapter, a “waiver or variance” means an action by the director that suspends, in whole or in part, the requirements or provisions of a rule in this chapter as applied to a state agency when the state agency establishes good cause for a waiver or variance of the rule. For simplicity, the term “waiver” shall include both a “waiver” and a “variance.”

**117.21(2) *Requests for waivers.*** A state agency seeking a waiver shall submit a written request for a waiver to the director. The written request shall identify the rule for which the state agency seeks a waiver or the contract or class of contracts for which the state agency seeks a waiver and the reasons that the state agency believes justify the granting of the waiver.

**117.21(3) *Criteria for waiver.*** In response to a request for a waiver submitted by a state agency, the director may issue an order waiving in whole or in part the requirements of a rule in this chapter if the director finds that the state agency has established good cause for the waiving of the requirements of the rule. “Good cause” includes, but is not limited to, the following: (1) the desired good or service is available from one source only, (2) the time frame required is such that an expedient purchase is in the best interest of the agency, or (3) a showing that a requirement or provision of a rule should be waived because the requirement or provision would likely result in an unintended, undesirable, or adverse consequence or outcome. An example of good cause for a waiver is when a contract duration period of longer than six years is more economically or operationally feasible than a six-year contract in light of the service being purchased by the state agency.

[ARC 2036C, IAB 6/10/15, effective 7/15/15]

These rules are intended to implement Iowa Code sections 8A.201 to 8A.203, 8A.206, 8A.207, 8A.301, 8A.302, 8A.311, 8A.341 to 8A.344, 73.1 and 73.2.

[Filed 10/7/03, Notice 8/20/03—published 10/29/03, effective 12/3/03]

[Filed 7/30/04, Notice 6/9/04—published 8/18/04, effective 9/22/04]

[Filed emergency 6/15/05—published 7/6/05, effective 7/1/05]

[Filed 8/24/05, Notice 7/6/05—published 9/14/05, effective 10/19/05]

[Filed 11/30/05, Notice 10/26/05—published 12/21/05, effective 1/25/06]

[Filed 12/29/05, Notice 11/23/05—published 1/18/06, effective 2/22/06]

[Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 9/6/06]

[Filed 8/22/07, Notice 7/18/07—published 9/12/07, effective 10/17/07]

[Filed 11/14/07, Notice 10/10/07—published 12/5/07, effective 1/9/08]

[Filed ARC 0952C (Notice ARC 0812C, IAB 6/26/13), IAB 8/21/13, effective 9/25/13]

[Filed ARC 1485C (Notice ARC 1302C, IAB 2/5/14), IAB 6/11/14, effective 7/16/14]

[Filed ARC 2036C (Notice ARC 1969C, IAB 4/15/15), IAB 6/10/15, effective 7/15/15]

[Filed ARC 2267C (Notice ARC 2145C, IAB 9/16/15), IAB 11/25/15, effective 12/30/15]

[Filed ARC 3676C (Notice ARC 3574C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

CHAPTER 50  
WOMEN, INFANTS, AND CHILDREN/FARMERS' MARKET NUTRITION PROGRAM  
AND SENIOR FARMERS' MARKET NUTRITION PROGRAM

**21—50.1(159,175B) Authority and scope.** This chapter establishes procedures to govern the administration of a farmers' market special supplemental food program by the department of agriculture and land stewardship for implementing the applicable agreement and guidelines set forth by the United States Department of Agriculture, Food and Nutrition Service Agreement, in accordance with Iowa Code chapter 175B.

Information may be obtained by contacting the Agricultural Diversification and Market Development Bureau, Iowa Department of Agriculture and Land Stewardship, Wallace State Office Building, Des Moines, Iowa 50319, telephone (515)281-5321.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.2(159,175B) Severability.** If any provision of a rule or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rule which can be given effect without the invalid provision or application, and, to this end, the provisions of these rules are severable.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.3(159,175B) Definitions.** For the purposes of this chapter:

*"Application"* means a request made by an individual to the department for vendor certification in the FMNP/SFMNP on a form provided by the horticulture and farmers' market bureau of the department.

*"Authorized CSA"* means a community supported agriculture program that is authorized by the department for the exchange of SFMNP funds for eligible foods.

*"Authorized farmers' market"* means a farmers' market site authorized by the department for the exchange of vouchers for eligible foods.

*"Authorized farmstand"* means a farmstand site authorized by the department for the exchange of vouchers for eligible foods.

*"Certified vendor"* means an individual who has met all FMNP/SFMNP conditions as outlined by the department and who is guaranteed payment on all vouchers accepted, provided compliance is maintained by that individual regarding all FMNP/SFMNP rules and procedures as outlined in the vendor certification handbook. Individuals who exclusively sell produce grown by someone else, such as wholesale distributors, cannot be certified to participate in the FMNP/SFMNP, except individuals employed by a farmer otherwise qualified under these rules.

*"Certified vendor identification sign"* means department-issued signage which shall be clearly displayed by the certified vendor at all times the vendor accepts or intends to accept vouchers in an authorized farmers' market/farmstand. Signs shall remain the sole property of the department with forfeiture by the certified vendor to the department in the event of disqualification or suspension.

*"Certified vendor number"* means a unique identification number issued for a designated period by the department and assigned to an individual whom the department has identified as a certified vendor. The certified vendor number shall be affixed to the certified vendor identification card and the certified vendor identification sign, and the certified vendor shall stamp the number on each voucher that is submitted for deposit. An individual shall be assigned no more than one certification number for any designated period.

*"Certified vendor stall"* means all of the area in an authorized farmers' market that is dedicated to a certified vendor for the purpose of displaying and offering product for sale. Certified vendors are permitted only one certified vendor stall per market. The only exceptions shall be:

1. If the certified vendor elects not to promote any of the area as FMNP/SFMNP for an entire farmers' market day; or
2. If the certified vendor elects to exclude a portion of the space by maintaining a distance of separation from the certified vendor stall by a minimum of two farmers' market vendors who are neither

affiliated with nor related to the certified vendor and who are actively participating in the farmers' market on the given day. An excluded area shall be operated independently of the certified vendor stall.

These exceptions shall hold only when the vendor neither accepts nor intends to accept vouchers.

*"Certified vendor stamp"* means a department-issued stamp of the certified vendor number.

*"Community supported agriculture"* means a program under which a farmer or group of farmers grows food for a group of shareholders (or subscribers) who pledge to buy a portion of the farmer's crop(s) for that season.

*"Days"* means calendar days.

*"Department"* means the Iowa department of agriculture and land stewardship.

*"Designated distribution site"* means a site authorized by the department for distribution of vouchers by the local agency.

*"Distribution"* means the process outlined by the department and the means by which local agencies actually dispense vouchers to eligible recipients.

*"Eligible foods"* means fresh, nutritious, unprepared, locally grown fruits, vegetables and herbs for human consumption. Eligible foods may not be processed or prepared beyond their natural state except for usual harvesting and cleaning processes. Locally produced, unpasteurized, pure honey is an eligible food only for the recipients of SFMNP benefits.

*"Farmers' market"* means a cooperative or nonprofit enterprise or association that consistently occupies a given site throughout the season, which operates principally as a common marketplace for a group of farmers to sell locally grown fresh produce directly to consumers, and where the majority of products sold are produced by the participating farmers with the sole intent and purpose of generating a portion of household income.

*"Farmstand"* means a consistent site throughout the season, in which a single individual farmer sells the farmer's produce directly to consumers.

*"FMNP"* means the women, infants, and children farmers' market nutrition program.

*"Fresh produce"* means fruits and vegetables that have not been processed in any manner. This term does not include such items as dried fruits and vegetables, potted or dried herbs, wild rice, nuts of any kind including raw nuts, popcorn, fruit or vegetable plants/seedlings, dried beans/peas, seeds/grains, flowers, maple syrup, cider, eggs, meat, cheese, and seafood.

*"Local agency"* means a nonprofit entity that certifies eligible recipients, issues FMNP/SFMNP vouchers, arranges for the distribution of eligible foods through CSA programs, or provides nutritional education or information on operational aspects of the FMNP/SFMNP to recipients and which has entered into a contract with the department.

*"Locally grown"* means produce that has a traceable point of origin either within Iowa or in a neighboring state in a county adjacent to Iowa's border.

*"Posted hours and days"* means the operational time frames stated in assurances submitted by a representative, who has the legal authority to obligate the farmers' market/farmstand, which include a beginning and an ending time and date for each year of operation.

*"Proxy"* means an individual authorized by an eligible recipient to act on the recipient's behalf, including application for, receipt of, or use of vouchers or acceptance of SFMNP foods provided through a CSA program as long as the benefits are ultimately received by the recipient. Minors shall not be used as proxies. A proxy may act on behalf of more than one eligible recipient only if the proxy is directly related to the additional eligible recipients.

*"Recipient"* means a person chosen by the Iowa department of agriculture and land stewardship to receive FMNP/SFMNP benefits.

1. To receive FMNP benefits, such person must be a woman, infant over four months of age, or child who receives benefits under the WIC program or is on the waiting list to receive benefits under the WIC program.

2. To receive SFMNP benefits, such person must meet the senior eligibility criteria of the SFMNP in Part 249.6 of Subpart C of Title 7 Code of Federal Regulations as of May 26, 2005.

“*Season*” means a clearly delineated period of time during a given year that has a beginning date and ending date, as specified by the department, which correlates with a major portion of the harvest period for locally grown fresh produce.

“*Secretary*” means the secretary of agriculture for the state of Iowa.

“*Service area*” means the geographic area that encompasses all of the designated distribution sites and authorized farmers’ markets, farmstands, and CSAs within Iowa for a designated period.

“*SFMNP*” means the senior farmers’ market nutrition program.

“*Shareholder*” means an SFMNP recipient for whom a full or partial share in a community supported agriculture program has been purchased by the department, and who receives SFMNP benefits in the form of actual eligible foods rather than vouchers that must be exchanged for eligible foods at farmers’ markets or farmstands.

“*USDA-FNS*” means the United States Department of Agriculture-Food and Nutrition Service.

“*Vendor certification handbook*” means a publication by the department that is based on USDA-FNS regulations and guidelines, addresses all FMNP/SFMNP rules and procedures applicable to a certified vendor, and provides the basis for vendor training. A copy of the publication shall be issued to each individual after certification training. New editions supersede all previous editions.

“*Voucher*” means a negotiable instrument issued by the department to recipients that is redeemable only for eligible foods from certified vendors at authorized farmers’ markets/farmstands with a limited negotiable period that directly correlates to the season designated by the department.

“*WIC*” means the Special Supplemental Food Program for Women, Infants and Children, as administered by the Iowa department of public health.

[ARC 8308B, IAB 11/18/09, effective 12/23/09; ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.4(159,175B) Program description and goals.** The women, infants, and children/farmers’ market nutrition program (FMNP) and the senior farmers’ market nutrition program (SFMNP) are jointly funded by the state of Iowa and the United States Department of Agriculture.

**50.4(1)** The dual purposes of the FMNP are:

*a.* To provide resources in the form of fresh, nutritious, unprepared foods (fruits and vegetables) from farmers’ markets to women, infants, and children who are nutritionally at risk and who are participating in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) or are on the waiting list for the WIC program, and

*b.* To expand the awareness of, use of and sales at farmers’ markets.

**50.4(2)** The purposes of the SFMNP are:

*a.* To provide resources in the form of fresh, nutritious, unprepared locally grown fruits, vegetables and herbs from farmers’ markets, roadside stands, and community supported agriculture (CSA) programs to low-income seniors;

*b.* To increase the domestic consumption of agricultural commodities by expanding or aiding in the expansion of domestic farmers’ markets, roadside stands, and CSAs; and

*c.* To develop or aid in the development of new and additional farmers’ markets, roadside stands, and CSAs.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.5(159,175B) Administration and agreements.**

**50.5(1)** The program shall be administered by the secretary or by the secretary’s designee.

**50.5(2)** The department shall maintain all conditions as outlined in the farmers’ market nutrition program/senior farmers’ market nutrition program state plan submitted to USDA-FNS.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.6(159,175B) Distribution of benefits.**

**50.6(1)** Iowa department of public health WIC client screening processes and records shall provide the basis for identifying recipients eligible for receipt of FMNP vouchers. The department may contract with local agencies to certify eligible recipients and distribute SFMNP vouchers. Senior recipient

eligibility criteria shall conform to Part 249.6 of Subpart C of Title 7 Code of Federal Regulations as of May 26, 2005.

**50.6(2)** Local agencies shall distribute vouchers at designated distribution sites to recipients in the manner specified by the department in the procedures guide for distribution site staff. Local agency services shall include, but not be limited to, ensuring that:

*a.* Each recipient is issued vouchers during each distribution as authorized by the department.  
*b.* The voucher serial numbers issued to the recipient correspond to the numbers in the distribution registry.

*c.* A proxy is allowed to act on behalf of a recipient.  
*d.* Each recipient is provided a thorough explanation of program guidelines and recipient responsibility as outlined by the department.

*e.* All FMNP/SFMNP support materials are put into use as outlined by the department.  
*f.* Accurate and complete records of all related FMNP/SFMNP activities in the possession of a local agency are maintained and retained for a minimum of three years following the date of submission of the final expenditure report for the period to which the report pertains. In the event of litigation or audit findings, the records shall be retained until all issues arising from such actions have been resolved or until the end of the prescribed retention period, whichever is later.

*g.* All agency records pertaining to this program are made available for inspection to representatives of USDA, the Comptroller General of the United States, the state auditor, the department, and other agencies working under contract with the department as necessary, at any time during normal business hours, and as frequently as is deemed necessary for inspection and audit. Otherwise, confidentiality of personal information on all recipients participating in the program shall be maintained at all times.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.7(159,175B) Recipient responsibilities.** Recipients shall be responsible for, but not limited to, all of the following:

1. Qualifying under FMNP/SFMNP guidelines and attending a designated distribution site when vouchers are distributed.

2. Properly signing a voucher(s) at time of use in the presence of the certified vendor who accepts a voucher in exchange for eligible foods.

3. Using vouchers only to purchase eligible foods from certified vendors who display certified vendor identification signs at authorized farmers' markets/farmstands.

4. Redeeming vouchers on or before the expiration date printed on the face of the voucher, or surrendering all claim to the value of vouchers that remain unredeemed.

5. Ensuring vouchers received are not assigned to any other party other than to a proxy.

6. Reporting violations or problems to the department or the local agency.

7. Reporting all incidents of lost or stolen vouchers to the local agency.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.8(159,175B) Farmers' market, farmstand, and community supported agriculture (CSA) authorization and priority.**

**50.8(1)** A farmers' market/farmstand/CSA shall be eligible for authorization based in part upon the submission of assurances by a representative who has the legal authority to obligate the farmers' market/farmstand/CSA. Farmers' market/farmstand/CSA assurances shall be submitted in a manner outlined by the a department and shall provide evidence of willingness by a person(s) associated with the farmers' market/farmstand/CSA to implement all FMNP/SFMNP requirements.

**50.8(2)** Assurances submitted by a farmers' market/farmstand shall include, but not be limited to, all of the following:

*a.* The name(s) of certified vendor participant(s).

*b.* Posted hours and days of operation to be maintained each week, specifically detailed to cover any anticipated fluctuations in operations over the course of the season. A farmers' market/farmstand must be actively operating a minimum of two consecutive hours each week.

- c.* Season of operation which ensures the farmers' market/farmstand is actively operating on the same day, on a weekly basis, for a majority of the weeks of the season.
- d.* Accessibility and consistency of farmers' market/farmstand site over the course of the season.
- e.* Local rules that do not overly restrict the number of certified vendors who may participate in the farmers' market or operate a farmstand.
- f.* Department is notified if the farmers' market/farmstand changes the posted hours and days of operation prior to the end of the authorization period.

**50.8(3)** A CSA program shall:

- a.* Provide such information as the department may require for its periodic reports to USDA-FNS.
- b.* Ensure that SFMNP recipients receive only eligible foods.
- c.* Provide eligible foods to SFMNP shareholders at or less than the price charged to other customers.
- d.* Ensure that the shareholders receive eligible foods that are of equitable value and quantity to their share.
- e.* Ensure that all funds from the department are used for planting of crops for SFMNP shareholders.
- f.* Provide to the department access to a tracking system that determines the value of the eligible foods provided and the remaining value owed to each SFMNP shareholder.
- g.* Ensure that SFMNP shareholders/authorized representatives provide written acknowledgment of receipt of eligible foods.
- h.* Accept training on SFMNP procedures and provide training to farmers and any employees with SFMNP responsibilities for such procedures.
- i.* Agree to be monitored for compliance with SFMNP requirements, including both overt and covert monitoring.
- j.* Be accountable for actions of farmers or employees in the provision of eligible foods and related activities.
- k.* Offer SFMNP shareholders the same courtesies as other customers.
- l.* Notify the department immediately when the CSA program is experiencing a problem with its crops and may be unable to provide SFMNP shareholders with the complete amount of eligible foods agreed upon between the CSA and the department.
- m.* Comply with Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Department of Agriculture regulations on nondiscrimination contained in Parts 15, 15a and 15b and FNS instructions as outlined in Part 249.7 of Title 7 Code of Federal Regulations, as of May 26, 2005.
- n.* Notify the department if any CSA program ceases operation prior to the end of the authorization period.

**50.8(4)** The department shall give priority to a farmers' market/farmstand/CSA with previous involvement in FMNP/SFMNP, provided the farmers' market/farmstand/CSA does not have a high incidence of certified vendor noncompliance, suspensions, or disqualifications.

**50.8(5)** A principal factor in determining farmers' market authorization shall pertain to the number of eligible applications received by the department prior to April 15 that indicate the intent to participate in the given farmers' market. A standard of three eligible certified vendor applications, indicating intent to participate in the farmers' market for the majority of weeks of the season, is required for a farmers' market to receive authorization.

**50.8(6)** The number of farmers' markets/farmstands/CSAs authorized for publication in the directory shall be determined by the department no later than May 1 prior to each season. Additional farmers' markets/farmstands/CSAs may be authorized no later than June 30.

**50.8(7)** An authorized farmers' market must ensure that at least one certified vendor remains at the authorized farmers' market during the posted days and hours of market operation. Failure to comply will result in a warning citation from the department. Repeated noncompliance could result in the revocation of the farmers' market authorization.

**50.8(8)** A farmstand authorized to participate in the FMNP/SFMNP shall be operated from a permanent building that is primarily used for the sale of eligible foods, is not moveable and remains in the same location year-round. The building shall have at least a roof, sidewalls, and solid floor to protect produce and people. Wood post frame, stud frame, rigid-frame metal, and concrete block construction are suitable farmstand construction. The building must be maintained in a manner consistent with standards generally accepted for this type of business. The structural requirements for a permanent building do not apply under either of the following circumstances:

*a.* The farmstand not meeting the structural requirements is authorized to participate in the FMNP/SFMNP and is primarily used for the sale of eligible food and has operated from a structure at the same location for a minimum of five consecutive years and has also been operating the majority of the market season from June 1 through October 31 for a minimum of 11 consecutive weeks annually. The vendor must submit with the vendor's application a letter of support acknowledging five years or more of operation at that location from a municipality, county or governmental agency.

*b.* Up to two moveable farmstands that do not meet the requirements of permanent farmstands may be authorized in cities and villages that are not located within ten miles of an authorized farmers' market.

**50.8(9)** If three or more applications for moveable farmstands within the same city or village are received by the department, the applicants shall be required to meet the authorization requirements of a farmers' market.

**50.8(10)** An authorized farmstand must be staffed during all hours of operation. Failure to comply will result in a warning citation from the department. Repeated noncompliance could result in the revocation of the farmstand authorization.

[ARC 2573C, IAB 6/8/16, effective 7/13/16; ARC 3677C, IAB 3/14/18, effective 4/18/18]

## **21—50.9(159,175B) Vendor certification.**

**50.9(1)** Vendor certification shall not be in effect and vouchers shall not be accepted until the applicant receives a certified vendor identification sign, a certified vendor stamp and either email confirmation of certification or the applicant copy of the department-vendor agreement.

**50.9(2)** Vendor certification expires at the end of each year of issuance. Individuals must annually apply for and receive vendor certification in order to participate in FMNP/SFMNP.

**50.9(3)** The department does not limit the number of vendors who may become certified under FMNP/SFMNP. The department issues a single certified vendor number for each separate and distinct agricultural operation. A vendor certified to accept program vouchers may accept vouchers at any authorized market in the state upon approval by the department to participate in that particular market and acceptance by the particular market. A vendor who satisfies all the following criteria shall be certified to accept vouchers.

*a.* Indicates an intent to participate in one or more authorized farmers' markets/farmstands for a majority of weeks of the market season. A vendor who does not participate in the FMNP/SFMNP for the majority of weeks of the season may be certified to accept vouchers only at farmers' markets that have been previously authorized. A certified vendor who does not participate in the FMNP/SFMNP for the majority of weeks of the season will not be considered in the standard of three eligible certified vendor applications required for a farmers' market to receive authorization.

*b.* Participates in training on FMNP/SFMNP rules and procedures through attendance in an entire session of one of the six scheduled training meetings conducted by department staff.

*c.* Meets the eligibility requirements based on the information submitted in a completed application to the department prior to the deadline.

*d.* Is 18 years of age or older and submits a completed and signed certified vendor agreement to the department.

*e.* Resides and grows eligible foods within Iowa or in a neighboring state in a county adjacent to Iowa's border.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.10(159,175B) Certified vendor obligations.** A certified vendor shall be responsible for, but not limited to, all of the following:

1. Beginning each market day with at least 20 percent of all products for sale or display in a certified vendor stall as eligible foods, having personally grown a majority of the eligible foods for sale or display, and with all produce being locally grown. When eligible foods are purchased for resale from another producer or wholesaler, valid receipts must be presented to the department upon request and must contain the following information: the name, address and telephone number of the producer/wholesaler; the date of purchase; location of the growing site; and quantity purchased, itemized by product type.

2. Accepting vouchers only for a transaction that takes place at the location, hours, and days of an authorized farmers' market/farmstand, only in exchange for eligible foods, and signed by the recipient or proxy at the time of purchase.

3. Prominently displaying a certified vendor identification sign that is located on the customer traffic side of the stall only at the location, hours, and days of an authorized farmers' market/farmstand. The certified vendor identification sign must be removed or covered when the eligible foods are sold out.

4. Providing eligible foods to recipients upon receipt of a valid and properly completed voucher, which is signed at the time of sale. Vouchers that are properly presented must be accepted by certified vendors participating in the FMNP/SFMNP.

5. Accepting vouchers as payment for eligible foods only if presented on or before the usage expiration date printed on the face of the voucher.

6. Stamping each transacted voucher with the certified vendor number prior to voucher deposit and submitting vouchers for payment on or before 15 days following the expiration date printed on the face of the voucher.

7. Handling transactions with recipients in the same manner as transactions with all other customers, to ensure that FMNP/SFMNP clients are not exposed to discriminatory practices in any form.

8. Not collecting state or local taxes on purchases involving vouchers.

9. Providing eligible foods to recipients at the current price or less than the current price charged to other customers.

10. Not levying a surcharge based on the use of vouchers by recipients.

11. Not returning cash or issuing credit in any form to recipients during sales transactions that involve vouchers only. In the event of a single transaction in which a recipient presents a combination of cash and vouchers for the purchase of locally grown fresh produce, cash or credit up to the value of the cash portion of the payment may be given to the recipient. Credits or refunds may not be issued on returned eligible foods that were purchased with vouchers.

12. Participating in training as the department deems necessary to carry out the intent of FMNP/SFMNP.

13. Cooperating with the department in the evaluation of each season by completely and accurately responding to a survey, with resubmission to the department in a specified and timely manner.

14. Immediately informing the department in the event of loss, destruction, or theft of the certified vendor identification sign or certified vendor stamp so that a replacement may be issued.

15. Complying with all procedures and rules as herein outlined and as delineated in the department vendor agreement, the certified vendor handbook, and written notices of clarification issued by the department to the vendor.

16. Complying with the requirements of Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, United States Department of Agriculture regulations on nondiscrimination contained in Parts 15, 15a and 15b and FNS instructions as outlined in 248.7 and 249.7 of the Title 7 Code of Federal Regulations as of May 26, 2005.

17. Agreeing to be monitored at farmers' markets/farmstands and growing sites for compliance with FMNP/SFMNP requirements, including both overt and covert monitoring, and providing directions to growing sites upon request of department staff.

18. Not seeking restitution from FMNP/SFMNP recipients for vouchers not paid by the department.

19. Paying the department for any vouchers transacted in violation of the FMNP/SFMNP regulations.

20. Ensuring that all other persons who act on behalf of the certified vendor at a farmers' market/farmstand act solely on behalf of the certified vendor and understand and adhere to the procedures and regulations of the FMNP/SFMNP.

21. Coordinating with other certified vendors to ensure that at least one certified vendor remains at the authorized farmers' market during the posted hours and days of operation.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.11(159,175B) Certified vendor noncompliance sanctions.**

**50.11(1)** A voucher shall be returned to the certified vendor unpaid if the certified vendor identification number is not properly stamped on the face of the voucher or if the recipient signature is missing on the face of the voucher. A voucher may be resubmitted for payment in the event that the signature or vendor certification identification error can be properly and legally corrected by the certified vendor.

**50.11(2)** Sanctions for violations of FMNP/SFMNP procedures and rules applicable to a certified vendor are as follows:

*a.* A warning citation may be the sanction for violation of the requirement to:

- (1) Appropriately display the certified vendor identification sign,
- (2) Post the current operating sticker to the vendor identification sign or vendor identification card,

or

(3) Coordinate with other certified vendors to ensure that at least one certified vendor remains at the authorized farmers' market during the posted hours and days of operation.

If a pattern of disregard is evident, the vendor may be suspended for the remainder of the current year and the following year.

*b.* A warning citation after the first violation and suspension from the FMNP/SFMNP for the remainder of the current year and the following year after the second violation (regardless of when the first violation occurred) may be the sanctions for violation of the requirement to:

(1) Begin each market day with at least 20 percent of all products for sale or on display in a certified vendor stall as eligible foods, having personally grown a majority of the eligible foods for sale or display, and with all produce being locally grown.

(2) Accept vouchers only at locations, hours, or days authorized by the department.

(3) Provide eligible foods to recipients upon receipt of a valid and properly completed voucher, which is signed at the time of sale.

(4) Accept vouchers as payment for eligible foods only if presented on or before the usage expiration date printed on the face of the voucher.

(5) Handle transactions with recipients in the same manner as transactions with all other customers to ensure that FMNP/SFMNP clients are not exposed to discriminatory practices in any form.

(6) Not collect state or local taxes on purchases involving vouchers.

(7) Provide eligible foods to recipients at the current price or less than the current price charged to other customers.

(8) Not levy a surcharge based on the use of vouchers by recipients.

(9) Comply with all procedures and rules as herein outlined and as delineated in the department vendor agreement, the certified vendor handbook, and written notices of clarification issued by the department to the vendor.

(10) Agree to be monitored at farmers' markets/farmstands and growing locations for compliance with FMNP/SFMNP requirements, including both overt and covert monitoring; provide proper receipts for produce purchased for resale; or provide directions to growing sites upon request of department staff.

(11) Refrain from abusive or discriminatory treatment of recipients or FMNP/SFMNP staff.

*c.* Disqualification without reinstatement may be the sanction for violation of the requirement to:

- (1) Accept vouchers only in exchange for eligible foods, or

(2) Return no cash or issue no credit in any form to recipients during sales transactions that involve vouchers only.

**50.11(3)** Violations involving the use of multiple vouchers in a single sales transaction shall be considered as a single violation. Violations involving multiple sales transactions, regardless of time elapsed, shall be considered multiple violations at a standard of one violation per sales transaction.

**50.11(4)** Citations. A written citation shall be issued to the certified vendor by the department within five days of receipt of evidence of a violation. A written citation from the department shall be pending for five days following receipt of the citation by the certified vendor. The certified vendor shall be granted the pending period for presenting sufficient evidence to the department to substantiate a reversal. Remedies undertaken in response to receipt of a written notice of a pending citation of noncompliance shall not constitute evidence in defense of such citation. Failure to present any evidence (oral or written) to the department within the specified period shall constitute acceptance of the citation by the certified vendor. Submission of insufficient evidence by the certified vendor for determination of reversal on the pending citation by the department may result in a sanction upon completion of the pending period.

**50.11(5)** Suspension. Suspension of a certified vendor from participation in FMNP/SFMNP shall remain in effect for the balance of the current year and the following year. During the suspension period, the cited vendor shall refrain from participating in FMNP/SFMNP. The department shall have the right to reimbursement from the vendor of an amount equal in value to vouchers deposited after the official date of the suspension notification. The suspended vendor is required to return the certified vendor identification sign(s) and certified vendor stamp to the department within 15 days of receipt of the suspension notice. At the conclusion of a suspension period, the vendor must reapply for and receive certification in order to resume participation in FMNP/SFMNP.

**50.11(6)** Disqualification. Disqualification shall be without reinstatement. The disqualified vendor is required to return the certified vendor identification sign(s) and certified vendor stamp to the department within 15 days of receipt of the disqualification notice. In the event of a disqualification, the department shall have the right to reimbursement from the vendor of an amount equal in value to vouchers deposited after the official date of disqualification notification.

**50.11(7)** Probationary status. Any vendor successfully recertified following suspension will be on probationary status for one full FMNP/SFMNP season. Recurrence of a substantiated suspension violation during the probationary period and for which the certified vendor has been cited shall be sufficient grounds for immediate and automatic disqualification.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.12(159,175B) Appeal.** A certified vendor who wishes to appeal a sanction made by the department which resulted in a suspension or disqualification may make a written request for administrative appeal to the department's FMNP/SFMNP director. This appeal must be made within 15 days of receipt of sanction notification by the certified vendor. The provisions of 21—Chapter 2 shall be applicable to an appeal except as otherwise provided in this chapter. The farmer/farmers' market/CSA program has the right to appeal a denial of an application to participate. Expiration of a contract or agreement shall not be subject to appeal.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.13(159,175B) Deadlines.**

**50.13(1)** *Submission of farmers' market/farmstand/CSA assurances.* Assurances, on forms provided by the department, must be submitted no later than May 1 in order for a farmers' market/farmstand/CSA to be published in the Directory of Authorized Locations. Assurances will be accepted no later than June 30.

**50.13(2)** *Submission of vendor application.* All applications shall be submitted no later than one month preceding the last date on which vouchers may be used by recipients at an authorized farmers' market/farmstand/CSA.

**50.13(3)** *Recipient voucher usage expiration.* Vouchers shall be valid for recipient use from the season starting date through the ending date as designated by the department. Such date shall be clearly printed on the voucher face. Vouchers shall be null and void after the expiration date.

**50.13(4) *Certified vendor voucher reimbursement.*** All vouchers accepted by a certified vendor shall be deposited on or before 15 days following the date of expiration for voucher usage by recipients. Such date shall be clearly printed in the endorsement space on the back of the voucher. Any claim to voucher payment beyond the voucher reimbursement expiration date is not valid and shall be denied.

**50.13(5) *Submissions by local agency.*** Deadlines for submission of records, reports, survey instruments and undistributed vouchers by local agencies shall be established by the department and specified in the agreement entered into with the local agency.

**50.13(6) *Operations plans and reports to USDA-FNS.*** The department shall develop and submit plans and reports in a manner prescribed by USDA-FNS.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

**21—50.14(159,175B) Discrimination complaints.** FMNP/SFMNP is open to all eligible persons. Persons seeking to file discrimination complaints based on race, national origin, age, sex, or disability may write to USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington, DC 20250-9410.

[ARC 2573C, IAB 6/8/16, effective 7/13/16]

These rules are intended to implement Iowa Code chapters 159 and 175B.

[Filed 4/10/91, Notice 12/12/90—published 5/1/91, effective 6/5/91]

[Filed emergency 3/30/01 after Notice 2/7/01—published 4/18/01, effective 3/30/01]

[Filed emergency 6/10/05—published 7/6/05, effective 6/10/05]

[Filed 4/6/06, Notice 2/15/06—published 4/26/06, effective 5/31/06]

[Filed emergency 7/26/07—published 8/15/07, effective 7/26/07]

[Filed ARC 8308B (Notice ARC 7867B, IAB 6/17/09), IAB 11/18/09, effective 12/23/09]

[Filed ARC 2573C (Notice ARC 2486C, IAB 4/13/16), IAB 6/8/16, effective 7/13/16]

[Filed ARC 3677C (Notice ARC 3567C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

**INSURANCE DIVISION[191]**

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

*ORGANIZATION AND PROCEDURES*

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**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)<br>for the (adoption, amendment, or repeal)<br>of rules relating to (state subject matter). | } | PETITION FOR<br>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 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, or carriers 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, or carrier 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 website.

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

(5) The system provides that, when the intended recipients log in to the insurer's notice system website, 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 email, 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; ARC 3682C, IAB 3/14/18, effective 4/18/18]

**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<br>(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.

[Filed July 1, 1975]

[Filed 3/2/79, Notice 1/10/79—published 3/21/79, effective 4/26/79]

[Editorially transferred from [501] to [191], IAC Supp. 10/22/86; see IAB 7/30/86]

[Filed 1/23/87, Notice 11/5/86—published 2/11/87, effective 3/18/87]

[Filed 4/30/99, Notice 3/24/99—published 5/19/99, effective 6/23/99]

[Filed 5/24/01, Notice 4/4/01—published 6/13/01, effective 7/18/01]

[Filed ARC 2415C (Notice ARC 2078C, IAB 8/5/15), IAB 2/17/16, effective 3/23/16]

[Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

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 Iowa Code section 514C.22 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, “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.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**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 191—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, or carrier, 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 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, or carrier to be effective, an insurer, employer, group policyholder, or carrier 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, or carrier 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; ARC 3682C, IAB 3/14/18, effective 4/18/18]

**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. 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.

*"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.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

### **191—35.24(509) Eligibility to enroll.**

**35.24(1)** A carrier 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 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 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 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.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—35.25(509) Special enrollments.**

**35.25(1)** A carrier 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 subrule 35.25(2) or 35.25(3) with respect to the individual for whom enrollment is requested. A carrier 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.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**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 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 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 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 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 ability to meet its contractual obligations.

*i.* At the time of coverage renewal, a carrier 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 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 doing business in one established geographic service area of the state and the carrier's operations in that service area.

**35.26(4)** Preexisting condition exclusions.

*a.* A carrier, 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 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 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 or carrier 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 191—35.29(509).

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—35.27(509) Methods of counting creditable coverage.** For purposes of reducing any preexisting condition exclusion period, a group health plan or carrier offering group health insurance coverage shall determine the amount of an individual's creditable coverage by using the standard method described in subrule 35.27(1) except that the plan or carrier may use the alternative method under subrule 35.27(2) with respect to any or all of the categories of benefits described under subrule 35.27(4).

**35.27(1)** Under the standard method, a group health plan or health insurance carrier offering group health insurance coverage shall determine the amount of creditable coverage without regard to the specific benefits included in the coverage.

*a.* For purposes of reducing the preexisting condition exclusion period, a group health plan or health insurance carrier offering group health insurance coverage shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. If on a particular day, an individual has creditable coverage from more than one source, all

the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

*b.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

*c.* Notwithstanding any other provisions of subrule 35.27(2) for purposes of reducing a preexisting condition exclusion period, a group health plan or a health insurance carrier 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 subrule 35.27(2).

**35.27(2)** Under the alternative method, a group health plan or a health insurance carrier offering group health insurance coverage shall determine the amount of creditable coverage based on coverage within any category of benefits described in subrule 35.27(4) 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 subrule 35.27(1).

**35.27(3)** A plan or carrier 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.

**35.27(4)** The alternative method for counting creditable coverage may be used for coverage for any of the following categories of benefits:

- a.* Mental health.
- b.* Substance abuse treatment.
- c.* Prescription drugs.
- d.* Dental care.
- e.* Vision care.

**35.27(5)** If the alternative method is used, the plan is required to:

- a.* 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;
- b.* Include in these statements a description of the effect of using the alternative method, including an identification of the category's uses; and
- c.* Count creditable coverage within a category if any level of benefits is provided within the category.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

### **191—35.28(509) Certificates of creditable coverage.**

**35.28(1)** Group health plans or carriers shall issue certificates of creditable coverage to persons losing coverage. A group health plan or carrier 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 or carrier;

*c.* The plan or carrier 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 or carrier 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 or carrier 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 or carrier 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 or carrier knows or should have known that the 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 or carrier shall consider information obtained by it or presented on behalf of an individual to determine whether the individual has creditable coverage.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

#### **191—35.29(509) Notification requirements.**

**35.29(1)** A group health plan or carrier 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 or carrier 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 or carrier and a statement that the current group health plan or carrier 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 or carrier shall provide written notice to the employee and dependents of a modification of a prior creditable coverage decision when the group health plan or carrier

subsequently determines either no or less creditable coverage existed provided that the group health plan or carrier acts according to its initial determination until the final determination is made.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—35.30(509) Mental health benefits.** Rescinded IAB 12/7/05, effective 1/11/06.

**191—35.31(509) Disclosure requirements.** All carriers shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all carriers 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 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.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**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 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 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 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.  
[ARC 3682C, IAB 3/14/18, effective 4/18/18]

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 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 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 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 does not provide benefits for a routine physical examination, the carrier 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 Iowa Code chapter 514C.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**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.

[ARC 9500B, IAB 5/4/11, effective 6/8/11]

[Filed 11/16/65]

[Filed 11/18/85, Notice 10/9/85—published 12/4/85, effective 1/8/86]

[Filed 7/11/86, Notice 6/4/86—published 7/30/86, effective 9/3/86]<sup>1</sup>

[Editorially transferred from [510] to [191] IAC Supp. 10/22/86; see IAB 7/30/86]

[Filed 9/18/87, Notice 8/12/87—published 10/7/87, effective 11/11/87]

[Filed 12/9/88, Notice 9/21/88—published 12/28/88, effective 2/1/89]

[Filed emergency 6/26/97—published 7/16/97, effective 7/1/97]

[Filed 10/10/97, Notice 7/16/97—published 11/5/97, effective 12/10/97]

[Filed 4/1/98, Notice 2/11/98—published 4/22/98, effective 5/27/98]

[Filed emergency 10/16/98—published 11/4/98, effective 10/16/98]

[Filed 12/28/98, Notice 12/2/98—published 1/13/99, effective 3/3/99]

[Filed emergency 6/25/99—published 7/14/99, effective 7/1/99]

[Filed 9/3/99, Notice 7/14/99—published 9/22/99, effective 10/27/99]

[Filed 4/10/00, Notice 1/12/00—published 5/3/00, effective 6/7/00]

[Filed 5/10/00, Notice 4/5/00—published 5/31/00, effective 7/5/00]

[Filed 8/17/00, Notice 7/12/00—published 9/6/00, effective 10/11/00]

[Filed emergency 10/26/01—published 11/14/01, effective 10/26/01]

[Filed 3/29/02, Notice 2/6/02—published 4/17/02, effective 5/22/02]

[Filed 7/18/03, Notice 6/11/03—published 8/6/03, effective 9/10/03]

[Filed 12/15/04, Notice 11/10/04—published 1/5/05, effective 2/9/05]

[Filed 11/16/05, Notice 10/12/05—published 12/7/05, effective 1/11/06]

[Filed 10/5/06, Notice 8/30/06—published 10/25/06, effective 11/29/06]

[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]

[Filed ARC 9500B (Notice ARC 9340B, IAB 1/26/11), IAB 5/4/11, effective 6/8/11]  
[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]  
[Filed ARC 2415C (Notice ARC 2078C, IAB 8/5/15), IAB 2/17/16, effective 3/23/16]  
[Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

<sup>1</sup> See IAB Insurance Division



CHAPTER 37  
MEDICARE SUPPLEMENT INSURANCE

DIVISION I  
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

**191—37.1(514D) Purpose.** The purpose of this chapter is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

**191—37.2(514D) Applicability and scope.**

**37.2(1)** Except as otherwise specifically provided in rules 191—37.6(514D), 191—37.13(514D), 191—37.14(514D), 191—37.17(514D) and 191—37.21(514D), this chapter shall apply to:

*a.* All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date hereof, and

*b.* All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

**37.2(2)** This chapter shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof; for employees or former employees, or a combination thereof; or for members or former members, or a combination thereof, of the labor organizations.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.3(514D) Definitions.** For purposes of this chapter:

*“1990 standardized Medicare supplement benefit plan,” “1990 standardized benefit plan” or “1990 plan”* means a group or individual policy of Medicare supplement insurance issued on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after June 1, 2010, which are not replaced by the issuer at the request of the insured.

*“2010 standardized Medicare supplement benefit plan,” “2010 standardized benefit plan” or “2010 plan”* means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

*“Applicant”* means:

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

2. In the case of a group Medicare supplement policy, the proposed certificate holder.

*“Bankruptcy”* means a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

*“Certificate”* means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

*“Certificate form”* means the form on which the certificate is delivered or issued for delivery by the issuer.

*“Continuous period of creditable coverage”* means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

*“Creditable coverage”* means, with respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10, United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);
9. A public health plan as defined in federal regulation;
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)); and

11. Short-term limited durational policy.

“Creditable coverage” shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers’ compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics; and
8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

“Creditable coverage” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;
2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
3. Such other similar, limited benefits as are specified in federal regulations.

“Creditable coverage” shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and
2. Hospital indemnity or other fixed indemnity insurance.

“Creditable coverage” shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
3. Similar supplemental coverage provided to coverage under a group health plan.

“*Employee welfare benefit plan*” means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

“*Insolvency*” means that an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer’s state of domicile.

“*Issuer*” includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

“*Medicare*” means the “Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as Then Constituted or Later Amended.”

“*Medicare Advantage plan*” means a plan of coverage for health benefits under Medicare Part C (as defined in 42 U.S.C. 1395w-28(b)(1)), and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

3. Medicare Advantage private fee-for-service plans.

*“Medicare supplement policy”* means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. *“Medicare supplement policy”* does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

*“Policy form”* means the form on which the policy is delivered or issued for delivery by the issuer.

*“Prestandardized Medicare supplement benefit plan”* or *“prestandardized plan”* means a group or individual policy of Medicare supplement insurance issued prior to January 1, 1992.

*“Secretary”* means the Secretary of the United States Department of Health and Human Services. [ARC 7964B, IAB 7/15/09, effective 8/19/09; ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—37.4(514D) Policy definitions and terms.** No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this rule.

*“Accident,” “accidental injury,”* or *“accidental means”* shall be defined to employ “result” language and shall not include words which establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: “Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.”

2. Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers’ compensation, employer’s liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

*“Benefit period”* or *“Medicare benefit period”* shall not be defined more restrictively than as defined in the Medicare program.

*“Convalescent nursing home,” “extended care facility,”* or *“skilled nursing facility”* shall not be defined more restrictively than as defined in the Medicare program.

*“Health care expenses”* means, for purposes of rule 191—37.14(514D), expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

*“Hospital”* may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

*“Medicare”* shall be defined in the policy and certificate. Medicare may be substantially defined as “The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended,” or “Title I, Part I of Pub. L. No. 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

*“Medicare eligible expenses”* shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

“*Physician*” shall not be defined more restrictively than as defined in the Medicare program.

“*Sickness*” shall not be defined to be more restrictive than the following: “Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.” The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers’ compensation, occupational disease, employer’s liability or similar law.

**191—37.5(514D) Policy provisions.**

**37.5(1)** Except for permitted preexisting condition clauses as described in 37.6(1) “a,” 37.7(1) “a,” and 37.8(1) “a,” no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

**37.5(2)** No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

**37.5(3)** No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

**37.5(4)** Subject to paragraphs 37.6(1) “d,” “e,” and “g” and 37.7(1) “d” and “e,” a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

**37.5(5)** A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

**37.5(6)** After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

*a.* The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual’s coverage under a Medicare Part D plan; and

*b.* Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.6(514D) Minimum benefit standards for prestandardized Medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992.** No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

**37.6(1) General standards.** The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

*a.* A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

*b.* A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

*c.* A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

*d.* A “noncancelable,” “guaranteed renewable,” or “noncancelable and guaranteed renewable” Medicare supplement policy shall not:

(1) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

*e.* (1) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(2) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph “*e*”(4) below, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

1. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

2. An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in 37.7(2).

(3) If membership in a group is terminated, the issuer shall:

1. Offer the certificate holder such conversion opportunities as are described in 37.6(1)“*e*”(2); or

2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

*f.* Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**37.6(2) Minimum benefit standards.**

*a.* Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

*b.* Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

*c.* Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare’s lifetime hospital inpatient reserve days;

*d.* Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

*e.* Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

*f.* Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (\$100);

*g.* Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.7(514D) Benefit standards for 1990 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

**37.7(1) General standards.** The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

*a.* A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

*b.* A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

*c.* A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

*d.* No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

*e.* Each Medicare supplement policy shall be guaranteed renewable and

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph 37.7(1)“e”(5), the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

1. Provides for continuation of the benefits contained in the group policy, or

2. Provides for such benefits as otherwise meets the requirements of this subrule.

(4) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

1. Offer the certificate holder the conversion opportunity described in subparagraph 37.7(1)“e”(3), or

2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

*f.* Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

g. (1) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.

(2) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(3) Reinstatement of such coverages:

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(4) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for the period provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

h. If an issuer makes a written offer to an insured who holds one or more of the issuer's 1990 Standardized Medicare supplement policies or certificates (as described in rule 191—37.9(514D)) to allow the insured to exchange that policy during a specified period of time for a 2010 standardized plan (as described in rule 191—37.10(514D)), the offer and subsequent exchange shall comply with the following requirements:

(1) An issuer need not provide justification to the commissioner if the insured exchanges a 1990 standardized policy or certificate for an issue-age-rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's 1990 standardized policy or certificate to be exchanged is priced on an issue-age rate schedule at the time of such offer, the rate charged to the insured for the new 2010 exchanged standardized policy or certificate shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue-age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner pursuant to rule 191—37.15(514D).

(2) The rating class of the new 2010 standardized policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(3) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new 2010 standardized policy or certificate for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged 1990 standardized policy or certificate.

(4) The new 2010 standardized policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

**37.7(2) Standards for Basic (“Core”) Benefits Common to A-J Benefit Plans.** Every issuer shall make available a policy or certificate including only the following basic “Core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic “Core” package, but not in lieu thereof.

- a. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;
- b. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
- c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;
- d. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
- e. Coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

**37.7(3) Standards for Additional Benefits.** The following additional benefits shall be included in Medicare Supplement Benefit Plans “B” through “J” only as provided by rule 191—37.9(514D).

- a. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
- b. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.
- c. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- d. Eighty percent of the Medicare Part B Excess Charges: Coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- e. One hundred percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- f. Basic Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- g. Extended Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- h. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

*i.* Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (2) and patient education to address preventive health care measures.

(2) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

*j.* At-Home Recovery Benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(1) For purposes of this benefit, the following definitions shall apply:

1. "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

2. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

3. "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

4. "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(2) Coverage requirements and limitations.

1. At-home recovery services provided must be primarily services which assist in activities of daily living.

2. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

3. Coverage is limited to:

- No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.

- The actual charges for each visit up to a maximum reimbursement of \$40 per visit.

- One thousand six hundred dollars per calendar year.

- Seven visits in any one week.

- Care furnished on a visiting basis in the insured's home.

- Services provided by a care provider as defined in this paragraph "j."

- At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

- At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(3) Coverage is excluded for:

1. Home care visits paid for by Medicare or other government programs; and

2. Care provided by family members, unpaid volunteers or providers who are not care providers.

*k.* Rescinded IAB 1/5/05, effective 2/9/05.

**37.7(4)** *Standards for Plan "K."* Standardized Medicare supplement benefit plan "K" shall consist of the following:

- a. Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;
- b. Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;
- c. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment in full and may not bill the insured for any balances;
- d. Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph "j";
- e. Skilled Nursing Facility Care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in paragraph "j";
- f. Hospice Care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph "j";
- g. Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in paragraph "j";
- h. Except for coverage provided in paragraph "i," coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in paragraph "j";
- i. Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
- j. Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

**37.7(5) Standards for Plan "L."** Standardized Medicare supplement benefit plan "L" shall consist of the following:

- a. The benefits described in paragraphs 37.7(4) "a," "b," "c," and "i";
- b. The benefits described in paragraphs 37.7(4) "d," "e," "f," "g," and "h" but substituting 75 percent for 50 percent; and
- c. The benefits described in paragraph 37.7(4) "j" but substituting \$2,000 for \$4,000.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.8(514D) Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. Insurers may begin submitting policies and certificates to the division for approval on or after January 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of rule 191—37.7(514D).

**37.8(1) General standards.** The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

*a.* A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

*b.* A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

*c.* A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

*d.* No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

*e.* Each Medicare supplement policy shall be guaranteed renewable.

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph 37.8(1)“e”(5), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

1. Provides for continuation of the benefits contained in the group policy; or

2. Provides for benefits that otherwise meet the requirements of paragraph 37.8(1)“e.”

(4) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

1. Offer the certificate holder the conversion opportunity described in subparagraph 37.8(1)“e”(3); or

2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the group policy that is being replaced on that policy’s date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

*f.* Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

*g.* Suspension of benefits.

(1) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(2) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder or certificate holder if the policyholder or certificate holder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder or certificate holder provides notice of loss of coverage within 90 days after the date of the loss.

(4) Reinstitution of coverage as described in subparagraphs 37.8(1) “g”(2) and (3):

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;
2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

**37.8(2) Standards for basic (core) benefits common to Medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M, and N.** Every issuer of Medicare supplement insurance benefit plans shall make available to each prospective insured a policy or certificate including only the following basic (core) package of benefits. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. The basic core package must provide:

- a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

- b. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

- c. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;

- d. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

- e. Coverage for the coinsurance amount or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible; and

- f. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

**37.8(3) Standards for additional benefits.** The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with high deductible, G, M, and N as provided by rule 191—37.10(514D):

- a. Medicare Part A Deductible: Coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

- b. Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

- c. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

- d. Medicare Part B Deductible: Coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

*e.* One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge; and

*f.* Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.9(514D) Standard Medicare supplement benefit plans for 1990 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage prior to June 1, 2010.**

**37.9(1)** An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic “Core” benefits as defined in subrule 37.7(2).

**37.9(2)** No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in subrule 37.9(7) and in rule 191—37.11(514D).

**37.9(3)** Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans “A” through “L” listed in this rule and conform to the definitions in rule 191—37.3(514D). Each benefit shall be structured in accordance with the format provided in subrules 37.7(2), 37.7(3), 37.7(4) and 37.7(5) and list the benefits in the order shown in this rule. For purposes of this rule, “structure, language, and format” means style, arrangement and overall content of a benefit.

**37.9(4)** An issuer may use, in addition to the benefit plan designations required in subrule 37.8(3), other designations to the extent permitted by law.

**37.9(5)** Makeup of benefit plans:

*a.* Standardized Medicare supplement benefit plan “A” shall be limited to the Basic (“Core”) Benefits Common to All Benefit Plans, as defined in subrule 37.7(2).

*b.* Standardized Medicare supplement benefit plan “B” shall include only the following: The Core Benefit as defined in subrule 37.7(2), plus the Medicare Part A Deductible as defined in paragraph 37.7(3) “a.”

*c.* Standardized Medicare supplement benefit plan “C” shall include only the following: The Core Benefit as defined in subrule 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in paragraphs 37.7(3) “a,” “b,” “c,” and “h,” respectively.

*d.* Standardized Medicare supplement benefit plan “D” shall include only the following: The Core Benefit, as defined in subrule 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in paragraphs 37.7(3) “a,” “b,” “h,” and “j,” respectively.

*e.* Standardized Medicare supplement benefit plan “E” shall include only the following: The Core Benefit, as defined in subrule 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in paragraphs 37.7(3) “a,” “b,” “h,” and “i,” respectively.

*f.* Standardized Medicare supplement benefit plan “F” shall include only the following: The Core Benefit, as defined in subrule 37.7(2), plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in paragraphs 37.7(3) “a,” “b,” “c,” “e,” and “h,” respectively.

*g.* Standardized Medicare supplement benefit plan “G” shall include only the following: The Core Benefit, as defined in subrule 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility

Care, 80 Percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in paragraphs 37.7(3)“a,” “b,” “d,” “h,” and “j,” respectively.

*h.* Standardized Medicare supplement benefit plan “H” shall consist of only the following: The Core Benefit, as defined in subrule 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in paragraphs 37.7(3)“a,” “b,” “f,” and “h,” respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

*i.* Standardized Medicare supplement benefit plan “I” shall consist of only the following: The Core Benefit, as defined in subrule 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 Percent of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in paragraphs 37.7(3)“a,” “b,” “e,” “f,” “h,” and “j,” respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

*j.* Standardized Medicare supplement benefit plan “J” shall consist of only the following: The Core Benefit, as defined in subrule 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in paragraphs 37.7(3)“a,” “b,” “c,” “e,” “g,” “h,” “i,” and “j,” respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

*k.* Standardized Medicare supplement benefit high deductible plan “F” shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan “F” deductible. The covered expenses include the Core Benefit as defined in subrule 37.7(2), plus the Medicare Part A Deductible Skilled Nursing Facility Care, the Medicare Part B Deductible, 100 percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in paragraphs 37.7(3)“a,” “b,” “c,” “e,” and “h,” respectively. The annual high deductible plan “F” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement plan “F” policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan “F” deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

*l.* Standardized Medicare supplement benefit high deductible plan “J” shall consist only of the following: 100 percent of covered expenses following the payment of the annual high deductible plan “J” deductible. The covered expenses include the Core Benefit as defined in subrule 37.7(2), plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medicare Part B deductible, 100 percent of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit as defined in paragraphs 37.7(3)“a,” “b,” “c,” “e,” “g,” “h,” “i,” and “j,” respectively. The annual high deductible plan “J” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan “J” policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

**37.9(6)** Standardized Medicare supplement benefit plan “K” mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall consist of only those benefits described in subrule 37.7(4). Standardized Medicare supplement benefit plan “L” mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall consist of only those benefits described in subrule 37.7(5).

**37.9(7) New or Innovative Benefits:** An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2004, the innovative benefit shall not include an outpatient prescription drug benefit.  
[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.10(514D) Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage on or after June 1, 2010.** The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of rules 191—37.6(514D) and 191—37.9(514D).

**37.10(1) Issuer to make form available.**

*a.* An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subrule 37.8(2).

*b.* If an issuer makes available any of the additional benefits described in subrule 37.8(3) or offers standardized benefit Plans K or L (as described in paragraphs 37.10(5) “*h*” and “*i*”), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in paragraph 37.10(1) “*a*,” a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph 37.10(5) “*c*”) or standardized benefit Plan F (as described in paragraph 37.10(5) “*e*”).

**37.10(2)** No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in subrule 37.10(6) and rule 191—37.11(514D).

**37.10(3)** Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in rule 191—37.10(514D) and conform to the definitions in rule 191—37.3(514D). Each benefit plan shall be structured in accordance with the format provided in subrules 37.8(2) and 37.8(3), or, in the case of Plan K or L, each benefit plan shall be structured in accordance with the format provided in paragraphs 37.10(5) “*h*” and “*i*.” Each plan shall list the benefits in the order shown. For purposes of this rule, “structure, language, and format” means style, arrangement and overall content of a benefit.

**37.10(4)** In addition to the benefit plan designations required in subrule 37.10(3), an issuer may use other designations to the extent permitted by law.

**37.10(5) Makeup of 2010 standardized benefit plans.**

*a.* Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subrule 37.8(2).

*b.* Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible as defined in paragraph 37.8(3) “*a*.”

*c.* Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “*a*,” “*c*,” “*d*,” and “*f*,” respectively.

*d.* Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible,

skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “a,” “c,” and “f,” respectively.

*e.* Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “a,” “c,” “d,” “e,” and “f,” respectively.

*f.* Standardized Medicare supplement Plan F with high deductible shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph 37.10(5) “f”(2).

(1) The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “a,” “c,” “d,” “e,” and “f,” respectively.

(2) The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by (regular) Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

*g.* Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) “a,” “c,” “e,” and “f,” respectively.

*h.* Standardized Medicare supplement Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) Part A hospital coinsurance from the sixty-first through ninetieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

(2) Part A hospital coinsurance from the ninety-first through one hundred fiftieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

(3) Part A hospitalization after 150 days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;

(4) Medicare Part A deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 37.10(5) “h”(10);

(5) Skilled nursing facility care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 37.10(5) “h”(10);

(6) Hospice care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 37.10(5) “h”(10);

(7) Blood: Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph 37.10(5) “h”(10);

(8) Part B cost sharing: Except for coverage provided in subparagraph 37.10(5) "h"(9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificate holder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 37.10(5) "h"(10);

(9) Part B preventive services: Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder or certificate holder pays the Part B deductible; and

(10) Cost sharing after out-of-pocket limits: Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

*i.* Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) The benefits described in subparagraphs 37.10(5) "h"(1), (2), (3) and (9);

(2) The benefits described in subparagraphs 37.10(5) "h"(4), (5), (6), (7) and (8), but substituting 75 percent for 50 percent; and

(3) The benefit described in subparagraph 37.10(5) "h"(10), but substituting \$2000 for \$4000.

*j.* Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 50 percent of the Medicare Part A deductible, 100 percent of skilled nursing facility care, and 100 percent of medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) "b," "c," and "f," respectively.

*k.* Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3) "a," "c," and "f," respectively, with copayments in the following amounts:

(1) The lesser of \$20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(2) The lesser of \$50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

**37.10(6)** New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. The commissioner shall use any guidelines issued by the National Association of Insurance Commissioners in determining whether to approve new or innovative benefits.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.11(514D) Medicare Select policies and certificates.**

**37.11(1)** *a.* Rule 191—37.11(514D) shall apply to Medicare Select policies and certificates, as defined in this rule.

*b.* No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this rule.

**37.11(2)** For the purposes of this rule:

*a.* "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

*b.* “*Grievance*” means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

*c.* “*Medicare Select Issuer*” means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

*d.* “*Medicare Select Policy*” or “*Medicare Select Certificate*” means respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

*e.* “*Network Provider*” means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

*f.* “*Restricted Network Provision*” means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

*g.* “*Service Area*” means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

**37.11(3)** The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this rule and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner finds that the issuer has satisfied all of the requirements.

**37.11(4)** A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

**37.11(5)** A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

*a.* Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(1) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(2) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

1. To adequately deliver all services that are subject to a restricted network provision; or

2. To make appropriate referrals.

(3) There are written agreements with network providers describing specific responsibilities.

(4) Emergency care is available 24 hours per day and seven days per week.

(5) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

*b.* A statement or map providing a clear description of the service area.

*c.* A description of the grievance procedure to be utilized.

*d.* A description of the quality assurance program, including:

(1) The formal organizational structure;

(2) The written criteria for selection, retention and removal of network providers; and

(3) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

*e.* A list and description, by specialty, of the network providers.

*f.* Copies of the written information proposed to be used by the issuer to comply with subrule 37.11(9).

*g.* Any other information requested by the commissioner.

**37.11(6)** *a.* A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing

such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

*b.* An updated list of network providers shall be filed with the commissioner at least quarterly.

**37.11(7)** A Medicare Select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

*a.* The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

*b.* It is not reasonable to obtain such services through a network provider.

**37.11(8)** A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

**37.11(9)** A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

*a.* An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(1) Other Medicare supplement policies or certificates offered by the issuer; and

(2) Other Medicare Select policies or certificates.

*b.* A description (including address, telephone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

*c.* A description of the restricted network provisions, including payments for coinsurance and deductibles, when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L."

*d.* A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

*e.* A description of limitations on referrals to restricted network providers and to other providers.

*f.* A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

*g.* A description of the Medicare Select issuer's quality assurance program and grievance procedure.

**37.11(10)** Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subrule 37.11(9) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

**37.11(11)** A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

*a.* The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

*b.* At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

*c.* Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

*d.* If a grievance is found to be valid, corrective action shall be taken promptly.

*e.* All concerned parties shall be notified about the results of a grievance.

*f.* The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

**37.11(12)** At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

**37.11(13) a.** At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

*b.* For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

**37.11(14)** Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

*a.* Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

*b.* For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

**37.11(15)** A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select program.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

#### **191—37.12(514D) Open enrollment.**

**37.12(1)** No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subrule without regard to age.

**37.12(2)** If an applicant under subrule 37.12(1) submits an application during the time period referenced in subrule 37.12(1) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

If the applicant qualifies under subrule 37.12(1) and submits an application during the time period referenced in subrule 37.12(1) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subrule.

**37.12(3)** Except as provided in rule 191—37.22(514D) or 191—37.25(514D), subrule 37.12(1) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based

on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.13(514D) Standards for claims payment.**

**37.13(1)** An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

- a. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;
- b. Notifying the participating physician or supplier and the beneficiary of the payment determination;
- c. Paying the participating physician or supplier directly;
- d. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;
- e. Paying user fees for claim notices that are transmitted electronically or otherwise; and
- f. Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

**37.13(2)** Compliance with the requirements set forth in subrule 37.13(1) shall be certified on the Medicare supplement insurance experience reporting form.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.14(514D) Loss ratio standards and refund or credit of premium.**

**37.14(1) Loss ratio standards.**

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

- (1) At least 75 percent of the aggregate amount of premiums earned in the case of group policies, or
- (2) At least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

1. Home office and overhead costs;
2. Advertising costs;
3. Commissions and other acquisition costs;
4. Taxes;
5. Capital costs;
6. Administrative costs; and
7. Claims processing costs.

b. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

c. For all policies issued prior to January 1, 1992, expected claims in relation to premiums shall meet:

- (1) The originally filed anticipated loss ratio when combined with the actual experience from inception;
- (2) The appropriate loss ratio requirement from subparagraphs 37.14(1)“a”(1) and (2) when combined with actual experience beginning with January 1, 1996, to date; and
- (3) The appropriate loss ratio requirement from subparagraphs 37.14(1)“a”(1) and (2) over the entire future period for which rates are computed to provide coverage.

**37.14(2) Refund or credit calculation.**

*a.* An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

*b.* If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

*c.* For purposes of this subrule, policies or certificates issued prior to January 1, 1992, the issuer shall make the refund calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1996. The first report shall be due May 31, 1998.

*d.* A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

**37.14(3) Annual filing of premium rates.** An issuer of Medicare supplement policies and certificates issued before or after the effective date of January 1, 1992, in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state:

*a.* (1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(2) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(3) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this rule.

*b.* Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

**37.14(4) Public hearings.** The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of January 1, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.15(514D) Filing and approval of policies and certificates and premium rates.**

**37.15(1)** An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed pursuant to rule 191—20.1(505,509,514A,515,515A,515F) and approved by the commissioner.

**37.15(2)** An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

**37.15(3)** An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

**37.15(4) a.** Except as provided in paragraph “*b*” of this subrule, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

*b.* An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

- (1) The inclusion of new or innovative benefits;
- (2) The addition of either direct response or agent marketing methods;
- (3) The addition of either guaranteed issue or underwritten coverage;
- (4) The offering of coverage to individuals eligible for Medicare by reason of disability.

*c.* For the purposes of this section, a “type” means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

**37.15(5) a.** Except as provided in subparagraph “*a*”(1) below, an issuer shall continue to make available for purchase any policy form or certificate form issued after January 1, 1992, that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph “*a*”(1) above shall not file for approval of a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

*b.* The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subrule.

c. A change in the rating structure or methodology shall be considered a discontinuance under paragraph “a” of this subrule unless the issuer complies with the following requirements:

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

**37.15(6) a.** Except as provided in paragraph “b” of this subrule, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in rule 191—37.14(514D).

b. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

#### **191—37.16(514D) Permitted compensation arrangements.**

**37.16(1)** An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

**37.16(2)** The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

**37.16(3)** No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

**37.16(4)** For purposes of this rule, “compensation” includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards and finders fees.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

#### **191—37.17(514D) Required disclosure provisions.**

##### **37.17(1) General rules.**

a. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provisions shall be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder’s age.

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

c. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as “usual and customary,” “reasonable and customary” or words of similar import.

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

e. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. (1) Issuers of accident and sickness policies, or certificates which provide hospital or medical expense coverage on an expense-incurred or indemnity basis to a person(s) eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

(2) For the purposes of this rule, "form" means the language, format, type size, type proportional spacing, bold character and line spacing.

**37.17(2) Notice requirements.**

a. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner.

(1) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

b. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

c. Such notices shall not contain or be accompanied by any solicitation.

**37.17(3) MMA notice requirements.** Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

**37.17(4) Outline of coverage requirements for Medicare supplement policies.**

a. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and

b. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

c. The outline of coverage provided to applicants pursuant to this subrule consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed.

The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

*d.* The following items shall be included in the outline of coverage in the order prescribed below.

**Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

**Basic Benefits:**

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

| A   | B   | C   | D   | F  | F* | G   | K  | L  | M   | N  |
|---|---|---|---|--|----|---|--|--|---|--|
| Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance* |    | Basic, including 100% Part B co-insurance | Hospitalization and preventive care paid at 100%; other basic benefits paid at 50% | Hospitalization and preventive care paid at 100%; other basic benefits paid at 75% | Basic, including 100% Part B co-insurance | Basic, including 100% Part B co-insurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER |
|   |   | Skilled Nursing Facility Co-insurance     | Skilled Nursing Facility Co-insurance     | Skilled Nursing Facility Co-insurance      |    | Skilled Nursing Facility Co-insurance     | 50% Skilled Nursing Facility Co-insurance  | 75% Skilled Nursing Facility Co-insurance  | Skilled Nursing Facility Co-insurance     | Skilled Nursing Facility Co-insurance  |
|   | Part A Deductible                         | Part A Deductible                         | Part A Deductible                         | Part A Deductible                          |    | Part A Deductible                         | 50% Part A Deductible  | 75% Part A Deductible  | 50% Part A Deductible                     | Part A Deductible  |
|   |   | Part B Deductible                         |   | Part B Deductible                          |    |   |  |  |   |  |
|   |   |   |   | Part B Excess (100%)                       |    | Part B Excess (100%)                      |  |  |   |  |
|   |   | Foreign Travel Emergency                  | Foreign Travel Emergency                  | Foreign Travel Emergency                   |    | Foreign Travel Emergency                  |  |  | Foreign Travel Emergency                  | Foreign Travel Emergency   |
|   |   |   |   |  |    |   | Out-of-pocket limit \$[4140]; paid at 100% after limit reached                     | Out-of-pocket limit \$[2070]; paid at 100% after limit reached                     |   |  |

\* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[1860] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

### PREMIUM INFORMATION

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

### DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [The last sentence of this paragraph shall not appear after June 1, 2011.]

### READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

### RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

### POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

### NOTICE

This policy may not fully cover all of your medical costs.

[for agents: ]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response: ]

[Insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare and You" for more details.

### COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page a chart showing the services, Medicare payments, plan payments and insured payments, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this subrule. An issuer may use additional benefit plan descriptions on these charts pursuant to subrule 37.10(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

**PLAN A**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES  | MEDICARE PAYS  | PLAN PAYS                          | YOU PAY                     |
|---|--|------------------------------------|-----------------------------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies  |  |                                    |                             |
| First 60 days   | All but \$[992]  | \$0                                | \$[992] (Part A deductible) |
| 61st through 90th day   | All but \$[248] a day  | \$[248] a day                      | \$0                         |
| 91st day and after:   |  |                                    |                             |
| —While using 60 lifetime reserve days   | All but \$[496] a day  | \$[496] a day                      | \$0                         |
| —Once lifetime reserve days are used:   |  |                                    |                             |
| —Additional 365 days  | \$0  | 100% of Medicare eligible expenses | \$0**                       |
| —Beyond the additional 365 days   | \$0  | \$0                                | All costs                   |
| <b>SKILLED NURSING FACILITY CARE*</b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. |  |                                    |                             |
| First 20 days   | All approved amounts   | \$0                                | \$0                         |
| 21st through 100th day  | All but \$[124] a day  | \$0                                | Up to \$[124] a day         |
| 101st day and after   | \$0  | \$0                                | All costs                   |
| <b>BLOOD</b>  |  |                                    |                             |
| First 3 pints   | \$0  | 3 pints                            | \$0                         |
| Additional amounts  | 100%   | \$0                                | \$0                         |
| <b>HOSPICE CARE</b><br>You must meet Medicare's requirements, including a doctor's certification of terminal illness.   | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0                         |

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | PLAN PAYS     | YOU PAY                        |
|---|---------------|---------------|--------------------------------|
| <b>MEDICAL EXPENSES—</b><br>IN OR OUT OF THE HOSPITAL AND<br>OUTPATIENT HOSPITAL TREATMENT, such<br>as physician's services, inpatient and outpatient<br>medical and surgical services and supplies, physical<br>and speech therapy, diagnostic tests, durable medical<br>equipment |               |               |                                |
| First \$[131] of Medicare-Approved Amounts***   | \$0           | \$0           | \$[131] (Part B<br>deductible) |
| Remainder of Medicare-Approved Amounts  | Generally 80% | Generally 20% | \$0                            |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)   | \$0           | \$0           | All costs                      |
| <b>BLOOD</b>  |               |               |                                |
| First 3 pints   | \$0           | All costs     | \$0                            |
| Next \$[131] of Medicare-Approved Amounts***  | \$0           | \$0           | \$[131] (Part B<br>deductible) |
| Remainder of Medicare-Approved Amounts  | 80%           | 20%           | \$0                            |
| <b>CLINICAL LABORATORY SERVICES—</b><br>TESTS FOR DIAGNOSTIC SERVICES   | 100%          | \$0           | \$0                            |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PARTS A & B**

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY                        |
|--|---------------|-----------|--------------------------------|
| <b>HOME HEALTH CARE</b><br>MEDICARE-APPROVED SERVICES              |               |           |                                |
| —Medically necessary skilled care services<br>and medical supplies | 100%          | \$0       | \$0                            |
| —Durable medical equipment   |               |           |                                |
| First \$[131] of Medicare-Approved<br>Amounts***                   | \$0           | \$0       | \$[131] (Part B<br>deductible) |
| Remainder of Medicare-Approved<br>Amounts                          | 80%           | 20%       | \$0                            |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN B**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                          | YOU PAY             |
|--|--|------------------------------------|---------------------|
| <b>HOSPITALIZATION*</b>  |  |                                    |                     |
| Semiprivate room and board, general nursing and miscellaneous services and supplies  |  |                                    |                     |
| First 60 days  | All but \$[992]  | \$[992] (Part A deductible)        | \$0                 |
| 61st through 90th day  | All but \$[248] a day  | \$[248] a day                      | \$0                 |
| 91st day and after:  |  |                                    |                     |
| —While using 60 lifetime reserve days  | All but \$[496] a day  | \$[496] a day                      | \$0                 |
| —Once lifetime reserve days are used:  |  |                                    |                     |
| —Additional 365 days   | \$0  | 100% of Medicare eligible expenses | \$0**               |
| —Beyond the additional 365 days  | \$0  | \$0                                | All costs           |
| <b>SKILLED NURSING FACILITY CARE*</b>  |  |                                    |                     |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. |  |                                    |                     |
| First 20 days  | All approved amounts   | \$0                                | \$0                 |
| 21st through 100th day   | All but \$[124] a day  | \$0                                | Up to \$[124] a day |
| 101st day and after  | \$0  | \$0                                | All costs           |
| <b>BLOOD</b>   |  |                                    |                     |
| First 3 pints  | \$0  | 3 pints                            | \$0                 |
| Additional amounts   | 100%   | \$0                                | \$0                 |
| <b>HOSPICE CARE</b>  |  |                                    |                     |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness.   |  |                                    |                     |
|  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0                 |

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | PLAN PAYS     | YOU PAY                        |
|---|---------------|---------------|--------------------------------|
| <b>MEDICAL EXPENSES—</b><br>IN OR OUT OF THE HOSPITAL AND<br>OUTPATIENT HOSPITAL TREATMENT, such<br>as physician's services, inpatient and outpatient<br>medical and surgical services and supplies, physical<br>and speech therapy, diagnostic tests, durable medical<br>equipment |               |               |                                |
| First \$[131] of Medicare-Approved Amounts***   | \$0           | \$0           | \$[131] (Part B<br>deductible) |
| Remainder of Medicare-Approved Amounts  | Generally 80% | Generally 20% | \$0                            |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)   | \$0           | \$0           | All costs                      |
| <b>BLOOD</b>  |               |               |                                |
| First 3 pints   | \$0           | All costs     | \$0                            |
| Next \$[131] of Medicare-Approved Amounts***  | \$0           | \$0           | \$[131] (Part B<br>deductible) |
| Remainder of Medicare-Approved Amounts  | 80%           | 20%           | \$0                            |
| <b>CLINICAL LABORATORY SERVICES—</b><br>TESTS FOR DIAGNOSTIC SERVICES   | 100%          | \$0           | \$0                            |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PARTS A & B**

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY                        |
|--|---------------|-----------|--------------------------------|
| <b>HOME HEALTH CARE</b><br>MEDICARE-APPROVED SERVICES              |               |           |                                |
| —Medically necessary skilled care services and<br>medical supplies | 100%          | \$0       | \$0                            |
| —Durable medical equipment   |               |           |                                |
| First \$[131] of Medicare-Approved<br>Amounts***                   | \$0           | \$0       | \$[131] (Part B<br>deductible) |
| Remainder of Medicare-Approved<br>Amounts                          | 80%           | 20%       | \$0                            |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN C**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                          | YOU PAY   |
|--|--|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b>  |  |                                    |           |
| Semiprivate room and board, general nursing and miscellaneous services and supplies  |  |                                    |           |
| First 60 days  | All but \$[992]  | \$[992] (Part A deductible)        | \$0       |
| 61st through 90th day  | All but \$[248] a day  | \$[248] a day                      | \$0       |
| 91st day and after:  |  |                                    |           |
| —While using 60 lifetime reserve days  | All but \$[496] a day  | \$[496] a day                      | \$0       |
| —Once lifetime reserve days are used:  |  |                                    |           |
| —Additional 365 days   | \$0  | 100% of Medicare eligible expenses | \$0**     |
| —Beyond the additional 365 days  | \$0  | \$0                                | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b>  |  |                                    |           |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. |  |                                    |           |
| First 20 days  | All approved amounts   | \$0                                | \$0       |
| 21st through 100th day   | All but \$[124] a day  | Up to \$[124] a day                | \$0       |
| 101st day and after  | \$0  | \$0                                | All costs |
| <b>BLOOD</b>   |  |                                    |           |
| First 3 pints  | \$0  | 3 pints                            | \$0       |
| Additional amounts   | 100%   | \$0                                | \$0       |
| <b>HOSPICE CARE</b>  |  |                                    |           |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness.   |  |                                    |           |
|  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0       |

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | PLAN PAYS                   | YOU PAY   |
|---|---------------|-----------------------------|-----------|
| <b>MEDICAL EXPENSES—</b><br>IN OR OUT OF THE HOSPITAL AND<br>OUTPATIENT HOSPITAL TREATMENT, such<br>as physician’s services, inpatient and outpatient<br>medical and surgical services and supplies, physical<br>and speech therapy, diagnostic tests, durable medical<br>equipment |               |                             |           |
| First \$[131] of Medicare-Approved Amounts***   | \$0           | \$(131) (Part B deductible) | \$0       |
| Remainder of Medicare-Approved Amounts  | Generally 80% | Generally 20%               | \$0       |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)   | \$0           | \$0                         | All costs |
| <b>BLOOD</b>  |               |                             |           |
| First 3 pints   | \$0           | All costs                   | \$0       |
| Next \$[131] of Medicare-Approved Amounts***  | \$0           | \$(131) (Part B deductible) | \$0       |
| Remainder of Medicare-Approved Amounts  | 80%           | 20%                         | \$0       |
| <b>CLINICAL LABORATORY SERVICES—</b><br>TESTS FOR DIAGNOSTIC SERVICES   | 100%          | \$0                         | \$0       |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PARTS A & B**

| SERVICES   | MEDICARE PAYS | PLAN PAYS                   | YOU PAY |
|--|---------------|-----------------------------|---------|
| <b>HOME HEALTH CARE</b><br>MEDICARE-APPROVED SERVICES              |               |                             |         |
| —Medically necessary skilled care services and<br>medical supplies | 100%          | \$0                         | \$0     |
| —Durable medical equipment   |               |                             |         |
| First \$[131] of Medicare-Approved<br>Amounts***                   | \$0           | \$(131) (Part B deductible) | \$0     |
| Remainder of Medicare-Approved<br>Amounts                          | 80%           | 20%                         | \$0     |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

| SERVICES   | MEDICARE PAYS | PLAN PAYS                                     | YOU PAY  |
|--|---------------|---|--|
| <b>FOREIGN TRAVEL—NOT COVERED BY<br/>MEDICARE</b><br>Medically necessary emergency care services<br>beginning during the first 60 days of each trip outside<br>the USA |               |   |  |
| First \$250 each calendar year   | \$0           | \$0   | \$250  |
| Remainder of charges   | \$0           | 80% to a lifetime maximum benefit of \$50,000 | 20% and amounts over the \$50,000 lifetime maximum |

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN D**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                          | YOU PAY   |
|--|--|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b>  |  |                                    |           |
| Semiprivate room and board, general nursing and miscellaneous services and supplies  |  |                                    |           |
| First 60 days  | All but \$[992]  | \$[992] (Part A deductible)        | \$0       |
| 61st through 90th day  | All but \$[248] a day  | \$[248] a day                      | \$0       |
| 91st day and after:  |  |                                    |           |
| —While using 60 lifetime reserve days  | All but \$[496] a day  | \$[496] a day                      | \$0       |
| —Once lifetime reserve days are used:  |  |                                    |           |
| —Additional 365 days   | \$0  | 100% of Medicare eligible expenses | \$0**     |
| —Beyond the additional 365 days  | \$0  | \$0                                | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b>  |  |                                    |           |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. |  |                                    |           |
| First 20 days  | All approved amounts   | \$0                                | \$0       |
| 21st through 100th day   | All but \$[124] a day  | Up to \$[124] a day                | \$0       |
| 101st day and after  | \$0  | \$0                                | All costs |
| <b>BLOOD</b>   |  |                                    |           |
| First 3 pints  | \$0  | 3 pints                            | \$0       |
| Additional amounts   | 100%   | \$0                                | \$0       |
| <b>HOSPICE CARE</b>  |  |                                    |           |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness.   |  |                                    |           |
|  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0       |

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | PLAN PAYS     | YOU PAY                     |
|---|---------------|---------------|-----------------------------|
| <b>MEDICAL EXPENSES—</b><br>IN OR OUT OF THE HOSPITAL AND<br>OUTPATIENT HOSPITAL TREATMENT, such<br>as physician's services, inpatient and outpatient<br>medical and surgical services and supplies, physical<br>and speech therapy, diagnostic tests, durable medical<br>equipment |               |               |                             |
| First \$[131] of Medicare-Approved Amounts***   | \$0           | \$0           | \$(131) (Part B deductible) |
| Remainder of Medicare-Approved Amounts  | Generally 80% | Generally 20% | \$0                         |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)   | \$0           | \$0           | All costs                   |
| <b>BLOOD</b>  |               |               |                             |
| First 3 pints   | \$0           | All costs     | \$0                         |
| Next \$[131] of Medicare-Approved Amounts***  | \$0           | \$0           | \$(131) (Part B deductible) |
| Remainder of Medicare-Approved Amounts  | 80%           | 20%           | \$0                         |
| <b>CLINICAL LABORATORY SERVICES—</b><br>TESTS FOR DIAGNOSTIC SERVICES   | 100%          | \$0           | \$0                         |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PARTS A & B**

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY                     |
|--|---------------|-----------|-----------------------------|
| <b>HOME HEALTH CARE</b><br>MEDICARE-APPROVED SERVICES              |               |           |                             |
| —Medically necessary skilled care services and<br>medical supplies | 100%          | \$0       | \$0                         |
| —Durable medical equipment   |               |           |                             |
| First \$[131] of Medicare-Approved<br>Amounts***                   | \$0           | \$0       | \$(131) (Part B deductible) |
| Remainder of Medicare-Approved<br>Amounts                          | 80%           | 20%       | \$0                         |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

| SERVICES   | MEDICARE PAYS | PLAN PAYS   | YOU PAY  |
|--|---------------|---|--|
| <b>FOREIGN TRAVEL—NOT COVERED<br/>BY MEDICARE</b><br>Medically necessary emergency care services<br>beginning during the first 60 days of each trip outside<br>the USA |               |   |  |
| First \$250 each calendar year   | \$0           | \$0   | \$250  |
| Remainder of charges   | \$0           | 80% to a lifetime<br>maximum benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN F or HIGH DEDUCTIBLE PLAN F  
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES  | MEDICARE PAYS  | [AFTER YOU PAY \$[1860] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO \$[1860] DEDUCTIBLE,**] YOU PAY |
|---|--|--|---|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies  |  |  |   |
| First 60 days   | All but \$[992]  | \$[992] (Part A deductible)                      | \$0   |
| 61st through 90th day   | All but \$[248] a day  | \$[248] a day                                    | \$0   |
| 91st day and after:   |  |  |   |
| —While using 60 lifetime reserve days   | All but \$[496] a day  | \$[496] a day                                    | \$0   |
| —Once lifetime reserve days are used:   |  |  |   |
| —Additional 365 days  | \$0  | 100% of Medicare eligible expenses               | \$0***  |
| —Beyond the additional 365 days   | \$0  | \$0  | All costs                                       |
| <b>SKILLED NURSING FACILITY CARE*</b><br>You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. |  |  |   |
| First 20 days   | All approved amounts   | \$0  | \$0   |
| 21st through 100th day  | All but \$[124] a day  | Up to \$[124] a day                              | \$0   |
| 101st day and after   | \$0  | \$0  | All costs                                       |
| <b>BLOOD</b>  |  |  |   |
| First 3 pints   | \$0  | 3 pints  | \$0   |
| Additional amounts  | 100%   | \$0  | \$0   |
| <b>HOSPICE CARE</b><br>You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.   | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance                   | \$0   |

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[\*\*This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.]

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

| SERVICES   | MEDICARE PAYS | [AFTER YOU PAY \$[1860] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO \$[1860] DEDUCTIBLE,**] YOU PAY |
|--|---------------|--|---|
| <b>MEDICAL EXPENSES—</b><br>IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |  |   |
| First \$[131] of Medicare-Approved Amounts***  | \$0           | \$(131) (Part B deductible)                      | \$0   |
| Remainder of Medicare-Approved Amounts   | Generally 80% | Generally 20%                                    | \$0   |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)  | \$0           | 100%   | \$0   |
| <b>BLOOD</b>   |               |  |   |
| First 3 pints  | \$0           | All costs  | \$0   |
| Next \$[131] of Medicare-Approved Amounts***   | \$0           | \$(131) (Part B deductible)                      | \$0   |
| Remainder of Medicare-Approved Amounts   | 80%           | 20%  | \$0   |
| <b>CLINICAL LABORATORY SERVICES—</b><br>TESTS FOR DIAGNOSTIC SERVICES  | 100%          | \$0  | \$0   |

[\*\*This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.]

\*\*\*Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

| SERVICES  | MEDICARE PAYS | [AFTER YOU PAY \$[1860] DEDUCTIBLE,**] PLAN PAYS | [IN ADDITION TO \$[1860] DEDUCTIBLE,**] YOU PAY |
|---|---------------|--|---|
| <b>HOME HEALTH CARE</b><br>MEDICARE-APPROVED SERVICES           |               |  |   |
| —Medically necessary skilled care services and medical supplies | 100%          | \$0  | \$0   |
| —Durable medical equipment                                      |               |  |   |
| First \$[131] of Medicare-Approved Amounts***                   | \$0           | \$(131) (Part B deductible)                      | \$0   |
| Remainder of Medicare-Approved Amounts                          | 80%           | 20%  | \$0   |

[\*\*This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.]

\*\*\*Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

## OTHER BENEFITS—NOT COVERED BY MEDICARE

| SERVICES   | MEDICARE PAYS | [AFTER YOU<br>PAY \$[1860]<br>DEDUCTIBLE,**]<br>PLAN PAYS | [IN ADDITION<br>TO \$[1860]<br>DEDUCTIBLE,**]<br>YOU PAY |
|--|---------------|---|--|
| <b>FOREIGN TRAVEL—NOT COVERED BY<br/>MEDICARE</b><br>Medically necessary emergency care services<br>beginning during the first 60 days of each trip outside<br>the USA |               |   |  |
| First \$250 each calendar year   | \$0           | \$0   | \$250  |
| Remainder of charges   | \$0           | 80% to a lifetime<br>maximum benefit of<br>\$50,000       | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

[\*\*This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN G**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                          | YOU PAY   |
|--|--|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b>  |  |                                    |           |
| Semiprivate room and board, general nursing and miscellaneous services and supplies  |  |                                    |           |
| First 60 days  | All but \$[992]  | \$[992] (Part A deductible)        | \$0       |
| 61st through 90th day  | All but \$[248] a day  | \$[248] a day                      | \$0       |
| 91st day and after:  |  |                                    |           |
| —While using 60 lifetime reserve days  | All but \$[496] a day  | \$[496] a day                      | \$0       |
| —Once lifetime reserve days are used:  |  |                                    |           |
| —Additional 365 days   | \$0  | 100% of Medicare eligible expenses | \$0**     |
| —Beyond the additional 365 days  | \$0  | \$0                                | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b>  |  |                                    |           |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. |  |                                    |           |
| First 20 days  | All approved amounts   | \$0                                | \$0       |
| 21st through 100th day   | All but \$[124] a day  | Up to \$[124] a day                | \$0       |
| 101st day and after  | \$0  | \$0                                | All costs |
| <b>BLOOD</b>   |  |                                    |           |
| First 3 pints  | \$0  | 3 pints                            | \$0       |
| Additional amounts   | 100%   | \$0                                | \$0       |
| <b>HOSPICE CARE</b>  |  |                                    |           |
| You must meet Medicare's requirements including a doctor's certification of terminal illness.  |  |                                    |           |
|  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0       |

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

| SERVICES  | MEDICARE PAYS | PLAN PAYS     | YOU PAY                     |
|---|---------------|---------------|-----------------------------|
| <b>MEDICAL EXPENSES—</b><br>IN OR OUT OF THE HOSPITAL AND<br>OUTPATIENT HOSPITAL TREATMENT, such<br>as physician’s services, inpatient and outpatient<br>medical and surgical services and supplies, physical<br>and speech therapy, diagnostic tests, durable medical<br>equipment |               |               |                             |
| First \$[131] of Medicare-Approved Amounts***   | \$0           | \$0           | \$(131) (Part B deductible) |
| Remainder of Medicare-Approved Amounts  | Generally 80% | Generally 20% | \$0                         |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)   | \$0           | 100%          | 0%                          |
| <b>BLOOD</b>  |               |               |                             |
| First 3 pints   | \$0           | All costs     | \$0                         |
| Next \$[131] of Medicare-Approved Amounts***  | \$0           | \$0           | \$(131) (Part B deductible) |
| Remainder of Medicare-Approved Amounts  | 80%           | 20%           | \$0                         |
| <b>CLINICAL LABORATORY SERVICES—</b><br>TESTS FOR DIAGNOSTIC SERVICES   | 100%          | \$0           | \$0                         |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PARTS A & B**

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY                     |
|--|---------------|-----------|-----------------------------|
| <b>HOME HEALTH CARE</b><br>MEDICARE-APPROVED SERVICES              |               |           |                             |
| —Medically necessary skilled care services and<br>medical supplies | 100%          | \$0       | \$0                         |
| —Durable medical equipment   |               |           |                             |
| First \$[131] of Medicare-Approved Amounts***                      | \$0           | \$0       | \$(131) (Part B deductible) |
| Remainder of Medicare-Approved Amounts                             | 80%           | 20%       | \$0                         |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

| SERVICES  | MEDICARE PAYS | PLAN PAYS   | YOU PAY  |
|---|---------------|---|--|
| <b>FOREIGN TRAVEL—NOT COVERED BY<br/>MEDICARE</b>   |               |   |  |
| Medically necessary emergency care services<br>beginning during the first 60 days of each trip outside<br>the USA |               |   |  |
| First \$250 each calendar year  | \$0           | \$0   | \$250  |
| Remainder of charges  | \$0           | 80% to a lifetime<br>maximum benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN K**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES  | MEDICARE PAYS   | PLAN PAYS   | YOU PAY*   |
|---|---|---|--|
| <b>HOSPITALIZATION**</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies<br><br>First 60 days<br><br>61st through 90th day<br><br>91st day and after:<br>—While using 60 lifetime reserve days<br>—Once lifetime reserve days are used:<br>—Additional 365 days<br><br>—Beyond the additional 365 days | All but \$[992]<br><br>All but \$[248] a day<br><br>All but \$[496] a day<br><br>\$0<br><br>\$0 | \$[496] (50% of Part A deductible)<br><br>\$[248] a day<br><br>\$[496] a day<br><br>100% of Medicare eligible expenses<br><br>\$0 | \$[496] (50% of Part A deductible)♦<br><br>\$0<br><br>\$0<br><br>\$0***<br><br>All costs |
| <b>SKILLED NURSING FACILITY CARE**</b><br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.<br><br>First 20 days<br><br>21st through 100th day<br><br>101st day and after                                    | All approved amounts<br><br>All but \$[124] a day<br><br>\$0                                    | \$0<br><br>Up to \$[62] a day<br><br>\$0  | \$0<br><br>Up to \$[62] a day ♦<br><br>All costs   |
| <b>BLOOD</b><br><br>First 3 pints<br><br>Additional amounts   | \$0<br><br>100%   | 50%<br><br>\$0  | 50%♦<br><br>\$0  |
| <b>HOSPICE CARE</b><br>You must meet Medicare's requirements, including a doctor's certification of terminal illness.   | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care      | 50% of copayment/coinsurance  | 50% of Medicare copayment/coinsurance♦   |

\*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of \$[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

\*\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

| SERVICES   | MEDICARE PAYS   | PLAN PAYS                                    | YOU PAY*  |
|--|---|--|---|
| <b>MEDICAL EXPENSES—<br/>IN OR OUT OF THE HOSPITAL AND<br/>OUTPATIENT HOSPITAL TREATMENT</b> , such<br>as physician's services, inpatient and outpatient<br>medical and surgical services and supplies, physical<br>and speech therapy, diagnostic tests, durable medical<br>equipment |   |  |   |
| First \$[131] of Medicare-Approved Amounts****   | \$0   | \$0  | \$[131] (Part B<br>deductible)**** ♦  |
| Preventive Benefits for Medicare-Covered Services  | Generally 75% or more<br>of Medicare-<br>Approved Amounts | Remainder of<br>Medicare-Approved<br>Amounts | All costs above<br>Medicare-Approved<br>Amounts   |
| Remainder of Medicare-Approved Amounts   | Generally 80%   | Generally 10%                                | Generally 10% ♦   |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)  | \$0   | \$0  | All costs (and they<br>do not count toward<br>annual out-of-pocket<br>limit of \$[4140])***** |
| <b>BLOOD</b>   |   |  |   |
| First 3 pints  | \$0   | 50%  | 50%♦  |
| Next \$[131] of Medicare-Approved Amounts****  | \$0   | \$0  | \$[131] (Part B<br>deductible)**** ♦  |
| Remainder of Medicare-Approved Amounts   | Generally 80%   | Generally 10%                                | Generally 10% ♦   |
| <b>CLINICAL LABORATORY SERVICES—<br/>TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%  | \$0  | \$0   |

\*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of \$[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

\*\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

\*\*\*\*\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[4140] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

## PARTS A &amp; B

| SERVICES  | MEDICARE PAYS | PLAN PAYS | YOU PAY*                      |
|---|---------------|-----------|-------------------------------|
| <b>HOME HEALTH CARE</b>   |               |           |                               |
| <b>MEDICARE-APPROVED SERVICES</b>                               |               |           |                               |
| —Medically necessary skilled care services and medical supplies | 100%          | \$0       | \$0                           |
| —Durable medical equipment                                      |               |           |                               |
| First \$[131] of Medicare-Approved Amounts****                  | \$0           | \$0       | \$[131] (Part B deductible) ♦ |
| Remainder of Medicare-Approved Amounts                          | 80%           | 10%       | 10%♦                          |

\*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of \$[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

\*\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN L**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                          | YOU PAY*                            |
|--|--|------------------------------------|-------------------------------------|
| <b>HOSPITALIZATION**</b>   |  |                                    |                                     |
| Semiprivate room and board, general nursing and miscellaneous services and supplies  |  |                                    |                                     |
| First 60 days  | All but \$[992]  | \$[744] (75% of Part A deductible) | \$[248] (25% of Part A deductible)♦ |
| 61st through 90th day  | All but \$[248] a day  | \$[248] a day                      | \$0                                 |
| 91st day and after:  |  |                                    |                                     |
| —While using 60 lifetime reserve days  | All but \$[496] a day  | \$[496] a day                      | \$0                                 |
| —Once lifetime reserve days are used:  |  |                                    |                                     |
| —Additional 365 days   | \$0  | 100% of Medicare eligible expenses | \$0***                              |
| —Beyond the additional 365 days  | \$0  | \$0                                | All costs                           |
| <b>SKILLED NURSING FACILITY CARE**</b>   |  |                                    |                                     |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. |  |                                    |                                     |
| First 20 days  | All approved amounts   | \$0                                | \$0                                 |
| 21st through 100th day   | All but \$[124] a day  | Up to \$[93] a day                 | Up to \$[31] a day♦                 |
| 101st day and after  | \$0  | \$0                                | All costs                           |
| <b>BLOOD</b>   |  |                                    |                                     |
| First 3 pints  | \$0  | 75%                                | 25%♦                                |
| Additional amounts   | 100%   | \$0                                | \$0                                 |
| <b>HOSPICE CARE</b>  |  |                                    |                                     |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness.   |  |                                    |                                     |
|  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | 75% of copayment/coinsurance       | 25% of copayment/coinsurance♦       |

\* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of \$[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

\*\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

| SERVICES   | MEDICARE PAYS   | PLAN PAYS                                    | YOU PAY*  |
|--|---|--|---|
| <b>MEDICAL EXPENSES—<br/>IN OR OUT OF THE HOSPITAL AND<br/>OUTPATIENT HOSPITAL TREATMENT</b> , such<br>as physician’s services, inpatient and outpatient<br>medical and surgical services and supplies, physical<br>and speech therapy, diagnostic tests, durable medical<br>equipment |   |  |   |
| First \$[131] of Medicare-Approved Amounts****   | \$0   | \$0  | \$[131] (Part B<br>deductible)**** ♦  |
| Preventive Benefits for Medicare-Covered Services  | Generally 75% or more<br>of Medicare-<br>Approved Amounts | Remainder of<br>Medicare-Approved<br>Amounts | All costs above<br>Medicare-Approved<br>Amounts   |
| Remainder of Medicare-Approved Amounts   | Generally 80%   | Generally 15%                                | Generally 5% ♦  |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)  | \$0   | \$0  | All costs (and they<br>do not count toward<br>annual out-of-pocket<br>limit of \$[2070])***** |
| <b>BLOOD</b>   |   |  |   |
| First 3 pints  | \$0   | 75%  | 25%♦  |
| Next \$[131] of Medicare-Approved Amounts****  | \$0   | \$0  | \$[131] (Part B<br>deductible) ♦  |
| Remainder of Medicare-Approved Amounts   | Generally 80%   | Generally 15%                                | Generally 5%♦   |
| <b>CLINICAL LABORATORY SERVICES—<br/>TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%  | \$0  | \$0   |

\* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of \$[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

\*\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

\*\*\*\*\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[2070] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

## PARTS A &amp; B

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY*                      |
|--|---------------|-----------|-------------------------------|
| <b>HOME HEALTH CARE</b>  |               |           |                               |
| <b>MEDICARE-APPROVED SERVICES</b>  |               |           |                               |
| —Medically necessary skilled care services and medical supplies              | 100%          | \$0       | \$0                           |
| —Durable medical equipment<br>First \$[131] of Medicare-Approved Amounts**** | \$0           | \$0       | \$[131] (Part B deductible) ♦ |
| Remainder of Medicare-Approved Amounts                                       | 80%           | 15%       | 5%♦                           |

\* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of \$[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

\*\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN M**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                          | YOU PAY                            |
|--|--|------------------------------------|------------------------------------|
| <b>HOSPITALIZATION*</b>  |  |                                    |                                    |
| Semiprivate room and board, general nursing and miscellaneous services and supplies  |  |                                    |                                    |
| First 60 days  | All but \$[992]  | \$[496] (50% of Part A deductible) | \$[496] (50% of Part A deductible) |
| 61st through 90th day  | All but \$[248] a day  | \$[496] a day                      | \$0                                |
| 91st day and after:  |  |                                    |                                    |
| —While using 60 lifetime reserve days  | All but \$[496] a day  | \$[496] a day                      | \$0                                |
| —Once lifetime reserve days are used:  |  |                                    |                                    |
| —Additional 365 days   | \$0  | 100% of Medicare eligible expenses | \$0**                              |
| —Beyond the additional 365 days  | \$0  | \$0                                | All costs                          |
| <b>SKILLED NURSING FACILITY CARE*</b>  |  |                                    |                                    |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. |  |                                    |                                    |
| First 20 days  | All approved amounts   | \$0                                | \$0                                |
| 21st through 100th day   | All but \$[124] a day  | Up to \$[124] a day                | \$0                                |
| 101st day and after  | \$0  | \$0                                | All costs                          |
| <b>BLOOD</b>   |  |                                    |                                    |
| First 3 pints  | \$0  | 3 pints                            | \$0                                |
| Additional amounts   | 100%   | \$0                                | \$0                                |
| <b>HOSPICE CARE</b>  |  |                                    |                                    |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness.   |  |                                    |                                    |
|  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0                                |

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

| SERVICES   | MEDICARE PAYS | PLAN PAYS     | YOU PAY                     |
|--|---------------|---------------|-----------------------------|
| <b>MEDICAL EXPENSES—<br/>IN OR OUT OF THE HOSPITAL AND<br/>OUTPATIENT HOSPITAL TREATMENT</b> , such<br>as physician's services, inpatient and outpatient<br>medical and surgical services and supplies, physical<br>and speech therapy, diagnostic tests, durable medical<br>equipment |               |               |                             |
| First \$[131] of Medicare-Approved Amounts***  | \$0           | \$0           | \$(131) (Part B deductible) |
| Remainder of Medicare-Approved Amounts   | Generally 80% | Generally 20% | 0%                          |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)  | \$0           | \$0           | All costs                   |
| <b>BLOOD</b>   |               |               |                             |
| First 3 pints  | \$0           | All costs     | \$0                         |
| Next \$[131] of Medicare-Approved Amounts***   | \$0           | \$0           | \$(131) (Part B deductible) |
| Remainder of Medicare-Approved Amounts   | 80%           | 20%           | \$0                         |
| <b>CLINICAL LABORATORY SERVICES—<br/>TESTS FOR DIAGNOSTIC SERVICES</b>   | 100%          | \$0           | \$0                         |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PARTS A & B**

| SERVICES   | MEDICARE PAYS | PLAN PAYS | YOU PAY                     |
|--|---------------|-----------|-----------------------------|
| <b>HOME HEALTH CARE<br/>MEDICARE-APPROVED SERVICES</b>             |               |           |                             |
| —Medically necessary skilled care services and<br>medical supplies | 100%          | \$0       | \$0                         |
| —Durable medical equipment   |               |           |                             |
| First \$[131] of Medicare-Approved Amounts***                      | \$0           | \$0       | \$(131) (Part B deductible) |
| Remainder of Medicare-Approved Amounts                             | 80%           | 20%       | \$0                         |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**OTHER BENEFITS—NOT COVERED BY MEDICARE**

| SERVICES  | MEDICARE PAYS | PLAN PAYS   | YOU PAY  |
|---|---------------|---|--|
| <b>FOREIGN TRAVEL—NOT COVERED<br/>BY MEDICARE</b>   |               |   |  |
| Medically necessary emergency care services<br>beginning during the first 60 days of each trip outside<br>the USA |               |   |  |
| First \$250 each calendar year  | \$0           | \$0   | \$250  |
| Remainder of charges  | \$0           | 80% to a lifetime<br>maximum benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**PLAN N**  
**MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD**

| SERVICES   | MEDICARE PAYS  | PLAN PAYS                          | YOU PAY   |
|--|--|------------------------------------|-----------|
| <b>HOSPITALIZATION*</b>  |  |                                    |           |
| Semiprivate room and board, general nursing and miscellaneous services and supplies  |  |                                    |           |
| First 60 days  | All but \$[992]  | \$[992] (Part A deductible)        | \$0       |
| 61st through 90th day  | All but \$[248] a day  | \$[248] a day                      | \$0       |
| 91st day and after:  |  |                                    |           |
| —While using 60 lifetime reserve days  | All but \$[496] a day  | \$[496] a day                      | \$0       |
| —Once lifetime reserve days are used:  |  |                                    |           |
| —Additional 365 days   | \$0  | 100% of Medicare eligible expenses | \$0**     |
| —Beyond the additional 365 days  | \$0  | \$0                                | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b>  |  |                                    |           |
| You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital. |  |                                    |           |
| First 20 days  | All approved amounts   | \$0                                | \$0       |
| 21st through 100th day   | All but \$[124] a day  | Up to \$[124] a day                | \$0**     |
| 101st day and after  | \$0  | \$0                                | All costs |
| <b>BLOOD</b>   |  |                                    |           |
| First 3 pints  | \$0  | 3 pints                            | \$0       |
| Additional amounts   | 100%   | \$0                                | \$0       |
| <b>HOSPICE CARE</b>  |  |                                    |           |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness.   |  |                                    |           |
|  | All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance     | \$0       |

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

| SERVICES   | MEDICARE PAYS             | PLAN PAYS   | YOU PAY   |
|--|---------------------------|---|---|
| <b>MEDICAL EXPENSES—</b><br>IN OR OUT OF THE HOSPITAL AND<br>OUTPATIENT HOSPITAL TREATMENT, such<br>as physician’s services, inpatient and outpatient<br>medical and surgical services and supplies, physical<br>and speech therapy, diagnostic tests, durable medical<br>equipment<br><br>First \$[131] of Medicare-Approved Amounts***<br><br>Remainder of Medicare-Approved Amounts | \$0<br><br>Generally 80%  | \$0<br><br>Balance, other than up<br>to \$[20] per office visit<br>and up to \$[50] per<br>emergency room visit.<br>The copayment of up<br>to \$[50] is waived if<br>the insured is admitted<br>to any hospital and<br>the emergency visit is<br>covered as a Medicare<br>Part A expense. | \$[131] (Part B<br>deductible)<br><br>Up to \$[20] per office<br>visit and up to \$[50] per<br>emergency room visit.<br>The copayment of up<br>to \$[50] is waived if<br>the insured is admitted<br>to any hospital and<br>the emergency visit is<br>covered as a Medicare<br>Part A expense. |
| <b>Part B Excess Charges</b><br>(Above Medicare-Approved Amounts)  | \$0                       | \$0   | All costs   |
| <b>BLOOD</b><br><br>First 3 pints<br><br>Next \$[131] of Medicare-Approved Amounts***<br><br>Remainder of Medicare-Approved Amounts  | \$0<br><br>\$0<br><br>80% | All costs<br><br>\$0<br><br>20%   | \$0<br><br>\$[131] (Part B<br>deductible)<br><br>\$0  |
| <b>CLINICAL LABORATORY SERVICES—</b><br>TESTS FOR DIAGNOSTIC SERVICES  | 100%                      | \$0   | \$0   |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

**PARTS A & B**

| SERVICES   | MEDICARE PAYS              | PLAN PAYS                 | YOU PAY  |
|--|----------------------------|---------------------------|--|
| <b>HOME HEALTH CARE</b><br>MEDICARE-APPROVED SERVICES<br><br>—Medically necessary skilled care services and<br>medical supplies<br><br>—Durable medical equipment<br>First \$[131] of Medicare-Approved Amounts***<br><br>Remainder of Medicare-Approved Amounts | 100%<br><br>\$0<br><br>80% | \$0<br><br>\$0<br><br>20% | \$0<br><br>\$[131] (Part B<br>deductible)<br><br>\$0 |

\*\*\* Once you have been billed \$[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

## OTHER BENEFITS—NOT COVERED BY MEDICARE

| SERVICES   | MEDICARE PAYS | PLAN PAYS                                     | YOU PAY  |
|--|---------------|---|--|
| <b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b><br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA |               |   |  |
| First \$250 each calendar year   | \$0           | \$0   | \$250  |
| Remainder of charges   | \$0           | 80% to a lifetime maximum benefit of \$50,000 | 20% and amounts over the \$50,000 lifetime maximum |

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

**37.17(5)** *Notice regarding policies or certificates which are not Medicare supplement policies.*

*a.* Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy, or other policy identified in rule 191—37.2(514D) issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.”

*b.* Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in paragraph 37.17(4)“*a*” shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.18(514D) Requirements for application forms and replacement coverage.**

**37.18(1)** Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

*a.* Statements.

- (1) You do not need more than one Medicare supplement policy.
- (2) If you purchase this policy (certificate), you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your

policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

*b.* Questions.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X".)

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes  No

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes  No

(c) If yes, what is the effective date? \_\_\_\_\_

(2) Are you covered for medical assistance through the state Medicaid program?

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

Yes  No

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes  No

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes  No

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START  /  /  END  /  /

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes  No

(c) Was this your first time in this type of Medicare plan?

Yes  No

(d) Did you drop a Medicare supplement policy to enroll in this plan?

Yes  No

(4) (a) Do you have another Medicare supplement policy in force?

Yes \_\_\_ No \_\_\_

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes \_\_\_ No \_\_\_

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes \_\_\_ No \_\_\_

(a) If so, with what company and what kind of policy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(b) What are your dates of coverage under the other policy?

START \_\_\_/\_\_\_/\_\_\_ END \_\_\_/\_\_\_/\_\_\_

(If you are still covered under the other policy, leave "END" blank.)

**37.18(2)** Agents shall list any other health insurance policies they have sold to the applicant.

- a. List policies sold which are still in force.
- b. List policies sold in the past five years which are no longer in force.

**37.18(3)** In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

**37.18(4)** Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

**37.18(5)** The notice required by subrule 37.18(4) for an issuer shall be provided in substantially the following form in no less than 12-point type:

**NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE  
OR MEDICARE ADVANTAGE**

[Insurance company's name and address]

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:  
I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement

coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. [optional only for Direct Mailers]
- Other. (Please specify.) \_\_\_\_\_

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

\_\_\_\_\_  
(Signature of Agent, Broker or Other Representative)\*  
[Typed Name and Address of Issuer, Agent or Broker]

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

\*Signature not required for direct response sales.

**37.18(6)** Statements 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.19(514D) Standards for marketing.**

**37.19(1)** An issuer, directly or through its producers, shall:

- a. Establish marketing procedures to ensure that any comparison of policies by its agent or other producers will be fair and accurate.
- b. Establish marketing procedures to ensure excessive insurance is not sold or issued.
- c. Display prominently by type, stamp or other appropriate means, on the first page of the policy, the following:

“Notice to buyer: This policy may not cover all of your medical expenses.”

*d.* Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

*e.* Establish auditable procedures for certifying compliance with this subrule.

*f.* At solicitation, provide written notice to the prospective policyholder or certificate holder of the name, address, and telephone number of the senior insurance counseling program approved in Iowa by the commissioner of insurance. The written notice shall be in a form prescribed by the commissioner.

**37.19(2)** In addition to the practices prohibited in Iowa Code chapter 507B, the following acts and practices are prohibited:

*a. Twisting.* Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

*b. High-pressure tactics.* Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

*c. Cold-lead advertising.* Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

**37.19(3)** The terms “Medicare Supplement,” “Medigap,” “Medicare Wrap-Around” and words of similar import shall not be used unless the policy is issued in compliance with this chapter.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.20(514D) Appropriateness of recommended purchase and excessive insurance.**

**37.20(1)** In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

**37.20(2)** Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

**37.20(3)** An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.21(514D) Reporting of multiple policies.**

**37.21(1)** On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

*a.* Policy and certificate number, and

*b.* Date of issuance.

**37.21(2)** The items set forth above must be grouped by individual policyholder.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.22(514D) Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates.**

**37.22(1)** If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

**37.22(2)** If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any

time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.23(514D) Prohibition against use of genetic information and requests for genetic testing.** This rule applies to all policies with policy years beginning on or after May 21, 2009.

**37.23(1)** For the purposes of this rule only, the following definitions shall apply:

*“Family member”* means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

*“Genetic information”* means, with respect to any individual, information about such individual’s genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. “Genetic information” includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by such pregnant woman or, with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term “genetic information” does not include information about the sex or age of any individual.

*“Genetic services”* means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

*“Genetic test”* means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. The term “genetic test” does not mean:

1. An analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or
2. An analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

*“Issuer of a Medicare supplement policy or certificate”* means the same as “issuer” as defined in rule 191—37.3(514D) and includes third-party administrator, or other person acting for or on behalf of such issuer.

*“Underwriting purposes”* means:

1. Rules for or determination of eligibility (including enrollment and continued eligibility) for benefits under the policy;
2. The computation of premium or contribution amounts under the policy;
3. The application of any preexisting condition exclusion under the policy; and
4. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

**37.23(2)** An issuer of a Medicare supplement policy or certificate:

*a.* Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) of an individual on the basis of the genetic information with respect to such individual; and

*b.* Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

**37.23(3)** Nothing in subrule 37.23(2) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

*a.* Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

*b.* Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of another individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

**37.23(4)** An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

**37.23(5)** Subrule 37.23(4) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with subrule 37.23(2).

**37.23(6)** For purposes of carrying out subrule 37.23(5), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

**37.23(7)** Notwithstanding subrule 37.23(4), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

*a.* The request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

*b.* The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts.

*c.* No genetic information collected or acquired under this subrule shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

*d.* The issuer notifies the Secretary of the U.S. Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subrule, including a description of the activities conducted.

*e.* The issuer complies with such other conditions as the Secretary of the U.S. Department of Health and Human Services may by regulation require for activities conducted under this subrule.

**37.23(8)** An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

**37.23(9)** An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

**37.23(10)** If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subrule 37.23(9) if such request, requirement, or purchase is not in violation of subrule 37.23(8).

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.24(514D) Prohibition against using SHIIP prepared materials** The Senior Health Insurance Information Program (SHIIP) may prepare a consumer Medicare supplement insurance premium guide and benefits comparison guide. This guide and the SHIIP name or logo shall not be used in the solicitation or sale of health insurance products. Violation of this provision shall be deemed an unfair trade practice under Iowa Code chapter 507B.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.25(514D) Guaranteed issue for eligible persons.**

**37.25(1)** Eligible persons are those individuals described in subrule 37.25(2) who seek to enroll under the policy during the period specified in subrule 37.25(3) and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subrule 37.25(5) that is offered and is available for issuance to

new enrollees by issuer, shall not discriminate in the pricing of such Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such Medicare supplement policy.

**37.25(2)** An eligible person is an individual described in any of the following paragraphs:

*a.* The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement benefits under Medicare and the plan terminates or the plan ceases to provide some or all such supplemental health benefits to the individual;

*b.* The individual is enrolled with a Medicare Advantage organization under Medicare Advantage under Part C of Medicare and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act and circumstances exist similar to those described below that would permit discontinuance of the individual's enrollment with such a provider if such individual were enrolled in Medicare Advantage:

(1) The certification of the organization or plan under this part has been terminated; or

(2) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; or

(3) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area; or

(4) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

1. The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

2. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(5) The individual meets such other exceptional conditions as the Secretary may provide;

*c.* The individual is enrolled with:

(1) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); or

(2) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; or

(3) An organization operating under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(4) An organization under Medicare Select policy; and

(5) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph 37.25(2) "b";

*d.* The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(1) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(2) The issuer of the policy substantially violated a material provision of the policy; or

(3) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

*e.* The individual was enrolled under a Medicare supplement policy and terminated enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under Medicare Advantage under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment under paragraph 37.25(2) "e" was terminated by the enrollee during any

period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

*f.* The individual upon first becoming enrolled for benefits under Part B of Medicare at age 65 or older enrolls in Medicare Advantage under Part C of Medicare or with a PACE provider under Section 1894 of the Social Security Act and disenrolls from the plan or program by no later than 12 months after the effective date of enrollment.

*g.* The individual enrolls in a Medicare Part D plan during the initial enrollment period, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph 37.25(5) "e."

**37.25(3) Guaranteed issue time periods.**

*a.* In the case of an individual described in paragraph 37.25(2) "a," the guaranteed issue period begins on the later of: (1) the date the individual receives a notice of termination or cessation of some or all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or (2) the date that the applicable coverage terminates or ceases; and ends 63 days thereafter.

*b.* In the case of an individual described in paragraph 37.25(2) "b," "c," "e" or "f" whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

*c.* In the case of an individual described in subparagraph 37.25(2) "d"(1), the guaranteed issue period begins on the earlier of (1) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (2) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

*d.* In the case of an individual described in paragraph 37.25(2) "b," subparagraph 37.25(2) "d"(2), subparagraph 37.25(2) "e"(2), paragraph 37.25(2) "e" or paragraph 37.25(2) "f" who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

*e.* In the case of an individual described in paragraph 37.25(2) "g," the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

*f.* In the case of an individual described in subrule 37.25(2) but not described in the preceding paragraphs 37.25(3) "a" to "e," the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

**37.25(4) Extended Medigap access for interrupted trial periods.**

*a.* In the case of an individual described in paragraph 37.25(2) "e" (or deemed to be so described pursuant to paragraph 37.25(4) "a") whose enrollment with an organization or provider described in paragraph 37.25(2) "e" is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.25(2) "e."

*b.* In the case of an individual described in paragraph 37.25(2) "f" (or deemed to be so described pursuant to paragraph 37.25(4) "b") whose enrollment with a plan or in a program described in paragraph 37.25(2) "f" is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.25(2) "f."

*c.* For purposes of paragraphs 37.25(2) "e" and "f," no enrollment of an individual with an organization or provider described in paragraph 37.25(2) "e," or with a plan or in a program described in paragraph 37.25(2) "f," may be deemed to be an initial enrollment under paragraph 37.25(4) "c"

after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

**37.25(5)** Products to which eligible persons are entitled. The Medicare supplement policy to which eligible persons are entitled under:

*a.* Subrule 37.25(2), paragraphs “*a*,” “*b*,” “*c*,” and “*d*,” is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

*b.* Subject to paragraph 37.25(5)“*c*,” paragraph 37.25(2)“*e*” is the same Medicare supplement policy in which the individual was most recently previously enrolled if available from the same issuer, or, if not so available, a policy described in paragraph 37.25(5)“*a*.”

*c.* After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this paragraph is:

(1) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(2) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.

*d.* Paragraph 37.25(2)“*f*” shall include any Medicare supplement policy offered by any issuer.

*e.* Paragraph 37.25(2)“*g*” is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual’s Medicare supplement policy with outpatient prescription drug coverage.

**37.25(6)** Notification of provisions.

*a.* At the time of an event described in subrule 37.25(2) because of which an individual loses coverage or benefits due to the termination or change of a contract or agreement, policy, or plan, the organization that terminates or changes the contract or agreement, the issuer terminating or changing the policy, or the administrator of the plan being terminated or changed, respectively, shall notify the individual of the individual’s rights under this rule and of the obligations of issuers of Medicare supplement policies under subrule 37.25(1). Such notice shall be communicated contemporaneously with the notification of termination.

*b.* At the time of an event described in subrule 37.25(2) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual’s rights under this rule and of the obligations of issuers of Medicare supplement policies under subrule 37.25(1). Such notice shall be communicated within ten working days of the issuer receiving notification of the disenrollment. [ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.26(514D) Severability.** If any provisions of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.27 to 37.49** Reserved.

DIVISION II  
MEDICARE SUPPLEMENT ADVERTISING

**191—37.50(507B,514D) Purpose.** The purpose of the rules in this division is to provide prospective purchasers with clear and unambiguous statements in the advertisement of Medicare supplement insurance and to assure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance. This purpose is intended to be accomplished by the establishment of guidelines and permissible and impermissible standards of conduct in the advertising

of Medicare supplement insurance in a manner which prevents unfair, deceptive and misleading advertising and which is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance producers and companies.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.51(507B,514D) Applicability.**

**37.51(1)** “Insurer,” for the purpose of these rules, shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd’s, fraternal benefit society, health maintenance organization, hospital service corporation, medical service corporation, prepaid health plan and any other legal entity which is defined as an “issuer” in rule 191—37.3(514D) and is engaged in the advertisement of itself, or Medicare supplement insurance.

These rules shall apply to any “advertisement” of Medicare supplement insurance, as that term is defined in rule 191—37.52(507B,514D), unless otherwise specified in Division II of this chapter, that the insurer or producer knows or reasonably should know is intended for presentation, distribution or dissemination in this state when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer or producer, as those terms are defined in rule 191—15.2(507B).

**37.51(2)** Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

**37.51(3)** The requirements of Iowa Code chapter 507B and 191—Chapter 15 also shall apply to insurers and producers to which 191—Chapter 37, Division II, applies, unless specifically exempted therein.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.52(507B,514D) Definitions.** In addition to the definitions in Iowa Code section 507B.2 and rule 191—15.2(507B), the following definitions shall apply to 191—Chapter 37, Division II. When there is a definition for a term in this rule and also in Iowa Code section 507B.2 or rule 191—15.2(507B), the definition in this rule shall take precedence.

“*Advertisement*” includes:

1. The definition of “advertisement” in rule 191—15.2(507B).
2. Advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.
3. The definition of “advertisement” does not include:
  - Items excluded in the definition of “advertisement” in rule 191—15.2(507B).
  - Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract.
  - Court-approved material ordered by a court to be disseminated to policyholders.

“*Certificate*” means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

“*Institutional advertisement*” means an advertisement having as its sole purpose the promotion of the reader’s, viewer’s or listener’s interest in the concept of Medicare supplement insurance, or the promotion of the insurer as a seller of Medicare supplement insurance.

“*Lead-generating device*” means any communication directed to the public that, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of Medicare supplement insurance.

“*Limitation*” means any provision other than an exception or a reduction that restricts coverage under the policy.

“*Medicare*” means “The Health Insurance for the Aged Act, Title XVIII of The Social Security Amendments of 1965 as Then Constituted or Later Amended,” or Title I, Part I, of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America, and also known as the “Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof,” or words of similar import.

*“Medicare supplement insurance”* means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

*“Person”* means a natural person, association, organization, partnership, trust, group, discretionary group, corporation or any other entity.

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

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.53(507B,514D) Form and content of advertisements.** An insurer must clearly identify its Medicare supplement insurance policy as an insurance policy. A policy trade name must be followed by the words “Insurance Policy” or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.54(507B,514D) Testimonials or endorsements by third parties.** In addition to complying with 191—subrule 15.3(7), when a testimonial refers to benefits received under a Medicare supplement insurance policy, the insurer shall retain the specific claim data, including claim number, date of loss, and other pertinent information, for a period of four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.55(507B,514D) Use of statistics; jurisdictional licensing; status of insurer.** Advertisements shall be in compliance with 191—subrule 15.3(5) and with the following:

**37.55(1)** An advertisement shall specifically identify the Medicare supplement insurance policy to which statistics relate and, where statistics are given which are applicable to a different policy, the advertisement shall state clearly that the data do not relate to the policy being advertised.

**37.55(2)** An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

**37.55(3)** An advertisement shall not create the impression directly or indirectly that the insurer, the insurer’s financial condition or status, the insurer’s payment of its claims, or the merits, desirability or advisability of the insurer’s policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of this state or of the United States government.

**37.55(4)** An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of this state or of the United States government. “Approval” of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, its advertising or its financial condition.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.56(507B,514D) Identity of insurer.** Advertisements shall be in compliance with 191—subrule 15.3(9) and with the following:

**37.56(1)** Advertisements, stationery or envelopes that employ words, letters, initials, symbols or other devices are not permitted if they are so similar to those used by governmental agencies or other insurers that they may lead the public to believe:

*a.* The advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers;

*b.* The advertiser is the same as, is connected with or is endorsed by the governmental agencies or the other insurers.

**37.56(2)** No advertisement shall use the name of a state or political subdivision thereof in a policy name or description.

**37.56(3)** No advertisement in the form of envelopes or stationery of any kind may use any name, service mark, slogan, symbol or any device in such a manner that implies that the insurer or the policy advertised, or that any producer who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.

**37.56(4)** No advertisement may incorporate the word “Medicare” in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating the plan or policy from Medicare. Such an advertisement, however, shall not use the phrase “\_\_\_\_\_ Medicare Department of the \_\_\_\_\_ Insurance Company,” or language of similar import.

**37.56(5)** No advertisement shall be used that fails to include a disclaimer to the effect of “Not connected with or endorsed by the U.S. government or the federal Medicare program.”

**37.56(6)** No advertisement may imply that the reader may lose a right, privilege or benefit under federal, state or local law if the reader fails to respond to the advertisement.

**37.56(7)** No insurer may use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

**37.56(8)** All advertisements used by producers or solicitors of an insurer shall have prior written approval of the insurer before the advertisements may be used.

**37.56(9)** A producer who makes contact with a consumer as a result of acquiring that consumer’s name from a lead-generating device shall disclose that fact in the initial contact with the consumer.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

#### **191—37.57(507B,514D) Introductory, initial or special offers.**

##### **37.57(1) Enrollment periods.**

*a.* An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such representation is true. An advertisement shall not contain phrases describing an enrollment period as “special,” “limited,” or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising Medicare supplement insurance.

*b.* An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not fewer than 10 days and not more than 40 days from the date that the enrollment period is advertised for the first time. This rule applies to all advertising media, e.g., mail, newspapers, electronic mail, websites, radio, television, magazines and periodicals, used by any one insurer. This rule is not applicable to solicitations of employees or members of a particular group or association that otherwise would be eligible for group, blanket or franchise insurance. The phrase “any one insurer” in this paragraph includes all the affiliated companies of a group of insurance companies under common management or control. The phrase “a particular insurance product” in this paragraph means an insurance policy that provides benefits substantially different from those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, or an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product’s being offered as a different product eligible for concurrent or overlapping enrollment periods.

*c.* This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless either is true.

**37.57(2)** An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium shall be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. The term “juxtaposition” means side by side or immediately above or below.

**37.57(3)** Special awards, such as a “safe driver’s award,” shall not be used in connection with advertisements of Medicare supplement insurance.

**37.57(4)** An invitation to inquire, which means an advertisement having as its objective the creation of a desire to inquire further about Medicare supplement insurance that is limited to a brief description of coverage, shall contain a provision in the following or substantially similar form:

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

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.58(507B,514D) Enforcement procedures—certificate of compliance.** Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of these rules must file with the insurance division, with the insurer’s annual statement, a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of the authorized officer’s knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied with or were made to comply in all respects with the provisions of these rules and the laws of this state as implemented and interpreted by these rules.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

**191—37.59(507B,514D) Filing for prior review.** The commissioner may, at the commissioner’s discretion, require the filing with the insurance division, for review prior to use, of any Medicare supplement insurance advertising material.

[ARC 7964B, IAB 7/15/09, effective 8/19/09]

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

| Line |  | (a)<br>Earned Premium <sup>3</sup> | (b)<br>Incurred Claims <sup>4</sup> |
|------|--|------------------------------------|-------------------------------------|
| 1.   | Current Year's Experience                          |                                    |                                     |
|      | a. Total (all policy years)                        |                                    |                                     |
|      | b. Current year's issues <sup>5</sup>              |                                    |                                     |
|      | c. Net (for reporting purposes = 1a - 1b)          |                                    |                                     |
| 2.   | Past Years' Experience (all policy years)          |                                    |                                     |
| 3.   | Total Experience<br>(Net Current Year + Past Year) |                                    |                                     |

|     |  |  |
|-----|--|--|
| 4.  | Refunds Last Year (excluding interest)   |  |
| 5.  | Previous Since Inception (excluding interest)  |  |
| 6.  | Refunds Since Inception (excluding interest)   |  |
| 7.  | Benchmark Ratio Since Inception (see worksheet for Ratio 1)  |  |
| 8.  | Experienced Ratio Since Inception (Ratio 2)<br>$\frac{\text{Total Actual Incurred Claims (line 3, col. b)}}{\text{Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)}}$  |  |
| 9.  | Life Years Exposed Since Inception<br><br>If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund. |  |
| 10. | Tolerance Permitted (obtained from credibility table)  |  |

Medicare Supplement Credibility Table

| Life Years Exposed                |           |
|-----------------------------------|-----------|
| Since Inception                   | Tolerance |
| 10,000 +                          | 0.0%      |
| 5,000 - 9,999                     | 5.0%      |
| 2,500 - 4,999                     | 7.5%      |
| 1,000 - 2,499                     | 10.0%     |
| 500 - 999                         | 15.0%     |
| If less than 500, no credibility. |           |

<sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select only.

<sup>2</sup> “SMSBP” = Standardized Medicare Supplement Benefit Plan – Use “P” for prestandardized plans.

<sup>3</sup> Includes Modal Loadings and Fees Charged.

<sup>4</sup> Excludes Active Life Reserves.

<sup>5</sup> This is to be used as “Issue Year Earned Premium” for Year 1 of next year’s “Worksheet for Calculation of Benchmark Ratios.”

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

|     |  |  |
|-----|--|--|
| 11. | Adjustment to Incurred Claims for Credibility<br>Ratio 3 = Ratio 2 + Tolerance |  |
|-----|--|--|

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.  
 If Ratio 3 is less than the Benchmark Ratio, then proceed.

|     |   |  |
|-----|---|--|
| 12. | Adjusted Incurred Claims<br>[Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)]<br>× Ratio 3 (line 11)                              |  |
| 13. | Refund =<br>Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6) -<br>[Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)] |  |

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name (Please type.)

\_\_\_\_\_  
Title (Please type.)

\_\_\_\_\_  
Date

<sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select only.  
<sup>2</sup> "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.

**REPORTING FORM FOR THE CALCULATION OF  
BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_**

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

| (a) <sup>3</sup> | (b) <sup>4</sup> | (c)    | (d)       | (e)                   | (f)       | (g)    | (h)       | (i)                   | (j)       | (o) <sup>5</sup>       |
|------------------|------------------|--------|-----------|-----------------------|-----------|--------|-----------|-----------------------|-----------|------------------------|
| Year             | Earned Premium   | Factor | (b) × (c) | Cumulative Loss Ratio | (d) × (e) | Factor | (b) × (g) | Cumulative Loss Ratio | (h) × (i) | Policy Year Loss Ratio |
| 1                |                  | 2.770  |           | 0.507                 |           | 0.000  |           | 0.000                 |           | 0.46                   |
| 2                |                  | 4.175  |           | 0.567                 |           | 0.000  |           | 0.000                 |           | 0.63                   |
| 3                |                  | 4.175  |           | 0.567                 |           | 1.194  |           | 0.759                 |           | 0.75                   |
| 4                |                  | 4.175  |           | 0.567                 |           | 2.245  |           | 0.771                 |           | 0.77                   |
| 5                |                  | 4.175  |           | 0.567                 |           | 3.170  |           | 0.782                 |           | 0.80                   |
| 6                |                  | 4.175  |           | 0.567                 |           | 3.998  |           | 0.792                 |           | 0.82                   |
| 7                |                  | 4.175  |           | 0.567                 |           | 4.754  |           | 0.802                 |           | 0.84                   |
| 8                |                  | 4.175  |           | 0.567                 |           | 5.445  |           | 0.811                 |           | 0.87                   |
| 9                |                  | 4.175  |           | 0.567                 |           | 6.075  |           | 0.818                 |           | 0.88                   |
| 10               |                  | 4.175  |           | 0.567                 |           | 6.650  |           | 0.824                 |           | 0.88                   |
| 11               |                  | 4.175  |           | 0.567                 |           | 7.176  |           | 0.828                 |           | 0.88                   |
| 12               |                  | 4.175  |           | 0.567                 |           | 7.655  |           | 0.831                 |           | 0.88                   |
| 13               |                  | 4.175  |           | 0.567                 |           | 8.093  |           | 0.834                 |           | 0.89                   |
| 14               |                  | 4.175  |           | 0.567                 |           | 8.493  |           | 0.837                 |           | 0.89                   |
| 15+ <sup>6</sup> |                  | 4.175  |           | 0.567                 |           | 8.684  |           | 0.838                 |           | 0.89                   |
| Total:           |                  |        | (k):      |                       | (l):      |        | (m):      |                       | (n):      |                        |

Benchmark Ratio Since Inception:  $(1 + n)/(k + m)$ : \_\_\_\_\_

- <sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select only.
- <sup>2</sup> “SMSBP” = Standardized Medicare Supplement Benefit Plan – Use “P” for prestandardized plans.
- <sup>3</sup> Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
- <sup>4</sup> For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- <sup>5</sup> These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.
- <sup>6</sup> To include the earned premium for all years prior to as well as the 15th year prior to the current year.

**REPORTING FORM FOR THE CALCULATION OF  
BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_**

TYPE<sup>1</sup> \_\_\_\_\_ SMSBP<sup>2</sup> \_\_\_\_\_  
 For the State of \_\_\_\_\_ Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_ Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

| (a) <sup>3</sup> | (b) <sup>4</sup> | (c)    | (d)       | (e)                   | (f)       | (g)    | (h)       | (i)                   | (j)       | (o) <sup>5</sup>       |
|------------------|------------------|--------|-----------|-----------------------|-----------|--------|-----------|-----------------------|-----------|------------------------|
| Year             | Earned Premium   | Factor | (b) × (c) | Cumulative Loss Ratio | (d) × (e) | Factor | (b) × (g) | Cumulative Loss Ratio | (h) × (i) | Policy Year Loss Ratio |
| 1                |                  | 2.770  |           | 0.442                 |           | 0.000  |           | 0.000                 |           | 0.40                   |
| 2                |                  | 4.175  |           | 0.493                 |           | 0.000  |           | 0.000                 |           | 0.55                   |
| 3                |                  | 4.175  |           | 0.493                 |           | 1.194  |           | 0.659                 |           | 0.65                   |
| 4                |                  | 4.175  |           | 0.493                 |           | 2.245  |           | 0.669                 |           | 0.67                   |
| 5                |                  | 4.175  |           | 0.493                 |           | 3.170  |           | 0.678                 |           | 0.69                   |
| 6                |                  | 4.175  |           | 0.493                 |           | 3.998  |           | 0.686                 |           | 0.71                   |
| 7                |                  | 4.175  |           | 0.493                 |           | 4.754  |           | 0.695                 |           | 0.73                   |
| 8                |                  | 4.175  |           | 0.493                 |           | 5.445  |           | 0.702                 |           | 0.75                   |
| 9                |                  | 4.175  |           | 0.493                 |           | 6.075  |           | 0.708                 |           | 0.76                   |
| 10               |                  | 4.175  |           | 0.493                 |           | 6.650  |           | 0.713                 |           | 0.76                   |
| 11               |                  | 4.175  |           | 0.493                 |           | 7.176  |           | 0.717                 |           | 0.76                   |
| 12               |                  | 4.175  |           | 0.493                 |           | 7.655  |           | 0.720                 |           | 0.77                   |
| 13               |                  | 4.175  |           | 0.493                 |           | 8.093  |           | 0.723                 |           | 0.77                   |
| 14               |                  | 4.175  |           | 0.493                 |           | 8.493  |           | 0.725                 |           | 0.77                   |
| 15+ <sup>6</sup> |                  | 4.175  |           | 0.493                 |           | 8.684  |           | 0.725                 |           | 0.77                   |
| Total:           |                  |        | (k):      |                       | (l):      |        | (m):      |                       | (n):      |                        |

Benchmark Ratio Since Inception:  $(1 + n)/(k + m)$ : \_\_\_\_\_

- <sup>1</sup> Individual, Group, Individual Medicare Select, or Group Medicare Select only.
- <sup>2</sup> "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.
- <sup>3</sup> Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
- <sup>4</sup> For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- <sup>5</sup> These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes.
- <sup>6</sup> To include the earned premium for all years prior to as well as the 15th year prior to the current year.

Appendix B

FORM FOR REPORTING  
MEDICARE SUPPLEMENT POLICIES

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and      Date of Issuance  
Certificate #

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (please type)

\_\_\_\_\_  
Date

APPENDIX C  
DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies  
Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Hospice
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare; or
- It pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- The benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

**Before You Buy This Insurance**

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or your state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

These rules are intended to implement Iowa Code chapters 507B and 514D.

[Filed 11/5/81, Notice 9/2/81—published 11/25/81, effective 12/31/81<sup>1</sup>]

[Editorially transferred from [510] to [191] IAC Supp. 10/22/86; see IAB 7/30/86]

[Filed emergency 12/9/88—published 12/28/88, effective 12/31/88]

[Filed 8/31/90, Notice 7/25/90—published 9/19/90, effective 12/1/90]

[Filed emergency 1/18/91—published 2/6/91, effective 1/18/91]

[Filed 4/26/91, Notice 2/6/91—published 5/15/91, effective 6/19/91]

[Filed 10/25/91, Notice 9/18/91—published 11/13/91, effective 1/1/92]

[Filed 6/4/92, Notice 4/1/92—published 6/24/92, effective 7/29/92]

[Filed 5/2/94, Notice 3/16/94—published 5/25/94, effective 7/1/94]

[Filed 2/8/96, Notice 1/3/96—published 2/28/96, effective 4/3/96]

[Filed without Notice 5/14/96—published 6/5/96, effective 7/10/96]

[Filed emergency 8/18/98—published 9/9/98, effective 8/18/98]

[Filed emergency 2/3/99—published 2/24/99, effective 2/3/99]

[Filed emergency 1/5/01—published 1/24/01, effective 1/5/01]

[Filed 11/21/01, Notice 10/17/01—published 12/12/01, effective 1/16/02]

[Filed 12/15/04, Notice 10/27/04—published 1/5/05, effective 2/9/05]

[Filed without Notice 2/11/05—published 3/2/05, effective 4/6/05]

[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]

[Filed ARC 7964B (Notice ARC 7795B, IAB 5/20/09), IAB 7/15/09, effective 8/19/09]

[Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

<sup>1</sup> Effective date of 12/31/81 delayed 70 days by Administrative Rules Review Committee.



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%                                   |

| Triggers for a Substantial Premium Increase |  |
|---|--|
| Issue Age                                   | Percent Increase<br>Over Initial Premium |
| 62  | 62%                                      |
| 63  | 58%                                      |
| 64  | 54%                                      |
| 65  | 50%                                      |
| 66  | 48%                                      |
| 67  | 46%                                      |
| 68  | 44%                                      |
| 69  | 42%                                      |
| 70  | 40%                                      |
| 71  | 38%                                      |
| 72  | 36%                                      |
| 73  | 34%                                      |
| 74  | 32%                                      |
| 75  | 30%                                      |
| 76  | 28%                                      |
| 77  | 26%                                      |
| 78  | 24%                                      |
| 79  | 22%                                      |
| 80  | 20%                                      |
| 81  | 19%                                      |
| 82  | 18%                                      |
| 83  | 17%                                      |
| 84  | 16%                                      |
| 85  | 15%                                      |
| 86  | 14%                                      |
| 87  | 13%                                      |
| 88  | 12%                                      |
| 89  | 11%                                      |
| 90 and over                                 | 10%                                      |

*d.* On or before the effective date of a substantial premium increase as defined in paragraph 39.29(6)“*c*,” the insurer shall:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subrule 39.29(7). This option may be elected at any time during the 120-day period referenced in paragraph 39.29(6)“*c*”; and

(3) Notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph 39.29(6)“*c*” shall be deemed to be the election of the offer to convert in subparagraph (2) above.

**39.29(7)** Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse, are described in this subrule.

*a.* For purposes of this subrule, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1 percent per year prior to age 50, and at least 3 percent per year beyond age 50.

*b.* For purposes of this subrule, the nonforfeiture benefit shall be of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph “*c.*”

*c.* The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limitation of subrule 39.29(8).

*d.* Benefit dates.

(1) The nonforfeiture benefit shall begin not later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(2) Notwithstanding subparagraph (1), for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

1. The end of the tenth year following the policy or certificate issue date; or

2. The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

*e.* Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

**39.29(8)** All benefits paid by the insurer while the policy or certificate is in premium-paying status and in paid-up status will not exceed the maximum benefits which would be payable if the policy or certificate had remained in premium-paying status.

**39.29(9)** There shall be no difference in the minimum nonforfeiture benefits as required under this rule for group and individual policies.

**39.29(10)** The requirements set forth in this rule shall become effective July 1, 2003, and shall apply as follows:

*a.* Except as provided in paragraph “*b.*” the provisions of this rule apply to any long-term care policy issued on or after February 1, 2003.

*b.* For certificates issued on or after July 1, 2003, under a group long-term care insurance policy which policy was in force on February 1, 2003, the provisions of this rule shall not apply.

**39.29(11)** Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit on lapse shall be subject to the loss ratio requirements of 39.13(2) or 191—39.28(514G), whichever applies, treating the policy as a whole.

**39.29(12)** To determine whether contingent nonforfeiture upon lapse provisions are triggered under paragraph 39.29(6) “*c.*” a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

**39.29(13)** A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:

*a.* The nonforfeiture provision shall be appropriately captioned;

*b.* The nonforfeiture provision shall provide a benefit available in the event of a default in the payment of any premiums and shall state that the amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium-paying contracts approved by the commissioner for the same contract form; and

*c.* The nonforfeiture provision shall provide at least one of the following:

(1) Reduced paid-up insurance;

(2) Extended term insurance;

- (3) Shortened benefit period; or
- (4) Other similar offerings approved by the commissioner.

**39.29(14)** Notwithstanding subrule 39.29(10), if an insurer requests a premium rate increase on any long-term care policy issued prior to February 1, 2003, the commissioner shall require as a condition of approval of such premium rate increase that the insurer provide notice to all affected policyholders and certificate holders that, in lieu of the requested premium rate increase, the insured may opt for one of the following:

*a.* A reduced benefit. The insurer may limit any reduction in coverage to plans or options available for that policy form and to those for which benefits will be available after consideration of claims paid or payable. The age used to determine the premium for the reduced coverage shall be based on the age used to determine the premiums for the coverage currently in force. The reduced benefit offered may include one or more of the following:

- (1) A reduced daily, weekly, or monthly benefit;
- (2) A longer waiting period;
- (3) A reduced benefit period or a reduced maximum lifetime benefit; or
- (4) Any other benefit or coverage reduction option consistent with the policy or certificate design or the carrier's administrative processes.

*b.* A contingent benefit upon lapse as described in subrules 39.29(7), 39.29(8), 39.29(9), and 39.29(12) if the requested premium rate increase results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in paragraph 39.29(6) "c."

*c.* Any other alternative mechanism filed by the insurer and approved by the commissioner.

#### **191—39.30(514G) Standards for benefit triggers.**

**39.30(1)** A long-term care insurance policy shall condition the payment of benefits on a determination of the insured's ability to perform activities of daily living and on cognitive impairment. Eligibility for the payment of benefits shall not be more restrictive than requiring either a deficiency in the ability to perform not more than three of the activities of daily living or the presence of cognitive impairment.

**39.30(2)** Activities of daily living.

*a.* Activities of daily living shall include at least the following as defined in rule 191—39.5(514G) and in the policy:

- (1) Bathing;
- (2) Continence;
- (3) Dressing;
- (4) Eating;
- (5) Toileting; and
- (6) Transferring.

*b.* Insurers may use other activities of daily living to trigger covered benefits as long as the activities are defined in the policy.

**39.30(3)** An insurer may use additional provisions for the determination of when benefits are payable under a policy or certificate; however, the provisions shall not restrict, and are not in lieu of, the requirements contained in subrules 39.30(1) and 39.30(2).

**39.30(4)** For purposes of this rule, the determination of a deficiency shall not be more restrictive than:

*a.* Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or

*b.* If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cuing by another person is needed in order to protect the insured or others.

**39.30(5)** Assessments of activities of daily living and cognitive impairment shall be performed by licensed or certified professionals, such as physicians, nurses or social workers.

**39.30(6)** Long-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.

**39.30(7)** The requirements set forth in this rule shall be effective July 1, 2003, and shall apply as follows:

*a.* Except as provided in paragraph “*b.*” the provisions of this rule apply to a long-term care policy issued in this state on or after February 1, 2003.

*b.* For certificates issued on or after July 1, 2003, under a group long-term care insurance policy as defined in Iowa Code section 514G.4(4) “*a.*” that was in force on February 1, 2003, the provisions of this rule shall not apply.

**191—39.31(514G) Additional standards for benefit triggers for qualified long-term care insurance contracts.**

**39.31(1)** For purposes of this rule, the following definitions apply:

“*Chronically ill individual*” has the meaning prescribed for this term by Section 7702B(c)(2) of the Internal Revenue Code of 1986. Under this provision, a chronically ill individual means any individual who has been certified by a licensed health care practitioner as:

1. Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

2. Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term “chronically ill individual” shall not include an individual otherwise meeting these requirements unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

“*Licensed health care practitioner*” means a physician, as defined in Section 1861(r)(1) of the Social Security Act, a registered professional nurse, licensed social worker or other individual who meets requirements prescribed by the Secretary of the Treasury.

“*Maintenance or personal care services*” means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

“*Qualified long-term care services*” means services that meet the requirements of Section 7702(c)(1) of the Internal Revenue Code of 1986, as follows: necessary diagnostic, preventive, therapeutic, curative, treatment, mitigation and rehabilitative services, and maintenance or personal care services which are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

**39.31(2)** A qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner.

**39.31(3)** A qualified long-term care insurance contract shall condition the payment of benefits on a determination of the insured’s inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

**39.31(4)** Certifications regarding activities of daily living and cognitive impairment required pursuant to subrule 39.31(3) shall be performed by the following licensed or certified professionals: physicians, registered professional nurses, licensed social workers, or other individuals who meet requirements prescribed by the Secretary of the Treasury.

**39.31(5)** Certifications required pursuant to subrule 39.31(3) may be performed by a licensed health care professional at the direction of the carrier as is reasonably necessary with respect to a specific claim, except that when a licensed health care practitioner has certified that an insured is unable to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity and the insured is in claim status, the certification may not be rescinded and additional certifications may not be performed until after the expiration of the 90-day period.

**39.31(6)** Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

**191—39.32(514G) Penalties.** Violations of this chapter shall be subject to the penalties imposed under Iowa Code chapter 507B.

**191—39.33(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 Iowa Code section 514G.109(2), the notice required in Iowa Code section 514G.110(2) “b” and “c” 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, Two Ruan Center, Fourth Floor, 601 Locust Street, Des Moines, Iowa 50309-3738;
- c. A copy of the insurer's benefit trigger determination letter must accompany the written request for an independent review.

[ARC 8271B, IAB 11/4/09, effective 12/9/09; ARC 3683C, IAB 3/14/18, effective 4/18/18]

**191—39.46(514G) Independent review request.** 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, Two Ruan Center, Fourth Floor, 601 Locust Street, Des Moines, Iowa 50309-3738.

[ARC 3683C, IAB 3/14/18, effective 4/18/18]

**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 email 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 website, [www.iid.state.ia.us](http://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 website, [www.iid.state.ia.us](http://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 website, [www.iid.state.ia.us](http://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 website at [www.serff.org](http://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 website.

[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.

[Filed 4/28/88, Notice 1/13/88—published 5/18/88, effective 7/1/88]

[Filed 1/19/90, Notice 11/29/89—published 2/7/90, effective 3/14/90]

[Filed 10/25/91, Notice 9/18/91—published 11/13/91, effective 1/1/92]

[Filed 12/3/93, Notice 8/18/93—published 12/22/93, effective 1/26/94]

[Filed 6/5/02, Notice 5/1/02—published 6/26/02, effective 7/31/02]

[Filed 3/9/07, Notice 1/31/07—published 3/28/07, effective 5/2/07]

[Filed 8/10/07, Notice 7/4/07—published 8/29/07, effective 10/3/07]<sup>1</sup>

[Filed emergency 12/12/07—published 1/2/08, effective 12/12/07]

[Filed 10/30/08, Notice 9/24/08—published 11/19/08, effective 1/1/09]<sup>◇</sup>

[Filed emergency 12/24/08—published 1/14/09, effective 1/1/09]

[Filed ARC 8271B (Notice ARC 8132B, IAB 9/9/09), IAB 11/4/09, effective 12/9/09]

[Filed ARC 1999C (Notice ARC 1943C, IAB 4/1/15), IAB 5/27/15, effective 7/1/15]

[Filed ARC 2415C (Notice ARC 2078C, IAB 8/5/15), IAB 2/17/16, effective 3/23/16]

[Filed ARC 3683C (Notice ARC 3570C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

<sup>◇</sup> Two or more ARCs

<sup>1</sup> 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.*



## 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 GroupInstructions

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 <sup>1</sup> |
|----|--|------------|------------------------------|
| 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 <sup>2</sup>                                  |            |                              |
| 9  | • Provider/Facility Not Qualified under the Policy <sup>3</sup>                                      |            |                              |
| 10 | • Benefit Eligibility Criteria Not Met <sup>4</sup>  |            |                              |
| 11 | • Other  |            |                              |

<sup>1</sup>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.

<sup>2</sup> Example—home health care claim filed under a nursing home only policy.

<sup>3</sup> Example—a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

<sup>4</sup> 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*

| <b>Contingent Nonforfeiture</b>   |  |
|---|--|
| <b>Cumulative Premium Increase Over Initial Premium<br/>That Qualifies for Contingent Nonforfeiture</b>     |  |
| (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.) |  |
| <b>Issue Age</b>  | <b>Percent Increase Over Initial Premium</b> |
| 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, email address [soudeke@dhs.state.ia.us](mailto: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, email address [soudeke@dhs.state.ia.us](mailto: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 email address of the person completing this form

\_\_\_\_\_  
Name

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
E-mail Address

CHAPTER 41  
LIMITED SERVICE ORGANIZATIONS

**191—41.1(514B) Definitions.**

“*Act*” when used in these rules shall mean Iowa Code chapter 514B.

“*Complaint*” means a written communication expressing a grievance concerning a limited service organization.

“*Governing body*” means the persons in which the ultimate responsibility and authority for the conduct of the LSO is vested.

“*Limited health services*” include dental care services, vision care services, mental health services, behavioral health care services, substance abuse services, pharmaceutical services, podiatric care services, chiropractic services, nursing services, services of a licensed dietitian, physical therapy services, or any other category of services approved by the commissioner. “Limited health services” do not include employee assistance programs which provide only assessment and referral services or intermediate or long-term care facilities.

“*Limited service organization*” or “*LSO*” means any corporation or limited liability company or other entity which, in return for prepayment, undertakes to provide or arrange for the provision of one or more limited health services to enrollees. Entities authorized to do business pursuant to Iowa Code chapters 508, 512B, 514, 514B (health maintenance organizations), 515, and 520 shall not be required to obtain separate licensure as an LSO.

“*Outpatient provider services*” means outpatient provider services provided within or outside of a hospital. These services shall include, but not be limited to, laboratory and diagnostic X-ray with emphasis directed toward primary care.

“*Producer*” means a person engaged in solicitation or enrollment for an LSO and who ultimately delivers the certificate of membership or policy to a member.

“*Provider*” means any person or institution duly licensed or otherwise authorized to deliver or furnish limited health services.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—41.2(514B) Application.** An application on forms provided by the insurance division accompanied by a filing fee of \$100 payable to State Treasurer, State of Iowa, shall be completed by an officer or authorized representative of the LSO. The application with copies in duplicate shall be executed in conformance with rule 191—41.10(514B) and shall be accompanied by the information found in Iowa Code sections 514B.3(1) to 514B.3(14). An application shall not be deemed to be filed until all information necessary to properly process said application has been received by the commissioner, as indicated in rule 191—41.10(514B). Amendments to the application form shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

**191—41.3(514B) Inspection of evidence of coverage.** Except for groups which maintain a cafeteria plan pursuant to Section 125 of the Internal Revenue Code (28 U.S.C.A. § 125), an enrollee may, if evidence of coverage is not satisfactory for any reason, return evidence of coverage within ten days of receipt of same and receive full refund of the deposit paid, if any. This right shall not act as a cure for misleading or deceptive advertising or marketing methods, nor may it be exercised if the enrollee utilizes the services of the LSO within the ten-day period. Enrollees in cafeteria plans must adhere to the plan provisions concerning termination or changes in coverage.

**191—41.4(514B) Governing body and enrollee representation.** An LSO shall have a basic written organizational document setting forth its scheme of organization and establishing a governing body appropriate to its form of organization. The governing body shall be responsible for matters of policy and operation.

The LSO shall develop bylaws or guidelines which describe the scope of the health care services the LSO renders to enrollees directly by a provider. Initial articles of incorporation, bylaws, guidelines

of the LSO and revisions thereto shall be submitted to the commissioner of insurance for review and approval.

The articles of incorporation, bylaws, guidelines, or similar document shall provide for “reasonable representation” on the governing body by enrollees. “Reasonable representation” as used in Iowa Code section 514B.7 shall require that not less than 30 percent of the governing board members be enrollees who are not providers or are not associated with a provider. Enrollees shall have the opportunity to nominate said enrollee representatives.

The LSO may provide upon its initial formation that all representatives on the governing board shall be selected by the organizers of the LSO. Such members shall serve until the first annual meeting or election. If there are no enrollee representatives on the initial governing board, they shall be elected at the first annual meeting or election. The nomination procedures for enrollee representatives should provide for the following to ensure an adequate opportunity for participation by enrollees:

**41.4(1)** An opportunity for adult enrollees to nominate candidates for the governing body.

**41.4(2)** Notice to all adult enrollees of the nomination and elective procedures. The LSO shall be deemed to have complied with these requirements if it provides notice in its regular newsletter to enrollees of the opportunity to and the procedures for nomination of enrollee representatives. Nomination procedures may be waived by the commissioner for a period of up to three years from the LSO’s commencement of delivery of services to enrollees.

**191—41.5(514B) Quality of care.** Each LSO shall:

**41.5(1)** Advise the insurance division annually of the ratio of full-time providers and ancillary health personnel to enrollees to ensure an adequate network. Changes in the provider ratios shall be immediately reported together with action taken to correct any deficiencies in the ratios.

**41.5(2)** Provide assurance that all personnel engaged in the provision of health services to enrollees are currently licensed or certified by the appropriate state agency where the providers are located to practice their respective professions. These personnel shall be no less qualified in their respective professions than the current level of qualification, which is maintained in the providers’ communities.

**41.5(3)** Provide assurance that any health care facilities utilized by the LSO are licensed by the appropriate state agency where the facilities are located. These facilities shall be accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association; or they shall be certified as a provider for Medicare or Medicaid; or as otherwise accredited or licensed in accordance with state or federal law.

**41.5(4)** Have a qualified administrator designated by the governing body who shall be responsible for the management of the LSO.

**41.5(5)** Provide for an ongoing internal peer review program.

**41.5(6)** Maintain a provider records system which includes at a minimum the following information:

- a. Documentation of utilization rates for every enrollee.
- b. Patient’s name, identification number, age, sex, and place of residence, and place of employment, if applicable.
- c. Services provided, when provided, where provided, and by whom.
- d. Provider diagnosis, treatment prescribed, therapy prescribed and drugs administered.
- e. Statement in regard to the status of the patient’s health, as appropriate.

**41.5(7)** Provide by contract or other arrangement for peer review. The plans for internal and external peer review shall be submitted to the commissioner of insurance for approval.

a. Internal peer review shall be conducted by the LSO staff on a continuing basis using standards adopted by the applicable accrediting body as a general guide. Internal peer review shall be structured to review the specific type of services for which the LSO is responsible. This review shall include but not be limited to the following:

- (1) Utilization review and evaluation of the quality of services provided enrollees.
- (2) The process or method by which services are provided.
- (3) The outcome of services.

*b.* External review may be satisfied either by NCQA certification or meeting the requirements of the external review group appointed by the commissioner. The criteria and methodology for selection of an external review group (ERG) are as follows:

- (1) The commissioner will appoint an ERG based on the following criteria:
  1. The group's experience in evaluating the quality of service provided.
  2. The degree to which the group is representative of the LSOs to be reviewed.
  3. The degree to which the group is knowledgeable about the delivery of the services provided by the LSO in Iowa.
  4. The group's ability to coordinate its activities with other review groups and with practitioners and providers of health services in Iowa.
  5. The group's knowledge of current and accepted provider opinion and its ability to make qualitative evaluations of clinical practice.
- (2) No provider shall review an LSO of which the provider is a member.
- (3) Appointment of an ERG will be for a four-year period, and only one ERG will be appointed at a time. Applications for appointment or reappointment will be accepted between 180 days and 90 days before the expiration of the acting ERG's four-year term.

*c.* The following are criteria and methodology by which an ERG will evaluate the effectiveness of an LSO's peer review program:

- (1) The ERG will conduct an on-site inspection of each Iowa-certified LSO every two years.
- (2) The inspection will consist of an interview with LSO staff and providers and a review of records (including clinical records of LSO patients) the ERG determines are necessary to conduct its inspection. The records may include any records or parts thereof maintained by the LSO or any of its provider members which pertain to LSO quality assurance operations or LSO patients, excluding financial records.
- (3) The function of the ERG will be to make a qualitative evaluation of the effectiveness of an LSO's internal peer review program and to report its findings to the insurance division.
- (4) The following items will be considered by the ERG in making its determination:
  1. The extent and acuity of the LSO's peer review program in evaluating the clinical management of enrollees provided by LSO providers.
  2. The ability of the LSO's program to identify aberrant practices in clinical management and to take appropriate disciplinary action.
  3. The method within the LSO by which the peer review program reports its findings to the provider staff and the governing body.
  4. The authority within the LSO to correct practices which the peer review program has found to be detrimental.
  5. The system developed within the LSO to facilitate the work of the peer review program.
  6. The commitment on the part of the LSO governing body and provider staff toward an active peer review program with a goal of quality assurance.

*d.* The following are procedures to be followed upon completion of an ERG's inspection:

- (1) Within 30 days of the completion of its inspection, the ERG will submit a written report of its findings to the LSO.
- (2) The LSO will have 45 days to respond to the ERG.
- (3) The ERG must file its final report with the insurance division within 90 days of the completion of its inspection. The final report must include any comments received from the LSO.
- (4) The insurance division may extend the time periods referred to in subparagraphs 41.5(7) "d"(1) to (3).
- (5) After considering the report of the ERG, the insurance commissioner shall determine if the LSO's certificate of authority is to be continued, suspended or revoked.

**191—41.6(514B) Change of name.** No name other than that certified by the division may be used. The name of the LSO may not be changed without prior approval of the division.

**191—41.7(514B) Change of ownership.** Each LSO which desires to transfer ownership of more than 10 percent of the stock or ownership interest in the LSO shall not do so without first submitting a proposed plan to the division for review and approval or disapproval.

**191—41.8(514B) Complaints.**

**41.8(1)** Each LSO shall provide in its bylaws for a system to resolve and record complaints.

**41.8(2)** The complaint system shall provide for the resolution of the following kinds of complaints and the recording of the information required to be reported to the commissioner.

- a. Complaints about the quality of health care services provided by the LSO.
- b. Complaints about the availability of such services.
- c. Complaints relating to enrollee participation in the operation of the LSO.

**41.8(3)** The complaints record shall be included in the annual report to the commissioner.

**41.8(4)** All complaint files shall be retained by the LSO until the examination for the period during which the complaint was received has been completed.

**191—41.9(514B) Cancellation of enrollees.**

**41.9(1)** Membership of an enrollee in an LSO may be terminated by the LSO for the following reasons and no other:

- a. Nonpayment of charges when due.
- b. Termination of the conditions, other than a change in the health of the enrollee, under which the enrollee became eligible to be enrolled under a group contract.
- c. Termination of the group contract under which the enrollee was enrolled.
- d. Change of place of residence of the enrollee from the geographic area served by the LSO.
- e. Failure of the enrollee to pay deductible or coinsurance charges permitted under Iowa Code section 514B.5(3).
- f. Unreasonable refusal of the enrollee to follow a prescribed course of treatment.
- g. A materially false statement or misrepresentation by the enrollee in an application for membership or benefits.
- h. Withdrawal of licensure by the LSO from the state. Upon withdrawal, an LSO has no obligation to secure replacement coverage for enrollees.

**41.9(2)** Membership of an enrollee in an LSO may be terminated only upon giving a notice of cancellation not less than 30 days before the date of termination. Such notice shall:

- a. Be given by delivery of the notice in duplicate to the enrollee in person or by certified mail addressed to the enrollee at the last address known to the LSO.
- b. State the date and hour upon which the enrollment shall terminate.
- c. State the reason for cancellation.
- d. If cancellation is for nonpayment of charges, state the amount of charges due, the cost of preparing and serving the notice, and the total cost of charges and preparing the notice, and that if the enrollee pays the amount of charges due plus the cost of preparing and serving the notice at any time before the cancellation date, the coverage will remain in force.
- e. State that the enrollee has the right to a hearing before the commissioner if requested by the enrollee within 20 days after receipt of notice of cancellation.
- f. Provide for the enrollee to indicate on the notice that the enrollee requests such hearing.
- g. State that the enrollee may request such hearing by forwarding one copy of the notice of cancellation, marked to request a hearing, to the Commissioner of Insurance, 330 E. Maple Street, Des Moines, Iowa 50319.

**41.9(3)** When a hearing is requested, the commissioner may require the LSO to continue to provide coverage during the pendency of the hearing and a period of not more than ten days after the decision is made known. The commissioner may require the enrollee, as a condition of granting continued coverage, to pay the LSO the charges for such period of coverage.

**41.9(4)** The hearing shall be held before the commissioner or the delegated administrative law judge in the following manner:

- a. Upon receipt of a request for hearing, the commissioner shall notify the LSO and the enrollee of the time and place of hearing.
- b. Formal rules of evidence need not be observed, but no evidence shall be received which does not relate to the issue.
- c. The burden of proof shall be upon the LSO to show by a preponderance of the evidence that it had good cause for cancellation for one or more of the reasons stated in the notice and provided herein, except that when the cancellation is for nonpayment of charges, the burden of proof shall be upon the enrollee to show a tender of payment before the date of cancellation.
- d. At the close of the hearing, or as soon thereafter as possible, the commissioner shall advise the parties of the commissioner's decision.

**191—41.10(514B) Application for certificate of authority.** The application for certificate of authority shall be in the following form:

LIMITED SERVICE ORGANIZATION  
APPLICATION FOR CERTIFICATE OF AUTHORITY  
(Name of Limited Service Organization)

Organized as \_\_\_\_\_ under the laws of the state of \_\_\_\_\_, makes application to the commissioner of insurance for a certificate of authority to establish and operate a limited service organization in compliance with Iowa Code chapter 514B.

Attached and made a part of this application are exhibits bearing numbers corresponding to the following:

1. A copy of the basic organizational document of the applicant, such as the articles of incorporation, articles of association or other applicable documents and all of its amendments.
2. A copy of the bylaws, rules or similar document regulating the conduct of the internal affairs of the applicant.
3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers if a corporation and the partners or members if a partnership or association.
  - 3.1 A list of the names and addresses of each owner of 5 percent or more of the LSO.
4. A copy of any contract made or to be made between any providers and the applicant.
  - 4.1 A copy of any contract made or to be made between the applicant and any person listed in paragraph "3" above.
  - 4.2 A copy of any contract made or to be made between the applicant and any person for management services.
5. A statement generally describing the LSO including, but not limited to, a description of its facilities and personnel.
6. A copy of the form of evidence of coverage.
7. A copy of the form of the group contract, if any, which is to be issued to employers, unions, trustees or other organizations.
8. Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by an independent certified public accountant, a copy of the applicant's most recent regular certified financial statement is attached.
  - 8.1 A copy of any contract made or to be made between the applicant and its reinsurer.
  - 8.2 A copy of any contract made or to be made between the applicant and any person for cash or asset management services.
9. A description of the proposed method of marketing the plan, a financial plan which includes a three-year projection of operating results anticipated, and a statement as to the sources of funding.
10. A power of attorney executed by the applicant, if not domiciled in this state, appointing the commissioner, the commissioner's successors in office and deputies as the true and lawful attorney of

the applicant for this state upon whom all lawful process in any legal action or proceeding against the LSO on a cause of action arising in this state may be served.

11. A statement reasonably describing the geographic area to be served and assessing in detail the economic feasibility of the LSO's projected operation.

12. A description of the complaint procedures to be utilized as required under Iowa Code section 514B.14.

13. A description of the procedures and programs to be implemented to meet the requirements for quality of health care as determined by the commissioner of insurance under Iowa Code section 514B.4.

14. A description of the mechanism by which enrollees shall be allowed to participate in matters of policy and operation as required by Iowa Code section 514B.7.

14.1 A copy of the notice to be given to enrollees of the procedure for nomination and election of members of the governing body.

15. A schedule of the liability and workers' compensation insurance to be maintained in force by the LSO.

#### VERIFICATION

The undersigned deposes and states that deponent has duly executed the attached application dated \_\_\_\_\_, \_\_\_\_\_, for and on behalf of \_\_\_\_\_; that  
(Year) (Name of Applicant)

the deponent is the \_\_\_\_\_ of such company, and that deponent is  
(Title of Officer)

authorized to execute and file such instrument. Deponent further states that deponent is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of deponent's knowledge, information and belief.

(Signature)

(type or print name beneath)

Subscribed and sworn to before me by \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_,  
\_\_\_\_\_.

(Year)

(Notary Public)

#### **191—41.11(514B) Net equity and deposit requirements.**

##### **41.11(1) Net equity requirements.**

*a.* Each LSO shall, at all times, have and maintain a tangible net equity at least equal to the greater of:

(1) \$100,000 at the inception of the first year of operation, \$200,000 at the inception of the second year of operation and thereafter; or

(2) Two percent of the organization's annual gross premium income, up to a maximum of the required capital and surplus of an accident and health insurer.

*b.* An LSO that has uncovered expenses in excess of \$500,000, as reported on the most recent annual financial statement filed with the commissioner, shall maintain tangible net equity equal to 25 percent of the uncovered expense in excess of \$500,000 in addition to the tangible net equity required by paragraph 41.11(1)"*a.*"

*c.* For the purpose of this rule, "net equity" shall mean the excess of total assets over total liabilities, excluding liabilities which have been subordinated in a manner acceptable to the commissioner; and "net equity" shall mean net equity reduced by the value assigned to intangible assets, including, but not limited to:

- (1) Goodwill;
- (2) Going-concern value;
- (3) Organizational expense;
- (4) Start-up costs;

(5) Obligations of officers, directors or affiliates, except short-term obligations of affiliates for goods or services arising in the normal course of business which are payable on the same terms as equivalent transactions with nonaffiliates and which are not past due;

(6) Long-term prepayments of deferred charges; and

(7) Nonreturnable deposits.

**41.11(2) Deposits.**

*a.* Each LSO shall deposit with the commissioner or with any organization or trustee meeting the requirements of rule 191—32.4(508) cash, securities or any combination of these that is acceptable to the commissioner having a fair market value equal to the minimum net worth of the LSO as determined by paragraph 41.11(1)“*a.*” The amount on deposit shall remain as an admitted asset of the organization in the determination of its net worth.

*b.* All income from deposits shall be an asset of the LSO. An LSO may withdraw a deposit or any part thereof, first having deposited, in lieu thereof, a deposit of cash, securities, or any combination of these in an amount and value equal to that to be withdrawn. Securities shall be approved by the commissioner before being substituted.

**41.11(3)** No LSO organized under the laws of another state shall, directly or indirectly, assume risks or provide the services of an LSO, as defined in Iowa Code section 514B.33, subsection (3), unless it first obtains licensure from the commissioner and complies with the requirements of rule 191—41.11(514B).

**41.11(4)** As deemed necessary by the division, each LSO that is a subsidiary of another person shall file with the division, in a form satisfactory to the division, a guarantee of the LSO’s obligations issued by the ultimate controlling parent or such other person satisfactory to the division.

**41.11(5)** Each LSO shall, at the time of application, pay to the division a one-time, nonrefundable fee of \$10,000 to be used by the division to create a special fund solely for the payment of administrative expenses in connection with the insolvency of an LSO.

**191—41.12(514B) Fidelity bond.** An LSO shall maintain in force a fidelity bond on employees and officers in an amount not less than \$100,000 or such other sum as may be prescribed by the commissioner. All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of cancellation or termination has been filed with the commissioner unless an earlier date of cancellation or termination is approved by the commissioner.

**191—41.13(514B) Annual report.** An LSO shall annually, on or before the first day of March, file with the commissioner of insurance a report verified by at least two of its principal officers and covering the preceding calendar year. The report shall be on the form designated by the National Association of Insurance Commissioners (NAIC) as the report form for LSOs. The report shall be completed using statutory accounting practices (SAP), and shall include any other information required under law or rule.

The commissioner of insurance may request additional reports and information from an LSO as often as is deemed necessary to enable the commissioner to carry out the duties of Iowa Code chapter 514B.

**191—41.14(514B) Cash or asset management agreements.** If an LSO utilizes a cash or asset management arrangement with its parent, affiliate, or any other person, the arrangement shall be written and subject to prior approval by the commissioner. Cash or asset management agreements shall meet the following minimum requirements:

1. Cash receipts shall be under the direct control of the LSO that generated the receipts. If the system is under the control of the LSO’s parent or affiliate, then receipts shall be transferred to the LSO within five working days.

2. Securities purchased shall be in the name of the LSO generating the funds for the security purchase.

3. An LSO's investments shall not be pooled with other entities' investments unless there is an agreement which vests an undivided interest in the pooled arrangement to the LSO. Such an agreement shall be subject to prior approval by the commissioner.

4. An LSO's cash or investments shall not be commingled with the cash or investments of any other person.

5. Investments made on behalf of an LSO shall be subject to the limitations imposed by Iowa Code sections 511.8 and 514B.15.

6. The agreement shall provide for prompt notice and verification of investments, establish responsibility for brokerage and other fees and provide for periodic reports on earnings and expenses.

7. A parent, affiliate, person, and employees thereof providing cash or asset management services shall be bonded and responsible for any physical loss of investments.

**191—41.15(514B) Reinsurance.** Reinsurance contracts and stop-loss agreements entered into by an LSO shall be subject to prior approval and shall meet the following minimum requirements:

1. Reinsurance contracts and stop-loss agreements shall provide that the commissioner of insurance be given notice of termination by certified mail at least 30 days prior to the effective date of termination of the reinsurance contract or stop-loss agreement.

2. Retention levels shall be reasonable in light of the LSO's financial condition and potential liabilities.

**191—41.16(514B) Provider contracts.** An LSO's arrangements for health care services shall be by written contract. Initial provider contracts shall be subject to prior approval. Thereafter, any provider contract deviating from previously submitted or approved contracts shall be submitted to the division for approval. In all instances, all provider contracts shall include the following provision:

(Provider), or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to, nonpayment by the LSO, LSO insolvency or breach of this agreement, shall (Provider), or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against subscriber/enrollee or persons other than the LSO acting on the providers' behalf for services provided pursuant to this agreement. This provision shall not prohibit collection of supplemental charges or copayments on LSO's behalf made in accordance with terms of (applicable agreement) between LSO and subscriber/enrollee.

(Provider), or its assignee or subcontractor, further agrees that (1) this provision shall survive the termination of this agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the LSO subscriber/enrollee and that (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between (Provider) and subscriber/enrollee or persons acting on their behalf.

**191—41.17(514B) Producers' duties.** In order to qualify for solicitation, enrollment, or delivery of a certificate of membership or policy in an LSO, a producer must comply with the licensing rules set forth in 191—Chapter 10 of the Iowa Administrative Code and in particular submit to an examination to determine the applicant's competence to sell accident and health insurance as described in rule 191—10.7(522), qualification 6.

**191—41.18(514B) Emergency services.** "Emergency services" (inpatient and outpatient), as defined in rule 191—40.20(514B), shall be provided by the LSO, either through its own facilities or through guaranteed arrangements with other providers, on a 24-hour basis unless a waiver from such services is approved by the commissioner. A provider and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since LSOs may not contract with every emergency care provider in an area, LSOs shall make every effort to inform members of participating providers.

**191—41.19(514B) Reimbursement.** Reimbursement to a provider of "emergency services," as defined in rule 191— 40.20(514B), shall not be denied by any LSO without that organization's review of the patient's provider history, presenting symptoms, and admitting or initial as well as final diagnosis,

submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the LSO as outlined in rule 191—40.9(514B). Upon denial of reimbursement for emergency services, the LSO shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

**191—41.20(514B) Limited service organization requirements.** An LSO shall not prohibit or otherwise restrict a participating provider from advising a covered person about the health status of the covered person or medical care or treatment of the covered person's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the provider is acting within the lawful scope of practice.

An LSO shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the LSO that, in the opinion of the provider, jeopardizes patient health or welfare.

**191—41.21(514B) Disclosure requirements.** All LSOs shall include in contracts and evidence of coverage forms a statement disclosing the existence of any prescription drug formularies. Upon request, all LSOs offering policies under this chapter that include a prescription drug formulary shall inform policyholders, and prospective policyholders at time of issuance, whether a prescription drug specified in the request is included in such formulary.

All LSOs shall also disclose the existence of any contractual arrangements providing rebates received by them for drugs or durable medical equipment. Durable medical equipment means equipment that can stand repeated uses and is primarily and customarily used to serve a medical purpose and is generally not useful to a person who is not sick or injured or used by other family members and is appropriate for home use for the purpose of improving bodily function or preventing further deterioration of the medical condition caused by sickness or injury.

These rules are intended to implement Iowa Code section 514B.33.

[Filed 4/30/99, Notice 1/13/99—published 5/19/99, effective 8/18/99]

[Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]



## HEALTH BENEFIT PLANS

## CHAPTER 71

## SMALL GROUP HEALTH BENEFIT PLANS\*

**191—71.1(513B) Purpose.** This chapter is intended to implement the provisions of Iowa Code chapter 513B to provide for the guaranteed issue of all health insurance products in the small group market, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health insurance coverages; to ensure renewability of coverage; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for development of “basic” and “standard” health insurance plans to be offered to all small employers; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; to improve the overall fairness and efficiency of the small group health insurance market and to promote broader spreading of risk in the small employer marketplace. Carriers that provide basic and standard health benefit plans, as herein set forth, to small employers are intended to be subject to all provisions of Iowa Code chapter 513B and this chapter.

**71.1(1)** Health insurance coverage subject to this chapter is available or renewable with respect to all eligible employees or their dependents, at the option of the employer, except for reasons set forth in Iowa Code section 513B.5.

**71.1(2)** A carrier subject to this chapter is required to guarantee issue small employer plans except for reasons set forth in Iowa Code chapter 513B.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.2(513B) Definitions.** As used in this chapter:

“*Associate member of an employee organization*” means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. 1002(1)) that is a multiemployer plan (as defined in 29 U.S.C. 1002(37A)), other than the following:

1. An individual (or the beneficiary of such individual) who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or
2. An individual who is a present or former employee (or a beneficiary of such employee) of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan (or of a related plan).

“*Beneficiary*” has the meaning given the term under Section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which states, “a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit” under the plan.

“*Bona fide association*” means, with respect to group health insurance coverage offered in Iowa, an association that meets the following conditions:

1. Has been actively in existence for at least five years.
2. Has been formed and maintained in good faith for purposes other than obtaining insurance.
3. Does not condition membership in the association on any health status-related factor relating to an individual including an employee of an employer or a dependent of any employee.
4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members or individuals eligible for coverage through a member.
5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

“*COBRA*” means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

\*NOTE: In some instances, the numbering of this chapter does not adhere to the scheme developed for the Iowa Administrative Code.

“*Continuation coverage*” means coverage under a COBRA continuation provision or a similar state program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar state program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

“*Creditable coverage*” includes short-term limited duration insurance.

“*Director*” means the director of public health appointed pursuant to Iowa Code section 135.2.

“*Employee*” means any individual employed by an employer.

“*Enrollment date*” means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

“*Exhaustion of continuation coverage*” means that an individual’s continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted continuation coverage if:

1. Coverage ceases due to the failure of the employer or other responsible entity to remit premiums on a timely basis, or
2. When the individual no longer resides, lives, or works in a service area of an HMO or similar program, whether or not within the choice of the individual, and there is no other continuation coverage available to the individual.

“*Health insurance coverage*” does not include the following:

1. Flexible spending accounts.
2. Short-term limited duration insurance.
3. Stop loss insurance coverage.

“*Health maintenance organization*” or “*HMO*” means a federally qualified health maintenance organization as defined in Section 1301(a) of the Public Health Services Act or an organization licensed under Iowa Code section 514.5.

“*Late enrollee*” means an individual, other than one who enrolls during a special enrollment period, who enrolls under a health benefit plan or health insurance coverage in connection with which it is issued, other than during the first period in which the individual is eligible to enroll under terms of the health benefit plan or group health plan.

“*Network plan*” means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care including items and services paid for as medical care are provided, in whole or in part, through a defined set of providers under contract with the carrier.

“*New entrant*” means an eligible employee, or the dependent of an eligible employee, who becomes part of an employer group after the initial period for enrollment in health insurance coverage.

“*Plan year*” means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

1. The deductible/limit year used under the plan.
2. If the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year.
3. If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer’s taxable year.

“*Preexisting condition exclusion*” means, with respect to health insurance coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual’s health status before the individual’s first day of coverage, such as a condition identified as

a result of a preenrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

“*Risk characteristic*” means the health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

“*Risk load*” means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

“*Short-term limited duration insurance*” means health insurance coverage provided under a contract with a carrier 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.

Other terms shall be defined pursuant to Iowa Code chapter 513B.  
[ARC 3682C, IAB 3/14/18, effective 4/18/18]

### **191—71.3(513B) Applicability and scope.**

**71.3(1) a.** Except as provided herein, this chapter shall apply to any health insurance coverage, whether provided on a group or individual basis, which:

- (1) Meets one or more of the conditions set forth in Iowa Code sections 513B.3(1) to 513B.3(3);
- (2) Provides coverage to one or more employees of a small employer located in this state without regard to whether the policy or certificate was issued in this state; and
- (3) Is in effect on or after July 1, 1991.

**b.** Except as specifically provided, the provisions of Iowa Code chapter 513B and this chapter shall not apply to health insurance coverages delivered or issued for delivery prior to the effective date of the Act.

**71.3(2) a.** A carrier that provides individual health insurance policies to one or more of the employees of a small employer shall be considered a small employer carrier and subject to the provisions of Iowa Code chapter 513B and this chapter with respect to such policies if the small employer contributes, directly or indirectly, to the premiums for the policies and the carrier is aware, or should have been aware, of such contribution.

**b.** In the case of a carrier that provides individual health insurance policies to one or more employees of a small employer, the small employer shall be considered an eligible small employer as defined in Iowa Code section 513B.10 and the small employer carrier subject to Iowa Code section 513B.10(1)“b”(2) if:

- (1) The small employer has at least two employees;
- (2) The small employer contributes, directly or indirectly, to the premiums charged by the carrier or ODS; and
- (3) The carrier is aware, or should have been aware, of the contribution by the employer.

**71.3(3)** Iowa Code chapter 513B and this chapter shall apply to health insurance coverage provided to a small employer or to the employees of a small employer without regard to whether the health insurance coverage is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

**71.3(4)** An individual health insurance policy shall not be subject to Iowa Code chapter 513B and this chapter solely because the policyholder elects a business expense deduction under Section 162(1) of the Internal Revenue Code, the health insurance coverage is treated as part of a plan or program for purposes of Section 125 of the Internal Revenue Code for which the employee makes all the contributions, or the employer provides payroll deduction of health insurance premiums on behalf of an employee if the health insurance coverage covers employees where the employer has applied for group health benefits and has received written notification that the group did not meet the small group carrier's minimum participation or contribution standards. The individual health insurance carrier shall maintain a copy of the employer's notification from the small group carrier for insurance division audit purposes.

**71.3(5) a.** If a small employer is issued health insurance coverage under the terms of Iowa Code chapter 513B, the provisions of Iowa Code chapter 513B and this chapter shall continue to apply to the health insurance coverage in the case that the small employer subsequently employs more than 50 eligible employees. A carrier providing coverage to such an employer shall, within 60 days of becoming aware that the employer has more than 50 eligible employees but no later than the anniversary date of the employer's health insurance coverage, notify the employer that the protections provided under Iowa Code chapter 513B and this chapter shall cease to apply to the employer if such employer fails to renew its current health insurance coverage or elects to enroll in different health insurance coverage. It is the responsibility of the employer to notify the carrier of changes in employment levels which could change the employer's status as a small employer for the purposes of this chapter.

*b.* (1) If health insurance coverage is issued to an employer that is not a small employer as defined, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more employees), the terms of Iowa Code chapter 513B shall not apply to the health insurance coverage. The carrier providing health insurance coverage to such an employer shall not become a small employer carrier under the terms of Iowa Code chapter 513B solely because the carrier continues to provide coverage under the health insurance coverage to the employer.

(2) A carrier providing coverage to an employer described in subparagraph 71.3(5) "b"(1) shall, within 60 days of becoming aware that the employer has 50 or fewer eligible employees, notify the employer of the options and protections available to the employer under Iowa Code chapter 513B, including the employer's option to purchase a small employer health insurance coverage from any small employer carrier. It is the responsibility of the employer to notify the carrier of changes in employment levels which could change the employer's status as a small employer for the purposes of this chapter.

**71.3(6) a.** (1) If a small employer has employees in more than one state, Iowa Code chapter 513B and this chapter shall apply to health insurance coverage issued to the small employer if:

1. The majority of eligible employees of such small employer are employed in this state; or
2. If no state contains a majority of the eligible employees of the small employer, the primary business location of the small employer is in this state.

(2) In determining whether the laws of this state or another state apply to health insurance coverage issued to a small employer described in subparagraph (1), the provisions of the paragraph shall be applied as of the date the health insurance coverage was issued to the small employer for the period that the health insurance coverage remains in effect.

*b.* If health insurance coverage is subject to Iowa Code chapter 513B and this chapter, the provisions of 513B and those set forth herein shall apply to all individuals covered under the health insurance coverage whether they reside in this state or in another state.

**71.3(7)** A carrier that is not operating as a small employer carrier in this state shall not become subject to the provisions of the Act and this regulation solely because a small employer that was issued health insurance coverage in another state by that carrier moves to this state.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

#### **191—71.4(513B) Establishment of classes of business.**

**71.4(1)** A small employer carrier that establishes more than one class of business as defined in Iowa Code section 513B.2 shall maintain on file for inspection by the commissioner the following information with respect to each class of business so established:

*a.* A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business;

*b.* A statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons as set forth in the definition of “class of business” in Iowa Code section 513B.2;

*c.* A statement disclosing which, if any, health insurance coverages are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

**71.4(2)** A carrier may not directly or indirectly use group size as a criterion for establishing eligibility for health insurance coverage or for a class of business.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.5(513B) Transition for assumptions of business from another carrier.**

**71.5(1) a.** A small employer carrier shall not transfer or assume the entire insurance obligation or risk of health insurance coverage covering a small employer in this state unless:

(1) The transaction has been approved by the commissioner of the state of domicile of the assuming carrier;

(2) The transaction has been approved by the commissioner of the state of domicile of the ceding carrier; and

(3) The transaction otherwise meets the requirements of this rule and Iowa Code section 513B.3(4) “c.”

*b.* A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation or risk of one or more small employer health benefit plans from another carrier shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction upon a finding that the transaction is in the best interests of the individuals insured under the health insurance coverages to be transferred and is consistent with the purposes of Iowa Code chapter 513B and this chapter. The commissioner shall not approve the transaction until at least 30 days after the date of the filing except that, if the ceding carrier is in hazardous financial condition, the commissioner may approve the transaction as soon as the commissioner deems reasonable after the filing.

*c.* (1) The filing required under paragraph 71.5(1) “b” shall:

1. Describe the class of business (including any eligibility requirements) of the ceding carrier from which the health insurance coverage will be ceded;

2. Describe whether the assuming carrier will maintain the assumed health insurance coverage as a separate class of business (pursuant to 71.5(3)) or will incorporate them into an existing class of business (pursuant to 71.5(4)). If the assumed health insurance coverage will be incorporated into an existing class of business, the filing shall describe the class of business of the assuming carrier into which the health insurance coverages will be incorporated;

3. Describe whether the health insurance coverages being assumed are currently available for purchase by small employers;

4. Describe the potential effect of the assumption (if any) on the benefits provided by the health insurance coverages to be assumed;

5. Describe the potential effect of the assumption (if any) on the premiums for the health insurance coverages to be assumed;

6. Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health insurance coverages to be assumed; and

7. Include any other information required by the commissioner.

(2) A small employer carrier required to make a filing under 71.5(1) “b” shall also make an informational filing with the commissioner of each state in which there are small employer health insurance coverages that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under 71.5(1) “b” and shall include at least the information specified in 71.5(1) “c”(1) for the small employer health insurance coverages in that state.

*d.* A small employer carrier shall not transfer or assume the entire insurance obligation or risk of health insurance coverage covering a small employer in this state unless it complies with the following provisions:

(1) The carrier has provided notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in 71.5(1)“*c*” for the health insurance coverages covering small employers in this state.

(2) If the assumption of a class of business would result in the assuming small employer carrier’s being out of compliance with the limitations related to premium rates contained in Iowa Code section 513B.4(1)“*a*,” the assuming carrier shall make a filing with the commissioner pursuant to Iowa Code section 513B.17 seeking suspension of the application of Iowa Code section 513B.4(1)“*a*.”

(3) An assuming carrier seeking suspension of the application of Iowa Code section 513B.4(1)“*a*” shall not complete the assumption of health insurance coverages covering small employers in this state unless the commissioner grants the suspension requested pursuant to 71.5(1)“*d*”(2).

(4) Unless a different period is approved by the commissioner, a suspension of the application of 513B.4(1)“*a*” shall, with respect to an assumed class of business, be for no more than 15 months and, with respect to each individual small employer, last only until the anniversary date of such employer’s coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the class of business).

**71.5(2) a.** Except as provided in paragraph 71.5(1)“*b*,” a small employer carrier shall not cede or assume the entire insurance obligation or risk for small employer health insurance coverage unless the transaction includes ceding to the assuming carrier the entire class of business that includes such health insurance coverage.

*b.* A small employer carrier may cede less than an entire class of business to an assuming carrier if:

(1) One or more small employers in the class have exercised their right under contract or state law to reject (either directly or by implication) the ceding of their health insurance coverage to another carrier. In that instance, the transaction shall include each health insurance coverage in the class of business except those health insurance coverages for which a small employer has rejected the proposed cession; or

(2) After a written request from the transferring carrier, the commissioner determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business.

**71.5(3)** Except as provided in 71.5(4), a small employer carrier that assumes one or more health insurance coverages from another carrier shall maintain such health insurance coverages as a separate class of business.

**71.5(4)** A small employer carrier that assumes one or more health insurance coverages from another carrier may exceed the limitation contained in Iowa Code section 513B.2 (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for a period of up to 15 months after the date of the assumption, provided that the carrier complies with the following provisions:

*a.* Upon assumption of the health insurance coverages, such health insurance coverages shall be maintained as a separate class of business. During the 15-month period following the assumption, each of the assumed small employer health insurance coverages shall be transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier shall select the class of business into which the assumed health insurance coverages will be transferred in a manner that results in the least possible change to the coverages and rating method of the assumed health insurance coverages.

*b.* The transfers authorized in paragraph “*a*” shall occur, with respect to each small employer, on the anniversary date of the small employer’s coverage, except that an individual small employer period may be extended beyond the first anniversary date up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the class of business.

*c.* A small employer carrier making a transfer pursuant to paragraph “*a*” may alter the benefits of the assumed health insurance coverages to conform to the benefits currently offered by the carrier in the class of business into which the health insurance coverages have been transferred.

*d.* The premium rate for an assumed small employer health insurance coverage shall not be modified by the assuming small employer carrier until the health insurance coverage is transferred pursuant to paragraph “*a*.” Upon transfer, the assuming small employer carrier shall calculate a new premium rate for the health insurance coverage from the rate manual established for the class of business into which the health insurance coverage is transferred. In making such calculation, the risk load applied to the health insurance coverage shall be no higher than the risk load applicable to such health insurance coverage prior to the assumption.

*e.* During the 15-month period provided in this subrule, the transfer of small employer health insurance coverages from the assumed class of business in accordance with this subrule shall not be considered a violation of the first sentence of Iowa Code section 513B.4(4).

**71.5(5)** An assuming carrier may not apply eligibility requirements (including minimum participation and contribution requirements) with respect to an assumed health insurance coverage (or with respect to any health insurance coverage subsequently offered to a small employer covered by such an assumed health insurance coverage) that are more stringent than the requirements applicable to such health insurance coverage prior to the assumption.

**71.5(6)** The commissioner may approve a longer period of transition upon application of a small employer carrier. The application shall be made within 60 days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

**71.5(7)** Nothing in this rule or in Iowa Code chapter 513B is intended to:

*a.* Reduce or diminish any legal or contractual obligation or requirement, including any obligation provided in Iowa Code chapters 521 and 521B, of the ceding or assuming carrier related to the transaction;

*b.* Authorize a carrier that is not admitted to transact the business of insurance in this state to offer health insurance coverages in this state; or

*c.* Reduce or diminish the protections related to an assumption reinsurance transaction provided in Iowa Code chapters 521 and 521B or otherwise provided by law.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

#### **191—71.6(513B) Restrictions relating to premium rates.**

**71.6(1)** *a.* A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this rule. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier’s discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion.

*b.* (1) A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this paragraph. The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purpose of Iowa Code chapter 513B and this chapter.

(2) A carrier may modify the rating method for a class of business only with prior approval of the commissioner. A carrier requesting to change the rating method for a class of business shall make a filing with the commissioner at least 30 days prior to the proposed date of the change. The filing shall contain at least the following information:

1. The reasons the change in rating method is being requested;
2. A complete description of each of the proposed modifications to the rating method;
3. A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium

rates may change by more than 10 percent due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in health insurance coverage);

4. A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

5. A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of Iowa Code section 513B.4.

(3) For the purpose of this rule, a change in rating method shall mean:

1. A change in the number of case characteristics used by a small employer carrier to determine premium rates for health insurance coverages in a class of business;

2. A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health insurance coverages in a class of business;

3. A change in the method of allocating expenses among health insurance coverages in a class of business; or

4. A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds 10 percent.

For the purpose of 71.6(1)“b”(3)“1,” a change in a rating factor shall mean the cumulative change, with respect to such factor, considered over a 12-month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12-month period, the carrier shall consider the cumulative effect of all such changes in applying the 10 percent test under paragraph 71.6(1)“b”(3)“1.” A filing which has not previously been approved, denied, or questioned is deemed approved on or after 30 days from receipt by the division.

**71.6(2) a.** The rate manual developed pursuant to 71.6(1) shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

*b.* A small employer carrier may not use case characteristics other than those specified in 513B.4(2) without the prior approval of the commissioner. A small employer carrier seeking such an approval shall make a filing with the commissioner for a change in rating method under 71.6(1)“b.”

*c.* A small employer carrier shall use the same case characteristics in establishing premium rates for each health insurance coverage in a class of business and shall apply them in the same manner in establishing premium rates for each health insurance coverage. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

*d.* The rate manual developed pursuant to 71.6(1) shall clearly illustrate the relationship among the base premium rates charged for each health insurance coverage in the class of business. If the new business premium rate is different than the base premium rate for a health insurance coverage, the rate manual shall illustrate the difference.

*e.* Differences among base premium rates for health insurance coverages shall be based solely on the reasonable and objective differences in the design and benefits of the health insurance coverages and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health insurance coverage. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that ensures that premium differences among health insurance coverages for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health insurance coverages and are not due to the actual or expected health status or claims experience of the small employer groups that choose, or are expected to choose, a particular health insurance coverage.

*f.* The rate manual developed pursuant to 71.6(1) shall provide for premium rates to be developed in a two-step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of Iowa Code section 513B.4, to reflect the risk characteristics of the group.

*g.* (1) Except as provided in subparagraph (2), a premium charged to a small employer for a health insurance coverage shall not include a separate application fee, underwriting fee or any other separate fee or charge.

(2) A carrier may charge a separate fee with respect to a health insurance coverage (but only one fee with respect to such plan) provided the fee is no more than \$5 per month per employee and is applied in a uniform manner to each health insurance coverage in a class of business.

*h.* A small employer carrier shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable a basis than expenses are allocated to other health insurance coverages in the class of business. The rate manual developed pursuant to 71.6(1) shall describe the method of allocating administrative expenses to the health insurance coverages in the class of business for which the manual was developed.

*i.* Each rate manual developed pursuant to 71.6(1) shall be maintained by the carrier for a period of six years. Updates and changes to the manual shall be maintained with the manual.

*j.* The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the commissioner.

**71.6(3)** If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification shall not exceed the lowest rate factor associated with such a classification by more than 20 percent.

**71.6(4)** The restrictions related to changes in premium rates in Iowa Code sections 513B.4(1) “*c*” and 513B.4(1) “*d*” shall be applied as follows:

*a.* A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

*b.* (1) If, for any health insurance coverage with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business premium rate shall be deemed the change in the base premium rate for the purposes of Iowa Code sections 513B.4(1) “*c*” and 513B.4(1) “*d*.”

(2) If, for any health insurance coverages with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health insurance coverage shall be considered health insurance coverage into which the small employer carrier is no longer enrolling new small employers for the purposes of Iowa Code sections 513B.4(1) “*c*” and 513B.4(1) “*d*.”

*c.* If, for any rating period, the change in the new business premium rate for health insurance coverage differs from the change in the new business premium rate for any other health insurance coverage in the same class of business by more than 20 percent, the carrier shall make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made within 30 days of the beginning of the rating period.

*d.* A small employer carrier shall keep on file, for a period of at least six years, the calculations used to determine the change in base premium rates and new business premium rates for each health insurance coverage for each rating period.

**71.6(5)** *a.* Except as provided in paragraphs “*b*” through “*d*,” a change in premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(1) The base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by

(2) One plus the sum of:

1. The risk load applicable to the small employer during the previous rating period, and

2. Fifteen percent (prorated for periods of less than one year).

*b.* In the case of health insurance coverage into which a small employer carrier is no longer enrolling new small employers, a change in a premium rate for a small employer shall produce a revised premium rate that is no more than the following:

(1) The base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by

(2) One plus the lesser of:

1. The change in the base rate or

2. The percentage change in the new business premium for the most similar health insurance coverage into which the small employer carrier is enrolling new small employers, multiplied by

(3) One plus the sum of:

1. The risk load applicable to the small employer during the previous rating period and

2. Fifteen percent (prorated for periods of less than one year).

c. In the case of health insurance coverage described in Iowa Code section 513B.4(2), if the current premium rate for the health insurance coverage exceeds the ranges set forth in Iowa Code section 513B.4(1), the formulae set forth in paragraphs “a” and “b” will be applied as if the 15 percent adjustment provided in 71.6(5) “a”(2) “2” and 71.6(5) “b”(3) “2” were a zero percent adjustment.

d. Notwithstanding the provisions of paragraphs “a” and “b,” a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in Iowa Code section 513B.4(1) “b.”

**71.6(6) a.** A representative of a Taft Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the commissioner a request for the waiver of application of the provisions of Iowa Code section 513B.4 with respect to such trust.

b. A request made under paragraph “a” shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provisions would:

(1) Adversely affect the participants and beneficiaries of the trust; and

(2) Require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.

c. A waiver granted under Iowa Code section 513B.4A shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

### **191—71.7(513B) Requirement to insure entire groups.**

**71.7(1) a.** A small employer carrier that offers coverage to a small employer shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. The small employer carrier shall provide the same health insurance coverage to each employee and dependent.

b. Except as provided in Iowa Code section 513B.10(4) (with respect to exclusions for preexisting conditions), the choice among insurance coverages may not be limited, restricted or conditioned upon the risk characteristics of the employees or their dependents.

**71.7(2) a.** Except as provided in this subrule, a small employer carrier may not issue health insurance coverage to a small employer unless the health insurance coverage covers all eligible employees and all dependents of eligible employees.

b. A small employer carrier may issue health insurance coverage to a small employer that excludes an eligible employee or the dependent of an eligible employee only if:

(1) The excluded individual has coverage under health insurance coverage or other health coverage arrangement, including that set forth in Iowa Code chapter 514E, that provides coverage similar to or exceeding benefits provided under the basic health insurance coverage;

(2) The excluded individual does not have a risk characteristic or other attribute that would cause the carrier to make a decision with respect to premiums or eligibility for health insurance coverage that is adverse to the small employer;

(3) The excluded individual states in a signed waiver that the individual has had coverage under health insurance coverage or other health arrangement, including that set forth in Iowa Code chapter 514E, within the previous six months and reasonably expects to have coverage within the succeeding six

months under health insurance coverage or other health arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan.

*c.* A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees. The small employer carrier shall require the small employer to provide appropriate supporting documentation in the form of a W-2 Summary Wage and Tax Form and federal or state quarterly withholding statements for the current year and the year immediately preceding the year of application for coverage.

(1) A small employer carrier shall secure a waiver, with respect to each eligible employee and each dependent of an eligible employee, declining an offer of coverage under health insurance coverage provided to a small employer. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health insurance coverage. The waiver form shall require that the reason for declining coverage be stated on the form and shall include a written warning of the penalties imposed on late enrollees. Waivers shall be maintained by the small employer carrier for a period of six years.

(2) A small employer carrier shall obtain, with respect to each individual who submits a waiver under 71.7(2)“c”(1), information sufficient to establish that the waiver is permitted under 71.7(2)“b.”

*d.* (1) A small employer carrier shall not issue coverage to a small employer if the carrier is unable to obtain the list required under 71.7(2)“c,” a waiver required under 71.7(2)“c”(1) or the information required under 71.7(2)“c”(2) in circumstances set forth in this subrule.

(2) 1. A small employer carrier shall not offer coverage to a small employer if the carrier, or a producer for such carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual’s risk characteristics.

2. A producer shall notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual’s risk characteristics.

**71.7(3) a.** New entrants to a small employer group shall be offered an opportunity to enroll in the health insurance coverage currently held by such group. A new entrant who does not exercise the opportunity to enroll in the health insurance coverage within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health insurance coverage extends at least 30 days after the date the new entrant is notified of the opportunity to enroll. If a small employer carrier has offered more than one health insurance coverage to a small employer group pursuant to 71.7(1)“b,” the new entrant shall be offered the same choice of health insurance coverages as the other members of the group.

*b.* A small employer carrier shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for preexisting medical conditions consistent with Iowa Code section 513B.10(4)), with respect to a new entrant that is longer than 60 days. This subrule does not affect an employer’s ability to determine an employee’s probationary period of work prior to the commencement of benefits.

*c.* New entrants to a group shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents except that a carrier may exclude coverage for preexisting medical conditions consistent with the provisions provided in Iowa Code section 513B.10.

*d.* A small employer carrier may assess a risk load to the premium rate associated with a new entrant consistent with the requirements of Iowa Code section 513B.4. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

**71.7(4) a.** Opportunity to enroll.

(1) In the case of an eligible employee (or dependent of an eligible employee) who, prior to July 1, 1993, was excluded from coverage or denied coverage by a small employer carrier in the process of providing health insurance coverage to an eligible small employer (as defined in Iowa Code section 513B.2(16)), the small employer carrier shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in health insurance coverage currently held by the small employer.

(2) A small employer carrier may require an individual who requests enrollment under this subrule to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that the coverage was not offered to the individual.

*b.* The opportunity to enroll shall meet the following requirements:

(1) The opportunity to enroll shall begin October 1, 1993, and extend for a period of at least three months.

(2) Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subrule shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with 71.7(3).

(3) The terms of coverage offered to an individual described in subparagraph “a”(1) may exclude coverage for preexisting medical conditions if the health insurance coverage currently held by the small employer contains such an exclusion, provided that the exclusion period shall be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual pursuant to this subrule.

(4) A small employer carrier shall provide written notice at least 45 days prior to the opportunity to enroll provided in 71.7(4) “a”(1) to each small employer insured under health insurance coverage offered by such carrier. The notice shall clearly describe the rights granted under this subrule to employees and dependents previously excluded or denied coverage and the process for enrollment of such individuals in the employer’s health insurance coverage.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

#### **191—71.8(513B) Case characteristics.**

**71.8(1)** A small employer carrier may use age, geographic area, family composition, and group size in establishing premium rates, subject to Iowa Code section 513B.4(2).

**71.8(2)** Additional rating factors are not allowed without the prior approval of the commissioner.

#### **191—71.9(513B) Application to reenter state.**

**71.9(1)** A carrier prohibited from writing coverage for small employers in this state pursuant to Iowa Code section 513B.5(2) may not resume offering health insurance coverage to small employers in this state until the carrier has made a petition to the commissioner or director to be reinstated as a small employer carrier and the petition has been approved by the commissioner or director. In reviewing a petition, the commissioner or director may ask for such information and assurances as the commissioner or director finds reasonable and appropriate.

**71.9(2)** In the case of a small employer carrier doing business in only one established geographic service area of the state, if the small employer carrier elects to nonrenew health insurance coverage under Iowa Code section 513B.5, the small employer carrier shall be prohibited from offering health insurance coverages to small employers in any other geographic area of the state without the prior approval of the commissioner or director. In considering whether to grant approval, the commissioner or director may ask for such information and assurances as the commissioner or director finds reasonable and appropriate.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.10(513B) Creditable coverage.** For purposes of this chapter, creditable coverage shall have the same definition as 1997 Iowa Acts, House File 701, section 10.

#### **191—71.11(513B) Rules related to fair marketing.**

**71.11(1) a.** A small employer carrier shall actively market health insurance coverages including one basic and one standard health benefit plan to small employers in this state. A small employer carrier may

not suspend the marketing or issuance of the basic and standard health benefit plans unless the carrier has good cause and has received the prior approval of the commissioner or director.

*b.* In marketing the basic and standard health benefit plans to small employers, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health insurance coverages to small employers.

**71.11(2) a.** A small employer carrier, in accordance with the provisions of Iowa Code section 513B.10, shall accept every small employer that applies for health insurance coverage from the small employer carrier and shall accept every eligible individual who applies for enrollment. The offer shall be in writing and shall include at least the following information:

(1) A general description of the benefits contained in the basic and standard health benefit plans and any other health insurance coverage being offered to the small employer, and

(2) Information describing how the small employer may enroll in the plans.

The offer may be provided directly to the small employer or delivered through a producer.

*b.* (1) A small employer carrier shall provide a price quote to a small employer (directly or through an authorized producer) within ten working days of receiving a request for a quote and other information as necessary to provide the quote. A small employer carrier shall notify a small employer (directly or through an authorized producer) of any additional information needed by the small employer carrier to provide the quote within five working days of receiving a request for a price quote.

(2) A small employer carrier shall not apply more stringent or detailed requirements related to the application process for the basic and standard health benefit plans than applied for other health insurance coverage offered by the carrier.

**71.11(3)** A small employer carrier shall establish and maintain a toll-free telephone service to provide information to small employers regarding the availability of health insurance coverages in this state. The service shall provide information to callers regarding application for coverage from the carrier. The information may include the names and telephone numbers of producers located in geographic proximity to the caller or such other information reasonably designed to assist the caller to locate an authorized producer or to otherwise apply for coverage.

**71.11(4)** The small group carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier except, if membership in an association or other group is a requirement for accepting a small employer into health insurance coverage, a small employer carrier may apply such requirement.

**71.11(5)** A small employer carrier may not require, as a condition to the offer or sale of health insurance coverage to a small employer, that the small employer purchase or qualify for any other insurance product or service.

**71.11(6) a.** Carriers offering individual and group health insurance coverages in this state shall be responsible for determining whether the plans are subject to the requirements of Iowa Code chapter 513B and this chapter. Carriers shall elicit the following information from applicants for such plans at the time of application:

(1) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(2) Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health insurance coverage as part of a plan or program under Section 162 (other than Section 162(1)), Section 125 or Section 106 of the United States Internal Revenue Code.

*b.* If a small employer carrier fails to comply with paragraph “a,” the small employer carrier shall be deemed on notice regarding any information that could reasonably have been attained if the small employer carrier had complied with paragraph “a.”

**71.11(7) a.** A small employer carrier shall annually file the following information with the commissioner related to health insurance coverages issued by the small employer carrier to small employers in this state:

(1) The number of small employers that were issued health insurance coverages in the previous calendar year (separated as to newly issued plans and renewals);

(2) The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year (separated as to newly issued plans and renewals and as to class of business);

(3) The number of small employer health insurance coverages in force in each county (or by ZIP code) of the state as of December 31 of the previous calendar year;

(4) The number of small employer health insurance coverages that were voluntarily not renewed by small employers in the previous calendar year;

(5) The number of small employer health insurance coverages that were terminated or nonrenewed (for reasons other than nonpayment of premium) by the carrier in the previous calendar year; and

(6) The number of small employer health insurance coverages that were issued to small employers that were uninsured for at least the three months prior to issue.

*b.* The information described in paragraph “*a*” shall be filed no later than March 15 of each year.

**71.11(8)** A small group carrier shall not price the basic and standard benefit plans nor set the commissions in such a way to make the plans unattractive for a producer to market. A small employer carrier shall provide reasonable compensation, as provided in the plan of operation, to a producer, if any, for the sale of a basic or standard health benefit plan.

**71.11(9)** A small employer carrier shall establish commission payments for the sale of basic and standard health benefit plans within each class of business at no less than 75 percent of the level of commission payments assessed on other small group health products.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.12(513B) Status of carriers as small employer carriers.**

**71.12(1)** Subject to 71.12(2), a carrier shall not offer health insurance coverages to small employers or continue to provide coverage under health insurance coverages previously issued to small employers in this state unless the carrier has made a filing with the commissioner or director that the carrier intends to operate as a small employer carrier in this state under the terms of this chapter.

**71.12(2) a.** If a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health insurance coverages previously issued to small employers in this state only if the carrier complies with the following provisions:

(1) The carrier complies with the requirements of Iowa Code chapter 513B (other than Iowa Code sections 513B.11 to 513B.13) with respect to each of the health insurance coverages previously issued to small employers by the carrier.

(2) The carrier provides coverage to each new entrant to health insurance coverage previously issued to a small employer by the carrier. The provisions of Iowa Code chapter 513B (other than Iowa Code sections 513B.11 to 513B.13) and this chapter shall apply to the coverage issued new entrants.

(3) The carrier complies with the requirements of Iowa Code section 513B.17A, and rule 191—71.13(513B), as they apply to small employers whose coverage has been terminated by the carrier, and to individuals and small employers whose coverage has been limited or restricted by the carrier.

*b.* A carrier that continues to provide coverage pursuant to this subrule shall not be eligible to participate in the reinsurance program established under Iowa Code section 513B.11.

**71.12(3)** If a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from operating as a small employer carrier in this state (except as provided for in 71.12(2)) for a period of five years from the date of this chapter. Upon a written request from such a carrier, the commissioner may reduce the period provided for in the previous sentence if the commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in the state.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.13(513B) Restoration of coverage.**

**71.13(1) a.** Except as provided in 71.13(1) “*b*,” a small employer carrier shall, as a condition of continuing to transact business in this state with small employers, offer to provide health insurance coverage as described in 71.13(3) to any small employer carrier after January 1, 1993, unless the carrier’s termination is pursuant to Iowa Code section 513B.5.

*b.* The offer required under 71.13(1)“*a*” shall not be required with respect to health insurance coverage that was not renewed if:

(1) The health insurance coverage was not renewed for reasons permitted in Iowa Code section 513B.5(1), or

(2) The nonrenewal was a result of the small employer voluntarily electing coverage under different health insurance coverage.

**71.13(2)** The offer made under 71.13(1) shall occur not later than 60 days after July 2, 1993. A small employer shall be given at least 60 days to accept an offer made pursuant to 71.13(1).

**71.13(3)** A health insurance coverage provided to a terminated small employer pursuant to 71.13(1) shall meet the following conditions:

*a.* The health insurance coverage shall contain benefits that are identical to the benefits in the health insurance coverage that was terminated or nonrenewed.

*b.* The health insurance coverage shall not be subject to any waiting periods (including exclusion periods for preexisting conditions) or other limitations on coverage that exceed those contained in the health insurance coverage that was terminated or nonrenewed. In applying such exclusions or limitations, the health insurance coverage shall be treated as if it were continuously in force from the date it was originally issued to the date that it is restored pursuant to 191—71.13(513B).

*c.* The health insurance coverage shall not be subject to any provisions that restrict or exclude coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

*d.* The health insurance coverage shall provide coverage to all employees who are eligible employees as of the date the plan is restored. The carrier shall offer coverage to each dependent of such eligible employees.

*e.* The premium rate for the health insurance coverage shall be no more than the premium rate charged to the small employer on the date the health insurance coverage was terminated or nonrenewed provided that, if the number or case characteristics of the eligible employees (or their dependents) of the small employer has changed between the date the health insurance coverage was terminated or nonrenewed and the date that it is restored, the carrier may adjust the premium rates to reflect any changes in case characteristics of the small employer. If the carrier has increased premium rates for other similar groups with similar coverage to reflect general increases in health care costs and utilization, the premium rate may be further adjusted to reflect the lowest such increase given to a similar group. The premium rate for the health insurance coverage may not be increased to reflect any changes in risk characteristics of the small employer group until one year after the date the health insurance coverage is restored. Any such increase shall be subject to the provisions of Iowa Code section 513B.4.

*f.* The health insurance coverage shall not be eligible to be reinsured under the provisions of Iowa Code section 513B.12, except that the carrier may reinsure new entrants to the health insurance coverage who enroll after the restoration of coverage.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

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

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

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

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

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

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

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

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

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

## SMALL EMPLOYER PRODUCTS

|  | MANDATED INDEMNITY                             |  | MANDATED HMOs                                     |                                    |
|--|--|--|---|------------------------------------|
|  | BASIC  | STANDARD                                       | BASIC   | STANDARD                           |
| Calendar Year Deductibles (S/F)          | \$500 x 3                                      | \$500 x 2                                      |   |                                    |
| E.R. Copayment                           | \$50 (waived if admitted)                      | \$50 (waived if admitted)                      | \$50 (waived if admitted)                         | \$50 (waived if admitted)          |
| Coinsurance                              | 60%  | 80%  | 60%   | 80%                                |
| Out-of-pocket per insured/family maximum | \$4,800/\$14,400                               | \$2,000/\$4,000                                | \$4,000/\$8,000 (excludes deductibles and copays) | \$2,000/\$4,000                    |
| Annual Maximum                           |  |  |   |                                    |
| Lifetime Maximum                         | \$250,000                                      | \$1,000,000                                    | \$250,000   | \$1,000,000                        |
| Pre-Existing                             | 513B.10(3)                                     | 513B.10(3)                                     | 513B.10(3)  | 513B.10(3)                         |
| Late Entrant                             | 513B.2(12)                                     | 513B.2(12)                                     | 513B.2(12)  | 513B.2(12)                         |
| Wellness                                 | 100% first \$100<br>60% over \$100             | 100% first \$150<br>80% over \$150             | 100% after \$20<br>copay per visit                | 100% after \$15<br>copay per visit |
| Maternity                                | 60% Enrollee or Spouse Only                    | 80% Enrollee or Spouse                         | 60%   | 80%                                |
| PHYSICIAN SERVICES                       |  |  |   |                                    |
| Office Visits                            | 60% <sup>(1)</sup>                             | 80% <sup>(2)</sup>                             | \$20 copay per office visit                       | \$15 copay per office visit        |
| Urgent Care                              | 60%  | 80%  | 60%   | 80%                                |
| Inpatient                                | 60%  | 80%  | 60%   | 80%                                |
| Outpatient                               | 60% <sup>(1)</sup>                             | 80% <sup>(2)</sup>                             | 60%   | 80%                                |
| Vision Screening                         |  |  |   |                                    |
| Vision Examinations                      |  |  |   |                                    |
| Immunizations                            | 60% <sup>(1)</sup>                             | 80% <sup>(2)</sup>                             | 60%   | 80%                                |
| Well Child                               | 60% <sup>(1)</sup> (Deductible does not apply) | 80% <sup>(2)</sup> (Deductible does not apply) | 100% after \$20 copay/visit                       | 100% after \$15 copay/visit        |
| Pre-Natal/Post-Natal Outpatient Visits   | 60% <sup>(1)</sup>                             | 80% <sup>(2)</sup>                             | 100% after \$50 copay/pregnancy                   | 100% after \$50 copay/pregnancy    |
| Inpatient                                | 60%  | 80%  | 60% of \$400/admit                                | 80% \$200/admit                    |
| Prostheses                               | 60%  | 80%  | 60%   | 80%                                |
| DME—including medical supplies           | 60%  | 80%  | 60%   | 80%                                |
| Ambulance-Emergency                      | 60%  | 80%  | 60%   | 80%                                |
| Hospice                                  | 60%  | 80%  | 60%   | 80%                                |
| Home Health and Physician House Calls    | 60%  | 80%  | 60%   | 80%                                |
| ALCOHOLISM/<br>SUBSTANCE ABUSE           |  |  |   |                                    |
| Inpatient                                |  | 80% <sup>(3)</sup>                             |   | 80% <sup>(3)</sup>                 |
| Outpatient                               |  | 80% <sup>(3)</sup> (\$50 max. eligible fee)    |   | 80% <sup>(3)</sup>                 |
| MENTAL HEALTH                            |  |  |   |                                    |

|             | MANDATED INDEMNITY |   | MANDATED HMOs                    |                                  |
|-------------|--------------------|---|----------------------------------|----------------------------------|
|             | BASIC              | STANDARD                                    | BASIC                            | STANDARD                         |
| Inpatient   |                    | 80% <sup>(3)</sup>                          |                                  | 80% <sup>(3)</sup>               |
| Outpatient  |                    | 80% <sup>(3)</sup> (\$50 max. eligible fee) |                                  | 80% <sup>(3)</sup>               |
| RX          | 60%                | 80%   | Copayment greater of \$15 or 25% | Copayment greater of \$10 or 25% |
| Transplants |                    | 80%   |                                  | 80%                              |

<sup>(1)</sup>For wellness services, covered 100% first \$100 and 60% over \$100

<sup>(2)</sup>For wellness services, covered 100% first \$150 and 80% over \$150

<sup>(3)</sup>\$50,000 lifetime max.

#### ACCEPTABLE EXCLUSIONS FOR USE IN BASIC AND STANDARD POLICIES

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

1. Which are not prescribed by, performed by, or upon the direction of a provider;
2. Which are not medically necessary;
3. Rendered by other than a hospital or a provider;
4. Which are investigational in nature; including any service, procedure, or treatment directly related to an investigational treatment;
5. For any condition, disease, illness, or bodily injury which occurs in the course of employment if benefits or compensation is carried or required, in whole or in part, under the provisions of any legislation or governmental unit. This exclusion applies whether or not the insured claims the benefits or compensation;
6. To the extent benefits are provided by any governmental unit except as required by federal law for the treatment of veterans in Veterans Administration or armed forces facilities for non-service- related medical conditions;
7. For any illness or injury suffered as a result of any act of war or while in the military service;
8. For which the insured would have no legal obligation to pay in the absence of this or any similar coverage;
9. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group;
10. Surgery and any related services intended solely to improve appearance including but not limited to the restoration of hair and appearance of skin. This does not include those services or surgeries that restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies of a newborn;
11. Rendered by a provider that is a member of the insured's immediate family;
12. Incurred prior to the effective date or during an inpatient admission that commenced prior to the insured's effective date of coverage;
13. Incurred after the date of termination of the insured's coverage;
14. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;
15. For telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form or charges for medical information;
16. For inpatient admissions which are primarily for diagnostic studies or physical therapy;
17. For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;
18. For custodial care, domiciliary care or rest cures;
19. For treatment in a facility, or part of a facility, that is mainly a place for: (a) rest; (b) convalescence; (c) custodial care; (d) the aged; (e) the care or treatment of alcoholism or drug addiction; (f) rehabilitation; or (g) training, schooling or occupational therapy;
20. For screening examinations including X-ray examinations made without film;
21. For sterilization or reversal of sterilizations, or both;

22. For dental work or treatment except for removal of malignant tumors and cysts or accidental injury (eating and chewing mishaps are not accidental injuries for the purposes of this policy) to natural teeth, if the accident occurs while the person is insured and the treatment is received within 12 months after the accident;
23. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, callouses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;
24. For eyeglasses or contact lenses and the visual examination for prescribing or fitting eyeglasses or contact lenses (except for aphasic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
25. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;
26. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
27. For any treatment leading to or in connection with transsexualism, sex changes or modifications, including but not limited to surgery or the treatment of sexual dysfunction not related to organic disease;
28. For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the insured's weight or for the treatment of obesity;
29. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or for inpatient confinement for environmental change;
30. For services and supplies for and related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intra-fallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures;
31. For travel whether or not recommended by a physician;
32. For complications or side effects arising from services, procedures, or treatments excluded by this policy;
33. For maternity care of dependent children except for complications of pregnancy which is covered as any other illness;
34. For services to the extent that those services are covered by Medicare;
35. For or related to organ transplants (unless a benefit is specifically provided and then only to the limits provided);
36. For or related to the transplantation of animal or artificial organs or tissues;
37. For the care or treatment of any injury that is intentionally self-inflicted, while sane or insane;
38. For the care or treatment of any injury incurred during the commission of, or an attempt to commit, a felony or any injury or sickness incurred while engaging in an illegal act or occupation or participation in a riot;
39. For lifestyle improvements including smoking cessation, nutrition counseling or physical fitness programs;
40. For the purchase of wigs or cranial prosthesis;
41. For weekend admission charges, except for emergencies and nonscheduled maternity admissions;
42. For orthomolecular therapy including nutrients, vitamins and food supplements;
43. For speech therapy, except to restore speech abilities which were lost due to sickness or injury.

**71.14(9)** All carriers shall provide benefits in the standard health benefit plan for the cost associated with equipment, supplies, and education for the treatment of diabetes pursuant to Iowa Code section 514C.14.

**191—71.15(513B) Methods of counting creditable coverage.**

**71.15(1)** For purposes of reducing any preexisting condition exclusion period, a group health plan or a carrier offering group health insurance coverage shall determine the amount of an individual's creditable coverage by using the standard method described in subrule 71.15(2), except that the plan or

carrier may use the alternative method under subrule 71.15(3) with respect to any or all of the categories of benefits described under paragraph 71.15(3)“b.”

**71.15(2)** Under the standard method, a group health plan and a health insurance carrier offering group health insurance coverage shall determine the amount of creditable coverage without regard to the specific benefits included in the coverage.

*a.* For purposes of reducing the preexisting condition exclusion period, a group health plan or a health insurance carrier offering group health insurance coverage shall determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. If on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

*b.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

*c.* Notwithstanding any other provision of paragraph 71.15(2)“b,” for purposes of reducing a preexisting condition exclusion period, a group health plan and a health insurance carrier offering group health insurance coverage may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in paragraph 71.15(2)“b.”

**71.15(3)** Under the alternative method, a group health plan or a health insurance carrier offering group health insurance coverage shall determine the amount of creditable coverage based on coverage within any category of benefits described in subparagraph 71.15(3)“b”(2) and not based on coverage. The plan may apply a different preexisting condition exclusion period with respect to each category and may apply a different preexisting condition exclusion period for benefits that are not within any category. The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual’s creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph 71.15(3)“a.”

*a.* A plan or carrier using the alternative method is required to apply it uniformly to all participants and beneficiaries in the plan or policy. The use of the alternative method must be set forth in the plan.

*b.* The alternative method for counting creditable coverage may be used for coverage for any of the following categories of benefits:

- (1) Mental health.
- (2) Substance abuse treatment.
- (3) Prescription drugs.
- (4) Dental care.
- (5) Vision care.

*c.* If the alternative method is used, the plan is required to:

(1) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan;

(2) Include in these statements a description of the effect of using the alternative method, including an identification of the category’s uses; and

(3) Under the alternative method, the group health plan or carrier counts creditable coverage within a category if any level of benefits is provided within the category.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

### **191—71.16(513B) Certificates of creditable coverage.**

**71.16(1)** Group health plans or carriers shall issue certificates of creditable coverage to persons losing coverage. A group health plan or carrier required to provide a certificate under this rule for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual’s creditable coverage and waiting or affiliation period is provided by the other party. Certificates shall be issued within a reasonable amount of time following termination to employees and dependents:

- a. Automatically upon the termination of an individual's group coverage;
- b. Automatically upon the termination of COBRA coverage;
- c. Upon request within 24 months after coverage ends.

**71.16(2)** Certificates in writing. Certificates of coverage must be in writing unless all of the following conditions are met:

- a. The individual requesting the certificate is not entitled to receive a certificate;
- b. The individual requests that the certificate be sent to another plan or carrier;
- c. The plan or carrier 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.

**71.16(3)** Required information. The certificate shall include the following information:

- a. The date the certificate is issued;
- b. The name of the group plan providing coverage;
- c. The name of the employee or dependent to whom the certificate applies, other relevant identifying information, and the name of the employee if the certificate is for a dependent;
- d. The plan administrator's name, address and telephone number;
- e. A telephone number to call for further information if different from above;
- f. Either a statement that the person has at least 18 months' creditable coverage without a significant break of coverage or the date any waiting period and creditable coverage began;
- g. The date creditable coverage ended or an indication that the coverage is in force.

**71.16(4)** Family information. Information for families may be combined on one certificate. Any differences in creditable coverages shall be clearly delineated.

**71.16(5)** Dependent coverage transition rule. A group health plan or carrier that does not maintain dependent data is deemed to have satisfied the requirement to issue dependent certificates by naming the employee and specifying that the coverage on the certificate is for dependent coverage.

**71.16(6)** Delivering certificates. The certificate shall be given to the individual, plan or carrier requesting the certificate. The certificates may be sent by first-class mail. When a dependent's last-known address differs from the employee's last-known address, a separate certificate shall be provided to the dependent at the dependent's last-known address. Separate certificates may be mailed together to the same location.

**71.16(7)** A group health plan or carrier shall establish a procedure for individuals to request and receive certificates.

**71.16(8)** A certificate is not required to be furnished until the group health plan or carrier knows or should have known that dependent's coverage terminated.

**71.16(9)** Demonstrating creditable coverage. An individual has the right to demonstrate creditable coverage, waiting periods, and affiliation periods when the accuracy of the certificate is contested or a certificate is unavailable. A group health plan or carrier shall consider information obtained by it or presented on behalf of an individual to determine whether the individual has creditable coverage.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

### **191—71.17(513B) Notification requirements.**

**71.17(1)** A group health plan or carrier shall provide written notice to the employee and dependents of:

- a. The existence of any preexisting condition exclusions.
- b. The length of time to which the exclusions will apply.
- c. The right of the employee or dependent to appeal a decision to impose a preexisting condition exclusion.
- d. The right of the person to demonstrate creditable coverage including:
  - (1) The right of the person to request a certificate from a prior group health plan or carrier;
  - (2) A statement that the current group health plan or carrier will assist in obtaining the certificate;

(3) That the group health plan or carrier will use the alternative method of counting creditable coverage; and

(4) Special enrollment rights when an employee declines coverage for the employee or dependents.

**71.17(2)** A group health plan or carrier shall provide written notice to the employee and dependents of the modification of a prior creditable coverage decision when the group health plan or carrier subsequently determines either no or less creditable coverage existed provided that the group health plan or carrier acts according to its initial determination until the final determination is made.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.18(513B) Special enrollments.**

**71.18(1)** A carrier shall permit individuals to enroll for coverage under terms of a health benefit plan, without regard to other enrollment dates permitted under the group health plan, if an eligible employee requests enrollment or, if the group health plan makes coverage available to dependents, on behalf of a dependent who is eligible but not enrolled under the group health plan, during the special enrollment period, which shall be 30 days following an event described in subrules 71.18(2) and 71.18(3) with respect to the individual for whom enrollment is requested. A carrier may impose enrollment requirements that are otherwise applicable under terms of the group health plan to individuals requesting immediate enrollment.

**71.18(2)** An individual, who previously had other coverage for medical care and for whom an eligible employee declined coverage under the group health plan, may be enrolled during a special enrollment period if the individual has lost the other coverage for medical care and:

*a.* If required by the group health plan, the eligible employee stated in writing when declining the coverage, after being given a notice of the requirement form, and the consequences of failure to submit a written statement that coverage was declined because the individual had coverage for medical care under another group health plan or otherwise; and

*b.* When enrollment was declined for the individual:

(1) The individual had coverage other than under a COBRA continuation provision and the coverage has been exhausted; or

(2) The individual had coverage other than under a COBRA continuation provision and the coverage has been terminated due to loss of eligibility for the coverage, including loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment and any loss of eligibility after a period that is measured by reference to any of the foregoing, or termination of employer contributions toward the other coverage.

*c.* For purposes of this subparagraph 71.18(2)“*b*”(2):

(1) Loss of eligibility for the coverages does not include loss of eligibility due to the eligible employee’s or dependent’s failure to make timely premium payments or termination of coverage for cause such as making a fraudulent claim or intentional misrepresentation of material fact in connection with the group health plan; and

(2) Employer contributions include contributions by any current or former employer of the individual or another person that was contributing to coverage for the individual.

(3) Exhaustion of COBRA continuation coverage means that an individual’s COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan. An individual is considered to have exhausted COBRA continuation coverage if the coverage ceases.

**71.18(3)** If the eligible employee has previously declined enrollment under the group health plan but acquires a dependent through marriage, birth, adoption or placement for adoption, the eligible employee or dependent may be enrolled during the special enrollment period with respect to the individual.

**71.18(4)** Enrollment of the eligible employee or dependent is effective not later than the first day of the calendar month or, for a newborn or adopted child, on the date of birth, adoption, or placement for adoption.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.19(513B) Disclosure requirements.** All carriers shall include in contracts and evidence of coverage forms a statement disclosing the existence of any drug formularies. Upon request, a carrier 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 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.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.20(514C) Treatment options.**

**71.20(1)** A carrier shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

**71.20(2)** A carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the carrier that, in the opinion of the provider, jeopardizes patient health or welfare.

**191—71.21(514C) Emergency services.** Benefits shall be available by the carrier for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since carriers may not contract with every emergency care provider in an area, carriers shall make every effort to inform members of participating providers.

**71.21(1)** The term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

**71.21(2)** The term "emergency medical condition" means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

- a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;
- b. Serious impairment to bodily function; or
- c. Serious dysfunction of any bodily organ or part.

**71.21(3)** Reimbursement to a provider of "emergency services" shall not be denied by any carrier without that organization's review of the patient's medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint. Upon denial of reimbursement for emergency services, the carrier shall notify the enrollee and the provider that they may register a complaint with the commissioner of insurance.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.22(514C) Provider access.** A carrier shall allow a female enrollee direct access to obstetrical or gynecological services from network and participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

These rules are intended to implement Iowa Code chapters 513B and 514C and 1999 Iowa Acts, Senate File 276.

**191—71.23(513B) Reconstructive surgery.**

**71.23(1)** A carrier that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

- a. Reconstruction of the breast on which the mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

**71.23(2)** The benefits under this rule shall be provided in a manner determined in consultation with the attending physician and the enrollee. The coverage may be subject to annual deductibles and coinsurance provisions that are consistent with other benefits under the plan or coverage.

**71.23(3)** Written notice of the availability of coverage in this rule shall be provided to the enrollee upon enrollment and then annually.

**71.23(4)** A carrier 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 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.  
[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.24(514C) Contraceptive coverage.**

**71.24(1)** A carrier that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

**71.24(2)** A carrier is not required to provide benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

**71.24(3)** A contraceptive drug or contraceptive device does not include surgical services intended for sterilization, including, but not limited to, tubal ligation or vasectomy.

**71.24(4)** A carrier shall be required to provide benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

**71.24(5)** If a carrier does not provide benefits for a routine physical examination, the carrier 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 Iowa Code section 514C.19.  
[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—71.25(513B) Suspension of the small employer health reinsurance program.** Upon the recommendation of the board of directors of the Iowa small employer health reinsurance program and the findings of the commissioner that the operation of the Iowa small employer health reinsurance program pursuant to Iowa Code chapter 513B is not currently cost-effective, the commissioner suspends the operation of the program, effective January 30, 2004, until further notice. After the effective date of the suspension, the program may continue its administration with regard to handling claims and refunds related to activities prior to the suspension as well as other administrative matters.

This rule is intended to implement Iowa Code section 513B.13(14).

**191—71.26(513B) Uniform health insurance application form.**

**71.26(1)** Small employer carriers shall use the small employer uniform health insurance application form as the only acceptable form when small employers apply for new health insurance coverage from small employer carriers. Small employer carriers shall implement procedures and policies necessary to use the small employer uniform health insurance application form.

**71.26(2)** Small employer carriers shall treat and accept a copy of the uniform health insurance application form as an original.

**71.26(3)** Use of the uniform health insurance application form shall not be required:

- a. Upon renewal of an existing small employer group policy, or
- b. When adding or removing employees or dependents under an existing small employer group policy.

**71.26(4)** Form and content of uniform health insurance application.

a. The uniform health insurance application form following this chapter contains the standardized data elements that must be included in the uniform health insurance application to ensure consistent usage by all small employer carriers when small employers apply for new health insurance coverage.

b. The standardized data elements shall not preclude a small employer carrier from utilizing electronic methods or other technologies to accommodate the uniform health insurance application form.

**71.26(5)** Small employer carriers may preprint the name of the small employer carrier on the uniform health insurance application form provided that the form contains at least three additional spaces to insert the names of small employer carriers to which the uniform health insurance application may be sent.

**71.26(6)** The information contained in each uniform health insurance application shall be considered current by the small employer carrier for a minimum of 60 days from receipt by the small employer carrier of the earliest signed and completed uniform health insurance application form. For the period of time that the information contained in the uniform health insurance application is considered current, small employer carriers shall not require an employee of a small employer to complete a new application form or any document, addendum or certification representing that the information contained in the completed uniform health insurance application is current.

**71.26(7)** A small employer carrier may accept and utilize information provided by an employee of a small employer subsequent to the date the employee signed the completed application if the employee is providing the small employer carrier with additional or modified information.

**71.26(8)** A small employer carrier may require employees of a small employer to complete and submit new uniform health insurance applications if either of the following occurs:

- a. The authorization signed by the employees does not include the name of the small employer carrier from which the small employer is requesting an underwritten premium amount and coverage; or
- b. The completed uniform health insurance applications are received by the small employer carrier after 60 days of completion of the earliest signed and completed uniform health insurance application.

**71.26(9)** A producer shall forward, within five business days from receipt of the applications, copies of the uniform health insurance applications to all small employer carriers identified in the uniform health insurance application authorization to receive the applications, or to an authorized representative of each small employer carrier, without requiring that a fee be paid for the photocopying or delivery of the copies of completed uniform health insurance applications. The producer may withhold distribution to a small employer carrier, or the carrier's authorized representative, at the written request of the small employer.

**71.26(10)** A copy of the completed uniform application, which may be in electronic or other reproduced forms, shall be maintained by the producer that submitted the application and by the small employer carrier that issued the policy.

**71.26(11)** Small employer carriers shall state the premium to the small employer within ten business days of receipt of all pertinent information required for a small employer carrier's underwriting of the small employer's application for group health insurance, including completed uniform health insurance applications.

**71.26(12)** Small employer carriers shall make a reasonable effort to promptly obtain information that a carrier determines is necessary to make an underwriting decision.

This rule is intended to implement Iowa Code Supplement section 513B.18.

Iowa Uniform Group Health Application

Agent No.

**Employer Data**

Employer \_\_\_\_\_ Group Number \_\_\_\_\_ Phone \_\_\_\_\_  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Fax \_\_\_\_\_

**Employee Data**

Employee Name \_\_\_\_\_ Soc Sec Disabled? Y N Medicare Enrolled? Y N Sex: M F  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone # \_\_\_\_\_ Home Phone # \_\_\_\_\_ Email \_\_\_\_\_  
 DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Social Security # \_\_\_\_\_ Job Title \_\_\_\_\_ Date of Hire \_\_\_\_\_  
 Primary Care  Physician \_\_\_\_\_  
 Average Hours Worked per Week \_\_\_\_\_ Salary/Wage \$ \_\_\_\_\_ Employment Status:  Full-Time  Part-Time  Retired  COBRA  
 Marital Status:  Married  Single  Divorced  Legally Separated  Widowed  Common Law Marriage (Notarized Affidavit Required)

**Coverage Selected**

|   |  |
|---|--|
| <b>Please indicate which eligible coverage(s) you are choosing:</b> | <input type="checkbox"/> Medical: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)<br><input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> HDHP <input type="checkbox"/> Other, define: _____<br><input type="checkbox"/> Dental: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)<br><input type="checkbox"/> Life: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)<br><input type="checkbox"/> Vision: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)<br><input type="checkbox"/> Disability: <input type="checkbox"/> Employee/Short Term <input type="checkbox"/> Employee/Long Term |
|---|--|

**Waiver of Coverage**

|   |  |
|---|--|
| <b>I decline coverage for:</b><br><input type="checkbox"/> Medical <input type="checkbox"/> Dental<br><input type="checkbox"/> Life <input type="checkbox"/> Vision<br><input type="checkbox"/> Disability  | <b>Declining coverage due to existence of other coverage:</b><br><input type="checkbox"/> Spouse's Employer's Plan <input type="checkbox"/> Individual Plan <input type="checkbox"/> Medicaid<br><input type="checkbox"/> Covered by Medicare <input type="checkbox"/> VA Eligibility <input type="checkbox"/> Tri-Care<br><input type="checkbox"/> COBRA from prior employer <input type="checkbox"/> Other, Explain: _____<br><input type="checkbox"/> I (we) have no other coverage at this time. |
| <p><b>I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a life change event, at the next open enrollment period or as a late enrollee, if applicable. I also understand that pre-existing limitations may apply as explained in the Rights and Responsibilities brochure which I have received with this form.</b></p> |  |

**Dependent Data**

| Name (First, MI, Last) | Sex  | Height | Weight | Birthdate | Social Security Number | Primary Care Physician | Full-time student?  | Medicare enrolled?  | Soc. Sec. enrolled?   |
|------------------------|--|--------|--------|-----------|------------------------|------------------------|---|---|---|
| Spouse                 | <input type="checkbox"/> M<br><input type="checkbox"/> F |        |        |           |                        |                        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent              | <input type="checkbox"/> M<br><input type="checkbox"/> F |        |        |           |                        |                        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent              | <input type="checkbox"/> M<br><input type="checkbox"/> F |        |        |           |                        |                        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Dependent              | <input type="checkbox"/> M<br><input type="checkbox"/> F |        |        |           |                        |                        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

Employee Name \_\_\_\_\_

**Other Coverage**

|   |  |   |                |
|---|--|---|----------------|
| <b>Medicare Coverage:</b> Name _____ ID# _____<br>Effective Date (Part A) _____ (Part B) _____ (Part D) _____   |  | <b>Previous Coverage:</b><br>Within the last 18 months, did you have health insurance coverage?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, please complete the following: |                |
| <b>Concurrent Coverage:</b> Will you, your spouse or your dependents keep other coverage in addition to this coverage? (Check all that apply.)<br><input type="checkbox"/> None <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Life <input type="checkbox"/> Vision <input type="checkbox"/> Disability  |  |   |                |
| Name of covered person(s)   |  | Name of covered person(s)   |                |
| Employer (if applicable)  |  | Employer (if applicable)  |                |
| Insurance Company/HMO Name and address  |  | Insurance Company Name/Address  |                |
| Policy No.  | <input type="checkbox"/> Employee<br><input type="checkbox"/> Employee/Spouse<br><input type="checkbox"/> Employee/Children<br><input type="checkbox"/> Employee/Spouse/Children | Effective Date  | Effective Date |
|   |  | End Date  | End Date       |
|   |  | Policy No.  | Effective Date |
|   |  | <input type="checkbox"/> Employee<br><input type="checkbox"/> Employee/Spouse<br><input type="checkbox"/> Employee/Children<br><input type="checkbox"/> Employee/Spouse/Children                      | End Date       |
| <b>Reason for Enrollment/Change:</b><br>Name of Affected Party _____ Date of Event _____<br><input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Special Enrollee <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Birth/Adoption <input type="checkbox"/> Death <input type="checkbox"/> Divorce<br><input type="checkbox"/> Employment Termination <input type="checkbox"/> COBRA <input type="checkbox"/> Cancel Coverage (reason) _____<br><input type="checkbox"/> Other: _____ |  |   |                |

**Designated Beneficiaries**

|   |                   |                     |                          |
|---|-------------------|---------------------|--------------------------|
| <b>Group Term Life and/or Voluntary Term Life Beneficiary Designation</b><br>(NOTE: The same beneficiary will be used for both Group Term Life and Voluntary Term Life. If you wish to name different beneficiaries for each coverage, please ask your employer for a beneficiary change form to complete in addition to the information shown below).<br><b>All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.</b> |                   |                     |                          |
| <b>Primary Beneficiaries:</b>   |                   |                     |                          |
| <i>Name and Address</i>   | <i>Percentage</i> | <i>Relationship</i> | <i>Social Security #</i> |
|   |                   |                     |                          |
|   |                   |                     |                          |
| <b>Contingent Beneficiaries:</b>  |                   |                     |                          |
| <i>Name and Address</i>   | <i>Percentage</i> | <i>Relationship</i> | <i>Social Security #</i> |
|   |                   |                     |                          |
|   |                   |                     |                          |
| The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.  |                   |                     |                          |
| If any beneficiary is designated as a trustee, it is understood and agreed that the Plan shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to the Plan.   |                   |                     |                          |
| If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.  |                   |                     |                          |

Employee Name \_\_\_\_\_



**Authorization and Certification**

I understand and agree with the following statements with regard to my application for coverage through an insurance Carrier:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed. I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits. If I refuse life or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by the Carrier. If I refuse coverage, I cannot enroll after retirement.
- I understand that the coverages applied for will not start until after this application and the appropriate coverage rates are received and accepted by the Carrier and an effective date of coverage is established by the Carrier. I further agree that the Carrier is not liable for a claim before the effective date of coverage and all policy provisions apply. During the first two years coverage for life or disability or medical is in force, false statements, omissions or material misrepresentations can cause changes in that coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to the life or disability carrier agents and employees of the Life or Disability Carrier and I authorize the Life or Disability Carrier to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by the Life or Disability Carrier for determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.
- I also understand collection of social security numbers for myself and my dependents will be used by the Carrier only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", including but not limited to, surgeons, physicians, psychologists, nurses, social workers, health care facilities and other entities covered under the HIPAA Privacy Rule and their agents and employees, to release and disclose my personal health information, including but not limited to, all health & mental records, including those records protected by Federal or State law relating to the diagnosis or treatment of AIDS or AIDS related complex, Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental health and substance abuse, the use of alcohol, drugs, and tobacco, and the past, present, or future treatments or conditions for myself or for my dependents eligible for health care coverage to the Carrier, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with the Carrier or other entities covered under the HIPAA Privacy Rule. I further understand that the personal health information described above may be disclosed to and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws. They may further disclose the protected health information, and it may no longer be protected by federal health information privacy laws. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to the Carrier. I understand that a revocation is not effective until received by the Carrier and that any revocation is not effective to the extent that the Carrier or Providers have relied on the protected health information disclosed to them. This Authorization and Certification does not authorize the redisclosure of medical information except as otherwise stated herein. Federal and State regulations do not allow further disclosure of mental health, substance abuse and AIDS/HIV related information. The Carrier maintains the confidentiality of all information received and it will not be released to any person or facility unless you apply for life and/or disability coverage underwritten by the Life or Disability Carrier in which case the application, without any further health records or Attending Physician Statements (APS) received, will be released to the Life or Disability Carrier. I understand that if I refuse this authorization, the Carrier may not make an eligibility determination, and I will not be considered for coverage with the Carrier.

I hereby authorize the following Carriers, their reinsurers, and their legal representatives to receive, use, and disclose my, my spouse and my dependent child(ren)'s Protected Health Information for the purpose of insurance coverage. I authorize the Carriers to disclose my, my spouse and my dependent child(ren)'s Protected Health Information between themselves, to reinsuring companies, and to the plan administrator or plan sponsor (if other than the employer), insurance intermediaries, or other persons or organizations performing business or legal services in connection with the purpose of insurance coverage: *(Either you or your broker must list all Carriers that are to receive this application for insurance.)*

Carrier \_\_\_\_\_ Carrier \_\_\_\_\_ Carrier \_\_\_\_\_  
Carrier \_\_\_\_\_ Carrier \_\_\_\_\_ Carrier \_\_\_\_\_

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I further certify that, after this application was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and that no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that the Carrier will rely on the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or concealed any material fact, the Carrier will be entitled to declare any contract or coverage issued pursuant to this application void and to refuse allowance on benefits to any person thereunder, which means that any claims incurred will become my liability. If the group policy does not require my contribution, I understand that I cannot decline any coverage unless the policy indicates otherwise. If the group policy requires my contribution, I authorize my employer to deduct from my pay. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from the Carrier.

Print Name \_\_\_\_\_  
Your signature X \_\_\_\_\_ Date signed \_\_\_\_\_

- [Filed emergency 7/2/93—published 7/21/93, effective 7/2/93]
- [Filed 10/20/93, Notice 7/21/93—published 11/10/93, effective 12/15/93]
- [Filed 5/2/94, Notice 3/2/94—published 5/25/94, effective 6/29/94]
- [Filed emergency 12/1/94—published 12/21/94, effective 1/1/95]
- [Filed 5/4/95, Notice 2/1/95—published 5/24/95, effective 7/1/95]
- [Filed 7/25/96, Notice 4/24/96—published 8/14/96, effective 9/18/96]

[Filed emergency 6/26/97—published 7/16/97, effective 7/1/97]  
[Filed 10/10/97, Notice 7/16/97—published 11/5/97, effective 12/10/97]  
[Filed emergency 10/16/98—published 11/4/98, effective 10/16/98]  
[Filed emergency 6/25/99—published 7/14/99, effective 7/1/99]  
[Filed 9/3/99, Notice 7/14/99—published 9/22/99, effective 10/27/99]  
[Filed 4/10/00, Notice 1/12/00—published 5/3/00, effective 6/7/00]  
[Filed 8/17/00, Notice 7/12/00—published 9/6/00, effective 10/11/00]  
[Filed 10/27/00, Notice 9/20/00—published 11/15/00, effective 12/20/00]  
[Filed emergency 10/26/01—published 11/14/01, effective 10/26/01]  
[Filed 3/29/02, Notice 2/6/02—published 4/17/02, effective 5/22/02]  
[Filed 4/9/04, Notice 3/3/04—published 4/28/04, effective 6/2/04]  
[Filed 2/22/08, Notice 12/5/07—published 3/12/08, effective 4/16/08]  
[Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]



CHAPTER 73  
HEALTH INSURANCE PURCHASING COOPERATIVES

**191—73.1(75GA,ch158) Purpose.** The purpose of this chapter is to implement 1993 Iowa Acts, chapter 158, section 2, authorizing the creation of privately established and operated health insurance purchasing cooperatives, subject to regulation by the division of insurance. The purpose of the health insurance purchasing cooperatives is to improve the quality, access, and affordability of health care by more effectively representing the interests of buyers and consumers and creating a value conscious market. Health insurance purchasing cooperatives as described in the Insurance Division's oral and written briefings, the Pooled Purchasing Group Subcommittee Report, and Jackson Hole papers relied upon by the legislature effectively organize buyers of insurance, risk management, and health care services to negotiate price and quality with sellers of insurance, risk management, and health care services, whether the sellers are organized as insurance companies, health maintenance organizations, or other legally permissible structures.

**191—73.2(75GA,ch158) Applicability and scope.**

**73.2(1)** This chapter shall apply to all health insurance purchasing cooperatives operating in this state. However, this chapter shall not apply to any other health insurance or health care marketing, distribution or purchasing mechanism otherwise permitted by law.

**73.2(2)** A health insurance purchasing cooperative under this chapter is exempt from any law in this state relating to the creation of groups for the purchase of insurance, prohibition of group purchasing, or any law that discriminates against a purchasing group or its members. An insurer is exempt from any law of the state that prohibits providing or offering to provide, to a purchasing group or its members, advantages based upon their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverage, or other matters. A purchasing group is subject to all other applicable laws of this state including Iowa Code chapter 522.

**73.2(3)** An entity not approved by the division as a HIPC and engaged in the purchase, sale, marketing or distribution of health insurance or health care plans shall not hold itself out as a HIPC, health insurance purchasing cooperative, purchasing cooperative, or otherwise use a confusingly similar name or marketing materials; and a nonapproved entity that does so shall be in violation of this chapter and subject to penalties under Iowa Code chapter 507B. This subrule is not intended to restrict the activities of a purchasing coalition of ERISA-qualified, self-funded employers engaged in the purchase of health care from providers on a nonrisk-bearing basis.

**191—73.3(75GA,ch158) Definitions.** As used in this chapter:

*“Adjusted community rating”* means a method used to develop a carrier's premiums which spreads financial risk across a large population and allows adjustments only for certain demographic factors and family composition as provided by state law for insurance carriers providing services to the same consumer or as otherwise approved by the commissioner to accommodate the unique characteristics of a health insurance purchasing cooperative.

*“Business plan”* means the plan of operation of the health insurance purchasing cooperative.

*“Carrier”* means any entity that provides health benefit plans in this state. For purposes of this chapter, carrier includes an insurance company, a hospital or medical service corporation, a fraternal benefit society, a health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state regulation.

*“Commissioner”* means the commissioner of insurance for the state of Iowa.

*“Division”* means the insurance division of the state of Iowa.

*“Health insurance purchasing cooperative”* means a group of individuals, a group of employers and employees, or a combination of individuals and employers and employees who join together to purchase health insurance or health care benefits.

*“HIPC”* means health insurance purchasing cooperative. This acronym shall be used interchangeably with the words “health insurance purchasing cooperative” throughout this chapter.

“*HIPC administrator*” means a person or organization charged with overseeing the day-to-day operations of a HIPC.

“*HIPC sponsor*” means an employer, group of employers, or private agent authorized under this chapter to facilitate the purchase of insurance and health care services for participating employers and employees.

“*Service territory*” means any of the following:

1. A regional HIPC as identified by the commissioner. A regional HIPC serves a defined regional market which shall at minimum include the surrounding rural market of any city included in the regional HIPC.

2. A statewide HIPC as identified by the commissioner shall offer service throughout the state. A statewide HIPC may establish regional service areas, governance and negotiations, provided those structures conform to the provisions of paragraph “1.”

“*Small employer*” means an employer as defined in Iowa Code section 513B.2.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

### **191—73.4(75GA,ch158) Division duties—application—filing requirements—license—audits and examinations.**

**73.4(1)** The division shall have the authority to regulate the establishment and conduct of a HIPC as set forth in this chapter.

**73.4(2)** A HIPC shall not operate in Iowa without an approved license from the division. An application form shall be completed and signed by an authorized representative of the HIPC sponsor and proposed HIPC administrator (if applicable). The completed application form shall be verified and filed at the division. An application will not be deemed to be filed until all information necessary to properly process the application has been received by the commissioner. Upon filing, the division will make its determination concerning the application and will provide notice of the determination to the HIPC. If approved, a copy of the approved license shall be provided to the HIPC sponsor. The license shall serve as the HIPC’s authorization until the yearly renewal date. Any amendment to the license shall be filed in the same manner as the application and approved by the commissioner before the change proposed by the amendment is effective.

**73.4(3)** Each HIPC doing business in the state shall file with the division the following information or documents:

*a.* A business plan for approval by the commissioner as provided in rule 191—73.7(75GA,ch158). The business plan is a detailed, written plan of operations explaining how the proposed HIPC intends to meet the public policy objectives of reduced cost, increased access and improved quality. The business plan is a written commitment by the HIPC if approved. Failure to comply with the business plan is a basis for license suspension or revocation. Material changes in policy or operations are subject to the prior approval of the commissioner on the same basis as the original business plan.

*b.* Quarterly financial statements and annual reports on forms approved by the commissioner. Financial statements and annual reports are to ensure the operation of the HIPC in a fiscally sound fashion; to ensure the HIPC is not a risk-bearing entity; to ensure sound financial controls and money management; and to prevent mismanagement or misappropriation of funds either through neglect or malfeasance.

*c.* Reports of any material changes in the business plan or operation. The changes are subject to approval by the commissioner prior to implementation. The original business plan is the basis of licensure. Material changes in the business plan therefore require similar prior approval by the commissioner.

*d.* Any other information required by the commissioner deemed pertinent to the operation of a HIPC in the state. The specifics of a business plan, market conditions, enforcement cases, or other issues may make it necessary for the commissioner to gather additional information to make an informed decision in the public interest. Failure to provide requested information is a basis for denial, suspension or revocation of a license.

*e.* A HIPC shall not enter the market place until the commissioner has approved the business plan.

**73.4(4)** Financial and performance audits or examinations of the HIPC shall be conducted on a regular basis by the division. Failure to meet minimum standards in a financial or performance audit or examination is the basis for license denial, suspension or revocation, or other action to protect consumers. The commissioner may impose conditions on licensure such as, but not limited to, the removal and replacement of managerial or marketing staff or contractors to remedy compliance or performance problems.

**191—73.5(75GA,ch158) Fidelity bond—letter of credit.** A HIPC shall maintain in force a fidelity bond on administrators, employees and officers in an amount not less than \$1,000,000 or such greater sum as may be prescribed by the commissioner. The fidelity bond shall be in the form prescribed by the commissioner. In the event a HIPC employs a contract administrator, the administrator shall maintain a \$250,000 letter of credit for the life of the contract payable to the HIPC sponsor. This letter of credit shall be in addition to the fidelity bond.

**191—73.6(75GA,ch158) Annual report.** The commissioner shall submit an annual report to the general assembly no later than February 1 of each year. The report shall include a description of the operations of all health insurance purchasing cooperatives, a review of the success of health insurance purchasing cooperatives as it pertains to improving the quality, access or affordability of health insurance. The commissioner may require HIPCs to provide information in uniform format for use in compliance with this report and for other public purposes.

**191—73.7(75GA,ch158) Business plan.** A HIPC shall submit its business plan for the prior review and approval by the commissioner. The business plan shall include but shall not be limited to the following information:

**73.7(1)** The specific steps by the HIPC sponsor to advance cost control, quality improvement, and improve access to health insurance or health care services. The business plan should affirmatively demonstrate that the HIPC has the technical expertise and physical capacity to serve as a significant group of buyers not currently being served by a HIPC. Significant means at least 10 percent of the population within the proposed service territory. The business plan should affirmatively demonstrate that the HIPC will reduce cost, improve quality and improve access to health insurance or health care services.

**73.7(2)** The scope of HIPC services to be offered in the service territory and the resources and expertise to be used to implement and administer the plan. The HIPC as a condition of licensure must demonstrate the technical and physical capacity to serve a significant group of buyers over a wide territory, encompassing at minimum a regional health care center and its associated rural market. The HIPC as a condition of licensure must demonstrate the technical and physical capacity to provide equal service quality throughout the entire HIPC service territory.

**73.7(3)** The corporate charter, bylaws and other business operation documents of the HIPC. As a condition of licensure the HIPC must demonstrate to the satisfaction of the commissioner that its corporate governance makes it an appropriate and effective representative of buyers' interests within the service territory. A HIPC must be more than a marketing or distribution channel for a single product or the products of a single carrier. A HIPC as a condition of licensure must organize and facilitate competition between multiple insurers or health care providers.

**73.7(4)** A list of officers and directors of the HIPC and the contract administrator if one is employed and personal biographical information or firm descriptions for each. The officers, directors, or contract administrator shall not have a prior record of administrative, civil or criminal violations within any financial service industry. The personal biographical information and firm descriptions shall demonstrate by clear and convincing evidence that those involved in the HIPC have the expertise, experience and character to effectively and professionally represent buyers in a fiduciary capacity.

**73.7(5)** Evidence of adequate security and prudence in the accounting, deposit, collection, handling and transfer of moneys. Because the HIPC may handle payments or accounting, the HIPC must affirmatively demonstrate adequate financial controls to the satisfaction of the division as a condition of

licensure. Failure to have adequate controls or failure to follow approved procedures shall be a basis to deny, suspend, or revoke licensure.

**73.7(6)** The market segments and participants to which the HIPC will be marketing. The HIPC must demonstrate to the satisfaction of the commissioner that it will extend HIPC services to a significant group of buyers not currently served by a HIPC. Failure to achieve this result can be the basis of later denial to renew a license.

**73.7(7)** Disclosure of any preexisting oral or written agreements. Preexisting agreements may raise questions of conflict or demonstrate the intention to create a marketing channel for a single product or single carrier. Conversely, preexisting agreements may assist in affirmatively demonstrating technical or physical capacity to serve a service territory or to extend HIPC services to a significant group of buyers not currently served by a HIPC. Regardless, any preexisting oral or written agreements must be disclosed. Failure to disclose an agreement is the basis for license denial or revocation.

**73.7(8)** Any other information required by the commissioner to verify the HIPC is qualified.

**191—73.8(75GA,ch158) Participants.** A HIPC may offer services to any of the following participants:

1. Individuals.
2. A small business as defined in 191—Chapter 71.
3. A business with more than 50 employees.
4. An association and its members.
5. The state or a local government unit.
6. Any other purchaser on a voluntary basis.

Underwriting standards shall be no more restrictive than required of small group health insurance under 191—Chapter 71.

A HIPC's business plan may impose conditions or limitations on members leaving the HIPC to protect against adverse selection. A HIPC shall accept all entities within its chosen market segment in accordance with the regulations governing marketing of insurance to that market segment, e.g., individual, small group, or large group.

A HIPC may provide services to participants out-of-state or out-of-region who elect to join for the benefit of representation and participation in health insurance or health care benefits only when an employer out-of-state or out-of-region has employees within the state or region or an individual is required to have coverage in the state or region due to specific circumstance.

**191—73.9(75GA,ch158) Health insurance purchasing cooperative—product offerings—exemptions.**

**73.9(1)** A HIPC shall offer at least one indemnity plan which provides an unrestricted choice of a physician. However, the indemnity plan may require an appropriate utilization review, preauthorization of treatments, or other reasonable cost and utilization oversight.

**73.9(2)** All small employer group carriers participating in a HIPC shall offer a basic and a standard benefit plan.

**73.9(3)** A HIPC is not required but may offer an employer-choice managed health care plan. The HIPC may also offer other indemnity plans.

**73.9(4)** A HIPC cannot offer insurance from a risk retention group not chartered in the state nor a carrier not admitted in the state.

**73.9(5)** A HIPC shall retain agents who are licensed pursuant to Iowa law if the HIPC markets the products of the HIPC through agents or sales representatives. Alternatively, if the HIPC does not use sales agents or representatives, the HIPC must demonstrate to the satisfaction of the commissioner that the alternative will provide consumer service meeting the same standards as that required of agents.

**73.9(6)** A participating health plan is not required to be offered outside of the HIPC but may be offered through other distribution or marketing channels. An entity may not be licensed as a HIPC if it offers only one health plan or the products of only one carrier, or related carriers.

**191—73.10(75GA,ch158) Insurance risk.** A HIPC shall bear no insurance risk. The HIPC shall facilitate the purchase of insurance and health care services. Provisions for participants to retain risk through deductibles, retention levels, or partial or complete self-funding shall be disclosed and shall be subject to approval by the commissioner prior to implementation to ensure that risk is not borne by the HIPC.

**191—73.11(75GA,ch158) Rates.**

**73.11(1)** A carrier shall use rate restrictions and regulations applicable to each market segment.

**73.11(2)** The HIPC may collect a different premium within the HIPC. This difference is predicated on marketing and administrative expenses which the HIPC would assume. Therefore, the carrier could offer the HIPC a lower final rate than the carrier would charge outside of the HIPC.

**191—73.12(75GA,ch158) Election—disclosure and confidentiality.**

**73.12(1)** A HIPC may elect to preclude for a period of time a participant who leaves the HIPC from returning to the HIPC to purchase health insurance or health care benefits. However, a HIPC shall not use this subrule to discriminate against high-risk participants.

**73.12(2)** Subject to review and approval by the commissioner, a HIPC may provide restricted access to information in its possession which is essential to the operation of the HIPC.

Confidentiality must:

- a. Be an inducement for voluntary participation in the program;
- b. Protect the privacy of participants;
- c. Protect negotiating strategy from disclosure to contractors or competitors; or
- d. Protect proprietary information in like circumstances as for insurance.

**191—73.13(75GA,ch158) Structure—merger and consolidation.**

**73.13(1)** A HIPC shall be a legal entity which operates on behalf of its sponsor or participants.

**73.13(2)** A HIPC shall disclose its total administrative cost in its annual report to the commissioner in the same manner and on the same basis as insurance carriers.

**73.13(3)** The change in control, merger or acquisition of a HIPC is subject to the prior review and approval of the commissioner on the same terms as a change in control, merger or acquisition of an Iowa domestic insurance company.

**191—73.14(75GA,ch158) Conflict of interest.**

**73.14(1)** Health care providers or insurers offering competing products within the same service territory shall not participate in a HIPC as a sponsor. A HIPC sponsor employing a HIPC administrator that offers competing products within the same service territory shall demonstrate to the satisfaction of the commissioner precautions to protect the HIPC from unfair competition or disclosure of proprietary information.

**73.14(2)** A HIPC sponsor shall not be an employee or be affiliated with or a subsidiary of a health care provider or insurer offering competing products within the same service territory.

**73.14(3)** The employees of a health care provider or insurer may receive services through a HIPC. The employer may vote in corporate governance elections of officers and directors. However, a health care provider or insurer or an employee of a health care provider or insurer may not serve as an officer of a HIPC. A health care provider or insurer or the employee of a health care provider or insurer may be a director of a HIPC or HIPC sponsor, but such persons shall not constitute a majority of the governing board or body of a HIPC or HIPC sponsor.

**73.14(4)** Compensation to the HIPC's sponsor, administrator, or agents shall not vary based upon the plan selected by participating members.

**191—73.15(75GA,ch158) Nondiscrimination and retaliatory protections.** An insurer shall not discriminate against or take retaliatory action against a participant employer, employee, agent, sponsor, or administrator of a HIPC. A HIPC shall not discriminate against or take retaliatory actions against an insurer or agent for activities relating to the HIPC.

**191—73.16(75GA,ch158) Annual health insurance or health care benefits plan selection.** A HIPC shall offer participants an opportunity at least once annually to change health insurance or health care benefits. The HIPC shall determine whether the change in health insurance or health care benefits may be made by the individual employees of an employer participant or by the employer participant on behalf of the employer's employees. The HIPC shall provide pertinent available information including cost and quality of risk management services on health insurance and health care benefits offered to assist the participants in making an informed decision in the selection of health insurance or health care benefits.

**191—73.17(75GA,ch158) License subject to conditions—waivers.** A new participating buyer shall join when the plan is offered to them or at the annual open enrollment.

**73.17(1)** The commissioner may limit the number of HIPCs licensed within a geographic service territory. A HIPC must demonstrate probable success in representing a substantial share of the purchasers within the proposed service territory and that it is likely to largely represent purchasers not already served by existing HIPCs within the same service territory. The commissioner may refuse to renew or condition the license of a HIPC that fails in actual operations to achieve these requirements.

**73.17(2)** Existing HIPCs may present evidence of the anticipated impact of a new HIPC within their geographic service territory to resist an additional licensee. This shall include but is not limited to evidence that the new HIPC will use risk selection against an existing HIPC and the new HIPC will adversely dilute the market leverage of an existing HIPC. The division shall provide notice to existing HIPCs of an applicant's filing. Existing HIPCs must file notice of intent to submit evidence within ten days of the notice. Existing HIPCs may request a hearing or submit evidence in writing.

**73.17(3)** The commissioner may impose risk adjustments between HIPCs within a geographic service area or between all HIPCs within the state to ensure competition based upon service and effective cost and quality control and not based upon risk selection.

**73.17(4)** The commissioner may impose additional conditions to protect the interests of participating buyers and consumers, ensure fair and efficient conduct of HIPC duties, and to protect HIPCs from adverse selection or bearing insurance risk.

**73.17(5)** The commissioner may impose additional conditions or waive restrictions for a specified period of time to facilitate orderly market transition to reform upon a showing of necessity by the applicant HIPC or upon the commissioner's own initiative.

**191—73.18(75GA,ch158) Procedures.** Actions by a HIPC before the division or the commissioner shall conform to the pertinent procedures set forth in the administrative rules of the insurance division.

**191—73.19(75GA,ch158) Data collection—quality evaluation.**

**73.19(1)** The HIPC shall conform to any pertinent reporting provisions of the community health management information system.

**73.19(2)** A HIPC shall conduct a qualitative review of plans offered through the HIPC in order to provide participating employers and employees an accurate comparative analysis of cost, quality, access, relative value, service, and customer satisfaction. The division may require HIPCs to cooperate in establishing a common basis and methodology for plan evaluation and customer education to facilitate informed choice between plans. A HIPC shall detail in its proposed business plan the methodologies and resources it intends to employ to satisfy this requirement. The HIPC must produce an annual report card on the performance of participating plans.

**73.19(3)** The division may establish data reporting standards to permit the objective evaluation of HIPCs and their impact on health care costs, quality and access.

**191—73.20(75GA,ch158) Examination—costs.** The commissioner shall examine a HIPC and may require the most recent audited financial statements from the administrator and such other interim evidence as the commissioner deems appropriate. Reasonable costs of the examination or audit are to be paid by the HIPC. Examination shall include, but not be limited to, premium collection, marketing practices, and financial condition.

**191—73.21(75GA,ch158) Trade practices.** A HIPC shall be subject to Iowa Code chapter 507B, Insurance Trade Practices.

**191—73.22(75GA,ch158) Grounds for denial, nonrenewal, suspension or revocation of certificate.** The following constitute grounds for denial, nonrenewal, suspension or revocation of the HIPC's certificate following notice and an opportunity for hearing:

1. Failure to comply with any provisions of the rules of this chapter;
2. Failure to comply with any lawful order of the commissioner;
3. Committing an unfair or deceptive act or practice as defined in Iowa Code chapter 507B;
4. Filing any necessary form with the division which contains fraudulent information or omission;
5. Misappropriation, conversion, illegal withholding, or refusal to pay over upon proper demand any moneys that belong to a person or health care carrier otherwise not entitled to the HIPC and that have been entrusted to the HIPC in its fiduciary capacity;
6. Failure to demonstrate through clear and convincing evidence that it will extend HIPC services to a significant group of buyers not currently being served by a HIPC; or
7. Failure to demonstrate through clear and convincing evidence that it will reduce the cost, improve the quality, and improve access to or choice of affordable health insurance or health care services.

In addition, the application for certification to be a HIPC may be denied upon a finding by the commissioner that a sufficient number of HIPCs are licensed within a geographic service area and an additional HIPC would adversely affect existing HIPCs.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—73.23(75GA,ch158) Hearing and appeal.** Prior to denying an application or a renewal application or suspending or revoking a certificate issued under this chapter, a certificate holder shall be provided with written notice of the commissioner's decision and provided an opportunity for a hearing and a right to appeal as provided in rule 191—3.1(17A,502,505) and Iowa Code chapter 17A.

**191—73.24(75GA,ch158) Solvency.** In the event a HIPC becomes insolvent, the division shall maintain jurisdiction of the HIPC for purposes of protection of the interests of the HIPC participants and the health insurance carriers and health benefit plans pursuant to the pertinent sections of Iowa Code chapter 507C.

These rules are intended to implement 1993 Iowa Acts, chapter 158, section 2.

[Filed emergency 7/1/94—published 7/20/94, effective 7/1/94]

[Filed 11/4/94, Notice 7/20/94—published 11/23/94, effective 12/28/94]

[Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]



CHAPTER 74  
HEALTH CARE ACCESS

**191—74.1(505) Purpose.** The purpose of this chapter is to implement Iowa Code section 505.21 requiring an employer to provide access to health care or health insurance to an employer's eligible employees. The employer shall, at a minimum, make health care information or health insurance information available to the employer's eligible employees by a written referral. However, the employer may also satisfy the health care access requirement by offering or paying for health care or health insurance.

**191—74.2(505) Applicability and scope.** This chapter shall apply to all employers doing business within the state of Iowa.

**191—74.3(505) Definitions.** As used in this chapter:

**74.3(1)** "*Division*" means the insurance division of the state of Iowa.

**74.3(2)** "*Eligible employee*" means a natural person who is employed in this state for wages by an employer and works on a regular full-time or regular part-time basis. An eligible employee may include a commission salesperson who takes orders or performs services on behalf of a principal and who is paid on the basis of commissions but does not include persons who purchase for their own account for resale.

For purposes of this chapter:

*a.* An eligible employee does not include a temporary employee which means an employee who works for a limited period of time, or an employee with seasonal, intermittent, internship, trainee, or temporary status.

*b.* A minor as defined in Iowa Code chapter 599 is not an eligible employee.

*c.* The following persons engaged in agriculture are not eligible employees:

(1) The spouse of the employer and relatives of either the employer or spouse including relatives employed by a family farm corporation, a family farm partnership or family farm limited liability company.

(2) A person engaged in agriculture as an owner-operator or tenant-operator and the spouse or relatives of either.

(3) Neighboring persons engaged in agriculture who are exchanging labor or other services.

*d.* An independent contractor is not an eligible employee.

*e.* An individual working in vocational rehabilitation programs and receiving health care coverage through governmental programs is not an eligible employee.

**74.3(3)** "*Employer*" means a person, as defined in Iowa Code chapter 4, doing business in the state who in this state employs for wages a natural person. The term employer does not include a multiple employer trust or a client, patient, customer, or other person who obtains professional services from a licensed person who provides the services on a fee service basis or who obtains services from an independent contractor.

**191—74.4(505) Access to health care or health insurance for an employee.**

**74.4(1)** Access to health care or health insurance means any of the following:

*a.* An employer provides a written referral to an eligible employee as to where the eligible employee can receive information concerning health care or health insurance.

*b.* An employer offers coverage or contributes to health insurance or a health benefit plan.

**74.4(2)** An employer who provides the eligible employee a written referral, offers coverage or contributes under subrule 74.4(1) to any of the following has satisfied the health care access requirement.

*a.* Health care coverage through an insurer or health maintenance organization authorized to do business in Iowa.

*b.* Access to health benefits through a health benefits plan qualified under the federal Employee Retirement Income Security Act of 1974.

c. Joining a health purchasing cooperative as defined in 191 IAC 73 whereby the employees may purchase health insurance offered by several health insurance or health care benefit programs.

**74.4(3)** To satisfy subrule 74.4(1), paragraph “a,” the employer shall contact a health insurance agent, health insurance carrier, or other health care organization which agrees with the employer to provide information to the eligible employee about health care or health insurance and possible purchase of health care or health insurance. In the event that an eligible employee cannot read or understand English, the employer shall offer assistance to the eligible employee in understanding the written referral. The employer shall provide the information to the eligible employee within a reasonable time of hiring the eligible employee.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—74.5(505) Employer participation.** The employer shall offer payroll deduction of the eligible employee’s contributions to the health care program or health insurance program to which the employer referred the eligible employee. However, payroll deduction shall occur only if the eligible employee has adequate wages to pay the cost of the health care or health insurance. In the event that the insurance carrier or health care organization does not provide for payment through payroll deduction, an automatic withdrawal from the employee’s savings or checking account shall comply with Iowa Code section 505.21.

**191—74.6(505) Violation of chapter.** A violation of this chapter may be reported to the consumer and legal affairs bureau of the division. The division, upon finding that the employer has failed to offer an eligible employee access to health care or health insurance, may do any of the following:

1. Issue a cease and desist order instructing the employer to cure the failure to provide access to health care and desist from future violations of this chapter.
2. Issue an order requiring the employer who has previously been the subject of a cease and desist order to pay an eligible employee’s reasonable health insurance premiums necessary to prevent or cure a lapse in health care coverage due to the employer’s failure to offer access to health care.
3. Assess the reasonable costs of the division’s investigation and enforcement to the employer.

These rules are intended to implement Iowa Code section 505.21.

[Filed 2/17/95, Notice 12/21/94—published 3/15/95, effective 5/1/95]

[Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

CHAPTER 75  
IOWA INDIVIDUAL HEALTH BENEFIT PLANS

**191—75.1(513C) Purpose.** This chapter is intended to implement the provisions of Iowa Code chapter 513C to promote the availability of health insurance coverage to individuals, regardless of their health status or claims experience; to prevent abusive rating practices; to require disclosure of rating practices to purchasers; to establish rules regarding the renewal of coverage; to establish limitations on the use of preexisting condition exclusions; to assure fair access to health benefit plans; to improve the overall fairness and efficiency of the individual health insurance market; and to provide for development of “basic” and “standard” health insurance plans to be offered to individuals. Carriers that provide individual health insurance benefit plans, as that term is defined in Iowa Code chapter 513C, to individuals are subject to all provisions of chapter 513C and this Chapter 75.

**191—75.2(513C) Definitions.** As used in this chapter:

“*Eligible resident*” means an individual who has been legally domiciled in this state for a period of 60 days. For purposes of this chapter, legal domicile is established by living in this state and obtaining an Iowa motor vehicle operator’s license, registering to vote in Iowa, or filing an Iowa income tax return. A child is legally domiciled in this state if the child lives in this state and if at least one of the child’s parents or the child’s guardian is legally domiciled in this state for a period of 60 days. A person with a developmental disability or another disability which prevents the person from obtaining an Iowa motor vehicle operator’s license, registering to vote in Iowa, or filing an Iowa income tax return, is legally domiciled in this state by living in the state for 60 days.

“*Insured group health plan*” as that term is referenced in Iowa Code section 513C.3 includes a health benefit plan offered directly through an employer with two or more employees and a plan offered through an employer with two or more employees under a group discretionary trust or association plan.

“*Risk characteristic*” means the health status, claims experience or any similar characteristic related to the health status or experience of an individual under a health benefit plan.

“*Risk load*” means the percentage above the applicable base premium rate that is charged by a carrier to an individual to reflect the risk characteristics of such individual.

Other terms shall be defined pursuant to 1995 Iowa Acts, chapter 5.  
[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—75.3(513C) Applicability and scope.**

**75.3(1)** Except as otherwise specifically provided, this chapter shall apply to any individual health benefit plan applied for on or after April 1, 1996.

**75.3(2)** Iowa Code chapter 513C and this chapter shall apply to an individual health benefit plan provided to an eligible individual.

**75.3(3)** An entity that is not operating as an individual health benefit plan carrier in this state shall not become subject to the provisions of the Act and this rule solely because an individual that was issued a health benefit plan in another state by that entity becomes a resident of this state.

**75.3(4)** This chapter shall not apply to health insurance policies or certificates that are subject to Iowa Code chapter 513B.

**75.3(5)** Except for basic or standard health benefit plans, nothing in Iowa Code chapter 513C or this chapter is applicable to underwriting practices, substandard ratings, or the addition of waivers or riders to policies or certificates.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—75.4(513C) Establishment of blocks of business.** A carrier shall file with the commissioner the following information with respect to each established block of business, as defined in Iowa Code section 513C.3.

1. A description of each criterion employed by the carrier for determining membership in the block of business;

2. A statement describing the justification for establishing the block as a separate block of business;

3. A statement disclosing which, if any, health benefit plans are currently available for purchase in the block and any significant limitations related to the purchase of such plans.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—75.5(513C) Transition for assumptions of business from another carrier.**

**75.5(1)** Transfer or assumption of insurance obligation.

*a.* A carrier shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering a block of business in this state unless the transaction has been approved by the commissioner of the state of domicile of the ceding carrier.

*b.* A carrier domiciled in this state that proposes to assume or cede the entire insurance obligation or risk or one or more blocks of business from another carrier shall make a filing for approval with the commissioner at least 60 days prior to the date of the proposed assumption. The commissioner may approve the transaction upon a finding that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of Iowa Code chapter 513C and this chapter.

*c.* The filing required under paragraph 75.5(1)“*b*” shall:

(1) Describe the block of business, including any eligibility requirements, of the ceding carrier from which the health benefit plans will be ceded;

(2) Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate block of business, pursuant to subrule 75.5(3), or will incorporate them into an existing block of business, pursuant to subrule 75.5(4). If the assumed health benefit plans will be incorporated into an existing block of business, the filing shall describe the block of business of the assuming carrier into which the health benefit plans will be incorporated;

(3) Describe whether the health benefit plans being assumed are currently available for purchase by individuals;

(4) Describe the potential effect of the assumption on the benefits provided by the health benefit plans to be assumed;

(5) Describe the potential effect of the assumption on the premiums for the health benefit plans to be assumed;

(6) Describe any other potential material effects of the assumption on the coverage provided to the individuals covered by the health benefit plans to be assumed; and

(7) Include any other information required by the commissioner.

*d.* A carrier required to make a filing under paragraph 75.5(1)“*b*” shall also make an informational filing with the commissioner of each state in which there are individual health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under paragraph 75.5(1)“*b*” and shall include at least the information specified in subparagraph 75.5(1)“*c*”(1) for the individual health benefit plans in that state.

*e.* A carrier shall not transfer or assume the entire insurance obligation or risk of a health benefit plan covering an individual in this state unless it complies with the following provisions:

(1) The carrier has provided notice to the commissioner at least 60 days prior to the date of the proposed assumption. The notice shall contain the information specified in paragraph 75.5(1)“*c*” for the health benefit plans covering individuals in this state.

(2) If the assumption of a block of business would result in the assuming carrier’s being out of compliance with the limitations related to premium rates contained in Iowa Code section 513C.5, the assuming carrier shall make a filing with the commissioner pursuant to Iowa Code section 513C.5 seeking suspension of the application of Iowa Code section 513C.5.

(3) An assuming carrier seeking suspension of the application of Iowa Code section 513C.5 shall not complete the assumption of health benefit plans covering individuals unless the commissioner grants the suspension requested pursuant to subparagraph 75.5(1)“*e*”(2).

(4) Unless a different period is approved by the commissioner, a suspension of the application of Iowa Code section 513C.5 shall, with respect to an assumed block of business, be for no more than 15 months and, with respect to each individual, last only until the anniversary date of such individual's coverage. With respect to an individual this period may be extended beyond its first anniversary date for a period of up to 12 months if the anniversary date occurs within 3 months of the date of assumption of the block of business.

**75.5(2)** Except as provided in subrule 75.5(1), a carrier shall not cede or assume the entire insurance obligation or risk for a health benefit plan, other than reinsurance, unless the carrier cedes to the assuming carrier the entire block of business that includes such health benefit plan, unless otherwise approved by the commissioner.

**75.5(3)** The commissioner may approve a longer period of transition upon application of a carrier. The application shall be made within 60 days after the date of assumption of the block of business and shall clearly state the justification for a longer transition period.

**75.5(4)** Nothing in this rule or in Iowa Code chapter 513C is intended to:

a. Reduce or diminish any legal or contractual obligation or requirements, including any obligation provided in Iowa Code chapters 521 and 521B, of the ceding or assuming carrier related to the transaction;

b. Authorize a carrier that is not admitted to transact the business of insurance in this state to offer health benefit plans in this state; or

c. Reduce or diminish the protections related to an assumption reinsurance transaction provided in Iowa Code chapters 521 and 521B or otherwise provided by law.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

#### **191—75.6(513C) Restrictions relating to premium rates.**

**75.6(1)** As provided by Iowa Code section 513C.5, each carrier must limit differences in premium due to such factors as experience and duration to the composite effect of 20 percent, 30 percent, and 30 percent. Allocation of cost differences due to experience and duration among the categories outlined in Iowa Code section 513C.5 may be determined by each carrier.

**75.6(2)** Nothing in this rule shall require rates be filed absent any other statutory requirements.

#### **191—75.7(513C) Availability of coverage.**

**75.7(1)** Except as provided in Iowa Code section 513C.7, the choice between the basic and standard health benefit plans may not be limited, restricted or conditioned upon the risk characteristics of the individuals or their dependents.

**75.7(2)** Insurers shall not require eligible family members to accept a basic or standard health benefit plan covering all family members. Those family members who qualify for an underwritten plan may be issued separate coverage from those who do not qualify for the underwritten plan but are eligible for guaranteed issue of the basic or standard plan.

**75.7(3)** Qualifying previous coverage for a newborn shall be the greater of the period or periods of qualifying previous coverage established by either of the newborn's parents prior to the date of birth.

**75.7(4)** Benefits paid under a basic or standard health benefit plan shall not duplicate benefits paid under any other health insurance coverage. Other coverage means benefits paid for hospital, surgical or other medical care or expenses for a covered person by any of the following:

- a. Insurance plan or policy; or
- b. Health benefit plan; or
- c. Welfare plan; or
- d. Prepayment plan; or
- e. Hospital service corporation plan or policy; or
- f. Medicare;

whether provided on an individual, family, or group basis or through an employer, union or association. If such other coverage is on a provision of service basis, the amount of benefits will be the amount that the services provided would have cost without such other coverage.

**191—75.8(513C) Disclosure of information.**

**75.8(1)** General rules. In connection with the offering for sale of a health benefit plan to individuals, each carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

*a.* The extent to which premium rates for a specified individual are established or adjusted in part based upon the actual or expected variation in claims costs or the actual or expected variation in health conditions of the individual and the individual's dependents, if any.

*b.* The provisions of such plan concerning the carrier's ability to change premium rates and the factors, other than claim experience, which affect changes in premium rates.

*c.* The provisions of such plan relating to the renewability of policies and contracts.

*d.* The provisions of such plan relating to the effect of any preexisting condition provision. The expression "preexisting conditions" shall not be used unless appropriately defined in the policy or contract.

*e.* The availability, upon request, of descriptive information about the benefits and premiums available under individual health benefit plans offered by the carrier for which the individual is qualified. For purposes of Iowa Code section 513C.7, carriers will be permitted to exclude from disclosure of plans those plans within the following categories:

(1) Plans distributed through a separate marketing channel.

(2) Plans offered through a membership association.

(3) Plans offered through a trust in which membership is otherwise limited.

(4) Other plans as reviewed and approved by the commissioner or director.

**75.8(2)** Information shall be provided under this rule in a manner determined to be understandable by the average individual and shall be accurate and sufficiently comprehensive to reasonably inform individuals of their rights and obligations under the plan.

Nothing in this rule supersedes the requirements for outlines of coverage for individual health insurance policies under rule 191—36.7(514D).

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—75.9(513C) Standards to ensure fair marketing.**

**75.9(1)** A carrier shall make available at least one basic and one standard health benefit plan to eligible individuals in this state.

**75.9(2)** The written information described in this subrule may be provided directly to the individual or delivered through an authorized producer:

*a.* A carrier shall not apply more stringent requirements related to the application process for the basic and standard health benefit plans than applied for other health benefit plans offered by the carrier.

*b.* A carrier shall supply a price quote for basic or standard plans to an eligible individual upon request.

*c.* If a carrier denies coverage under a health benefit plan to an individual on the basis of a risk characteristic, the denial shall be in writing and state with specificity the reasons for the denial subject to any restrictions related to confidentiality of medical information. The denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the carrier and may be combined with the notification requirements of Iowa Code chapter 514E. The explanation shall include the following information about the basic and standard benefit plans:

(1) A general description of the benefits and policy provisions contained in each plan;

(2) A price quote for each plan; and

(3) Information describing eligibility and how an eligible individual may enroll in such plans.

**75.9(3)** The carrier shall not require an individual to join or contribute to any association or group as a condition of being accepted for coverage except, if membership in an association or other group is a requirement for accepting an individual into a particular health benefit plan, a carrier may apply such requirement.

**75.9(4)** A carrier may not require as a condition to the offer or sale of a health benefit plan to an individual that the individual purchase or qualify for any other insurance product or service.

**75.9(5)** Carriers offering individual or group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of Iowa Code chapter 513C. [ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—75.10(513C) Basic health benefit plan and standard health benefit plan policy forms.**

**75.10(1)** The form and level of coverage of the basic health benefit plan and the standard health benefit plan are contained in the rules and table.

**75.10(2)** Termination of pregnancy is to be covered when performed for therapeutic reasons. Elective termination of pregnancy is not to be covered in either the basic or standard plan.

**75.10(3)** A provision shall be made in the basic health benefit plan and the standard health benefit plan covering diagnosis and treatment of human ailments for payment or reimbursement for necessary diagnosis and treatment provided by a chiropractor licensed under Iowa Code chapter 151, if the diagnosis or treatment is provided within the scope of the chiropractor’s license.

**75.10(4)** Prescription oral contraceptives and contraceptive devices that are approved by the United States Food and Drug Administration are to be covered in both policy forms.

**75.10(5)** The division of insurance and the department of health have available “safe harbor” policy forms for the basic and standard health benefit plans required pursuant to Iowa Code chapter 513C.

**Iowa Individual Products**

| Hospital Services                     | MANDATED INDEMNITY |          |     |     | MANDATED HMO |             |
|---------------------------------------|--------------------|----------|-----|-----|--------------|-------------|
|                                       | BASIC              | STANDARD | PPO |     | BASIC        | STANDARD    |
|                                       |                    |          | In  | Out |              |             |
| Inpatient                             | 60%                | 80%      | 80% | 60% | 60%          | 80%         |
| Outpatient                            |                    |          |     |     | \$400/admit  | \$200/admit |
| Prostheses                            | 60%                | 80%      | 80% | 60% | 60%          | 80%         |
| DME—including medical supplies        | 60%                | 80%      | 80% | 60% | 60%          | 80%         |
| Ambulance—Emergency                   | 60%                | 80%      | 80% | 60% | 60%          | 80%         |
| Hospice                               | 60%                | 80%      | 80% | 60% | 60%          | 80%         |
| Home Health and Physician House Calls | 60%                | 80%      | 80% | 60% | 60%          | 80%         |

| Alcoholism<br>Substance Abuse | MANDATED INDEMNITY |  |                    |                    | MANDATED HMO |                                 |
|-------------------------------|--------------------|--|--------------------|--------------------|--------------|---------------------------------|
|                               | BASIC              | STANDARD                                       | PPO                |                    | BASIC        | STANDARD                        |
|                               |                    |  | In                 | Out                |              |                                 |
| Inpatient                     | —                  | 80% <sup>(1)</sup>                             | 80% <sup>(1)</sup> | 60% <sup>(1)</sup> | —            | 80%                             |
| Outpatient                    | —                  | 80% <sup>(1)</sup><br>(\$50 max. eligible fee) | 80% <sup>(1)</sup> | 60% <sup>(1)</sup> | —            | 80%<br>(\$50 max. eligible fee) |

| Mental Health | MANDATED INDEMNITY |  |  |  | MANDATED HMO |                                 |
|---------------|--------------------|--|--|--|--------------|---------------------------------|
|               | BASIC              | STANDARD                                       | PPO  |  | BASIC        | STANDARD                        |
|               |                    |  | In   | Out  |              |                                 |
| Inpatient     | —                  | 80% <sup>(1)</sup>                             | 80% <sup>(1)</sup>                             | 60% <sup>(1)</sup>                             | —            | 80%                             |
| Outpatient    | —                  | 80% <sup>(1)</sup><br>(\$50 max. eligible fee) | 80% <sup>(1)</sup><br>(\$50 max. eligible fee) | 60% <sup>(1)</sup><br>(\$50 max. eligible fee) | —            | 80%<br>(\$50 max. eligible fee) |

<sup>(1)</sup>\$50,000 Lifetime Max.

### Iowa Individual Products

| General                                  | MANDATED INDEMNITY   |                      |                      |                      | MANDATED HMO               |                            |
|--|----------------------|----------------------|----------------------|----------------------|----------------------------|----------------------------|
|  | BASIC                | STANDARD             | PPO                  |                      | BASIC                      | STANDARD                   |
|  |                      |                      | In                   | Out                  |                            |                            |
| Calendar year deductibles (S/F)          | \$1,500 x 3          | \$1,000 x 3          | \$1,000 x 3          | \$1,000 x 3          | —                          | —                          |
| E.R. Copayment                           | —                    | —                    | —                    | —                    | \$50 (waived if admitted)  | \$50 (waived if admitted)  |
| Coinsurance                              | 60%                  | 80%                  | 80%                  | 60%                  | 60%                        | 80%                        |
| Annual out-of-pocket max. <sup>(1)</sup> | \$4,800/<br>\$14,400 | \$2,000/<br>\$4,000  | \$2,000/<br>\$4,000  | \$3,000/<br>\$6,000  | \$4,000/<br>\$8,000        | \$2,000/<br>\$4,000        |
| Lifetime Maximum                         | \$250,000            | \$1,000,000          | \$1,000,000          | \$1,000,000          | \$250,000                  | \$1,000,000                |
| Pre-existing                             | 513C.7(4)<br>(a)&(b) | 513C.7(4)<br>(a)&(b) | 513C.7(4)<br>(a)&(b) | 513C.7(4)<br>(a)&(b) | 513C.7(4)<br>(a)&(b)       | 513C.7(4)<br>(a)&(b)       |
| Rx                                       | 60%                  | 80%                  | 80%                  | 60%                  | Copayment of > \$30 or 25% | Copayment of > \$20 or 25% |
| Transplants                              | None                 | 80%                  | 80%                  | 80%                  | None                       | 80%                        |

<sup>(1)</sup>Excludes deductibles and copays

| Physician Services               | MANDATED INDEMNITY |          |                    |                   | MANDATED HMO                |                             |
|----------------------------------|--------------------|----------|--------------------|-------------------|-----------------------------|-----------------------------|
|                                  | BASIC              | STANDARD | PPO                |                   | BASIC                       | STANDARD                    |
|                                  |                    |          | In                 | Out               |                             |                             |
| Office visits including wellness | 60%                | 80%      | \$20 copay<br>100% | \$40 copay<br>60% | \$20 copay per office visit | \$15 copay per office visit |
| Urgent Care                      | 60%                | 80%      | 80%                | 60%               | 60%                         | 80%                         |
| Inpatient                        | 60%                | 80%      | 80%                | 60%               | 60%                         | 80%                         |
| Outpatient                       | 60%                | 80%      | 80%                | 60%               | 60%                         | 80%                         |

#### ACCEPTABLE EXCLUSIONS FOR USE IN BASIC AND STANDARD POLICIES

**75.10(6)** Except as specifically provided for, no benefits will be provided for services, supplies or charges:

1. Which are not prescribed by, performed by, or upon the direction of a provider;
2. Which are not medically necessary;
3. Rendered by other than a hospital or a provider;
4. Which are investigational in nature; including any service, procedure, or treatment directly related to an investigational treatment;
5. For any condition, disease, illness, or bodily injury which occurs in the course of employment if benefits or compensation is carried or required, in whole or in part, under the provisions of any legislation or governmental unit. This exclusion applies whether or not the insured claims the benefits or compensation;
6. To the extent benefits are provided by any governmental unit except as required by federal law for the treatment of veterans in Veterans Administration or armed forces facilities for non-service-related medical conditions;
7. For any illness or injury suffered as a result of any act of war, declared or undeclared, or military service;
8. For which the insured would have no legal obligation to pay in the absence of this or any similar coverage;

9. For which no expense is incurred;
10. Surgery and any related services intended solely to improve appearance including but not limited to the restoration of hair and appearance of skin. This does not include those services or surgeries that restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies of a newborn;
11. Rendered by a provider that is a member of the insured's immediate family;
12. Incurred prior to the effective date or during an inpatient admission that commenced prior to the insured's effective date of coverage;
13. Incurred after the date of termination of the insured's coverage;
14. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment;
15. For telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form or charges for medical information;
16. For inpatient admissions which are primarily for diagnostic studies or physical therapy;
17. For whole blood, blood components and blood derivatives which are not classified as drugs in the official formularies;
18. For custodial care, domiciliary care or rest cures;
19. For treatment in a facility, or part of a facility, that is mainly a place for:
  - Rest;
  - Convalescence;
  - Custodial care;
  - Aged;
  - Care or treatment of alcoholism or drug addiction;
  - Rehabilitation; or
  - Training, schooling or occupational therapy;
20. For screening examinations including X-ray examinations made without film;
21. For sterilization or reversal of sterilizations, or both;
22. For dental work or treatment except for removal of malignant tumors and cysts or accidental injury (eating and chewing mishaps are not accidental injuries for the purposes of this policy) to natural teeth, if the accident occurs while the person is insured and the treatment is received within 12 months after the accident;
23. For treatment of weak, strained or flat feet, including orthopedic shoes or other supportive devices, or for cutting, removal or treatment of corns, calluses or nails, other than with corrective surgery, or for metabolic or peripheral vascular disease;
24. For eyeglasses or contact lenses and the visual examination for prescribing or fitting eyeglasses or contact lenses (except for aphasic patients and soft lenses or sclera shells intended for use in the treatment of disease or injury);
25. For radial keratotomy, myopic keratomileusis and any surgery which involves corneal tissue for the purpose of altering, modifying or correcting myopia, hyperopia or stigmatic error;
26. For hearing aids and supplies, tinnitus maskers, or examinations for the prescription or fitting of hearing aids;
27. For any treatment leading to or in connection with transsexualism, sex changes or modifications, including but not limited to surgery or the treatment of sexual dysfunction not related to organic disease;
28. For any treatment or regimen, medical or surgical, for the purpose of reducing or controlling the insured's weight or for the treatment of obesity;
29. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or for inpatient confinement for environmental change;
30. For services and supplies for and related to fertility testing, treatment of infertility and conception by artificial means, including but not limited to: artificial insemination, in vitro fertilization, ovum or embryo placement or transfer, gamete intrafallopian tube transfer, or cryogenic or other preservation techniques used in such or similar procedures;
31. For travel whether or not recommended by a physician;

32. For complications or side effects arising from services, procedures, or treatments excluded by this policy;
  33. For maternity care except for complications of pregnancy which is covered as any other illness;
  34. For services to the extent that those services are covered by Medicare;
  35. For or related to organ transplants (unless a benefit is specifically provided and then only to the limits provided);
  36. For or related to the transplantation of animal or artificial organs or tissues;
  37. For the care or treatment of any injury that is intentionally self-inflicted, while sane or insane;
  38. For the care or treatment of any injury incurred during the commission of, or an attempt to commit, a felony or any injury or sickness incurred while engaging in an illegal act or occupation or participation in a riot;
  39. For lifestyle improvements including smoking cessation, nutrition counseling or physical fitness programs;
  40. For the purchase of wigs or cranial prosthesis;
  41. For weekend admission charges, except for emergencies;
  42. For orthomolecular therapy including nutrients, vitamins and food supplements;
  43. For speech therapy, except to restore speech abilities which were lost due to sickness or injury.
- [ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—75.11(513C) Maternity benefit rider.** Every individual insurance carrier shall offer an optional maternity benefit rider for the basic and standard health benefit plans providing benefits, as any other illness, for a pregnancy and delivery without complications with a 12-month waiting period. Credit toward meeting the waiting period shall be given for prior coverage of a pregnancy without complications provided there was no more than a 63-day break in coverage. A maternity rider offered under this rule shall only be offered when the basic or standard plan is initially purchased. Premiums for the rider shall be calculated based upon generally accepted actuarial principles and shall not be subject to the premium restrictions in Iowa Code subsection 513C.10(6). The earned premiums and paid losses associated with the rider shall not be considered by the Iowa Individual Health Benefit Reinsurance Association for purposes of Iowa Code section 513C.10.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—75.12(513C) Disclosure requirements.** All carriers shall include in contracts and evidence of coverage forms a statement disclosing the existence of any drug formularies. Upon request, a carrier 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 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.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—75.13(514C) Treatment options.**

**75.13(1)** A carrier shall not prohibit a participating provider from or penalize a participating provider for discussing treatment options with covered persons, irrespective of the carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.

**75.13(2)** A carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the carrier that, in the opinion of the provider, jeopardizes patient health or welfare.

**191—75.14(514C) Emergency services.** Benefits shall be available by the carrier for inpatient and outpatient emergency services. A physician and sufficient other licensed and ancillary personnel shall be readily available at all times to render such services. Since carriers may not contract with every emergency care provider in an area, carriers shall make every effort to inform members of participating providers.

**75.14(1)** The term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish the services that are needed to evaluate or stabilize an emergency medical condition.

**75.14(2)** The term “emergency medical condition” means a medical condition manifesting itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

- a. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;
- b. Serious impairment to bodily function; or
- c. Serious dysfunction of any bodily organ or part.

**75.14(3)** Reimbursement to a provider of “emergency services” shall not be denied by any carrier without that organization’s review of the patient’s medical history, presenting symptoms, and admitting or initial as well as final diagnosis, submitted by the provider, in determining whether, by definition, emergency services could reasonably have been expected to be provided. Reimbursement for emergency services shall not be denied solely on the grounds that services were performed by a noncontracted provider. If reimbursement for emergency services is denied, the enrollee may file a complaint with the carrier. Upon denial of reimbursement for emergency services, the carrier shall notify the enrollee and provider that they may register a complaint with the commissioner of insurance.

**191—75.15(514C) Provider access.** A carrier shall allow a female enrollee direct access to obstetrical or gynecological services from network and participating providers. The plan shall also allow a pediatrician to be the primary care provider for a child through the age of 18.

**191—75.16(514C) Diabetic coverage.** All carriers shall provide benefits in the standard health benefit plan for the cost associated with equipment, supplies, and education for the treatment of diabetes pursuant to Iowa Code section 514C.14.

These rules are intended to implement Iowa Code chapters 513C and 514C and 1997 Iowa Acts, House File 701; 1995 Iowa Acts, chapter 204, section 14; 1996 Iowa Acts, chapter 1219, section 52; and 1999 Iowa Acts, Senate File 276.

**191—75.17(513C) Reconstructive surgery.**

**75.17(1)** A carrier that provides medical and surgical benefits with respect to a mastectomy shall provide the following coverage in the event an enrollee receives benefits in connection with a mastectomy and elects breast reconstruction:

- a. Reconstruction of the breast on which the mastectomy has been performed;
- b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- c. Prostheses and coverage of physical complications at all stages of a mastectomy including lymphedemas.

**75.17(2)** The benefits under this rule shall be provided in a manner determined in consultation with the attending physician and the enrollee. The coverage may be subject to annual deductibles and coinsurance provisions that are consistent with other benefits under the plan or coverage.

**75.17(3)** Written notice of the availability of coverage in this rule shall be provided to the enrollee upon enrollment and then annually.

**75.17(4)** A carrier 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 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.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

**191—75.18(514C) Contraceptive coverage.**

**75.18(1)** A carrier that provides benefits for outpatient prescription drugs or devices shall provide benefits for prescription contraceptive drugs or prescription contraceptive devices which prevent conception and are approved by the United States Food and Drug Administration or generic equivalents approved as substitutable by the United States Food and Drug Administration.

**75.18(2)** A carrier is not required to offer benefits for over-the-counter contraceptive drugs or contraceptive devices that do not require a prescription for purchase.

**75.18(3)** A contraceptive drug or contraceptive device does not include surgical services intended for sterilization, including, but not limited to, tubal ligation or vasectomy.

**75.18(4)** A carrier shall make available benefits for services related to outpatient contraceptive services for the purpose of preventing conception if the policy or contract provides benefits for other outpatient services provided by a health care professional.

**75.18(5)** If a carrier does not provide benefits for a routine physical examination, the carrier 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 Iowa Code chapter 514C.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

[Filed 2/8/96, Notice 12/6/95—published 2/28/96, effective 4/3/96]

[Filed emergency 6/26/97—published 7/16/97, effective 7/1/97]

[Filed 10/10/97, Notice 7/16/97—published 11/5/97, effective 12/10/97]

[Filed emergency 10/16/98—published 11/4/98, effective 10/16/98]

[Filed emergency 6/25/99—published 7/14/99, effective 7/1/99]

[Filed 9/3/99, Notice 7/14/99—published 9/22/99, effective 10/27/99]

[Filed 4/10/00, Notice 1/12/00—published 5/3/00, effective 6/7/00]

[Filed 8/17/00, Notice 7/12/00—published 9/6/00, effective 10/11/00]

[Filed 10/27/00, Notice 9/20/00—published 11/15/00, effective 12/20/00]

[Filed emergency 10/26/01—published 11/14/01, effective 10/26/01]

[Filed 3/29/02, Notice 2/6/02—published 4/17/02, effective 5/22/02]

[Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

CHAPTER 78  
UNIFORM PRESCRIPTION DRUG INFORMATION CARD

**191—78.1(514L) Purpose.** The purpose of this chapter is to implement the use of a uniform prescription drug information card or other technology by the providers of third-party payment or prepayment of prescription drug expenses, by the providers' contractors or agents and pharmacy benefit managers, and by administrators of the providers and payors. The purpose of the uniform prescription drug information card or other technology is to benefit patients, insurers, pharmacy benefit managers and pharmacists through enhanced patient convenience and processing of claims for prescription benefits, decreased calls to help desks due to missing or incorrect card information, and improved delivery of prescription benefit services to consumers.

**191—78.2(514L) Definitions.**

*“Administrator”* or *“administrator of the payor”* means the claims administrator or administrators to which claims for prescription drug benefits are submitted, processed and adjudicated, and includes pharmacy benefit managers, and excludes administrators for self-funded employer-sponsored health benefit plans qualified under the federal Employee Retirement Income Security Act of 1974.

*“BIN number,” “IIN/BIN number,” “BIN,”* or *“RxBIN”* means the ANSI-assigned issuer identification number, or IIN, which was formerly known as the “bank identification number” or “BIN,” and which is identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide as the “BIN number.” The “Rx” prefix is not required if the same BIN number is used for pharmacy and medical claims submission.

*“Card”* or *“card or other technology for claims processing”* means a card or other technology that is issued to insureds, enrollees, and covered individuals. Insureds, enrollees, and covered individuals provide the card to pharmacies to receive prescription drug benefits. Pharmacies use the information, required by Iowa Code chapter 514L to be on the card, for prescription drug claims submission, processing and adjudication with providers, administrators, pharmacy benefit managers or similar entities.

*“Cardholder ID”* means the cardholder's unique identification number that is issued by the provider to the insured, enrollee, or covered individual, and which is identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide.

*“Cardholder name”* means the cardholder's first name, middle initial and last name.

*“Card issuer identifier number”* means the number identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide as the international identifier for the United States of America, which has not yet been enumerated and may remain blank on cards until such number is determined.

*“Card issuer's name and logo”* means the name and identifying mark of the entity issuing the card or other technology, identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide.

*“Consistent with the guide”* means that the information and data elements on the card shall conform to the standards set forth in the most recent release of the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide, except that the address of the pharmacy benefit manager may be excluded and the information and data elements may be placed at different locations on the card as reasonably necessary to accommodate space and logistical needs.

*“Group ID number,” “Grp,”* or *“RxGrp”* means the group identification number or group ID number as identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide. The “Rx” prefix is not required if the same group number is used for pharmacy and medical claims submission.

*“Guide”* or *“National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide”* means the most recent document issued by the National Council for Prescription Drug Programs.

*“Pharmacy benefit manager”* means an entity that receives and processes claims for payment or prepayment for prescription drug expenses from pharmacies and that may issue cards or other technology for prescription claims processing.

*“Processor control number,” “PCN,”* or *“RxPCN”* means the processor control number as identified in the National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide. The “Rx” prefix is not required if the same PCN number is used for pharmacy and medical claims submission.

*“Provider of third-party payment or prepayment of prescription drug expenses”* or *“provider”* means a provider of an individual or group policy of accident or health insurance or an individual or group hospital or health care service contract issued pursuant to Iowa Code chapter 509, 514 or 514A, a provider of a plan established pursuant to Iowa Code chapter 509A for public employees, a provider of an individual or group health maintenance organization contract issued and regulated under Iowa Code chapter 514B, a provider of a preferred provider contract issued pursuant to Iowa Code chapter 514F, a provider of a self-insured multiple employer welfare arrangement, and any other entity providing health insurance or health benefits which provide for payment or prepayment of prescription drug expenses coverage subject to state insurance regulation.

*“Substantially consistent with the guide”* means that the location of the uniform prescription drug information on the card or other technology shall conform to the standards set forth in the most recent National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide. The information may be placed at different locations on the card as reasonably necessary to accommodate space and logistical needs.

*“Uniform prescription drug information”* means the requirements set forth in the most recent National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide, including the data elements information required on the card, such as the content, format and the location.

[ARC 3682C, IAB 3/14/18, effective 4/18/18]

### **191—78.3(514L) Implementation.**

**78.3(1)** Cards or other technology for prescription claims processing issued by providers, administrators, pharmacy benefit managers, and other entities shall contain data elements and other required information that is substantially consistent with the most recent National Council for Prescription Drug Programs Pharmacy ID Card Implementation Guide. The location of the data elements and information shall be substantially consistent with the guide, and the cards or other technology shall at a minimum contain the following:

- a. The BIN number labeled as “BIN” or “RxBIN.”
- b. The processor control number labeled as “PCN” or “RxPCN” if required for claims processing.
- c. The group identification number labeled as “Grp” or “RxGrp” if required for claims processing.
- d. The card issuer’s identification number if available.
- e. The cardholder’s name.
- f. The card issuer’s name or logo.
- g. The help desk name and telephone number for claims submission, processing and other assistance clearly labeled as “Help Desk” or “Pharmacy Service,” except that this information may be excluded from the card if the name and telephone number is provided electronically in a readable manner to the pharmacy computer at the time of claims processing and submission.

Notwithstanding the foregoing, nothing in this rule shall be interpreted to preclude the inclusion of additional data elements and information.

**78.3(2)** If the card or other technology is issued by the provider of third-party payment or prepayment of prescription drug expenses, the provider shall be responsible for issuing the card or other technology in compliance with these rules.

**78.3(3)** If the card or other technology is not issued by the provider of third-party payment or prepayment of prescription drug expenses and the card or other technology is issued by an administrator, pharmacy benefit manager, or other entity, the provider and entity shall enter into an agreement as to whether the provider or entity shall be responsible for compliance with these rules.

**78.3(4)** For new insureds, enrollees, or otherwise covered individuals, the provider, administrator, pharmacy benefit manager, or other entity responsible for issuing cards or other technology in compliance with these rules shall issue the cards or other technology no later than 30 days after the insured, enrollee, or covered individual becomes eligible for prescription drug benefits.

**78.3(5)** The provider, administrator, pharmacy benefit manager, or other entity responsible for issuing cards or other technology shall reissue cards in compliance with these rules at least once per year if the material information required on the cards or other technology under these rules changes. Nothing in these rules shall prevent such entities from issuing cards or other technology more than once per year.

**78.3(6)** The data elements and information required on the cards or other technology pursuant to these rules shall be printed in a clear and readable form.

**78.3(7)** Nothing in this rule shall prohibit the provider, administrator, pharmacy benefit manager or any other entity required to comply with these rules from issuing a card or other technology containing a magnetic strip or other technological component or device enabling the electronic transmission of information for prescription claims submission, processing, or adjudication, provided that the information required by these rules is printed on the card or other technology in a clear and readable form.

These rules are intended to implement Iowa Code chapter 514L.

[Filed emergency 8/27/03—published 9/17/03, effective 8/27/03]

[Filed ARC 3682C (Notice ARC 3571C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]



UTILITIES AND  
TRANSPORTATION DIVISIONS

CHAPTER 15  
COGENERATION AND SMALL POWER PRODUCTION

[Ch 15 renumbered as Ch 7,10/20/75]

[Prior to 10/8/86, Commerce Commission[250]]

**199—15.1(476) Definitions.** Terms defined in the Public Utility Regulatory Policies Act of 1978 (PURPA), 16 U.S.C. 2601, et seq., shall have the same meaning for purposes of these rules as they have under PURPA, unless further defined in this chapter.

“*AEP facility*” means any of the following: (1) an electric production facility which derives 75 percent or more of its energy input from solar energy, wind, waste management, resource recovery, refuse-derived fuel, agricultural crops or residues, or wood burning; (2) a hydroelectric facility at a dam; (3) land, systems, buildings, or improvements that are located at the project site and are necessary or convenient to the construction, completion, or operation of the facility; or (4) transmission or distribution facilities necessary to conduct the energy produced by the facility to the purchasing utility.

“*Alternate energy purchase (AEP) program*” means a utility program that allows customers to contribute voluntarily to the development of alternate energy in Iowa.

“*Avoided costs*” means the incremental costs to an electric utility of electric energy or capacity or both which, but for the purchase from the qualifying facility or qualifying facilities, such utility would generate itself or purchase from another source.

“*Backup power*” means electric energy or capacity supplied by an electric utility to qualifying facilities and AEP facilities to replace energy ordinarily generated by a facility’s own generation equipment during an unscheduled outage of the facility.

“*Board*” means the Iowa utilities board.

“*Disconnection device*” means a lockable visual disconnect or other disconnection device capable of isolating, disconnecting, and de-energizing the residual voltage in a distributed generation facility.

“*Distributed generation facility*” means a qualifying facility, an AEP facility, or an energy storage facility.

“*Electric meter*” means a device used by an electric utility that measures and registers the integral of an electrical quantity with respect to time.

“*Interconnection costs*” means the reasonable costs of connection, switching, metering, transmission, distribution, safety provisions and administrative costs incurred by the electric utility directly related to the installation and maintenance of the physical facilities necessary to permit interconnected operations with qualifying facilities and AEP facilities, to the extent the costs are in excess of the corresponding costs which the electric utility would have incurred if it had not engaged in interconnected operations, but instead generated an equivalent amount of electric energy itself or purchased an equivalent amount of electric energy or capacity from other sources. Interconnection costs do not include any costs included in the calculation of avoided costs.

“*Interruptible power*” means electric energy or capacity supplied by an electric utility subject to interruption by the electric utility under specified conditions.

“*Maintenance power*” means electric energy or capacity supplied by an electric utility during scheduled outages of qualifying facilities and AEP facilities.

“*Purchase*” means the purchase of electric energy or capacity or both from qualifying facilities and AEP facilities by an electric utility.

“*Qualifying facility*” means a cogeneration facility or a small power production facility which is a qualifying facility under 18 CFR Part 292, Subpart B.

“*Rate*” means any price, rate, charge, or classification made, demanded, observed or received with respect to the sale or purchase of electric energy or capacity, or any rule, regulation, or practice respecting any rate, charge, or classification, and any contract pertaining to the sale or purchase of electric energy or capacity.

“*Sale*” means the sale of electric energy or capacity or both by an electric utility to qualifying facilities and AEP facilities.

“*Supplementary power*” means electric energy or capacity supplied by an electric utility, regularly used by qualifying facilities and AEP facilities in addition to that which the facility generates itself.

“*System emergency*” means a condition on a utility’s system which is likely to result in imminent significant disruption of service to customers or is imminently likely to endanger life or property.  
[ARC 3694C, IAB 3/14/18, effective 4/18/18]

**199—15.2(476) Scope.**

**15.2(1) *Applicability.***

a. Subrule 15.2(2) and rule 199—15.10(476) of this chapter apply to all electric utilities, all qualifying facilities, and all AEP facilities.

b. Rule 199—15.3(476) of this chapter applies to electric utilities which are subject to rate regulation by the board.

c. Rules 199—15.4(476) and 199—15.5(476) of this chapter apply to qualifying facilities and electric utilities which are subject to rate regulation by the board.

d. Rules 199—15.6(476) to 199—15.9(476) of this chapter apply to all qualifying facilities and AEP facilities, and electric utilities which are subject to rate regulation by the board.

e. Rule 199—15.11(476) of this chapter lists additional requirements that apply to AEP facilities, and electric utilities which are subject to rate regulation by the board, pursuant to Iowa Code sections 476.41 to 476.45.

**15.2(2) *Negotiated rates or terms.*** These rules do not:

a. Limit the authority of any electric utility, any qualifying facility, or any AEP facility to agree to a rate for any purchase, or terms or conditions relating to any purchase, which differ from the rate or terms or conditions which would otherwise be required by these rules; or

b. Affect the validity of any contract entered into between an electric utility and a qualifying facility or AEP facility for any purchase.

**199—15.3(476) Information to board.** In addition to the information required to be supplied to the board under 18 CFR 292.302, all rate-regulated electric utilities shall supply to the board copies of contracts executed for the purchase or sale, for resale, of energy or capacity. If the purchases or sales are made other than pursuant to the terms of a written contract, then information as to the relevant prices and conditions shall be supplied to the board. All information required to be supplied under this rule shall be filed with the board by May 1 and November 1 of each year for all transactions occurring since the last filing was made.

**199—15.4(476) Rate-regulated electric utility obligations under this chapter regarding qualifying facilities.** For purposes of this rule, “electric utility” means a rate-regulated electric utility.

**15.4(1) *Obligation to purchase from qualifying facilities.*** Each electric utility shall purchase, in accordance with these rules, any energy and capacity which is made available from a qualifying facility:

a. Directly to the electric utility; or

b. Indirectly to the electric utility in accordance with subrule 15.4(4).

**15.4(2) *Obligation to sell to qualifying facilities.*** Each electric utility shall sell to any qualifying facility, in accordance with these rules and the other requirements of law, any energy and capacity requested by the qualifying facility.

**15.4(3) *Obligation to interconnect.*** Any electric utility shall make the interconnections with any qualifying facility as may be necessary to accomplish purchases or sales under these rules. The obligation to pay for any interconnection costs shall be determined in accordance with rule 199—15.8(476). However, no electric utility is required to interconnect with any qualifying facility if, solely by reason of purchases or sales over the interconnection, the electric utility would become subject to regulation as a public utility under Part II of the Federal Power Act.

**15.4(4) *Transmission to other electric utilities.*** If a qualifying facility agrees, an electric utility which would otherwise be obligated to purchase energy or capacity from the qualifying facility may transmit the energy or capacity to any other electric utility. Any electric utility to which the energy or capacity

is transmitted shall purchase the energy or capacity under this subpart as if the qualifying facility were supplying energy or capacity directly to the electric utility. The rate for purchase by the electric utility to which the energy is transmitted shall be adjusted up or down to reflect line losses and shall not include any charges for transmission.

**15.4(5) *Parallel operation.*** Each electric utility shall offer to operate in parallel with a qualifying facility, provided that the qualifying facility complies with any applicable standards established in accordance with these rules.

**199—15.5(476) Rates for purchases from qualifying facilities by rate-regulated electric utilities.** For purposes of this rule, “electric utility” or “utility” means a rate-regulated electric utility.

**15.5(1) *Rates for purchases.*** Rates for purchases shall:

*a.* Be just and reasonable to the electric consumer of the electric utility and in the public interest; and

*b.* Not discriminate against qualifying cogeneration and small power production facilities. Nothing in these rules requires any electric utility to pay more than the avoided costs, as set forth in these rules, for purchases.

**15.5(2) *Relationship to avoided costs.*** For purposes of this subrule, “new capacity” means any purchase from capacity of a qualifying facility, construction of which was commenced on or after November 9, 1978.

A rate for purchases satisfies the requirements of this rule if the rate equals the avoided costs determined after consideration of the factors set forth in subrule 15.5(6); except that a rate for purchases other than from new capacity may be less than the avoided cost if the board determines that a lower rate is consistent with subrule 15.5(1) and is sufficient to encourage cogeneration and small power production.

Unless the qualifying facility and the utility agree otherwise, rates for purchases shall conform to the requirements of this rule regardless of whether the electric utility making purchases is simultaneously making sales to the qualifying facility.

In the case in which the rates for purchases are based upon estimates of avoided costs over the specific term of the contract or other legally enforceable obligation, the rates for purchases do not violate this rule if the rates for the purchases differ from avoided costs at the time of delivery.

**15.5(3) *Standard rates for purchases.*** Each electric utility shall file and maintain with the board tariffs specifying standard rates for purchases from qualifying facilities with a design capacity of 100 kilowatts or less. These tariffs may differentiate between qualifying facilities using various technologies on the basis of the supply characteristics of the different technologies. All utilities shall include a seasonal differential in these rates for purchases to the extent avoided costs vary by season. All utilities shall make available time of day rates for those facilities with a design capacity of 100 kilowatts or less, provided that the qualifying facility shall pay, in addition to the interconnection costs set forth in these rules, all additional costs associated with the time of day metering.

The standard rates set forth in this rule shall indicate what portion of the rate is attributable to payments for the utility’s avoided energy costs, and what portion of the rate, if any, is attributable to payments for capacity costs avoided by the utility. If no capacity credit is provided in the standard tariff, a qualifying facility may petition the board for an allowance of the capacity credit. The petition shall be handled by the board as a contested case proceeding, and the burden of proof shall be on the qualifying facility to demonstrate that capacity credit is warranted in the case in question.

The board may require utilities interconnected with qualifying facilities to provide metering and other equipment necessary for the collection test and monitoring of information concerning the time and conditions under which energy and capacity are available from the qualifying facility. The costs of such metering shall be treated by the utility in the same manner as any other research expenditure.

**15.5(4) *Other purchases.*** Rates for purchases from qualifying facilities with a design capacity of greater than 100 kilowatts shall be determined in contested case proceedings before the board, unless the rates are otherwise agreed upon by the qualifying facility and the utility involved.

**15.5(5)** *Purchases “as available” or pursuant to a legally enforceable obligation.* Each qualifying facility shall have the option either:

*a.* To provide energy as the qualifying facility determines the energy to be available for the purchases, in which case the rates for the purchases shall be based on the purchasing utility’s avoided costs calculated at the time of delivery; or

*b.* To provide energy or capacity pursuant to a legally enforceable obligation for the delivery of energy or capacity over a specified term, in which case the rates for the purchases shall, at the option of the qualifying facility exercised prior to the beginning of the specified term, be based on either: The avoided costs calculated at the time of delivery; or the avoided costs calculated at the time the obligation is incurred.

**15.5(6)** *Factors affecting rates for purchases.* In determining avoided costs, the following factors shall, to the extent practicable, be taken into account:

*a.* The prevailing rates for capacity or energy on any interstate power grid with which the utility is interconnected.

*b.* The incremental energy costs or capacity costs of the utility itself or utilities in the interstate power grid with which the utility is interconnected.

*c.* The time of day or season during which capacity or energy is available, including:

(1) The ability of the utility to dispatch the qualifying facility;

(2) The expected or demonstrated reliability of the qualifying facility;

(3) The terms of any contract or other legally enforceable obligation, including the duration of the obligation, termination notice requirement and sanctions for noncompliance;

(4) The extent to which scheduled outages of the qualifying facility can be usefully coordinated with scheduled outages of the utility’s facilities;

(5) The usefulness of energy and capacity supplied from a qualifying facility during system emergencies, including its ability to separate its load from its generation; and

(6) The individual and aggregate value of energy and capacity from qualifying facilities on the electric utility’s system.

*d.* The costs or savings resulting from variations in line losses from those that would have existed in the absence of purchases from the qualifying facility, if the purchasing electric utility generated an equivalent amount of energy itself.

**15.5(7)** *Periods during which purchases not required.* Any electric utility will not be required to purchase electric energy or capacity during any period during which, due to operational circumstances, purchases from qualifying facilities will result in costs greater than those which the utility would incur if it did not make the purchases, but instead generated an equivalent amount of energy itself; provided, however, that any electric utility seeking to invoke this subrule must notify each affected qualifying facility within a reasonable amount of time to allow the qualifying facility to cease the delivery of energy or capacity to the electric utility.

*a.* Any electric utility which fails to comply with the provisions of this subrule will be required to pay the usual rate for the purchase of energy or capacity from the facility.

*b.* A claim by an electric utility that such a period has occurred or will occur is subject to verification by the board.

[ARC 0781C, IAB 6/12/13, effective 7/17/13]

**199—15.6(476) Rates for sales to qualifying facilities and AEP facilities by rate-regulated utilities.** For purposes of this rule, “utility” means a rate-regulated electric utility. Rates for sales to qualifying facilities and AEP facilities shall be just, reasonable and in the public interest, and shall not discriminate against qualifying facilities and AEP facilities in comparison to rates for sales to other customers with similar load or other cost-related characteristics served by the utility. The rate for sales of backup or maintenance power shall not be based upon an assumption (unless supported by data) that forced outages or other reductions in electric output by all qualifying facilities and AEP facilities will occur simultaneously or during the system peak, or both, and shall take into account the extent to which

scheduled outages of qualifying facilities and AEP facilities can be usefully coordinated with scheduled outages of the utility's facilities.

**199—15.7(476) Additional services to be provided to qualifying facilities and AEP facilities by rate-regulated electric utilities.** For purposes of this rule, “electric utility” or “utility” means a rate-regulated electric utility.

**15.7(1)** Upon request of qualifying facilities and AEP facilities, each electric utility shall provide supplementary power, backup, maintenance power, and interruptible power. Rates for such service shall meet the requirements of subrule 15.5(6), and shall be in accordance with the terms of the utility's tariff.

The board may waive this requirement pursuant to rule 199—1.3(17A,474) only after notice in the area served by the utility and an opportunity for public comment. The waiver may be granted if compliance with this rule will:

- a. Impair the electric utility's ability to render adequate service to its customers, or
- b. Place an undue burden on the electric utility.

**15.7(2)** Reserved.

**199—15.8(476) Interconnection costs.** For purposes of this rule, “utility” means a rate-regulated electric utility.

**15.8(1)** Qualifying facilities and AEP facilities shall be obligated to pay interconnection costs, as described in 199—Chapter 45.

**15.8(2)** Reserved.

[ARC 8859B, IAB 6/16/10, effective 7/21/10]

**199—15.9(476) System emergencies.** For purposes of this rule, “electric utility” means a rate-regulated electric utility. Qualifying facilities and AEP facilities shall be required to provide energy or capacity to an electric utility during a system emergency only to the extent:

**15.9(1)** Provided by agreement between the qualifying facility or AEP facility and the electric utility; or

**15.9(2)** Ordered under Section 202(c) of the Federal Power Act. During any system emergency, an electric utility may immediately discontinue:

- a. Purchases from qualifying facilities and AEP facilities if purchases would contribute to the emergency; and
- b. Sales to qualifying facilities and AEP facilities, provided that the discontinuance is on a nondiscriminatory basis.

**199—15.10(476) Standards for interconnection, safety, and operating reliability.** For purposes of this rule, “electric utility” or “utility” means both rate-regulated and non-rate-regulated electric utilities.

**15.10(1) Acceptable standards.** The interconnection of distributed generation facilities and associated interconnection equipment to an electric utility system shall meet the applicable provisions of the publications listed below:

a. Standard for Interconnecting Distributed Resources with Electric Power Systems, IEEE Standard 1547. For guidance in applying IEEE Standard 1547, the utility may refer to:

(1) IEEE Recommended Practices and Requirements for Harmonic Control in Electrical Power Systems—IEEE Standard 519-2014; and

(2) IEC/TR3 61000-3-7 Assessment of Emission Limits for Fluctuating Loads in MV and HV Power Systems.

b. Iowa Electrical Safety Code, as defined in 199—Chapter 25.

c. National Electrical Code, ANSI/NFPA 70-2014.

**15.10(2) Modifications required.** Rescinded IAB 7/23/03, effective 8/27/03.

**15.10(3) Interconnection facilities.**

a. A distributed generation facility placed in service after July 1, 2015, is required to have installed a disconnection device. The disconnection device shall be installed, owned, and maintained by the owner of the distributed generation facility and shall be easily visible and adjacent to an interconnection

customer's electric meter at the facility. Disconnection devices are considered easily visible and adjacent: for a home or business, up to ten feet away from the meter and within the line of sight of the meter, at a height of 30 inches to 72 inches above final grade; or for large areas with multiple buildings that require electric service, up to 30 feet away from the meter and within the line of sight of the meter, at a height of 30 inches to 72 inches above final grade. The disconnection device shall be labeled with a permanently attached sign with clearly visible letters that gives procedures/directions for disconnecting the distributed generation facility.

(1) If an interconnection customer with distributed generation facilities installed prior to July 1, 2015, adds generation capacity to its existing system that does not require upgrades to the electric meter or electrical service, a disconnection device is not required, unless required by the electric utility's tariff. The customer must notify the electric utility before the generation capacity is added to the existing system.

(2) If an interconnection customer with distributed generation facilities installed prior to July 1, 2015, upgrades or changes its electric service, the new or modified electric service must meet all current utility electric service rule requirements.

*b.* For all distributed generation installations, the customer shall be required to provide and place a permanent placard no more than ten feet away from the electric meter. The placard must be visible from the electric meter. The placard must clearly identify the presence and location of the disconnection device for the distributed generation facilities on the property. The placard must be made of material that is suitable for the environment and must be designed to last for the duration of the anticipated operating life of the distributed generation facility. If no disconnection device is present, the placard shall state "no disconnection device".

If the distributed generation facility is not installed near the electric meter, an additional placard must be placed at the electric meter to provide specific information regarding the distributed generation facility and the disconnection device.

*c.* The interconnection shall include overcurrent devices on the facility to automatically disconnect the facility at all currents that exceed the full-load current rating of the facility.

*d.* Distributed generation facilities with a design capacity of 100 kilowatts or less must be equipped with automatic disconnection upon loss of electric utility-supplied voltage.

*e.* Those facilities that produce a terminal voltage prior to the closure of the interconnection shall be provided with synchronism-check devices to prevent closure of the interconnection under conditions other than a reasonable degree of synchronization between the voltages on each side of the interconnection switch.

**15.10(4) Access.** If a disconnection device is required, the operator of the distributed generation facility, the utility, and emergency personnel shall have access to the disconnection device at all times. For distributed generation facilities installed prior to July 1, 2015, an interconnection customer may elect to provide the utility with access to a disconnection device that is contained in a building or area that may be unoccupied and locked or not otherwise accessible to the utility by installing a lockbox provided by the utility that allows ready access to the disconnection device. The lockbox shall be in a location determined by the utility, in consultation with the customer, to be accessible by the utility. The interconnection customer shall permit the utility to affix a placard in a location of the utility's choosing that provides instructions to utility operating personnel for accessing the disconnection device. If the utility needs to isolate the distributed generation facility, the utility shall not be held liable for any damages resulting from the actions necessary to isolate the generation facility.

**15.10(5) Inspections and testing.** The operator of the distributed generation facility shall adopt a program of inspection and testing of the generator and its appurtenances and the interconnection facilities in order to determine necessity for replacement and repair. Such a program shall include all periodic tests and maintenance prescribed by the manufacturer. If the periodic testing of interconnection-related protective functions is not specified by the manufacturer, periodic testing shall occur at least once every five years. All interconnection-related protective functions shall be periodically tested, and a system that depends upon a battery for trip power shall be checked and logged. The operator shall maintain test reports and shall make them available upon request by the electric utility. Representatives of the utility

shall have access at all reasonable hours to the interconnection equipment specified in subrule 15.10(3) for inspection and testing with reasonable prior notice to the applicant.

**15.10(6) *Emergency disconnection.*** In the event that an electric utility or its customers experience problems of a type that could be caused by the presence of alternating currents or voltages with a frequency higher than 60 Hertz, the utility shall be permitted to open and lock the interconnection switch pending a complete investigation of the problem. Where the utility believes the condition creates a hazard to the public or to property, the disconnection may be made without prior notice. However, the utility shall notify the operator of the distributed generation facility by written notice and, where possible, verbal notice as soon as practicable after the disconnections.

**15.10(7) *Notification.*** When the distributed generation facility is placed in service, owners of interconnected distributed generation facilities are required to notify local fire departments via U.S. mail of the location of distributed generation facilities and the associated disconnection device(s). The owner is required to provide any information related to the distributed generation facility as reasonably required by that local fire department including but not limited to:

*a.* A site map showing property address; service point from utility company; distributed generation facility and disconnect location(s); location of rapid shutdown and battery disconnect(s), if applicable; property owner's or owner's representative's emergency contact information; utility company's emergency telephone number; and size of the distributed generation facility.

*b.* Information to access the disconnection device.

*c.* A statement from the owner verifying that the distributed generation facility was installed in accordance with the current state-adopted National Electrical Code.

**15.10(8) *Disconnections.*** If an interconnection customer fails to comply with the foregoing requirements of this rule, the electric utility may require disconnection of the applicant's distributed generation facility until the facility complies with this rule. The disconnection process shall be specified in individual electric utility tariffs or in the interconnection agreement. If separate disconnection of only the distributed generation facility is not feasible or safe, the customer's electric service may be disconnected as provided in 199—Chapter 20.

**15.10(9) *Reconnections.*** If a customer's distributed generation facility or electric service is disconnected due to noncompliance with this rule, the customer shall be responsible for payment of any costs associated with reconnection once the facility is in compliance with the rules.

[ARC 8859B, IAB 6/16/10, effective 7/21/10; ARC 1359C, IAB 3/5/14, effective 4/9/14; ARC 3694C, IAB 3/14/18, effective 4/18/18]

**199—15.11(476) Additional rate-regulated utility obligations regarding AEP facilities.** For purposes of this rule, “MW” means megawatt, “MWH” means megawatt-hour, and “utility” means a rate-regulated electric utility.

**15.11(1) *Obligation to purchase from AEP facilities.*** Each utility shall purchase, pursuant to contract, its share of at least 105 MW of AEP generating capacity and associated energy production. The utility's share of 105 MW is based on the utility's estimated percentage share of Iowa peak demand, which is based on the utility's highest monthly peak shown in its 1990 FERC Form 1 annual report, and on its related Iowa sales and total company sales and losses shown in its 1990 FERC Form 1 and IE-1 annual reports. Each utility's share of the 105 MW is determined to be as follows:

|                            | Percentage Share<br>of <u>Iowa Peak</u> | Utility Share of<br><u>105 MW</u> |
|----------------------------|---|-----------------------------------|
| Interstate Power and Light | 47.43%                                  | 49.8 MW                           |
| MidAmerican Energy         | 52.57%                                  | 55.2 MW                           |

A utility is not required to purchase from an AEP facility that is not owned or operated by an individual, firm, copartnership, corporation, company, association, joint stock association, city, town, or county that meets both of the following: (1) is not primarily engaged in the business of producing or selling electricity, gas, or useful thermal energy other than electricity, gas, or useful thermal energy sold

solely from AEP facilities; and (2) does not sell electricity, gas, or useful thermal energy to residential users other than the tenants or the owner or operator of the facility.

**15.11(2) Purchases pursuant to a legally enforceable obligation.** Each AEP facility shall provide electricity on a best-efforts basis pursuant to a legally enforceable obligation for the delivery of electricity over a specified contract term.

**15.11(3) Annual reporting requirement.** Beginning April 1, 2004, each utility shall file an annual report listing nameplate MW capacity and associated monthly MWH purchased from AEP facilities, itemized by AEP facility.

**15.11(4) Tariff filings.** Rescinded IAB 6/16/10, effective 7/21/10.

**15.11(5) Net metering.** Each utility shall offer to operate in parallel through net metering (with a single meter monitoring only the net amount of electricity sold or purchased) with an AEP facility, provided that the facility complies with any applicable standards established in accordance with these rules.

In the alternative, by choice of the facility, the utility and facility shall operate in a purchase and sale arrangement whereby any electricity provided to the utility by the AEP facility is sold to the utility at the fixed or negotiated buy-back rate, and any electricity provided to the AEP facility by the utility is sold to the facility at the tariffed rate.

[ARC 8859B, IAB 6/16/10, effective 7/21/10]

**199—15.12(476) Rates for purchases from qualifying alternate energy and small hydro facilities by rate-regulated electric utilities.** Rescinded IAB 7/23/03, effective 8/27/03.

**199—15.13(476) Rates for sales to qualifying alternate energy production and small hydro facilities by rate-regulated utilities.** Rescinded IAB 7/23/03, effective 8/27/03.

**199—15.14(476) Additional services to be provided to qualifying alternate energy production and small hydro facilities.** Rescinded IAB 7/23/03, effective 8/27/03.

**199—15.15(476) Interconnection costs.** Rescinded IAB 7/23/03, effective 8/27/03.

**199—15.16(476) System emergencies.** Rescinded IAB 7/23/03, effective 8/27/03.

These rules are intended to implement Iowa Code sections 476.1, 476.8, 476.41 to 476.45, and 546.7, Section 210 of the Public Utility Regulatory Policies Act of 1978, and 18 CFR Part 292.

**199—15.17(476) Alternate energy purchase programs.**

Any consumer-owned utility, including any electric cooperative corporation or association or any municipally owned electric utility, may apply to the board for a waiver under this rule.

This rule shall not apply to non-rate-regulated electric utilities physically located outside of Iowa that serve Iowa customers.

**15.17(1) Obligation to offer programs.**

*a.* Beginning January 1, 2004, each electric utility, whether or not subject to rate regulation by the board, shall offer an alternate energy purchase program that allows customers to contribute voluntarily to the development of alternate energy in Iowa, and allows for the exceptions listed in paragraph 15.17(1)“c.”

*b.* Each electric utility subject to rate regulation by the board, except for utilities that elect rate regulation pursuant to Iowa Code section 476.1A, shall demonstrate on an annual basis that it produces or purchases sufficient energy from program AEP facilities located in Iowa to meet the needs of its Iowa program. These Iowa-based AEP facilities shall not include AEP facilities for which the utility has sought cost recovery under rule 199—20.9(476) prior to July 1, 2001.

*c.* The electric utility may partially or fully base its program on energy produced by AEP facilities located outside of Iowa under any of the following circumstances:

(1) The energy is purchased by the electric utility pursuant to a contract in effect prior to July 1, 2001, and continues until the expiration of the contract, including any options to renew that are exercised by the electric utility.

(2) The electric utility has a financial interest, as of July 1, 2001, in an AEP facility that is located outside of Iowa or in an entity that has a financial interest in an AEP facility located outside of Iowa; or

(3) The energy is purchased by an electric utility that is not subject to rate regulation by the board, or which elects rate regulation pursuant to Iowa Code section 476.1A, and that is required to purchase all of its electric power requirements from one or more suppliers that are physically located outside of Iowa.

**15.17(2) Customer notification.**

a. Each electric utility shall notify eligible customer classes of its alternate energy purchase program and proposed program modifications at least 60 days prior to implementation of the program or program modification. The notification shall include, as applicable:

(1) A description of the availability and purpose of the program or program modification, clarifying that customer contributions will not involve the direct sale of alternate energy to individual customers;

(2) The effective date of the program or program modification;

(3) Customer classes eligible for participation;

(4) Forms and levels of customer contribution available to program participants;

(5) A utility telephone number for answering customers' questions about the program; and

(6) Customer instructions that explain how to participate in the program.

b. In addition to the notification requirements under paragraph 15.17(2) "a," each electric utility subject to rate regulation by the board, excluding utilities that elect rate regulation pursuant to Iowa Code section 476.1A, shall:

(1) Include fuel report information described under subrule 15.17(5); and

(2) Submit the proposed notification to the board for approval at least 30 days prior to the proposed date of issuance of the notification.

**15.17(3) Program plan filing requirements for rate-regulated utilities.** On or before October 1, 2003, each electric utility subject to rate regulation by the board, excluding utilities that elect rate regulation pursuant to Iowa Code section 476.1A, shall file with the board a plan for the utility's alternate energy purchase program. Initial program plans and any subsequent modifications will be subject to board approval. Modification filings need only include information about elements of the program that are being modified. The initial program plan filing shall include:

a. The program tariff;

b. The program effective date;

c. A sample of the customer notification, including a description of the method of distribution;

d. Customer classes eligible for participation and the schedule for extending participation to all customer classes;

e. Identification of each AEP facility used for the program, including:

(1) Fuel type;

(2) Nameplate capacity;

(3) Estimated annual kWh output;

(4) Estimated in-service date;

(5) Ownership, including any utility affiliation;

(6) A copy of any contract for utility purchases from the facility;

(7) A description of the method or procedure used to select the facility;

(8) Facility location; and

(9) If the facility is located outside of Iowa, an explanation of how the facility qualifies under paragraph 15.17(1) "c";

f. The forms and levels of customer contribution available to program participants, including, but not limited to:

(1) kWh rate premiums applied to percentages of participant kWh usage, with an explanation of how the kWh rate premiums are derived; or

(2) kWh rate premiums applied to fixed kWh blocks of participant usage, with an explanation of how the kWh rate premiums are derived; or

(3) Fixed contributions, with an explanation of how the fixed amounts are derived;

g. The maximum allowable time lag between the beginning of customer contributions and the in-service date for identified AEP facilities, and the procedures for suspending customer contributions if the maximum time lag is exceeded;

h. The intended treatment of program participants under 199—20.9(476) energy automatic adjustment and AEP automatic adjustment clauses;

i. An accounting plan for identifying and tracking participant contributions and program costs, including:

(1) Identification of incremental program costs not otherwise recovered through the utility's rates, including but not limited to: program start-up and administration costs; program marketing costs; and program energy and capacity costs associated with identified AEP facilities;

(2) Methods for quantifying, assigning, and allocating costs of the program and for segregating those costs in the utility's accounts; and

j. Marketing and customer information plan, including schedules and copies of all marketing and information materials, as available.

**15.17(4) Annual reporting requirements for rate-regulated utilities.** On or before April 1, 2005, and annually thereafter, each electric utility subject to rate regulation by the board, excluding utilities that elect rate regulation pursuant to Iowa Code section 476.1A, shall file with the board a report of program activity for the previous calendar year. The annual report shall include:

a. Program information including:

(1) The number of program participants, by customer class;

(2) Participant contribution revenues, by customer class, by form and level of contribution, and associated participant kWh sales;

(3) Program electricity generated from each program AEP facility and the associated costs; and

(4) Other program costs, by cost type.

b. An annual reconciliation of participant contributions and program costs.

(1) Program costs are incremental costs associated with the utility's alternate energy purchase program not otherwise recovered through the utility's base tariff rates, and electricity costs dedicated to the program and separated from the utility's 199—20.9(476) energy or AEP automatic adjustment clauses.

(2) The excess of participant contributions over program costs is an annual program surplus, and the excess of program costs over participant contributions is an annual program deficit.

(3) Annual program surpluses and deficits are cumulative over successive years.

(4) A program deficit may be recovered through the utility's 199—20.9(476) AEP automatic adjustment clause.

(5) Any program surplus shall be used to offset prior years' program deficits previously recovered through the AEP automatic adjustment clause, and the offset amount shall be credited through the utility's AEP automatic adjustment clause.

c. Identification of any other AEP or renewable energy requirements being met with program AEP facilities and identification of any revenues derived from the separate sale of the renewable energy attributes of program AEP facilities.

d. Documentation that shows the energy produced by the utility's program AEP facilities in Iowa (whether contracted, leased, or owned), not including AEP facilities for which the utility has sought cost recovery under 199—20.9(476) prior to July 1, 2001, is sufficient to meet the requirement of the utility's Iowa alternate energy purchase program.

e. A description of program marketing and customer information activities, including schedules and copies of all marketing and information materials related to the program.

f. Program modifications and uses for any program surplus that are under consideration, including procurement or assignment of additional electricity from AEP facilities.

g. A copy of the utility's annual fuel report to customers under subrule 15.17(5).

**15.17(5) Annual fuel reporting requirements for rate-regulated utilities.**

a. Each electric utility subject to rate regulation by the board, excluding utilities that elect rate regulation pursuant to Iowa Code section 476.1A, shall annually report to all its Iowa customers its percentage mix of fuel and energy inputs used to produce electricity. The report shall, to the extent practical, specify percentages of electricity produced by coal, nuclear energy, natural gas, oil, AEP electricity produced for the utility's alternate energy purchase program, non-program AEP electricity, and resources purchased from other companies. The percentages for AEP electricity shall further specify percentages of electricity produced by wind, solar, hydropower, biomass, and other technologies.

b. The report shall include an estimate of sulfur dioxide (SO<sub>2</sub>), nitrogen oxide (NO<sub>x</sub>), and carbon dioxide (CO<sub>2</sub>) emissions for each known fuel and energy input type. The emission estimate shall be expressed in pounds per 1000 kWh.

**15.17(6) Tariff filing requirements for non-rate-regulated utilities.**

a. On or before January 1, 2004, each electric utility that is not subject to rate regulation by the board or that elects rate regulation pursuant to Iowa Code section 476.1A shall file with the board a tariff for the utility's alternate energy purchase program. Initial tariff filings and any subsequent modifications shall be filed for informational purposes only. Tariff modification filings need only include information about elements of the program that are being modified. The initial tariff filings shall include, as applicable:

- (1) The program tariff;
- (2) The program effective date;
- (3) A sample of the customer notification, including a description of the method of distribution;
- (4) Customer classes eligible for participation;
- (5) Identification of any specific AEP facilities to be included in the program, including: fuel type; nameplate capacity; estimated annual kWh output; estimated in-service date; ownership, including any utility affiliation; location; and, if the facility is located outside of Iowa, an explanation of how the facility qualifies under paragraph 15.17(1) "c"; and
- (6) Forms and levels of customer contribution available to program participants.

b. Joint filings. An electric utility that is not subject to rate regulation by the board or that elects rate regulation pursuant to Iowa Code section 476.1A may file its tariff jointly with other non-rate-regulated utilities or through an agent. A joint tariff filing shall contain the information required by paragraph 15.17(6) "a," separately identified for each utility participating in the joint tariff. The information for each utility may be provided by reference to an attached document or to a section of the joint tariff filing. A joint tariff filing filed by an agent shall state the agent's relationship to each utility and include a document from each utility authorizing the agent to act on the utility's behalf.

**199—15.18(476B) Certification of eligibility for wind energy tax credits under Iowa Code chapter 476B.** Any person applying for certification of eligibility for state tax credits for wind energy pursuant to Iowa Code section 476B.5 as amended by 2005 Iowa Acts, chapter 179, section 166, is subject to this rule.

**15.18(1) Filing requirements.** Any person applying for certification of eligibility for wind energy tax credits must file with the board an application that contains substantially all of the following information:

a. Information regarding the applicant, including the legal name, address, telephone number, and (as applicable) facsimile transmission number and electronic mail address of the applicant.

b. Information regarding the ownership of the facility, including the legal name of each owner, information demonstrating the legal status of each owner, and the percentage of equity interest held by each owner, and a statement attesting that owners meeting the eligibility requirements of Iowa Code section 476B.5 are not owners of more than two eligible renewable energy facilities. In determining whether the two-facility limit is exceeded, the Board will consider not only the legal entity that owns the utility, if other than a natural person, but the equity owners of the legal entity. If the owner of the facility is other than a natural person, information regarding the equity owners must be provided.

c. A description of the facility, including at a minimum the following information:

- (1) Type of facility (that is, a qualified facility as defined in Iowa Code section 476B.1);

(2) Total nameplate generating capacity rating. For applications filed on or after March 1, 2008, the facility must have a combined nameplate capacity of no less than 2 megawatts and no more than 30 megawatts. For applications filed on or after July 1, 2009, by a private college or university, community college, institution under the control of the state board of regents, public or accredited nonpublic elementary and secondary school, or public hospital as defined in Iowa Code section 249J.3, the facility must have a combined nameplate capacity of no less than  $\frac{3}{4}$  of a megawatt;

(3) A description of the location of the facility in Iowa, including an address or other geographic identifier;

(4) The date the facility is expected to be placed in service (that is, placed in service on or after July 1, 2005, but before July 1, 2012, for eligibility under Iowa Code chapter 476B as amended by 2005 Iowa Acts, chapter 179).

*d.* A signed statement from the owner attesting that the owner intends to either sell all the electricity generated by the facility, consume all the electricity on site, or a combination of both. For purposes of this rule, electricity consumed on site means any electricity produced by the facility and not sold.

*e.* If the owner intends to sell electricity generated by the facility, a copy of the executed power purchase agreement or other agreement to purchase electricity. If the power purchase agreement has not yet been finalized and executed, the board will accept as an other agreement an executed agreement signed by at least two parties that includes both a commitment to purchase electricity from the facility upon completion of the project and most of the essential elements of a contract.

The board will also accept a copy of an executed interconnection agreement service agreement, in lieu of a power purchase agreement, if the facility owner has instead agreed to sell electricity from the facility directly or indirectly to a wholesale power pool market.

*f.* A statement indicating the type of tax credit being sought; that is, indicating that the applicant is applying for tax credits pursuant to Iowa Code chapter 476B as amended by 2005 Iowa Acts, chapter 179 (1 cent per kWh, wind energy only tax credits).

**15.18(2) *Review and notification.*** Upon receipt of a complete application, the board will review it to make a preliminary determination regarding whether the facility is an eligible renewable energy facility. The board will notify the applicant by letter of the approval or denial of the application within 30 days of the date the application was filed. If the board fails to send the letter within 30 days, the application will be deemed denied. An applicant who receives a determination denying an application may file an appeal with the board within 30 days of the date of the denial, pursuant to the provisions of Iowa Code chapter 17A and Iowa Code section 476B.5. In the absence of a timely appeal, the preliminary determination shall be final.

**15.18(3) *Incomplete application and additional information.*** If an incomplete application is filed, the board may, upon request and for good cause shown, grant an extension of time to allow the applicant to provide additional information. Also, the board and its staff may request additional information at any time for purposes of determining initial or continuing eligibility for tax credits.

**15.18(4) *Loss of eligibility status.*** Within 18 months following board approval of eligibility, the applicant shall file information demonstrating that the eligible facility is operational and producing usable energy. If the board determines that the eligible facility was not operational within 18 months of board approval, the facility will lose eligibility status.

However, if the facility is not operational within 18 months due to the unavailability of necessary equipment, the applicant may apply for a 12-month extension of the filing requirement, attesting to the unavailability of necessary equipment. After granting a 12-month extension, if the board determines that the facility was not operational within 30 months of board approval, the facility will lose eligibility status. Otherwise, the facility may reapply to the board for new eligibility.

**15.18(5) *Allocation of capacity among eligible applicants.*** Iowa Code section 476B.5 establishes the maximum amount of nameplate generating capacity of facilities eligible for the tax credits. In the event the board receives applications for tax credits that, in total, exceed the statutory limits, the board will rule on the applications in the order they are received, based upon the date of receipt. Because the board does not track the time of day that filings are made with the board, if the board receives more

than one application on a particular date such that the combined capacity of the applications exceeds applicable statutory limits, the board will allocate the final eligibility determinations proportionally among all applications received on that date. Alternatively, the board may withhold this allocation unless a petition for allocation is filed with the board by one of the applicants who filed its application on that particular date. If such a petition is submitted, the board will notify all applicants who filed on that particular date, allowing each applicant to opt into the allocation within 45 days of the date of the filing of the petition. Applicants who opt in must comply with subrule 15.18(4) after receiving eligibility under the allocation or lose their eligibility status. Applicants who do not opt in will maintain their original application date.

**15.18(6) *Waiting list for excess applications.*** The board will maintain a waiting list of excess eligibility applications for facilities that might have received preliminary eligibility under subrule 15.18(2), but for the maximum capacity and capability restrictions under subrule 15.18(5). The priorities of the waiting list will be in the order the applications were received, based upon the dates of receipt. If additional capacity becomes available within the capacity restrictions under subrule 15.18(5), the board will review the applications on the waiting list based on their priorities, before reviewing new applications. Applications will be removed from the waiting list after they are either approved or denied. Beginning August 31, 2007, each applicant on the waiting list shall annually provide the board a statement of verification attesting that the information contained in the applicant's eligibility application remains true and correct, or stating that the information has changed and providing the new information.

This rule is intended to implement Iowa Code chapter 476B.  
[ARC 8060B, IAB 8/26/09, effective 9/30/09]

**199—15.19(476C) Certification of eligibility for wind energy and renewable energy tax credits under Iowa Code chapter 476C.** Any person applying for certification of eligibility for state tax credits for wind energy or renewable energy pursuant to Iowa Code section 476C.3 is subject to this rule.

**15.19(1) *Filing requirements.*** Any person applying for certification of eligibility for wind energy or renewable energy tax credits must file with the board an application that contains substantially all of the following information:

*a.* Information regarding the applicant, including the legal name, address, telephone number, and (as applicable) facsimile transmission number and electronic mail address of the applicant.

*b.* Information regarding the ownership of the facility, including the legal name of each owner, information demonstrating the legal status of each owner, and the percentage of equity interest held by each owner. The "legal status of each owner" refers to either ownership of a small wind energy system operating in a small wind innovation zone as defined in Iowa Code section 476.48(1) and 199—15.22(476), or, alternatively, the ownership requirements of Iowa Code section 476C.1(6) "b," which provides that an eligible renewable energy facility must be at least 51 percent owned by one or more or any combination of the following:

- (1) A resident of Iowa;
- (2) An authorized farm corporation, authorized limited liability company, or authorized trust, as defined in Iowa Code section 9H.1;
- (3) A family farm corporation, family farm limited liability company, or family farm trust, as defined in Iowa Code section 9H.1;
- (4) A revocable trust as defined in Iowa Code section 9H.1;
- (5) A testamentary trust as defined in Iowa Code section 9H.1;
- (6) A small business as defined in Iowa Code section 15.102;
- (7) An electric cooperative association organized pursuant to Iowa Code chapter 499 that sells electricity to end users located in Iowa or has one or more members organized pursuant to Iowa Code chapter 499, a municipally owned city utility as defined in Iowa Code section 362.2, or a public utility subject to rate regulation pursuant to Iowa Code chapter 476;
- (8) A cooperative corporation organized pursuant to Iowa Code chapter 497 or a limited liability corporation organized pursuant to Iowa Code chapter 489 whose shares and membership are held by an entity that is not prohibited from owning agricultural land under Iowa Code chapter 9H; or

- (9) A school district located in Iowa.
- c.* A statement attesting that each owner meeting the eligibility requirements of Iowa Code section 476C.1(6)“*b*” does not have an ownership interest in more than two eligible renewable energy facilities.
- d.* For any owner meeting the eligibility requirements of Iowa Code section 476C.1(6)“*b*” with an equity interest in the facility equal to or greater than 51 percent, a statement attesting that the owner does not have an equity interest greater than 10 percent in any other eligible renewable energy facility.
- e.* For any owner meeting the eligibility requirements of Iowa Code section 476C.1(6)“*b*” with an equity interest in the facility greater than 10 percent and less than 51 percent, a statement attesting that the owner does not have an equity interest equal to or greater than 51 percent in any other eligible renewable energy facility.
- f.* A description of the facility, including at a minimum the following information:
- (1) Type of facility (that is, a wind energy conversion facility, biogas recovery facility, biomass conversion facility, methane gas recovery facility, solar energy conversion facility, or refuse conversion facility, as defined in Iowa Code section 476C.1);
  - (2) Total nameplate generating capacity rating, plus maximum hourly output capability for any energy production capacity equivalent as defined in Iowa Code section 476C.1. For applications filed on or after July 1, 2011, the facility’s combined nameplate capacity or energy production capacity equivalent must be no less than three-fourths of a megawatt if all or part of the facility’s renewable energy production is used for the owners’ on-site consumption, and no more than 60 megawatts if the facility is not a wind energy conversion facility;
  - (3) A description of the location of the facility in Iowa, including an address or other geographic identifier;
  - (4) The date the facility is expected to be placed in service; that is, placed in service on or after July 1, 2005, but before January 1, 2017, for eligibility under Iowa Code chapter 476C; and
  - (5) For eligibility under Iowa Code chapter 476C, demonstration that the facility’s combined MW nameplate generating capacity and maximum hourly output capability of energy production capacity equivalent (as defined in Iowa Code section 476C.1(7)), divided by the number of separate owners meeting the requirements of Iowa Code chapter 476C, equals no more than 2.5 MW of capacity per eligible owner.
- g.* A signed statement from the owners attesting that the owners intend to either sell all the renewable energy produced by the facility, consume all the renewable energy on site, or use all the renewable energy through a combination of sale and consumption. For purposes of the signed statement, renewable energy consumed on site means any renewable energy produced by the facility and not sold.
- h.* If the owners intend to sell renewable energy produced by the facility, a copy of the power purchase agreement or other agreement to purchase electricity, hydrogen fuel, methane or other biogas, or heat for a commercial purpose, which shall designate either the producer or the purchaser as eligible to apply for the renewable energy tax credit. If the power purchase agreement or other agreement has not yet been finalized and executed, the board will accept a binding statement from the applicant that designates which party will be eligible to apply for the renewable energy tax credit; that designation shall not be subject to change.
- i.* A statement indicating the type of tax credit being sought; that is, indicating that the applicant is applying for tax credits pursuant to Iowa Code chapter 476C (1.5 cents per kWh, wind and other renewable energy tax credits).

**15.19(2) Review and notification.** Upon receipt of a complete application, the board will review it to make a preliminary determination regarding whether the facility is an eligible renewable energy facility. The board will notify the applicant by letter of the approval or denial of the application within 30 days of the date the application was filed. If the board fails to send the letter within 30 days, the application will be deemed denied. An applicant who receives a determination denying an application may file an appeal with the board within 30 days of the date of the denial, pursuant to the provisions of Iowa Code chapter 17A and Iowa Code section 476C.3(2). In the absence of a timely appeal, the preliminary determination shall be final.

**15.19(3) *Incomplete application and additional information.*** If an incomplete application is filed, the board may, upon request and for good cause shown, grant an extension of time to allow the applicant to provide additional information. Also, the board and its staff may request additional information at any time for purposes of determining initial or continuing eligibility for tax credits.

**15.19(4) *Loss of eligibility status.***

*a.* Within 30 months following board approval of eligibility, the applicant shall file information demonstrating that the eligible facility is operational and producing usable energy. If the board determines that the eligible facility was not operational within 30 months of board approval, the facility will lose eligibility status.

*b.* If the facility is a wind energy conversion facility and is not operational within 18 months due to the unavailability of necessary equipment, the applicant may apply for a 12-month extension of the 30-month limit, attesting to the unavailability of necessary equipment. After granting the 12-month extension, if the board determines that the facility was not operational within 42 months of board approval, the facility will lose eligibility status.

*c.* Prior to expiration of the time periods specified in paragraphs 15.19(4)“*a*” and “*b*,” the applicant may apply for a further 12-month extension if the facility is still expected to become operational. Extensions may be renewed for succeeding 12-month periods if the applicant applies for the extension prior to expiration of the current extension period. If the applicant does not apply for further extension, the facility will lose eligibility status.

*d.* If the owners of a facility discontinue efforts to achieve operational status, the owners shall notify the board. Upon the board’s receipt of such notification, the facility will lose eligibility status.

*e.* If the facility loses eligibility status, the applicant may reapply to the board for new eligibility.

**15.19(5) *Allocation of capacity among eligible applicants.*** Iowa Code section 476C.3(4) establishes the maximum amounts of nameplate generating capacities and energy production capacity equivalents eligible for the tax credits. In the event the board receives applications for tax credits that, in total, exceed the statutory limits, the board will rule on the applications in the order they are received, based upon the date of receipt. Because the board does not track the time of day that filings are made with the board, if the board receives more than one application on a particular date such that the combined capacity of the applications exceeds applicable statutory limits, the board will allocate the final eligibility determinations proportionally among all applications received on that date. Alternatively, the board may withhold this allocation unless a petition for allocation is filed with the board by one of the applicants who filed its application on that particular date. If such a petition is submitted, the board will notify all applicants who filed on that particular date, allowing each applicant to opt into the allocation within 45 days of the date of the filing of the petition. Applicants who opt in must comply with subrule 15.19(4) after receiving eligibility under the allocation or lose their eligibility status. Applicants who do not opt in will maintain their original application date.

**15.19(6) *Waiting lists for excess applications.*** The board will maintain waiting lists of excess eligibility applications for facilities that might have received preliminary eligibility under subrule 15.19(2), but for the maximum capacity and capability restrictions under subrule 15.19(5). The priorities of the waiting lists will be in the order the applications were received, based upon the dates of receipt. If additional capacity becomes available within the capacity restrictions under subrule 15.19(5), the board will review the applications on the waiting lists based on their priorities, before reviewing new applications. Applications will be removed from the waiting lists after they are either approved or denied. Beginning August 31, 2007, each applicant on a waiting list shall annually provide the board a statement of verification attesting that the information contained in the applicant’s eligibility application remains true and correct, or stating that the information has changed and providing the new information.

This rule is intended to implement Iowa Code chapter 476C.

[ARC 8060B, IAB 8/26/09, effective 9/30/09; ARC 8949B, IAB 7/28/10, effective 9/1/10; ARC 9752B, IAB 9/21/11, effective 10/26/11; ARC 1716C, IAB 11/12/14, effective 12/17/14; ARC 2244C, IAB 11/25/15, effective 12/30/15]

**199—15.20(476B) Applications for wind energy tax credits under Iowa Code chapter 476B.** The wind energy tax credits equal one cent per kilowatt-hour of electricity generated by eligible wind energy

facilities under 199—15.18(476B), which is sold or used for on-site consumption by the owner, for tax years beginning on or after July 1, 2006. The owners of an eligible facility may apply for wind energy tax credits for up to ten tax years following the date the facility is placed in service. Wind energy tax credits will not be issued for wind energy sold or used for on-site consumption after June 30, 2022. For purposes of this rule, wind energy used for on-site consumption means any electricity produced by an eligible facility and not sold.

For the first tax year for which tax credits can be claimed, the kilowatt-hours generated by and purchased from an eligible facility may exceed 12 months' production.

EXAMPLE: An eligible facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which tax credits can be claimed is the year ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credits for the 2007 tax year can include energy produced and purchased between April 1, 2006, and December 31, 2007.

**15.20(1) Application process for wind energy tax credits.** A wind energy facility must be approved as eligible by the board under 199—15.18(476B) in order to qualify for wind energy tax credits.

If the facility is located in a city or county neither of which has enacted an ordinance under Iowa Code section 427B.26, or if the facility is not eligible for special valuation pursuant to an ordinance adopted by the city or county under Iowa Code section 427B.26, the wind energy facility must also be approved by the city council or county board of supervisors of the city or county in which the facility is located, in accordance with Iowa Code section 476B.6(1) as amended by 2009 Iowa Acts, Senate File 456, section 4. Once the owners receive approval from their city council or county board of supervisors, additional approval from the city council or county board of supervisors is not required for subsequent tax years.

Tax credit applications for eligible facilities must be filed with the board no later than 30 days after the close of the tax year for which the credits are to be applied. The tax credit applications must be filed in paper format and are not subject to the electronic filing requirements of 199—14.2(17A,476). The tax credit applications will be held confidential by the board and the department of revenue as, among other things, documents containing customer-specific or personal information (199—paragraph 1.9(5)“c”) and information related to tax returns (Iowa Code section 422.20). The information will be held confidential by the board upon filing, and by the department of revenue upon receipt from the board, and will be subject to the provisions of 199—subparagraph 1.9(8)“b”(3). Accordingly, the applicant should mark each of the pages of the tax credit application “CONFIDENTIAL” in bold or large letters.

a. If a facility is jointly owned, then owners applying for the tax credits must file their application jointly. For each application, an original and two copies must be filed according to the following format, including a cover letter that cites this rule (199—15.20(476B)), and the following 13 information items separately identified by item number:

(1) A copy of the original application for facility eligibility under 199—15.18(476B), plus any subsequent amendments to the application.

(2) A copy of the board's determination approving the facility as eligible for tax credits under 199—15.18(476B).

(3) Either a copy of the city council's or county board of supervisors' approval, from the city or county in which the facility is located, issued pursuant to Iowa Code section 476B.6(1) as amended by 2009 Iowa Acts, Senate File 456, section 4; or a statement explaining why such approval is not required under Iowa Code section 476B.6(1) as amended by 2009 Iowa Acts, Senate File 456, section 4.

(4) A statement attesting that neither the owners nor the purchaser have received renewable energy tax credits for the facility under 199—15.21(476C).

(5) For any electricity sold, a copy of the executed power purchase agreement or other agreement to purchase electricity. Alternatively, a copy of an executed interconnection agreement or transmission service agreement is acceptable if the owners have elected to sell electricity from the facility directly or indirectly to a wholesale power pool market.

(6) For any electricity sold, the owner must provide a statement attesting that the electricity for which tax credits are sought has been generated by the eligible facility and sold to an unrelated purchaser. For purposes of the wind energy tax credits, the definition of “related person” is the same as specified in

department of revenue 701—subrules 42.25(2) and 52.26(2). That is, the definition of “related person” uses the same criteria set forth in Section 45(e)(4) of the Internal Revenue Code relating to the federal renewable electricity production credit. Persons shall be treated as related to each other if such persons are treated as a single employer under Treasury Regulation §1.52-1. In the case of a corporation that is a member of an affiliated group of corporations filing a federal consolidated return, such corporation shall be treated as selling electricity to an unrelated person if such electricity is sold to the person by another member of the affiliated group.

For any electricity used for on-site consumption, the owner must provide a signed statement attesting under penalty of perjury that the electricity for which tax credits are sought was generated by the eligible facility and not sold.

(7) The date that the eligible facility was placed in service (that is, between July 1, 2005, and July 1, 2012).

(8) The total number of kilowatt-hours of electricity generated by the facility during the tax year.

(9) For any electricity sold, invoices or other information that documents the number of kilowatt-hours of electricity generated by the eligible facility and sold to an unrelated purchaser during the tax year.

For any electricity used for on-site consumption, the number of kilowatt-hours of electricity generated by the eligible facility during the tax year and not sold.

(10) Information regarding the facility owners, including the name, address, and tax identification number of each owner, and the percentage of equity interest held by each owner during the period for which wind energy tax credits will be sought under Iowa Code chapter 476B as amended by 2009 Iowa Acts, Senate File 456. If an owner is other than a natural person, information regarding the equity owners must also be provided. This information shall be consistent with information provided in the original application for facility eligibility, as amended, under 199—15.18(476B).

(11) The type of tax for which the credits will be applied and the first tax year in which the credits will be applied.

(12) Identification of any applicants that are eligible to receive renewable electricity production credits authorized under Section 45 of the Internal Revenue Code. This identification should include a statement from the applicant attesting to the applicant’s eligibility and any available supporting documentation.

(13) If any of the applicants is a partnership, limited liability company, S corporation, estate, trust, or any other reporting entity, all of whose income is taxed directly to its equity holders or beneficiaries for taxes imposed under Iowa Code chapter 422, division II or III, the application shall include a list of the partners, members, shareholders, or beneficiaries of the entity. This list shall include the name, address, tax identification number, and pro-rata share of earnings from the entity, for each of the partners, members, shareholders, or beneficiaries of the entity. The wind energy tax credits will flow through to the entity’s partners, shareholders, or members in accordance with their pro-rata share of earnings from the entity.

If the entity is also eligible to receive renewable electricity production credits authorized under Section 45 of the Internal Revenue Code, the entity may designate specific partners if the business is a partnership, shareholders if the business is an S corporation, or members if the business is a limited liability company, to receive the wind energy tax credits issued under Iowa Code chapter 476B as amended by 2009 Iowa Acts, Senate File 456, and the percentage allocable to each. Such an entity may also designate a percentage of the tax credits allocable to an equity holder or beneficiary as a liquidating distribution or portion thereof, of a holder or beneficiary’s interest in the applicant entity. Otherwise, in the absence of such designations, the wind energy tax credits will flow through to the entity’s partners, shareholders, or members in accordance with their pro-rata share of earnings from the entity.

Alternatively, the tax credits will be issued directly to the entity if the entity is a partnership, limited liability company, S corporation, estate, trust, or any other reporting entity, all of whose income is taxed directly to its equity holders or beneficiaries for taxes imposed under Iowa Code chapter 422, division V, or under Iowa Code chapter 423, 432, or 437A.

b. The board will forward the tax credit applications to the department of revenue for review and processing. Along with each forwarded application, the board will provide staff analysis and opinion regarding:

- (1) The completeness of the application.
- (2) The facility's eligibility status under 199—15.18(476B).
- (3) Whether the reported kilowatt-hours of electricity generated by the facility and sold or used by the owner for on-site consumption during the tax year seem accurate and eligible for wind energy tax credits.

**15.20(2) *Review process and computation of wind energy tax credits.*** The department of revenue will review the applications and opinions forwarded by the board, calculate the tax credits, and issue wind energy tax credit certificates to the facility owners, in accordance with department of revenue requirements and procedures under rules 701—42.25(422,476B), 701—52.26(422,476B), and 701—58.15(422,476B).

[ARC 8060B, IAB 8/26/09, effective 9/30/09]

**199—15.21(476C) Applications for renewable energy tax credits under Iowa Code chapter 476C.** The renewable energy tax credits equal 1.5 cents per kilowatt-hour of electricity, or 44 cents per 1,000 standard cubic feet of hydrogen fuel, or \$4.50 per 1 million British thermal units of methane gas or other biogas used to generate electricity, or \$4.50 per 1 million British thermal units of heat for a commercial purpose, generated by eligible renewable energy facilities under 199—15.19(476C), which is sold or used for on-site consumption by the owners, for tax years beginning on or after July 1, 2006. For renewable energy that is sold, either the owners of an eligible facility or a designated purchaser of renewable energy from the facility may apply for renewable energy tax credits for up to ten tax years following the date the facility is placed in service. For renewable energy used for on-site consumption, the owners of an eligible facility may apply for renewable energy tax credits for up to ten tax years following the date the facility is placed in service. Renewable energy tax credits will not be issued for renewable energy sold or used for on-site consumption after December 31, 2026. For purposes of this rule, renewable energy used for on-site consumption means any renewable energy produced by the facility and not sold.

For the first tax year for which tax credits can be claimed, the kilowatt-hours, standard cubic feet, or British thermal units generated by and purchased from an eligible facility may exceed 12 months' production.

EXAMPLE: An eligible facility was placed in service on April 1, 2006, and the taxpayer files on a calendar-year basis. The first year for which tax credits can be claimed is the year ending December 31, 2007, since that is the first tax year that began on or after July 1, 2006. The credit for the 2007 tax year can include renewable energy produced and purchased between April 1, 2006, and December 31, 2007.

**15.21(1) *Application process for renewable energy tax credits.*** A renewable energy facility must be approved as eligible by the board under 199—15.19(476C) in order to qualify for renewable energy tax credits. Tax credit applications must be filed with the board no later than 30 days after the close of the tax year for which the credits are to be applied. The tax credit applications must be filed in paper format and are not subject to the electronic filing requirements of 199—14.2(17A,476). The tax credit applications will be held confidential by the board and the department of revenue as, among other things, documents containing customer-specific or personal information (199—paragraph 1.9(5)“c”) and information related to tax returns (Iowa Code section 422.20). The information will be held confidential by the board upon filing, and by the department of revenue upon receipt from the board, and will be subject to the provisions of 199—subparagraph 1.9(8)“b”(3). Accordingly, the applicant should mark each of the pages of the tax credit application “CONFIDENTIAL” in bold or large letters.

a. Either the facility owners or the purchaser of renewable energy shall be eligible to apply for the tax credits related to renewable energy that is sold, as designated under paragraph 15.19(1)“h.” Only facility owners shall be eligible to apply for tax credits related to renewable energy used for on-site consumption. If a facility is jointly owned, then owners applying for the tax credits must file their application jointly. For each application, an original and two copies must be filed according to the

following format, including a cover letter that cites this rule (199—15.21(476C)), and the following 12 information items separately identified by item number:

(1) A copy of the original application for facility eligibility under 199—15.19(476C), plus any subsequent amendments to the application.

(2) A copy of the board's determination approving the facility as eligible for tax credits under 199—15.19(476C).

(3) A statement attesting that the owners have not received wind energy tax credits for the facility under 199—15.20(476B).

(4) For any renewable energy sold, a copy of the power purchase agreement or other agreement to purchase from the facility electricity, hydrogen fuel, methane or other biogas, or heat for a commercial purpose. The agreement shall designate whether the producer or purchaser of renewable energy will be eligible to apply for the tax credits and shall be consistent with the designation originally filed under paragraph 15.19(1) "h."

(5) For any renewable energy sold, the owners must provide a statement attesting that the electricity, hydrogen fuel, methane or other biogas, or heat for a commercial purpose, for which tax credits are sought, has been generated by the eligible facility and sold to an unrelated purchaser. For purposes of the renewable energy tax credits, persons are related to each other if either person owns an 80 percent or more equity interest in the other person. For any renewable energy used for on-site consumption, the owners must provide a signed statement attesting under penalty of perjury that the claimed amount of electricity, hydrogen fuel, methane or other biogas, or heat for a commercial purpose for which tax credits are sought has been generated by the eligible facility and not sold.

(6) The date that the eligible facility was placed in service (that is, between July 1, 2005, and January 1, 2017).

(7) The total number of kilowatt-hours of electricity, standard cubic feet of hydrogen fuel, British thermal units of methane gas or other biogas used to generate electricity, or British thermal units of heat for a commercial purpose generated by the eligible facility during the tax year.

(8) For any renewable energy sold, invoices or other information that documents the number of kilowatt-hours of electricity, standard cubic feet of hydrogen fuel, British thermal units of methane gas or other biogas used to generate electricity, or British thermal units of heat for a commercial purpose generated by the eligible facility and sold to an unrelated purchaser during the tax year. For any renewable energy used for on-site consumption, the number of kilowatt-hours of electricity, standard cubic feet of hydrogen fuel, British thermal units of methane gas or other biogas used to generate electricity, or British thermal units of heat for a commercial purpose generated by the eligible facility during the tax year and not sold.

(9) Information regarding the facility owners or designated eligible purchaser, including the name, address, and tax identification number of each owner or purchaser. If the application is filed by the facility owners, this shall also include the percentage of equity interest held by each owner during the period for which renewable energy tax credits will be sought under Iowa Code chapter 476C. This information shall be consistent with ownership information provided in the original application for facility eligibility, as amended, under 199—15.19(476C).

(10) The type of tax for which the credits will be applied and the first tax year in which the credits will be applied.

(11) Identification of any applicants that are eligible to receive renewable electricity production credits authorized under Section 45 of the Internal Revenue Code. This identification should include a statement from the applicant attesting to the applicant's eligibility and any available supporting documentation.

(12) If any of the applicants is a partnership, limited liability company, S corporation, estate, trust, or any other reporting entity all of whose income is taxed directly to its equity holders or beneficiaries for taxes imposed under Iowa Code chapter 422, division II or III, the application shall include a list of the partners, members, shareholders, or beneficiaries of the entity. This list shall include the name, address, tax identification number, and pro-rata share of earnings from the entity for each of the partners, members, shareholders, or beneficiaries of the entity. The renewable energy tax credits will flow through

to the entity's partners, shareholders, or members in accordance with their pro-rata share of earnings from the entity.

If the entity is also eligible to receive renewable electricity production credits authorized under Section 45 of the Internal Revenue Code, the entity may designate specific partners if the business is a partnership, shareholders if the business is an S corporation, or members if the business is a limited liability company to receive the renewable energy tax credits issued under Iowa Code chapter 476C and the percentage allocable to each. Such an entity may also designate a percentage of the tax credits allocable to an equity holder or beneficiary as a liquidating distribution or portion thereof of a holder or beneficiary's interest in the applicant entity. Otherwise, in the absence of such designations, the renewable energy tax credits will flow through to the entity's partners, shareholders, or members in accordance with their pro-rata share of earnings from the entity.

Alternatively, the tax credits will be issued directly to the entity if the entity is a partnership, limited liability company, S corporation, estate, trust, or any other reporting entity, all of whose income is taxed directly to its equity holders or beneficiaries for taxes imposed under Iowa Code chapter 422, division V, or under Iowa Code chapter 423, 432, or 437A.

*b.* The board will forward the tax credit applications to the department of revenue for review and processing. Along with each forwarded application, the board will provide staff analysis and opinion regarding:

- (1) The completeness of the application.
- (2) The facility's eligibility status under 199—15.19(476C).
- (3) Whether the reported kilowatt-hours of electricity, standard cubic feet of hydrogen fuel, British thermal units of methane gas or other biogas used to generate electricity, or British thermal units of heat for a commercial purpose generated by the facility and sold or used by the owners for on-site consumption during the tax year seem accurate and eligible for renewable energy tax credits.

**15.21(2) Review process and computation of renewable energy tax credits.** The department of revenue will review the applications and opinions forwarded by the board, calculate the tax credits, and issue renewable energy tax credit certificates to the facility owners or designated purchaser, in accordance with department of revenue requirements and procedures under 701—42.26(422,476C), 701—52.27(422,476C), and 701—58.16(422,476C).

[ARC 8060B, IAB 8/26/09, effective 9/30/09; ARC 9752B, IAB 9/21/11, effective 10/26/11; ARC 1716C, IAB 11/12/14, effective 12/17/14]

### **199—15.22(476) Small wind innovation zones.**

**15.22(1) Definitions.** For purposes of this rule:

“*Electric utility*” means a public utility that furnishes electricity to the public for compensation.

“*Model interconnection agreement*” means the applicable standard interconnection agreement under 199—Chapter 45.

“*Model ordinance*” means the model ordinance developed pursuant to Iowa Code section 476.48(3), which when adopted will be posted on the websites of the Iowa League of Cities at [www.iowaleague.org](http://www.iowaleague.org) and the Iowa State Association of Counties at [www.iowacounties.org](http://www.iowacounties.org).

“*Small wind energy system*” means a wind energy conversion system that collects and converts wind into energy to generate electricity, which has a nameplate generating capacity of 100 kilowatts or less. A small wind energy system located in a small wind innovation zone but in the exclusive service territory of an electric utility that is not subject to 199—Chapter 45 and has not adopted the standard forms, procedures, and interconnection agreements in 199—Chapter 45 is not eligible for the streamlined application process referred to in Iowa Code section 476.48(2)“*a.*”

“*Small wind innovation zone*” means a political subdivision of this state, including but not limited to a city, county, township, school district, community college, area education agency, institution under the control of the state board of regents, or any other local commission, association, or tribal council which adopts, or is encompassed within a local government which adopts, the model ordinance.

**15.22(2) Application for small wind innovation zone designation.** A political subdivision of this state, including but not limited to a city, county, township, school district, community college,

area education agency, institution under the control of the state board of regents, or any other local commission, association, or tribal council, may apply to the board for designation as a small wind innovation zone under Iowa Code section 476.48. The application must include the following information:

- a.* The name, location, description, and legal boundary of the political subdivision seeking designation as a small wind innovation zone;
- b.* Contact information for the applicant filing on behalf of the political subdivision, including legal name, address, telephone number, and, as applicable, facsimile transmission number and electronic mail address;
- c.* If the political subdivision is other than a local government:
  - (1) Identification of the local government (or governments) that encompasses the political subdivision;
  - (2) Confirmation that all identified local governments have either adopted or are about to adopt the model ordinance, including copies of model ordinances adopted by the local governments, or copies of pending amendments to existing zoning ordinances intended to comply with the model ordinance; and
  - (3) Dates the model ordinances were adopted or anticipated dates of adoption of pending amendments to existing zoning ordinances intended to comply with the model ordinance;
- d.* If the political subdivision is a local government:
  - (1) A copy of the model ordinance adopted by the local government or copy of a pending amendment to an existing zoning ordinance intended to comply with the model ordinance; and
  - (2) Date the model ordinance was adopted or anticipated date of adoption of the pending amendment to an existing zoning ordinance intended to comply with the model ordinance;
- e.* Identification of the electric utilities that provide service within the political subdivision; and
- f.* Documentation from each electric utility that provides service within the political subdivision confirming that the electric utility is serving the political subdivision and that the utility is either:
  - (1) A utility subject to the provisions of 199—Chapter 45; or
  - (2) A utility not subject to the provisions of 199—Chapter 45, but which nonetheless agrees to use the standard forms, procedures, and standard interconnection agreements of 199—Chapter 45 for small wind energy systems in its service territory within the political subdivision; or
  - (3) A utility that is not subject to the provisions of 199—Chapter 45 and has not adopted them.

NOTE: Electric utilities shall provide political subdivisions the documentation required in paragraph 15.22(2)“f.”

**15.22(3)** *Motion for modification of a model interconnection agreement in a small wind innovation zone.* An electric utility that uses the standard interconnection agreements in 199—Chapter 45 and the owner of a small wind energy system in a small wind innovation zone may jointly seek to modify their version of the model interconnection agreement by jointly filing a motion for board approval. The motion must include the following information:

- a.* The name, location, and description of the political subdivision designated as a small wind innovation zone;
- b.* The interconnecting electric utility;
- c.* Information regarding the owner of the small wind energy system, including legal name, address, telephone number, and, as applicable, facsimile transmission number and electronic mail address;
- d.* Description of the small wind energy system, including location and nameplate generating capacity;
- e.* A copy of the modified interconnection agreement clearly identifying the proposed modifications;
- f.* A description of the reasons and circumstances that require the modifications; and
- g.* Signed statements from the electric utility and the owner of the small wind energy system attesting that the proposed modifications to the interconnection agreement are mutually agreeable.

**15.22(4)** *Annual reporting requirement.* A current listing of small wind innovation zones shall be maintained on the board’s website at [www.state.ia.us/iub](http://www.state.ia.us/iub). Beginning April 1, 2011, each electric utility

that has one or more small wind innovation zones in its service territory shall file an annual report for the previous calendar year listing the nameplate kW capacity of each small wind energy system that was interconnected (or previously interconnected) with the utility and produced electricity in each of the small wind innovation zones served by the utility. The information shall be provided in the following format:

| Small Wind<br>Innovation Zone | Customer<br>Name | Nameplate<br>kW Capacity |
|-------------------------------|------------------|--------------------------|
|-------------------------------|------------------|--------------------------|

[ARC 8949B, IAB 7/28/10, effective 9/1/10]

These rules are intended to implement Iowa Code sections 476.1, 476.8, 476.41 to 476.45, and 546.7, Section 210 of the Public Utility Regulatory Policies Act of 1978, and 18 CFR Part 292.

[Filed 3/26/81, Notice 10/29/80—published 4/15/81, effective 5/20/81]

[Filed emergency 6/28/82—published 7/21/82, effective 6/28/82]

[Filed 7/27/84, Notice 4/25/84—published 8/15/84, effective 9/19/84]

[Filed emergency 9/18/86—published 10/8/86, effective 9/18/86]

[Filed emergency 9/4/87—published 9/23/87, effective 9/4/87]

[Filed 4/25/91, Notice 12/26/90—published 5/15/91, effective 6/19/91]

[Filed 6/4/93, Notice 1/20/93—published 6/23/93, effective 7/28/93]

[Filed 10/20/94, Notice 6/22/94—published 11/9/94, effective 12/14/94]

[Filed 10/12/00, Notice 8/23/00—published 11/1/00, effective 12/6/00]

[Filed 3/29/02, Notice 2/6/02—published 4/17/02, effective 5/22/02]

[Filed 7/3/03, Notice 3/5/03—published 7/23/03, effective 8/27/03]

[Filed 8/29/03, Notice 5/14/03—published 9/17/03, effective 10/22/02]

[Filed 9/24/04, Notice 8/18/04—published 10/13/04, effective 11/17/04]

[Filed emergency 6/20/05—published 7/20/05, effective 6/20/05]

[Filed 1/26/06, Notice 7/20/05—published 2/15/06, effective 3/22/06]

[Filed 11/28/06, Notice 9/27/06—published 12/20/06, effective 1/24/07]

[Filed 5/2/07, Notice 3/28/07—published 5/23/07, effective 6/27/07]

[Filed 7/31/08, Notice 6/18/08—published 8/27/08, effective 10/1/08]

[Filed ARC 8060B (Notice ARC 7849B, IAB 6/17/09), IAB 8/26/09, effective 9/30/09]

[Filed ARC 8859B (Notice ARC 8201B, IAB 10/7/09), IAB 6/16/10, effective 7/21/10]

[Filed ARC 8949B (Notice ARC 8335B, IAB 12/2/09), IAB 7/28/10, effective 9/1/10]

[Filed ARC 9752B (Notice ARC 9609B, IAB 7/13/11), IAB 9/21/11, effective 10/26/11]

[Filed ARC 0781C (Notice ARC 0455C, IAB 11/14/12), IAB 6/12/13, effective 7/17/13]

[Filed ARC 1359C (Notice ARC 1169C, IAB 11/13/13), IAB 3/5/14, effective 4/9/14]

[Filed ARC 1716C (Notice ARC 1600C, IAB 9/3/14), IAB 11/12/14, effective 12/17/14]

[Filed ARC 2244C (Notice ARC 2116C, IAB 9/2/15), IAB 11/25/15, effective 12/30/15]

[Filed ARC 3694C (Notice ARC 3538C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

CHAPTER 34  
NONUTILITY SERVICE

**199—34.1(476) Statement of purpose.** A public utility which engages in a systematic marketing effort, other than on an incidental or casual basis, to promote the availability of a nonutility service from the public utility shall allow competitors access to certain services.

**199—34.2(476) Definition—nonutility service.** “*Nonutility service*” as defined in this chapter means the sale, lease, or other conveyance of commercial and residential gas or electric appliances, interior lighting systems and fixtures, or heating, ventilating, or air-conditioning systems and component parts or the servicing, repair, or maintenance of the equipment.

**199—34.3(476) Definition—systematic marketing effort.** In determining whether activity constitutes a “*systematic marketing effort, other than on an incidental or casual basis,*” the board will consider whether the effort is regular or irregular, recurring or nonrecurring, active or passive in nature and whether the effort is done on a comprehensive basis. Factors that shall be considered include, but are not limited to, the types and number of media used, the frequency, extent, and duration of the marketing effort, the amount of marketing expenses incurred, and whether the public utility appeared to intend to increase significantly its market share.

**199—34.4(476) Engaged primarily in providing the same competitive nonutility services in the area—defined.** “*A person is engaged primarily in providing the same competitive nonutility services in the area*” when the person on an ongoing basis sells or leases equipment or products or offers services, accounting for at least 60 percent of the person’s gross business revenue, which are functionally interchangeable and considered similar by the public with the nonutility service provided by a public utility in the same identifiable geographic area where the public utility provides utility service.

[ARC 3695C, IAB 3/14/18, effective 4/18/18]

**199—34.5(476) Charges permitted.** A person meeting the requirements of rule 199—34.4(476) shall be permitted to use, to the same extent utilized by the public utility for its nonutility service in connection with nonutility services as defined in rule 199—34.2(476), the customer lists, billing and collection system, and mailing system of the public utility company engaged in a systematic marketing effort, other than on an incidental or casual basis. The person shall be charged for the cost or expense incurred by the public utility in providing access to its systems and its lists. The charge shall not be greater than the charge, fee, or cost imposed upon or allocated to the provision of nonutility service by the utility for the similar use of the systems.

**199—34.6(476) Procedures for utilization of billing and collection system.**

**34.6(1)** When a person meeting the requirements of rule 199—34.4(476) uses the billing and collection system of a public utility, the public utility shall promptly remit to that person all funds collected by the public utility on behalf of the person.

**34.6(2)** Where a customer makes a partial payment and owes both a public utility and a person(s) meeting the requirements of rule 199—34.4(476) for services or goods provided, the payment received shall be allocated first to the regulated utility bill plus tax, unless otherwise allocated by the customer. Any balance remaining after payment of the utility bill plus tax shall be allocated between the public utility for any unpaid nonutility services and any other person(s) utilizing the utility’s billing system according to the ratio of the amount billed by each unless otherwise allocated by the customer. A public utility shall not disconnect a customer’s utility service for nonpayment of a bill for nonutility services.

A person shall not use a public utility’s billing and collection systems to bill and receive payments only from customers who are habitually delinquent or who have failed or refused to make payment to the person.

**199—34.7(476) Complaints.** The procedures in 199—Chapter 6 shall apply to all complaints regarding the provision of nonutility service.

These rules are intended to implement Iowa Code sections 476.78, 476.80, and 476.81.

[Filed 1/4/91, Notice 8/8/90—published 1/23/91, effective 2/27/91]

[Filed 6/6/03, Notice 12/25/02—published 6/25/03, effective 7/30/03]

[Filed ARC 3695C (Notice ARC 3457C, IAB 11/22/17), IAB 3/14/18, effective 4/18/18]

**COLLEGE STUDENT AID COMMISSION[283]**

[Prior to 8/10/88, see College Aid Commission[245]]

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CHAPTER 21  
APPROVAL OF POSTSECONDARY SCHOOLS

**283—21.1(261B,261G) Postsecondary registration and participation in the commission-approved reciprocity agreement.** The college student aid commission examines college and university applications for registration to operate in Iowa and monitors schools approved by the commission to operate in the state. The commission also examines Iowa college and university applications for participation in an interstate reciprocity agreement under which the commission is an approved participant.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.2(261B,261G) Definitions.** As used in this chapter:

“*Interstate reciprocity agreement administrator*” means the entity with which the commission has an agreement to participate in interstate reciprocity under Iowa Code chapter 261G.

“*Registration*” means the process by which a school must seek, or voluntarily seeks, the commission’s explicit approval to operate in Iowa or offer courses of instruction to Iowans under Iowa Code chapter 261B.

“*School*” means a postsecondary educational institution that applies to register or is currently registered to offer all or a portion of a program in Iowa under Iowa Code chapter 261B. “School” also means a postsecondary educational institution that is seeking to participate in the commission’s approved interstate reciprocity agreement under Iowa Code chapter 261G or that is a “participating resident institution” as defined in Iowa Code section 261G.2. A postsecondary educational institution that maintains a physical location outside of the state of Iowa and that must register under Iowa Code chapter 261B to operate at a physical location in this state is not a school that is eligible to participate in the commission’s approved interstate reciprocity agreement under Iowa Code chapter 261G.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.3(261B,261G) Registration approval criteria.** The college student aid commission will approve an applicant school that completes a registration application provided by the commission and meets all of the following criteria:

**21.3(1)** The applicant school is accredited by an agency recognized by the United States Department of Education or its successor agency. The applicant school shall certify to the commission the school’s status with the accrediting agency at the time of the application and provide information about any pending or final action that may affect the school’s status with its accrediting agency.

As applicable, the applicant school shall provide the commission the name of any programmatic accrediting agency recognized by the United States Department of Education that accredits the specific programs the applicant school proposes to offer under its registration.

**21.3(2)** The applicant school certifies to the commission that the applicant school’s approval to operate in a state has not been revoked by the state, the school has not been sanctioned by a state within a year prior to the date of its application, and the school is not under investigation or bound by the terms of a judgment issued by a state’s attorney general or other enforcement authority.

**21.3(3)** The applicant school certifies that it is not subject to a limitation, suspension or termination order issued by the United States Department of Education or its successor agency. The applicant school shall provide the commission with a copy of the school’s current program participation agreement with the United States Department of Education.

**21.3(4)** The applicant school complies with Iowa Code section 261B.7, which prohibits a school from advertising that the school is approved or accredited by the commission or the state of Iowa. However, an applicant school must demonstrate the method by which it will disclose that the school is registered with the commission and provide the commission’s contact information for students who wish to inquire about the school or file a complaint.

**21.3(5)** The applicant school provides the commission with institutional policies adopted by the school that comply with the requirements of Iowa Code section 261.9(1) “e” to “h.”

*a.* For a program in which a student's academic progress is measured only in clock hours, the school shall provide a full refund of tuition and mandatory fees to a student who withdraws and who requests that benefit under Iowa Code section 261.9(1) "g" for the payment period in which the student withdrew. The payment period is determined under rules promulgated by the United States Department of Education for the disbursement of federal Stafford loan funds.

*b.* The employee policy for reporting suspected incidents of child physical or sexual abuse required by Iowa Code section 261.9(1) "h" shall apply to individuals the school compensates to conduct activities on the school's behalf at an Iowa location.

**21.3(6)** If required by the commission, the applicant school files annual reports that the commission also requires from all Iowa colleges and universities.

**21.3(7)** The applicant school demonstrates financial viability by providing a copy of the institution's most recent audit that was prepared by a certified public accounting firm no more than 12 months prior to the date of the application and that provides an unqualified opinion. An applicant school must provide the auditor's report as an attachment to the registration application, which is posted on the commission's Internet site. However, the school may provide financial statements associated with the audit in a separate electronic file that is marked "confidential." Financial statements that a school identifies as "confidential" will not be treated as public records under Iowa Code chapter 22.

**21.3(8)** The applicant school provides a description of the learning resources it offers to students, including appropriate library and other support services the school provides to its students.

**21.3(9)** The applicant school provides evidence that faculty within an appropriate discipline are involved in developing and evaluating curriculum for the program(s) being registered in Iowa.

**21.3(10)** The applicant school provides documentation or information posted on its Internet site that describes the educational and experiential qualifications of all faculty or instructors who teach in the programs the school proposes to offer under its registration and the general subject matter in which faculty members or instructors teach. The applicant school shall also provide the number of full-time and part-time faculty and instructors who will teach the courses offered to Iowans.

**21.3(11)** The applicant school provides documentation demonstrating that a program which prepares a student for an occupation that requires professional licensure in Iowa and which the school proposes to offer under its registration:

*a.* Has been approved by the appropriate state of Iowa licensing agency and accrediting agency, if such approval is required, or

*b.* Meets curriculum standards of the appropriate state of Iowa licensing agency such that the state of Iowa licensing agency does not require the student to complete additional coursework or practicum hours that the school did not offer in its professional licensure preparation program.

**21.3(12)** The school submits a request for amendment of its registration subject to commission approval in the event the school makes a substantive change in location, program offering, or accreditation during its registration term. A substantive change in program offering occurs when a school proposes to initiate a program that requires the approval of the state board of education or any other program that prepares a student for an occupation that requires professional licensure in this state.

**21.3(13)** During its registration term, the school notifies the commission within 90 days after adding a program that does not require the school to seek the commission's amendment approval under subrule 21.3(12).

**21.3(14)** The applicant school certifies that it will immediately notify the commission of any pending or final sanction issued by the school's accrediting agency, another state agency that registers or licenses the school during its registration term, or a state attorney general's office or other enforcement authority.

**21.3(15)** The applicant school provides a statement, signed by its chief executive officer, demonstrating the applicant school's commitment to the delivery of programs offered in Iowa and agreeing to provide alternatives for students to complete their programs at the same or other schools if the applicant school discontinues a program, the applicant school closes, or the applicant school closes an Iowa site before students have completed their courses of study.

Notwithstanding any limitations on student eligibility for a teach-out plan approved by a school's accrediting agency, the alternatives that the school provides under this agreement with the commission

shall ensure that all academically eligible students attending the programs the school offers under its registration are provided with a viable option(s) to finish the program(s).

**21.3(16)** If the applicant school is for profit, the applicant school provides evidence that its most recently calculated percentage of revenue derived from funds received under Title IV of the Higher Education Act of 1965, as amended, does not exceed the threshold established by the United States Department of Education.

**21.3(17)** If the applicant school is nonpublic, the applicant school provides evidence of its official financial responsibility composite score, as calculated using the method prescribed by the United States Department of Education.

*a.* A school demonstrates that its financial responsibility composite score is official by providing written confirmation of its composite score from the United States Department of Education.

*b.* A school that does not participate in the postsecondary student financial aid programs authorized by the United States Department of Education demonstrates that its financial responsibility composite score is official by providing written confirmation of its composite score from its accrediting agency. If the school's accrediting agency does not independently verify the school's composite score, the school must submit written confirmation from its independent auditor.

**21.3(18)** A nonpublic school that does not have a legal governing body, such as a board of directors or board of trustees, shall provide the names, titles, and educational and experiential qualifications of the persons holding key academic and operational leadership positions at the school.

**21.3(19)** A nonpublic school that is a subsidiary of another organization provides all of the following:

*a.* The name of the parent organization.

*b.* The names and titles of the members of the parent organization's legal governing body, such as a board of directors or board of trustees. In the absence of a legal governing body, the school provides the information described in subrule 21.3(18).

*c.* The name(s) of any other school(s) that is a subsidiary of the same parent organization.

**21.3(20)** The school posts a list of required and suggested textbooks for all courses and corresponding international standard book numbers for such textbooks at least 14 days before the start of each semester or term at the locations where textbooks are sold on campus and on the school's Internet site.

**21.3(21)** The school provides any additional information the commission requires to evaluate the school.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.4(261B,261G) Additional approval criteria for an applicant school that applies for registration to maintain a fixed location in Iowa.** In addition to meeting the registration approval criteria in rule 283—21.3(261B,261G), a school that applies for registration to operate a campus, branch campus, student services center, or administrative office at a fixed location in Iowa shall meet all of the following additional criteria:

1. The applicant school employs at least one full-time Iowa faculty member or one program or student services coordinator devoted to Iowa students.

2. The applicant school provides to the commission the name of and business contact information for a contact person in Iowa.

3. The applicant school demonstrates that it has adequate physical facilities located in Iowa appropriate for the programs and services offered.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.5(261B,261G) Additional criteria for an out-of-state applicant school that applies for registration to offer programs via in-person instruction but in a nontraditional format.**

**21.5(1)** In addition to meeting the approval criteria in rule 283—21.3(261B,261G), an out-of-state school that applies for registration to offer programs via in-person instruction but in a nontraditional format shall notify the commission in writing within 90 days of the date that the school establishes a new Iowa location at which Iowa students will receive instruction in the school's nontraditional program. Notification to the commission via electronic mail is acceptable. If the school's accrediting agency

requires preapproval of the new Iowa location, the school's notice to the commission must include a copy of that accrediting agency's approval. If the school's accrediting agency does not require preapproval of the new Iowa location, the school must certify that accrediting agency approval is not required. Such a school is not required to submit a registration amendment request under subrule 21.3(12).

**21.5(2)** For the purposes of this rule, "nontraditional format" includes, but is not limited to, the following:

- a. A program offered partially via distance education and partially via in-person instruction at a location in Iowa by faculty or instructors compensated by the applicant school.
- b. A program offered partially at the applicant school's out-of-state campus and partially via in-person instruction at a location in Iowa by faculty or instructors compensated by the applicant school.
- c. A program offered at a location in Iowa through compressed courses scheduled on Saturday or Sunday.
- d. A program offered only during the summer months.
- e. A program offered at temporary locations in Iowa where the school identifies cohorts of students who have expressed interest in the program.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.6(261B,261G) Additional approval criteria and exception for an out-of-state applicant school that applies for registration to offer distance education programs.**

**21.6(1)** An out-of-state school offering distance education programs is not required to register in Iowa if its home state approves the school to participate in a commission-approved interstate reciprocity agreement. If an out-of-state applicant school providing distance education programs in Iowa is not approved by the school's home state to participate in a commission-approved interstate reciprocity agreement, in addition to meeting the approval criteria in rule 283—21.3(261B,261G), the out-of-state applicant school shall meet all of the following additional criteria:

- a. The applicant school discloses the name and business contact information of any person compensated by the school (including by honorarium) to remotely provide instruction or academic supervision in the school's distance education courses from any Iowa location.
- b. The applicant school discloses the name, business contact information, and duties of any person the applicant school compensates to remotely perform operational activities from any Iowa location.

**21.6(2)** Exception. If a school applies for registration solely to offer distance education programs that include a structured field experience in which the student will participate at an Iowa location and the applicant school maintains no other presence in Iowa as defined in Iowa Code section 261B.2, the school is not required to implement a policy that complies with Iowa Code section 261.9(1) "h."

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.7(261B,261G) Recruiting for an out-of-state applicant school's residential programs from an Iowa location.**

**21.7(1)** An out-of-state applicant school that compensates a party to recruit Iowans for its campus-based, residential programs shall apply for registration if the recruiter maintains an Iowa address. In addition to meeting all of the criteria in rule 283—21.3(261B,261G), the applicant school shall disclose the name of and business contact information for its Iowa-based recruiter.

**21.7(2)** An out-of-state applicant school that compensates a person to recruit students for its campus-based, residential programs is not required to apply for registration if the school's recruitment activities at a location in Iowa are occasional and short-term; for example, at a college fair or conference.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.8(261B,261G) Provisional registration.**

**21.8(1)** The commission may grant provisional registration under the following conditions:

- a. An out-of-state applicant school is accredited by an entity or organization recognized by the United States Department of Education or its successor agency at the time the school submits its registration application; and

*b.* The applicant school must obtain the commission's approval before the school's accrediting agency will consider approving the applicant school to operate at a physical location in Iowa.

**21.8(2)** The commission may prohibit the school from initiating instruction at a location in Iowa until the school obtains its accrediting agency's approval to operate at an Iowa location.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.9(261B,261G) Duration of registration; application for renewal.**

**21.9(1)** Upon approval by the commission, an applicant school is registered for a period of two calendar years, contingent upon the school's compliance with commission requirements as provided in this chapter.

**21.9(2)** A registered school shall submit a completed registration renewal application to the commission at least six months before the ending date of the school's current registration term. A school is solely responsible for submitting a timely renewal application.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.10(261B,261G) Limitation, denial, or revocation of registration.**

**21.10(1)** At the time of initial registration or registration renewal and during a registration term, the commission may take action that includes, but is not limited to, limiting a school's program offerings or enrollment or denying or revoking the school's registration as a result of any of the following:

- a.* An adverse notice, warning, or other sanction issued by the school's accrediting agency.
- b.* An adverse action or sanction issued by the United States Department of Education.
- c.* A lawsuit filed by a state agency, a state attorney general's office, or another enforcement authority.
- d.* A judgment issued by a state attorney general's office or another enforcement authority.
- e.* A for-profit school's most recently calculated percentage of revenue derived from funds received under Title IV of the Higher Education Act of 1965, as amended, that exceeds the threshold established by the United States Department of Education.
- f.* Repeated complaints about a school received from the school's students by the commission, by another state, or by a state attorney general's office.
- g.* Notice that the school has experienced a change of ownership or governance. The school shall notify the commission no later than 30 calendar days after the change in ownership or governance.
- h.* Failure to pay fees due to the commission in accordance with rule 283—21.12(261B,261G).
- i.* Other actions deemed by the commission as significant evidence that the school should not be allowed to operate under this chapter.

**21.10(2)** Reserved.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.11(261B,261G) School, Iowa site, or program closure.**

**21.11(1)** No later than 90 days before a registered school takes action to discontinue a program that is offered by the school under its registration, close an Iowa site, or close the school, the school must notify the commission in writing.

**21.11(2)** The school's notice to the commission shall include all of the following:

- a.* The full name, residential address, telephone number, email address, program name, and anticipated graduation date of affected Iowa resident students or, as applicable, affected students at the school's Iowa campus(es). The school shall organize this list in alphabetical order by student last name.
- b.* Documentation of the school's proposed notice to students.
- c.* The school's specific plan to provide alternatives for affected students to complete the programs offered under the school's registration in accordance with the agreement described in subrule 21.3(15). The school shall obtain the prior approval of the commission for any agreement the school proposes to establish with another institution that provides completion alternatives for programs the school offered under its registration.
- d.* The school's plan for permanent storage and retrieval of student transcript information.
- e.* Specific information about how the school will provide transitional support to affected students.

*f.* Contact information for the specific entity and individual who will accept responsibility for all of the following:

(1) Ensuring that unearned federal student aid is returned to the United States Department of Education on a timely basis.

(2) Finalizing student account records and providing copies of the students' final account statements to the students and, upon request, to the commission.

(3) Collecting outstanding bills a student owes to the school for tuition and other educational expenses.

(4) Collecting on private education loans or other institutional loans made to students by the school and, if applicable, the school's private preferred lender(s).

**21.11(3)** The commission may require a registered school that has a continuous corporate surety bond in effect pursuant to Iowa Code section 714.18 to maintain the bond, at minimum, for one year after the school ceases operation in Iowa, closes an Iowa site, or ceases new enrollment in programs previously offered to Iowa resident students.

**21.11(4)** If the commission takes action to discontinue a school's program, close a school's Iowa site, or terminate a school's operation in Iowa, the school shall provide to the commission the information in subrule 21.11(2) and shall be subject to the requirements of subrule 21.11(3).

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.12(261B,261G) Initial registration application fees and subsequent annual fees.**

**21.12(1)** A school that applies for initial registration as required under Iowa Code chapter 261B shall remit an initial registration application fee payable to the commission in the amount of \$5,000. This fee is nonrefundable regardless of the commission's decision with respect to the school's eligibility for registration in Iowa. A school that fails to pay the initial registration application fee shall be denied initial registration consideration.

**21.12(2)** A school that is approved for registration shall remit an annual fee payable to the commission in the amount due on July 15 of each year. If a school's registration terminates during a year, the school shall pay the annual fee to the commission if the school's registration is valid as of July 15 of that year. The annual fee is nonrefundable and will be assessed based on a school's full-time equivalent (FTE) enrollment as follows:

- Under 2,500 FTE – \$2,000.
- 2,500 to 9,999 FTE – \$4,000.
- 10,000 FTE or more – \$6,000.

**21.12(3)** A school that registers and pays fees under rule 283—21.12(261B,261G) is not required to pay fees under rule 283—21.15(261B,261G) if participating in the interstate reciprocity agreement.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.13(261B,261G) Authorization to operate in Iowa for certain nonpublic, nonprofit colleges and universities exempt from registration.**

**21.13(1)** The state of Iowa considers a nonpublic, nonprofit institution located in Iowa, which qualifies for an exemption from registration under Iowa Code section 261B.11(1) "j" and "l," to be authorized to lawfully operate in Iowa as a postsecondary educational institution that grants a degree, diploma, or certificate for the purpose of state authorization regulations established by the United States Department of Education, provided the institution meets the following additional conditions:

- a. The institution is exempt from federal taxation under Section 501(c)(3) of the Internal Revenue Code on or after July 1, 2013; and
- b. The institution originated in this state and has undergone no change in ownership or control since July 1, 2011.

**21.13(2)** The following Iowa colleges and universities are authorized under subrule 21.13(1):

- a. Allen College;
- b. Briar Cliff University;
- c. Buena Vista University;
- d. Central College;

- e.* Clarke University;
- f.* Coe College;
- g.* Cornell College;
- h.* Des Moines University;
- i.* Divine Word College;
- j.* Dordt College;
- k.* Drake University;
- l.* Emmaus Bible College;
- m.* Faith Baptist Bible College and Theological Seminary;
- n.* Graceland University;
- o.* Grand View University;
- p.* Grinnell College;
- q.* Iowa Wesleyan College;
- r.* Loras College;
- s.* Luther College;
- t.* Maharishi University of Management;
- u.* Mercy College of Health Sciences;
- v.* Mercy St. Luke's School of Radiologic Technology;
- w.* Morningside College;
- x.* Mount Mercy College;
- y.* Northwestern College;
- z.* Palmer College of Chiropractic;
- aa.* Simpson College;
- ab.* St. Ambrose University;
- ac.* St. Luke's College;
- ad.* Unity Point Health – Des Moines School of Radiologic Technology;
- ae.* University of Dubuque;
- af.* Upper Iowa University;
- ag.* Wartburg College;
- ah.* Wartburg Theological Seminary; and
- ai.* William Penn University.

[ARC 1216C, IAB 12/11/13, effective 1/15/14; ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.14(261B,261G) Verification of exemption from registration to operate in Iowa.**

**21.14(1)** A school claiming an exemption from registration under Iowa Code chapter 261B shall demonstrate the following:

*a.* The school provides the reference under which it requests exemption from registration under Iowa Code section 261B.11.

*b.* If the school offers a course of instruction leading to a degree, with the exception of a school that qualifies for an exemption under Iowa Code section 261B.11(1)“*h*,” the school is accredited by an accrediting agency recognized by the United States Department of Education and will notify the commission of any negative changes to its accrediting status.

*c.* The school has a policy that prohibits unlawful possession, use, or distribution of controlled substances by students and employees on school-owned or -leased property or in conjunction with activities sponsored by the school. The school will provide information about the policy to all students and employees, including any sanctions for violation of the policy and any substance abuse prevention programs for students and employees.

*d.* The school has a policy addressing sexual abuse including counseling, campus security, education, and facilitating accurate and prompt reporting of sexual abuse.

*e.* The school has an employee policy for reporting suspected incidents of child physical or sexual abuse that includes individuals whom the school compensates to conduct activities on the school's behalf at an Iowa location.

*f.* The school has a military refund policy for students who are members of the Iowa national guard or reserve forces of the United States and the spouses of such members if the members have dependent children when the members are ordered into active duty as required by Iowa Code sections 261.9(1)“g,”262.9(30), and 260C.14(20). The policy shall include:

(1) Withdrawal from all or a portion of the student’s registration and receipt of a full refund of tuition and mandatory fees that the school assessed for courses from which the student withdrew. For a program in which a student’s academic progress is measured only in clock hours, the school shall provide a full refund of tuition and mandatory fees to a student who withdraws and who requests that benefit for the payment period in which the student withdrew. The payment period is determined under rules promulgated by the United States Department of Education for the disbursement of federal Stafford loan funds.

(2) Making arrangements for instructors to report grades or report incomplete grades that will be completed at a later date.

*g.* The school posts a list of required and suggested textbooks for all courses and corresponding international standard book numbers for such textbooks at least 14 days before the start of each semester or term at the locations where textbooks are sold on campus and on the school’s Internet site.

*h.* The school has procedures for preservation of student records and the contact information to be used by students and graduates who seek to obtain transcript information.

*i.* A covered institution under Iowa Code chapter 261F has a code of conduct that complies with Iowa Code section 261F.2.

*j.* A covered institution under Iowa Code chapter 261F with a preferred lender list meets the requirements of Iowa Code section 261F.6.

*k.* The school provides the commission with the name of and business contact information for a person whom the school designates to receive student complaints from the commission and coordinate the school’s response. The commission will provide a link to a page on its website for students to use to seek additional information about a school or to file a complaint about a school. A school that is approved for an exemption from registration will prominently provide on its website the link to the commission’s web page for students.

**21.14(2)** A nonpublic school must provide evidence of financial responsibility under Iowa Code section 714.18 or demonstrate eligibility for an exemption under Iowa Code section 714.19.

**21.14(3)** A for-profit school must demonstrate and maintain compliance with Iowa Code section 714.23. The school shall apply the policy it adopts under Iowa Code section 714.23 to students who attend its campus(es) in Iowa, if applicable, as well as to Iowa resident students who attend distance education programs.

**21.14(4)** A for-profit school that does not participate in the student financial assistance programs administered by the United States Department of Education must demonstrate and maintain compliance with Iowa Code section 714.25.

[ARC 2580C, IAB 6/22/16, effective 5/27/16]

**283—21.15(261B,261G) Approval criteria for a school seeking to participate or renew participation in a commission-approved interstate reciprocity agreement under Iowa Code chapter 261G.** A school that applies to participate in a commission-approved interstate reciprocity agreement shall meet the following criteria:

**21.15(1)** The applicant school shall be in compliance with Iowa Code chapter 261B as provided in this chapter.

**21.15(2)** The applicant school shall submit an institutional participation application as required by the commission-approved interstate reciprocity agreement. The application shall be signed by the school’s chief executive officer or chief academic officer.

**21.15(3)** A nonpublic applicant school must submit evidence that its most recent, official financial responsibility composite score, as calculated using the method prescribed by the United States Department of Education, is at least 1.5. A school demonstrates that its financial responsibility composite score is official by providing written confirmation of its composite score from the United

States Department of Education. In accordance with policies established by the interstate reciprocity agreement administrator, the commission shall determine the official financial responsibility composite score for a school that does not participate in the postsecondary student financial aid programs authorized by the United States Department of Education.

**21.15(4)** The commission will consider the application of a nonpublic school whose most recent, official financial responsibility composite score is between 1.0 and 1.49. The applicant school must submit a copy of the school's most recently audited financial statements accompanied by a written explanation of the circumstances that caused the school's composite score to be below 1.5 and the school's plan to raise its composite score to 1.5 within a time frame determined by the commission. The commission may approve, provisionally approve, or deny the school's application.

**21.15(5)** A for-profit applicant school must demonstrate and maintain compliance with Iowa Code sections 714.18 and 714.23. The school shall apply the policy it adopts under Iowa Code section 714.23 to students who attend its campus(es) in Iowa and to Iowa resident and nonresident students who attend distance education programs the school offers under the commission-approved interstate reciprocity agreement.

**21.15(6)** The applicant school shall demonstrate that the military deployment tuition and fee refund policy required under Iowa Code sections 261.9(1)“g,” 262.9(30), and 260C.14(20), subrule 21.3(5) and paragraph 21.14(1)“f” applies to students who attend its campus(es) in Iowa and to Iowa resident and nonresident students who attend distance education programs the school offers under the commission-approved interstate reciprocity agreement.

**21.15(7)** An approved school will prominently disclose on its website the school's participation in the commission-approved interstate reciprocity agreement and provide the commission's contact information in a format prescribed by the commission for students who wish to inquire about the school or file a complaint. The school will provide the commission with the name of and business contact information for a person whom the school designates to receive student complaints from the commission and coordinate the school's response.

**21.15(8)** A school that is approved to participate in the commission-approved interstate reciprocity agreement shall remit an annual fee payable and due to the commission on July 15 of each year. The school shall pay the annual fee to the commission if the commission's approval to participate in the interstate reciprocity agreement is valid as of July 15 of that year. The annual fee is nonrefundable and will be assessed based on a school's full-time equivalent (FTE) enrollment as follows:

- Under 2,500 FTE – \$2,000.
- 2,500 to 9,999 FTE – \$4,000.
- 10,000 FTE or more – \$6,000.

**21.15(9)** A school that is approved to participate in the commission-approved interstate reciprocity agreement shall remit to the interstate reciprocity agreement administrator any required fees.

**21.15(10)** Upon approval by the interstate reciprocity agreement administrator, a school may continue its participation in the reciprocity agreement as long as it meets all requirements of the interstate reciprocity agreement.

[ARC 2580C, IAB 6/22/16, effective 5/27/16; ARC 3678C, IAB 3/14/18, effective 4/18/18]

These rules are intended to implement Iowa Code chapters 261, 261B, and 261G.

[Filed 9/29/00, Notice 8/9/00—published 10/18/00, effective 11/22/00]

[Filed 8/30/02, Notice 4/17/02—published 9/18/02, effective 10/23/02]

[Filed 1/30/03, Notice 11/13/02—published 2/19/03, effective 3/26/03]

[Filed 1/24/04, Notice 10/29/03—published 2/18/04, effective 3/24/04]<sup>1</sup>

[Filed 3/24/05, Notice 1/5/05—published 4/13/05, effective 5/18/05]

[Filed ARC 1216C (Notice ARC 0946C, IAB 8/21/13), IAB 12/11/13, effective 1/15/14]

[Filed Emergency After Notice ARC 2580C (Notice ARC 2143C, IAB 9/16/15; Amended Notice ARC 2437C, IAB 3/16/16), IAB 6/22/16, effective 5/27/16]

[Filed ARC 3678C (Notice ARC 3540C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

<sup>1</sup> Effective date of 3/24/04 delayed 70 days by the Administrative Rules Review Committee at its meeting held March 8, 2004.



## **HUMAN SERVICES DEPARTMENT[441]**

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.

Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/11/87.

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TITLE VIII  
MEDICAL ASSISTANCE  
CHAPTER 73  
MANAGED CARE

PREAMBLE

This chapter provides that most Iowa medical assistance program benefits will be provided through managed care. Notwithstanding any provisions of 441—Chapters 74 through 91, program benefits shall be provided through managed care as provided in this chapter. The program benefits provided through managed care will be paid for by managed care organizations participating in the program pursuant to this chapter, subject to the conditions, procedures, and payment rates or methodologies established by the managed care organization, consistent with this chapter and with the contract between the department and the managed care organization.

Implementation of managed care pursuant to this chapter is subject to approval by the Secretary of the United States Department of Health and Human Services (Secretary) of any Iowa state plan amendments and any waivers of the requirements of Title XIX of the Social Security Act that are required to allow for federal funding.

This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements under Title XIX or the terms of the waiver shall prevail.

**441—73.1(249A) Definitions.**

“*Behavioral health services*” means mental health and substance use disorder treatment services.

“*Capitated payment*” means a monthly payment to the contractor on behalf of each enrollee for the provision of health services under the contract. Payment is made regardless of whether the enrollee receives services during the month.

“*Choice counseling*” means the provision of unbiased information on managed care plans or provider options and answers to related questions and access to personalized assistance to help members understand the materials provided by the managed care organizations or the state, to answer questions about each of the options available, and to facilitate enrollment with a managed care organization.

“*Claim*” means a formal request for payment for benefits received or services rendered.

“*Clean claim*” means a claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. “Clean claim” does not include a claim from a provider that is under investigation for fraud or abuse or a claim under review for medical necessity.

“*CMS*” means the Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

“*Code of Federal Regulations (CFR)*” means the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

“*Community-based case management*” means a collaborative process of planning, facilitation, and advocacy for options and services to meet a member’s needs through communication and available resources to promote high-quality, cost-effective outcomes.

“*Contract*” means a contract between the department and a managed care organization. These contracts shall meet all applicable requirements of state and federal law, including the requirements of the Code of Federal Regulations, Title 42 CFR 434 as amended to October 16, 2015.

“*Covered services*” means physical health, behavioral health and long-term care services set forth in rule 441—73.5(249A).

“*Department*” means the Iowa department of human services.

“*Discharge planning*” means the process, which begins at admission, of determining an enrollee’s continued need for treatment services and of developing a plan to address ongoing needs.

*“Emergency medical condition”* means a physical or behavioral 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 the absence of immediate medical attention to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

*“Emergency services”* means covered inpatient and outpatient services that are both furnished by a provider that is qualified to furnish these services and needed to evaluate or stabilize an emergency medical condition.

*“EMTALA”* means the Emergency Medical Treatment and Active Labor Act.

*“Enrollee”* means a HAWK-I, Iowa Health and Wellness Plan or Medicaid member who is eligible for managed care organization enrollment and has been enrolled with a managed care organization as defined in subrule 73.3(2).

*“Enrollment broker”* means the entity the department uses to enroll persons in a managed care organization. The enrollment broker must be conflict free and meet all applicable requirements of state and federal law, including 42 CFR 438.10 as amended to October 16, 2015.

*“HAWK-I program”* means the healthy and well kids in Iowa program as set forth in 441—Chapter 86, the Iowa program to provide health care coverage for uninsured children of eligible families as authorized by Title XXI of the federal Social Security Act.

*“Health maintenance organization”* means a public or private organization which is licensed as a managed care organization or prepaid health plan under insurance division rules set forth in 191—Chapter 40.

*“HIPP”* means the health insurance premium payment program.

*“Home- and community-based services (HCBS)”* means services that are provided as an alternative to long-term care institutional services in a nursing facility or an intermediate care facility for persons with an intellectual disability (ICF/ID) or to delay or prevent placement in a nursing facility or ICF/ID.

*“Incident reporting”* means the reporting of critical events or incidents deemed sufficiently serious to warrant near-term review and follow-up by an appropriate authority. Such incidents may include but are not limited to:

1. Abuse and neglect;
2. The unauthorized use of restraint, seclusion or restrictive interventions;
3. Serious injuries that require medical intervention or result in hospitalization, or both;
4. Criminal victimization;
5. Death;
6. Financial exploitation;
7. Medication errors; and
8. Other incidents or events that involve harm or risk of harm to a participant.

*“Insolvency”* means a financial condition that exists when an entity is unable to pay its debts as they become due in the usual course of business or when the liabilities of the entity exceed its assets.

*“Iowa Health and Wellness Plan”* means the medical assistance program set forth in 441—Chapter 74.

*“Level of care”* means an evaluation to determine and establish an individual’s need for the level of care provided in a hospital, a nursing facility, or an ICF/ID within the near future.

*“Long-term care (LTC)”* or *“long-term services and supports (LTSS)”* means the services of a nursing facility (NF), an intermediate care facility for persons with an intellectual disability (ICF/ID), state resource centers or services funded through Section 1915(c) home- and community-based services waivers, Section 1915(i) state plan home- and community-based habilitation program and the PACE program.

“*Managed care organization (MCO)*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” in Iowa Code section 514B.1.

“*Mandatory enrollment*” means mandatory participation in a managed care organization as specified in subrule 73.3(2).

“*Medical loss ratio (MLR)*” means the percentage of capitation payments that is used to pay medical expenses.

“*Medically necessary services*” means those covered services that are, under the terms and conditions of the contract, determined through contractor utilization management to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the condition of the member;
2. Provided for the diagnosis or direct care and treatment of the condition of the member to enable the member to make reasonable progress in treatment;
3. Within standards of professional practice and given at the appropriate time and in the appropriate setting;
4. Not primarily for the convenience of the member, the member’s physician or other provider; and
5. The most appropriate level of covered services that can safely be provided.

“*Medical records*” means all medical, behavioral health, and long-term care histories; records, reports and summaries; diagnoses; prognoses; record of treatment and medication ordered and given; X-ray and radiology interpretations; physical therapy charts and notes; lab reports; other individualized medical, behavioral health, and long-term care documentation in written or electronic format; and analyses of such information.

“*Member*” means any person determined by the department to be eligible for the HAWK-I program, the Iowa Health and Wellness Plan, or the Medicaid program.

“*Money Follows the Person (MFP) Rebalancing Demonstration Grant*” means a federal grant that will assist Iowa in transitioning individuals from a nursing facility or ICF/ID into the community and in rebalancing long-term care expenditures.

“*Needs-based eligibility*” means an evaluation to determine and establish an individual’s need for habilitation services.

“*Network*” or “*provider network*” means a group of participating health care providers (both individual and group practitioners) linked through contractual arrangements to the contractor to supply a range of health care services.

“*Out-of-network provider*” means any provider that is not directly or indirectly employed by or does not have a provider agreement with the contractor or any of its subcontractors pursuant to the contract between the department and the contractor.

“*PACE*” means the program for all-inclusive care for the elderly.

“*Participating providers*” means the providers of covered physical health, behavioral health and long-term care services that have contracted with a managed care organization.

“*PMIC*” means a psychiatric medical institution for children.

“*Prior authorization*” means the process of obtaining prior approval as to the appropriateness of a service or medication. Prior authorization does not guarantee coverage.

“*Warm transfer*” means a telecommunications mechanism in which the person answering the call facilitates transfer to a third party, announces the caller and issue and remains engaged as necessary to provide assistance.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.2(249A) Contracts with a managed care organization.**

**73.2(1)** The department may enter into a contract with a managed care organization licensed under the provisions of insurance division rules set forth in 191—Chapter 40 for the scope of services as defined in rule 441—73.6(249A).

**73.2(2)** The department shall determine that the managed care organization meets the following requirements:

*a.* The managed care organization shall make available the services it provides to enrollees as established in the contract.

*b.* The managed care organization shall provide satisfaction to the department against the risk of insolvency and ensure that neither Medicaid members nor the state shall be responsible for the managed care organization's debts if the managed care organization becomes insolvent. The managed care organization shall comply with insurance division provisions set forth in rule 191—40.12(514B) regarding net worth and rule 191—40.14(514B) containing reporting requirements.

*c.* The managed care organization shall attain and maintain accreditation by the National Committee on Quality Assurance (NCQA) or URAC (formerly known as the Utilization Review Accreditation Commission).

**73.2(3)** If not already accredited, the managed care organization must demonstrate it has initiated the accreditation process as of the contract effective date and must achieve accreditation at the earliest date allowed by NCQA or URAC. Prior to the contract effective date, the managed care organization must be licensed and in good standing in the state of Iowa as a health maintenance organization in accordance with insurance division rules set forth in 191—Chapter 40.

**73.2(4)** The contract shall meet the following minimum requirements. The contract shall:

- a.* Be in writing.
- b.* Specify the duration of the contract period.
- c.* List the services which must be covered.
- d.* Describe service access and provide access information.
- e.* List conditions for nonrenewal, termination, suspension, and modification.
- f.* Specify the method and rate of reimbursement.
- g.* Provide for disclosure of ownership and subcontracted relationships.
- h.* Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the managed care organization, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.
- i.* Specify appeal and grievance rights.
- j.* Specify all operational and service delivery expectations.
- k.* Specify reporting requirements.
- l.* Specify requirements for utilization management and quality improvement.
- m.* Specify requirements for program integrity.
- n.* Specify termination requirements and assessment of penalties.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.3(249A) Enrollment.**

**73.3(1)** *Enrollment area.* The coverage area for enrollment shall be statewide.

**73.3(2)** *Members subject to enrollment.* All HAWK-I program and Iowa Health and Wellness Plan members shall be subject to mandatory enrollment in a managed care organization. All Medicaid members, with the exception of the following, shall be subject to mandatory enrollment in a managed care organization:

- a.* Members who are medically needy as defined at 441—subrule 75.1(35).
- b.* Individuals eligible only for emergency medical services because the individuals do not meet citizenship or alienage requirements, pursuant to 441—subrule 75.11(4).
- c.* Persons who are currently presumptively eligible as defined in 441—subrules 75.1(30), 75.1(40), and 75.1(44).
- d.* Persons eligible for the program of all-inclusive care for the elderly (PACE) who voluntarily elect PACE coverage as defined in 441—subrule 88.24(1).
- e.* Persons enrolled in the health insurance premium payment program (HIPP) pursuant to rule 441—75.21(249A).

*f.* Persons eligible only for the Medicare savings program as defined in rules 441—75.1(249A) and 441—76.1(249A).

*g.* American Indian and Alaska Native populations who are exempt from mandatory enrollment pursuant to 42 CFR 438.50(d)(2) but who may enroll voluntarily.

**73.3(3) Enrollment process.** The department shall notify members who must be enrolled in a managed care organization of enrollment and the effective date of enrollment. The department will implement an enrollment process in accordance with federal funding requirements, including 42 CFR 438 as amended to October 16, 2015.

*a. General.* Members may receive managed care organization choice counseling from the enrollment broker. The enrollment broker will provide information about individual managed care organization benefit structures, services and network providers, as well as information about other Medicaid programs as requested by the Medicaid member to assist the member in making an informed selection.

*b. Tentative assignment.* Members shall be tentatively assigned to a managed care organization and offered the opportunity to choose from the available managed care organizations within a time frame specified in the tentative assignment letter.

*c. Request to change enrollment.*

(1) A member shall have a minimum of ten days from the date of the tentative assignment letter to request enrollment with a different managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).

(2) An enrollee may, within 90 days of initial enrollment, request to change enrollment from one managed care organization and enroll in another managed care organization. The request may be made on a form designated by the department, in writing, or by telephone call to the enrollment broker's toll-free member telephone line. Changes are subject to the effective date provisions of subrule 73.3(4).

*d. Ongoing enrollment.* Enrollees shall remain enrolled with the chosen managed care organization for a total of 12 months.

*e. Enrollment cycle.* Prior to the end of the enrollee's annual enrollment period, the enrollee shall be notified of the option to maintain enrollment with the current managed care organization or to enroll with a different managed care organization.

**73.3(4) Effective date of enrollment.** The effective date of enrollment shall be no later than the first day of the second month beginning after the date on which the managed care organization receives the designated managed health care choice form or written or verbal request.

**73.3(5) Benefit reimbursement prior to enrollment.**

*a.* Prior to the effective date of managed care enrollment, except as provided in paragraph 73.3(5) "b," the Medicaid program shall reimburse providers for covered program benefits pursuant to 441—Chapters 74 to 91, as applicable for eligible members.

*b.* The managed care organization shall be responsible for covering newly retroactive Medicaid eligibility periods, prior to the effective date of enrollment, in the following cases:

(1) Babies born to Medicaid-enrolled women who are retroactively eligible to the month of birth; and

(2) Children enrolled in the HAWK-I program retroactive to the date of application. For purposes of this requirement, a retroactive Medicaid eligibility period is defined as a period of time up to three months prior to the Medicaid determination month.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.4(249A) Disenrollment process.**

**73.4(1) Enrollee-requested disenrollment.** An enrollee may request disenrollment with a managed care organization as follows:

*a.* During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, the enrollee may request disenrollment, for any reason, in writing or by a telephone call to the enrollment broker's toll-free member telephone line.

b. After the 90 days following the date of the enrollee's enrollment with the managed care organization, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written filing of the issue through the managed care organization's grievance system. If the member does not experience resolution, the managed care organization shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment. Good-cause changes include the following:

(1) The managed care organization does not, because of moral or religious objections, cover the service the member seeks.

(2) The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.

(3) Other reasons, including but not limited to poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's health care needs, or eligibility and choice to participate in a program not available in managed care (for example, PACE).

c. The final decision for disenrollment shall be determined by the department.

**73.4(2) *Disenrollment by department.*** Disenrollment will occur when:

a. The contract between the department and the managed care organization is terminated.

b. The enrollee becomes ineligible for Medicaid, the HAWK-I program or the Iowa Health and Wellness Plan. If the enrollee becomes ineligible and is later reinstated to these programs, enrollment in the managed care organization will also be reinstated.

c. The enrollee transfers to an eligibility group excluded from managed care organization enrollment. See definition of "enrollee" in rule 441—73.1(249A).

d. The department has determined that participation in the HIP program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

e. Death of the enrollee.

f. The enrollee has changed residence to another state.

**73.4(3) *Managed care organization-requested disenrollment.*** A managed care organization shall not disenroll an enrollee or encourage an enrollee to disenroll for any reason, including the enrollee's health care needs or change in health care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs (except when the enrollee's continued enrollment seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception applies, the managed care organization shall provide evidence to the department that continued enrollment of an enrollee seriously impairs the managed care organization's ability to furnish services to either this particular enrollee or other enrollees. The managed care organization shall have methods by which the department is assured that disenrollment is not requested for another reason.

**73.4(4) *Disenrollment effective date.*** The effective date of a department-approved disenrollment shall be no later than the first day of the second calendar month beginning after the month in which: (1) the enrollee requests disenrollment pursuant to subrule 73.4(1); (2) the department notifies the enrollee and managed care organization of disenrollment pursuant to subrule 73.4(2); or (3) the managed care organization requests disenrollment pursuant to subrule 73.4(3). The enrollee shall remain enrolled in the managed care organization and the managed care organization will be responsible for services covered under the contract until the effective date of disenrollment unless the enrollee is in an inpatient setting at the time of disenrollment. If the enrollee is in an inpatient setting at the time of disenrollment, the managed care organization shall be responsible for the inpatient services for 60 days or until the enrollee is discharged.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.5(249A) Covered services.**

**73.5(1) *Required services.*** A managed care organization shall provide:

a. For enrollees other than Iowa Health and Wellness Plan enrollees and HAWK-I program enrollees, services as set forth in 441—Chapters 78, 81, 82, 83, 84, 85, and 87, with the exception of the following:

- (1) Area education agency services.
  - (2) Dental services not provided in an outpatient hospital setting.
  - (3) Infant and toddler program services.
  - (4) Local education agency services.
  - (5) State of Iowa Veterans Home services.
  - (6) Money Follows the Person Grant-funded services.
- b. Services as set forth in 441—Chapter 74 for Iowa Health and Wellness Plan enrollees.
- c. Services as set forth in 441—Chapter 86 for HAWK-I program enrollees.

**73.5(2) Community-based case management service.** The managed care organization is required to provide services that meet requirements specified in the contract and in 441—subrule 90.5(1).

**73.5(3) Health home services.** The managed care organization is required to provide services that meet the requirements specified in 441—subrule 78.53(1) and as specified in the contract.

**73.5(4) Value-added services.** A managed care organization may develop optional services and supports to address the needs of enrollees. These services and supports shall be implemented only after approval by the department.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.6(249A) Amount, duration and scope of services.**

**73.6(1)** The managed care organization shall provide, at a minimum, all benefits and services deemed medically necessary that are covered under the contract with the agency. In accordance with federal funding requirements, including 42 CFR 438.210(a)(3) as amended to October 16, 2015, the managed care organization shall furnish covered services in an amount, duration and scope reasonably expected to achieve the purpose for which the services are furnished. The managed care organization may not arbitrarily deny or reduce the amount, duration and scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee. With the exception of court-ordered services, the managed care organization shall require as a condition of payment managed care organization approval of admissions to a nursing facility, an intermediate care facility for persons with an intellectual disability, psychiatric medical institutions for children, and a mental health institute. Managed care organizations shall also require managed care organization approval of out-of-state placements as a condition of payment.

**73.6(2)** The managed care organization may place appropriate limits on services on the basis of medical necessity criteria for the purpose of utilization management, provided the services can reasonably be expected to achieve their purpose in accordance with the contract. The managed care organization shall not:

- a. Avoid costs for services covered in the contract by referring members to publicly supported health care resources.
- b. Deny reimbursement of covered services based on the presence of a preexisting condition.

**73.6(3)** The managed care organization shall allow each enrollee to choose a health professional, to the extent possible and appropriate, within the managed care organization's provider network. The managed care organization shall ensure compliance with the Americans with Disabilities Act (ADA) in the delivery and approval of all services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

#### **441—73.7(249A) Emergency services.**

**73.7(1)** Emergency services shall be available 24 hours a day, 7 days a week.

**73.7(2)** In accordance with federal funding requirements, including 42 CFR 438.114 as amended to October 16, 2015, the managed care organization shall:

- a. Cover emergency services without the need for prior authorization and may not limit reimbursement to network providers.

*b.* Cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the managed care organization.

*c.* Pay noncontracted providers for emergency services the amount that would have been paid if the service had been provided under the state's fee-for-service Medicaid program.

*d.* Cover the medical screening examination, as defined by EMTALA, provided to a member who presents to an emergency department with an emergency medical condition.

**73.7(3)** The managed care organization shall not deny payment for:

*a.* Treatment obtained when an enrollee has an emergency medical condition, including cases in which the absence of immediate medical attention would result in placing the health of the enrollee in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

*b.* Treatment obtained when a representative of the managed care organization instructs the enrollee to seek emergency medical services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.8(249A) Access to service.**

**73.8(1)** The managed care organization shall ensure enrollees have access to services as specified in the contract. In general, the managed care organization shall provide available, accessible, and adequate numbers of institutional facilities, service locations, and service sites and professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hours-a-day, 7-days-a-week basis. At a minimum, access to services shall comply with the standards described in the contract. For areas of the state where provider availability is insufficient to meet these standards, for example, in health professional shortage areas and medically underserved areas, the access standards shall meet the usual and customary standards for the community. Exceptions to the requirements contained in this rule shall be justified and documented to the state on the basis of community standards. All other services not specified in this rule shall meet the usual and customary standards for the community.

**73.8(2)** Choice of providers. An enrollee shall use the managed care organization's provider network unless the managed care organization has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). In accordance with federal funding requirements, including 42 CFR 431.51(b)(2) as amended to October 16, 2015, the managed care organization shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers who are not in the managed care organization's network.

**73.8(3)** Continuity of care. The managed care organization shall have policies and procedures that provide for the continuity of care of treatment to ensure that a new enrollee's existing services are honored as required in the contract.

**73.8(4)** Adequate service referral support and after-hours call-in coverage. The managed care organization shall ensure enrollee access to service information and medical coverage 24 hours a day, 7 days a week, 365 days a year.

*a. Member helpline.* The managed care organization shall maintain a dedicated toll-free member services helpline as established in the contract to handle a variety of member inquiries and to provide warm transfer of enrollees to outside entities, such as provider offices, and to internal managed care organization departments, such as to care coordinators.

*b. Nurse call line.* The managed care organization shall operate a toll-free nurse call line that provides nurse triage telephone services for members to receive medical advice 24 hours a day, 7 days a week from trained medical professionals.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.9(249A) Incident reporting.** The managed care organization shall develop and implement a critical incident reporting and management system for participating providers in accordance with the department requirements for reporting incidents for Section 1915(c) HCBS Waivers, the Section 1915(i) Habilitation Program, and as required for licensure of programs through the department of inspections

and appeals. The managed care organization shall develop and implement policies and procedures, subject to department review and approval, to:

1. Address and respond to incidents;
2. Report incidents to the appropriate entities in accordance with required time frames; and
3. Track and analyze incidents.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.10(249A) Discharge planning.** The managed care organization shall establish policies and procedures, subject to approval by the department, that protect an individual from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The managed care organization shall facilitate a seamless transition whenever a member transitions between facilities or residences.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.11(249A) Level of care assessment and annual reviews.** The managed care organization shall establish policies and procedures to ensure the implementation of level of care and needs-based eligibility assessments and reassessments as required in the contract and consistent with the department's level of care and needs-based eligibility assessment process and the requirements provided in 441—Chapters 75, 78, 81, 82, 83, and 85. Waiver level of care determinations must be consistent with those made for the appropriate institutional level of care under the state plan.

**73.11(1) Initial level of care assessment.** Managed care organizations are responsible for conducting level of care and needs-based eligibility assessments for a current enrollee who requires a level of care or a needs-based eligibility assessment. The managed care organization shall perform the assessment using department-approved assessment tools. The results of the assessment shall be submitted to the IME medical services unit for determination of level of care or needs-based eligibility.

**73.11(2) Annual continued stay reviews, continued care reviews and redeterminations.** When an enrollee requires a continued stay review, a continued care review or a redetermination, the managed care organization shall use department-approved assessment tools. If the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect the enrollee's level of care or needs-based eligibility, the managed care organization shall submit the assessment findings to the IME medical services unit for determination of level of care or needs-based eligibility.

**73.11(3) At any time, if the managed care organization becomes aware that the enrollee's functional or medical status has changed in a way that may affect level of care or needs-based eligibility, the managed care organization shall conduct a level of care or needs-based assessment using the department-approved tools and submit the assessment to the IME medical services unit for determination of level of care or needs-based eligibility.**

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.12(249A) Appeal of managed care organization actions.** The managed care organization shall have written appeal policies and procedures for an enrollee, or an enrollee's authorized representative, to appeal a managed care organization action. The policies must address contractual requirements and federal funding requirements, including 42 CFR 438.400(b) as amended to October 16, 2015.

**73.12(1) Managed care organization appealable actions.** Managed care organization actions that may be appealed include:

- a. Denial or limited authorization of a requested service, including the type or level of service.
- b. Reduction, suspension, or termination of a previously authorized service.
- c. Denial, in whole or in part, of payment of service.
- d. Failure to provide services in a timely manner as defined by the department.
- e. Failure of the managed care organization to act within the required time frames set forth in federal funding requirements, including 42 CFR 438.408(b) as amended to October 16, 2015.

*f.* For a resident of a rural area that has only one appropriate provider of a needed service, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside of the MCO's network.

**73.12(2) Appeal process.** The managed care organization appeal process shall be approved by the department and shall:

*a.* Allow for the appeal request to be submitted in writing or verbally. If the request is submitted verbally, it must be followed up with a written submission.

*b.* Require acknowledgment of the receipt of a request for an appeal within three working days.

*c.* Allow for participation by the enrollee and the provider.

*d.* Provide for resolution of nonexpedited appeals to be concluded within 30 calendar days of receipt of the request unless an extension is requested.

*e.* Provide for resolution of expedited appeals where the standard time period could seriously jeopardize the member's health or ability to maintain or regain maximum function to be within 72 hours of receipt of the notice pursuant to federal funding requirements, including 42 CFR 438.402 as amended to October 16, 2015.

*f.* Ensure that the review will be made by qualified professionals who were not involved with the original action.

*g.* Ensure issuance of a notice of decision for each appeal. These notices shall contain the member's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

[ARC 2358C, IAB 1/6/16, effective 1/1/16; ARC 3667C, IAB 3/14/18, effective 2/14/18]

**441—73.13(249A) Appeal to department.** If the enrollee is not satisfied with the final decision rendered by the managed care organization through the managed care organization's appeal process, the enrollee may appeal an action in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.14(249A) Continuation of benefits.** The managed care organization shall be required to continue the member's benefits during the appeal in accordance with federal funding requirements, including 42 CFR 438.420 as amended to October 16, 2015.

**73.14(1)** If the benefits are continued or reinstated while the appeal is pending, the benefits must be continued until one of the following occurs:

*a.* The enrollee withdraws the appeal request;

*b.* Ten days pass after the MCO mailed the notice providing the resolution of the appeal against the enrollee, unless the enrollee, within the ten-day time frame, has requested a state fair hearing with continuation of benefits until a state fair hearing decision is reached; or

*c.* The time period or service limits of a previously authorized service have been met.

**73.14(2)** If the final resolution of the appeal is adverse to the enrollee, that is, it upholds the managed care organization's action, the managed care organization may recover the cost of the services furnished to the enrollee while the appeal is pending, to the extent that services were furnished solely because of the requirements to maintain benefits during the appeal.

**73.14(3)** If the managed care organization or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the managed care organization must authorize and provide the disputed services promptly and as expeditiously as the member's health condition requires. If the managed care organization or the state fair hearing officer reverses a decision to deny authorization of services and the enrollee received the disputed services while the appeal was pending, the managed care organization must pay for these services.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.15(249A) Grievances.** The managed care organization shall have policies and procedures for review of any nonclinical incidents, nonclinical complaints, or nonclinical concerns. Grievances may be communicated verbally or in writing and require that the review be conducted by someone other than

the person or persons involved in the grievance. All policies related to the review of grievances shall be approved by the department prior to implementation.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.16(249A) Written record.** All enrollee appeals and grievances shall be logged and reported to the department. The log shall include the status and resolution of all appeals and grievances.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.17(249A) Information concerning procedures relating to the review of managed care organization decisions and actions.** The managed care organization's written procedures for the review of managed care organization decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.18(249A) Records and reports.**

**73.18(1) Records system.** The managed care organization shall document and maintain clinical and fiscal records in accordance with federal and state requirements, including rule 441—79.3(249A) and 42 CFR 456 as amended to October 16, 2015, throughout the course of the contract. The records system shall:

*a.* Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.

*b.* Provide a rationale for and documentation of decisions made by the managed care organization, based upon medical necessity.

*c.* Permit effective professional review for medical audit processes.

*d.* Facilitate an adequate system for monitoring treatment reimbursed by the managed care organization including follow up of the implementation of discharge plans and referral to other providers.

**73.18(2) Content of individual treatment record.** The managed care organization shall ensure that participating providers maintain an adequate record-keeping system that includes a complete medical or service record for each enrolled member including documentation of all services provided to each enrollee in compliance with the contract and provisions of rule 441—79.3(249A) and pursuant to federal funding requirements, including 42 CFR 456 as amended to October 16, 2015.

**73.18(3) Confidentiality of health care, mental health care, and substance abuse information.** The managed care organization shall protect and maintain the confidentiality of health care, mental health care, and substance abuse information by implementing policies for staff and through contract terms with participating providers. The policies must comply with applicable state and federal laws.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.19(249A) Audits.** The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the managed care organization. The department or HHS may audit and inspect any records of a managed care organization, or the subcontractor of the managed care organization, that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.20(249A) Marketing.** Managed care organization marketing activities and materials shall comply with applicable laws and regulations regarding marketing by the managed care organizations and contract terms. The department shall approve all marketing materials, which must comply with federal funding requirements, including 42 CFR 438.10 and 42 CFR 438.104 as amended to October 16, 2015.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.21(249A) Enrollee education.**

**73.21(1) *Use of services.*** The managed care organization shall provide written information to all enrollees on the use of services the managed care organization is responsible to arrange, monitor, and reimburse. Information must include the array of services covered; how to access covered services; the providers participating; an explanation of the process for the review of managed care organization decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; a statement of consumer rights and responsibilities; out-of-area use of service information; availability of toll-free telephone information and crisis assistance; and the appropriate use of the referral system.

**73.21(2) *Outreach to members with special needs.*** The managed care organization shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, an intellectual disability or other cognitive impairments, illiterate persons, non-English-speaking persons, and persons with visual or hearing impairments.

**73.21(3) *Patient rights and responsibilities.*** The managed care organization shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of the packet of enrollment information provided to all new enrollees.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.22(249A) Payment to the managed care organization.**

**73.22(1) *Capitation rate.*** In consideration for all services rendered by a managed care organization under a contract with the department, the managed care organization will receive a payment each month for each enrolled member. The monthly reimbursement may be reduced by amounts withheld for pay-for-performance components of the contract. The withheld amounts will be distributed based on the terms defined in the managed care contract. Additionally, the department will make an allowance for obligations resulting from Section 9010 of the Patient Protection and Affordable Care Act, the health insurance providers fee. This capitation rate, inclusive of the amounts withheld and the health insurance providers fee, represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled members under the contract except as otherwise designated in the contract rate. Pay-for-performance terms will allow for incentive reimbursement if the managed care organization meets metrics defined in the managed care contract.

**73.22(2) *Determination of rate.*** The actuarially sound capitation rate will be determined according to the terms of federal funding requirements, including 42 CFR 438.6 as amended to October 16, 2015, Actuarial Standards of Practice 49, and other related CMS regulations and generally accepted actuarial principles and practices.

**73.22(3) *Third-party liability.*** If an enrolled member has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses, it is the right and responsibility of the managed care organization to investigate these third-party resources and attempt to obtain payment. The managed care organization shall retain all funds collected from third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

**73.22(4) *Medical loss ratio.*** The managed care organization shall report the experienced medical loss ratio for each contract rate period. In the event that the medical loss ratio falls below the department-designated target, the department shall recoup excess capitation paid to the managed care organization.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.23(249A) Claims payment by the managed care organization.**

**73.23(1)** The managed care organizations shall pay or deny:

- a. Ninety percent of all clean claims within 14 calendar days of receipt,
- b. Ninety-nine point five percent of all clean claims within 21 calendar days of receipt, and
- c. One hundred percent of all claims within 90 calendar days of receipt.

**73.23(2)** Limits on payment responsibility for services.

*a.* The managed care organization is not required to reimburse providers for the provision of services that do not meet the criteria of medical necessity.

*b.* The managed care organization has the right to require prior authorization of covered services and to deny reimbursement to providers that do not comply with such requirements.

*c.* Payment responsibilities for emergency room services are as provided at rule 441—73.7(249A).

**73.23(3)** Payment to nonparticipating providers. In reimbursing nonparticipating providers, the managed care organization is obligated to pay 90 percent of the payment to participating providers.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.24(249A) Quality assurance.** The managed care organization shall have in effect an internal quality assurance and performance improvement system that meets the requirements of any or all applicable state and federal laws.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

**441—73.25(249A) Certifications and program integrity.** The managed care organization shall develop and implement policies, procedures and a mandatory compliance plan to ensure compliance with the contract requirements for certification, program integrity and prohibited affiliations. The managed care organization shall cooperate and collaborate with the department on all program integrity activities. The managed care organization shall comply with state and federal laws pertaining to these requirements, including 42 CFR 438.608 and 42 CFR 455 as amended to October 16, 2015.

[ARC 2358C, IAB 1/6/16, effective 1/1/16]

These rules are intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, section 12.

[Filed Emergency After Notice ARC 2358C (Notice ARC 2241C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]

[Filed Emergency After Notice ARC 3667C (Notice ARC 3514C, IAB 12/20/17), IAB 3/14/18, effective 2/14/18]



CHAPTER 119  
RECORD CHECK EVALUATIONS FOR  
CERTAIN EMPLOYERS AND EDUCATIONAL TRAINING PROGRAMS

PREAMBLE

These rules establish procedures for the performance of record check evaluations by the department of human services for personnel employed by health care facilities and other programs and for students in educational training programs for nurses and certified nurse aides. Record check evaluations are performed, at the request of a prospective employer or training program, on persons who have been found to have been convicted of a crime under a law of any state or have a record of founded child or dependent adult abuse, to determine whether the crimes or founded abuses warrant prohibition of employment or enrollment in a training program.

[ARC 0486C, IAB 12/12/12, effective 2/1/13]

**441—119.1(135B,135C) Definitions.**

*“Deferred judgment”* means deferred judgment as defined in Iowa Code section 907.1 and is considered an admission of committing an act. Under this chapter, the admission of committing an act must be considered a conviction for purposes of public protection.

*“Department”* means the department of human services.

*“Requesting entity”* means an entity covered by these rules that is requesting an evaluation to determine if the person being evaluated can be employed by the entity or participate in an educational training program and includes the following:

1. Health care facilities as defined in Iowa Code section 135C.1.
2. Programs in which the provider is regulated by the state or receives any state or federal funding and the employee being evaluated provides direct services to consumers including but not limited to programs that employ homemakers or home health aides, programs that provide adult day services, hospices, federal home- and community-based services waiver providers, elder group homes, and assisted living programs.
3. Substance abuse programs for juveniles as described in Iowa Code section 125.14A.
4. Hospitals as defined in Iowa Code section 135B.1.
5. Psychiatric medical institutions for children as defined in Iowa Code section 135H.1.
6. The department as described in Iowa Code section 217.44.
7. Department institutions as defined in Iowa Code section 218.13.
8. Child foster care facilities as defined in Iowa Code section 237.1.
9. Medicaid home- and community-based services waiver providers as defined in Iowa Code section 249A.29.
10. Certified nurse aide training programs as defined in Iowa Code section 135C.33(9).
11. Nursing training programs as described in Iowa Code chapter 152.
12. The department as described in Iowa Code section 217.45.

[ARC 0486C, IAB 12/12/12, effective 2/1/13; ARC 1263C, IAB 1/8/14, effective 3/1/14; ARC 2604C, IAB 7/6/16, effective 9/1/16; ARC 3680C, IAB 3/14/18, effective 4/18/18]

**441—119.2(135B,135C) When record check evaluations are requested.**

**119.2(1)** *Record check evaluations on prospective employees and students.* A requesting entity shall request a record check evaluation prior to employment or enrollment of a person whose background check indicates a criminal or dependent adult abuse or child abuse record. Any deferred judgments will be considered in criminal background checks. Criminal, child abuse and dependent adult abuse background checks are required on all prospective employees or students, including employees or students who have terminated employment or participation in a training program for any reason or any length of time and wish to return to the same employment or training program, unless an exemption is provided in these rules.

*a.* A hospital or licensee of a health care facility may employ a person for up to 60 calendar days pending completion of the evaluation if all of the following criteria are met:

- (1) The employment does not involve operation of a motor vehicle; and
- (2) The person to be employed has been convicted of a simple misdemeanor offense (under Iowa Code section 123.47 or chapter 321) or a first offense of operating a motor vehicle while intoxicated (under Iowa Code section 321J.2(1)); and
- (3) The person to be employed does not have a record of founded child or dependent adult abuse; and
- (4) The hospital or licensee has requested an evaluation.

*b.* A training program in a facility licensed under Iowa Code chapter 135C may allow a student who is applying for, enrolled in, or returning to a certified nurse aide training program to participate in the clinical education component of the training program for up to 60 calendar days pending completion of the evaluation if all of the following criteria are met:

- (1) The student's clinical education component of the training program involves children or dependent adults; and
- (2) The program does not involve operation of a motor vehicle; and
- (3) The student has been convicted of a simple misdemeanor offense (under Iowa Code section 123.47 or chapter 321) or a first offense of operating a motor vehicle while intoxicated (under Iowa Code section 321J.2(1)); and
- (4) The student does not have a record of founded child or dependent adult abuse; and
- (5) The training program has requested an evaluation.

**119.2(2)** *Record check evaluations on current employees and students.* A requesting entity shall request a record check evaluation on current employees and students when a current employee or student background check indicates a criminal conviction (other than an Iowa Code chapter 321 simple misdemeanor or equivalent simple misdemeanor offense from another jurisdiction) or dependent adult or child abuse record and the requesting entity intends to continue to employ the employee or to continue the student's enrollment in a training program. The requesting entity shall request a current criminal or dependent adult or child abuse record check when the entity receives credible information as determined by the entity that a current employee or student has a criminal or dependent adult or child abuse record that has not been previously considered by the requesting entity.

**119.2(3)** *Transfer of employee between facilities.* If a person owns or operates more than one facility, and an employee of one of the facilities is transferred to another facility without a lapse in employment, the facility is not required to request additional criminal or abuse record checks of the employee or obtain a new record check evaluation.

**119.2(4)** *Exceptions to record check evaluation requirements for employment under Iowa Code chapter 135B or 135C or participation in a training program in facilities licensed under Iowa Code chapter 135C.* If an evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment, the person who is or was employed by a hospital licensed under Iowa Code chapter 135B and is hired by another hospital or the person who is or was employed by a facility licensed under Iowa Code section 135C.33 and is hired by another facility licensed under Iowa Code section 135C.33 may commence employment without further action by the department subject to the following conditions:

- a.* The record check performed by the subsequent employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.
- b.* The position with the subsequent employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.
- c.* Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.
- d.* The person subject to the record checks has maintained a copy of the previous evaluation and provides the evaluation to the subsequent employer, or the previous employer provides the previous evaluation from the person's personnel file pursuant to the person's authorization. If a physical copy of the previous evaluation is not provided to the subsequent employer, a new record check evaluation shall be performed.

*e.* Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

*f.* The subsequent employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

**119.2(5)** *Exceptions to record check evaluation requirements for new employees under Iowa Code chapter 135B or 135C or participants in a training program in facilities licensed under Iowa Code chapter 135C.* If the person approved for employment or participation does not start employment or attend the training program, as defined in subrule 119.4(3), within 30 days from the notice of decision approving the person, the requesting entity must perform a new record check.

*a.* If the evaluation was previously performed by the department and the department determined the person's criminal and abuse background did not warrant prohibition of employment or participation in a training program, the person being considered for employment may commence employment without further action by the department subject to the following conditions:

(1) The record check performed by the employer does not indicate that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation.

(2) The position with the employer is substantially the same or has the same job responsibilities as the position for which the previous evaluation was performed.

(3) Any restriction placed on the person's employment in the previous evaluation by the department shall remain applicable in the person's subsequent employment.

(4) The employer or person subject to the record checks has maintained a copy of the previous evaluation. If a physical copy of the previous evaluation is not maintained, a new record check evaluation shall be requested.

(5) Although an authorized new evaluation is not required, the subsequent employer may choose to request a reevaluation of the person's criminal and abuse background and may employ the person while the reevaluation is being performed.

(6) The employer must maintain the previous evaluation in the employee's or student's personnel file for verification of the exception to the requirement for a record check evaluation.

*b.* If the record check indicates that a crime was committed or that a founded abuse record was entered subsequent to the previous evaluation, a new record check evaluation shall be performed.

*c.* Record check evaluations completed in accordance with paragraph 119.4(3) "c" are valid for 30 days from the date the notice of decision is issued. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply. "Start employment or attend the training program" means to begin to receive a salary or take classes.

[ARC 0486C, IAB 12/12/12, effective 2/1/13; ARC 1263C, IAB 1/8/14, effective 3/1/14; ARC 2604C, IAB 7/6/16, effective 9/1/16]

#### **441—119.3(135C) Request for evaluation.**

**119.3(1)** *Required documentation.* The requesting entity and the prospective employee or student shall complete and submit the record check evaluation form to the department to request an evaluation. The requesting entity shall submit the form and required documentation to the Department of Human Services, Central Abuse Registry, P.O. Box 4826, Des Moines, Iowa 50305-4826. The department shall not process evaluations that are not signed by the prospective employee or student. The position sought or held must be clearly written on the first page of the record check evaluation form. The form shall be accompanied by the following documents:

*a.* A copy of the documentation of the person's status on the DCI criminal history database generated within 30 days of the date on which the request for evaluation is submitted to the department.

*b.* A copy of the Iowa criminal history data, if there is a history, as provided to the requesting entity by the division of criminal investigation.

*c.* A copy of the documentation of the person's status on the dependent adult abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

*d.* A copy of the documentation of the person's status on the child abuse registry generated within 30 days of the date on which the request for evaluation is submitted to the department.

**119.3(2) Additional documentation.**

a. The requesting entity may provide or the department may request from the prospective employee or student or from the requesting entity information to assist in performance of the evaluation that includes, but is not limited to, the following:

- (1) Documentation of criminal justice proceedings.
- (2) Documentation of rehabilitation.
- (3) Written employment references or applications.
- (4) Documentation of substance abuse education or treatment.
- (5) Criminal history records, child abuse information, and dependent adult abuse information from other states.
- (6) Documentation of the applicant's prior residences.

b. Any person or agency that might have pertinent information regarding the criminal or abuse history and rehabilitation of a prospective employee or student may be contacted.

[ARC 0486C, IAB 12/12/12, effective 2/1/13; ARC 1263C, IAB 1/8/14, effective 3/1/14]

**441—119.4(135B,135C) Completion of evaluation.**

**119.4(1) Considerations.** The department shall consider the following when conducting a record check evaluation:

- a. The nature and seriousness of the crime or founded child or dependent adult abuse in relation to the position sought or held.
- b. The time elapsed since the commission of the crime or founded child or dependent adult abuse.
- c. The circumstances under which the crime or founded abuse was committed.
- d. The degree of rehabilitation.
- e. The likelihood that the person will commit a crime or founded child or dependent adult abuse again.
- f. The number of crimes or instances of founded child or dependent adult abuse committed by the person involved.

**119.4(2) Evaluation conclusions.**

- a. The department may determine the following:
  - (1) The person may be employed by the entity or enroll in the training program with no restrictions.
  - (2) The person may be employed by the entity or enroll in the training program with restrictions.
  - (3) The person may be employed by the entity or enroll in the training program with restrictions specific to a position within the program.
  - (4) The person may not be employed by the entity or enroll in the training program.
- b. Restrictions on a person's employment or enrollment status shall be based upon what is necessary for the protection of the person or persons receiving care.
- c. Medicaid waiver consumer-directed attendant care evaluations shall determine that either the person may work or the person may not work pursuant to Medicaid law.

**119.4(3) Notice of decision.** The department shall issue a notice of decision in writing to the requesting entity. The requesting entity is responsible for providing a copy of the notice to the prospective employee or student.

- a. The notice shall be valid only for employment with the employer or enrollment in a training program that requested the record check evaluation.
- b. The notice shall not be valid for employment with any other prospective employer or enrollment in another training program.
- c. Record check evaluations are valid for 30 days from the date the notice of decision is issued. If the person does not start employment or attend the training program within the 30-day time period, the conditions in subrule 119.2(5) shall apply. "Start employment or attend the training program" means to begin to receive a salary or take classes.
- d. The notice of decision shall contain the notice of right to appeal.

[ARC 0486C, IAB 12/12/12, effective 2/1/13; ARC 1263C, IAB 1/8/14, effective 3/1/14]

**441—119.5(135B,135C) Appeal rights.** Any person or the person's attorney may file a written statement with the department requesting an appeal of the record check evaluation decision within 30 days of the date of the notice of the results of the record check evaluation in accordance with 441—Chapter 7.

[ARC 1263C, IAB 1/8/14, effective 3/1/14]

These rules are intended to implement Iowa Code section 135C.33.

[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]

[Filed ARC 0486C (Notice ARC 0324C, IAB 9/5/12), IAB 12/12/12, effective 2/1/13]

[Filed ARC 1263C (Notice ARC 1046C, IAB 10/2/13), IAB 1/8/14, effective 3/1/14]

[Filed ARC 2604C (Notice ARC 2504C, IAB 4/27/16), IAB 7/6/16, effective 9/1/16]

[Filed ARC 3680C (Notice ARC 3515C, IAB 12/20/17), IAB 3/14/18, effective 4/18/18]



CHAPTER 167  
JUVENILE DETENTION REIMBURSEMENT  
[Prior to 2/11/87, Human Services [498]]

DIVISION I  
ANNUAL REIMBURSEMENT PROGRAM

**441—167.1(232) Definitions.**

“*Allowable costs*” means those expenses of the county or multicounty related to the establishment, improvements, operation, and maintenance of county or multicounty juvenile detention homes.

“*County or multicounty*” means that the governing body is a county board of supervisors or a combination of members of participating county boards of supervisors.

“*Detained*” means the period of time a youth is physically occupying a bed in a juvenile detention home (that is, from the time of intake at the juvenile detention home (nothing prior to this) to the time a youth is discharged from the bed at the home (nothing after this)).

“*Eligible costs*” are those allowable costs that are directly attributable to the function of detaining youth in the home, from the point of intake through discharge from the home, as further defined in subrule 167.3(3).

[ARC 8716B, IAB 5/5/10, effective 7/1/10; ARC 3681C, IAB 3/14/18, effective 5/1/18]

**441—167.2(232) Availability of funds.** Any year that the Iowa legislature makes funds available for this program, the department shall accept requests for reimbursement from eligible facilities.

**441—167.3(232) Eligible detention homes.** County and multicounty juvenile detention homes shall be eligible for reimbursement under this program when:

**167.3(1)** The home is approved by the department under the standards of Iowa Code chapter 232 and IAC 441—Chapter 105.

**167.3(2)** The home submits the reports in paragraphs 167.3(2)“a” and 167.3(2)“b” by March 15 and the certified audit in paragraph 167.3(2)“c” by March 15 or within ten days of completion if after March 15 of the year following the conclusion of the state fiscal year for which reimbursement will be made:

a. A written statement delivered in printed form or via electronic mail identifying the eligible total net cost that will be claimed under rule 441—167.5(232).

b. A printed or electronic copy of the department-authorized financial and statistical report for juvenile detention homes.

(1) Certification page.

(2) Schedule A, Revenue Report.

(3) Schedule C, Property and Equipment Depreciation and Related Party Property Costs.

(4) Schedule D, Expense Report.

c. A printed or electronic copy of the home’s certified audit containing financial information for the period for which reimbursement is being claimed.

**167.3(3)** The department has reviewed the information submitted and determined that the costs to be claimed meet eligibility requirements. Eligible costs shall be determined by using a cost allocation methodology that follows generally accepted accounting principles (GAAP). Eligible costs shall be based on the portions of the allowable costs that are directly attributable to the function of detaining youth in the home.

a. Costs are not eligible for reimbursement if a supplemental funding, reimbursement, or refund source is available to the home. County payments to an eligible home for the function of detaining youth in the home (“care and keep”) are not considered to be supplemental funding, reimbursement, or refund sources for the purpose of this subrule. Ineligible costs include, but are not limited to:

(1) Refundable deposits.

(2) Services funded by sources other than the juvenile detention reimbursement program.

(3) Operational activities such as the food and nutrition program that is funded by the Iowa department of education.

*b.* Costs attributed to portions of the home not directly used for detaining children are not eligible for reimbursement.

*c.* Costs of alternatives to detaining youth in the approved detention home are not eligible for reimbursement. Services ineligible for reimbursement include, but are not limited to:

(1) Community tracking and monitoring activities.  
 (2) Transportation during the time a youth is detained that is not related to service or care and keep or that is the responsibility of or funded by another source.

(3) Outreach services.

(4) In-home detention.

*d.* Capital expenses shall be depreciated over the useful life of the item following generally accepted accounting principles. The annual depreciated amount for items that are eligible costs may be claimed for reimbursement.

(1) Capital expenses shall include items costing more than \$5,000 that have a useful life of over two years.

(2) Depreciation schedules shall be filed annually as needed.

[ARC 8716B, IAB 5/5/10, effective 7/1/10; ARC 3681C, IAB 3/14/18, effective 5/1/18]

**441—167.4(232) Available reimbursement.** The reimbursement for the participating detention homes shall be based on the distribution formula authorized by Iowa law.

[ARC 3681C, IAB 3/14/18, effective 5/1/18]

**441—167.5(232) Submission of voucher.** Eligible detention homes shall submit a complete signed and dated Form GAX, General Accounting Expenditure, to the department to claim reimbursement.

**167.5(1)** Form GAX shall be submitted to the Department of Human Services, Division of Fiscal Management, First Floor, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, by August 1.

**167.5(2)** The Form GAX shall include the total net eligible costs incurred between July 1 and June 30 of the year covered by the reimbursement. These costs will be used to calculate the reimbursement amount based on the distribution formula authorized by Iowa law.

**167.5(3)** Only detention homes that submit Form GAX by August 1 shall receive reimbursement.

[ARC 8716B, IAB 5/5/10, effective 7/1/10; ARC 3681C, IAB 3/14/18, effective 5/1/18]

**441—167.6(232) Reimbursement by the department.** Reimbursement shall be made to those participating juvenile detention homes that have complied with these rules.

[ARC 3681C, IAB 3/14/18, effective 5/1/18]

These rules are intended to implement Iowa Code section 232.142.

**441—167.7 to 167.10** Reserved.

DIVISION II  
SEVENTY-TWO HOUR REIMBURSEMENT PROGRAM  
Reserved

[Filed 11/18/83, Notice 5/25/83—published 12/7/83, effective 2/1/84]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]

[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]

[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]

[Filed 4/13/95, Notice 3/1/95—published 5/10/95, effective 7/1/95]

[Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]

[Filed ARC 8716B (Notice ARC 8527B, IAB 2/10/10), IAB 5/5/10, effective 7/1/10]

[Filed ARC 3681C (Notice ARC 3546C, IAB 1/3/18), IAB 3/14/18, effective 5/1/18]

CHAPTER 1  
ORGANIZATION  
[Prior to 1/7/04, see 581—21.1]

**495—1.1(97B) Organization.** The agency shall administer the retirement system created by Iowa Code chapter 97B. Specific powers and duties of the agency, CEO, board, committee, and agency staff are set forth in Iowa Code chapter 97B and these administrative rules.

Operational units within the agency shall develop and administer policies and procedures governing retirement system programs, including accounting functions for the collection of funds from employers and employee members; disbursement of retirement benefits, death benefits, lump sum payments, and disability retirement benefits; training to employers and subsequent review of employer records for compliance with Iowa Code chapter 97B, rules and policies; preparation and release of informational newsletters and the annual report; and investment of funds contributed to the retirement system by employers and employee members. The retirement system is also the state administrator to the federal Social Security Administration pursuant to Iowa Code chapter 97C.

[ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

**495—1.2(97B) Definitions.** Unless otherwise prescribed by federal or state regulations, the terms used in this chapter shall have the following meanings:

“*Agency*” means the Iowa public employees’ retirement system (IPERS) created as an independent agency within the executive branch of state government to administer Iowa Code chapter 97B.

“*Board*” means the IPERS’ investment board as created in Iowa Code section 97B.8A.

“*Chief benefits officer*” means the person employed by IPERS’ chief executive officer, following consultation with the committee, to administer benefits programs and other member services provided under the retirement system.

“*Chief executive officer*” means the administrator of the agency appointed pursuant to Iowa Code section 97B.3 and whose term shall be determined pursuant to Iowa Code section 97B.3.

“*Chief investment officer*” means the person employed by IPERS’ chief executive officer, following consultation with the board, to administer the investment program of the retirement system.

“*Committee*” means the benefits advisory committee created pursuant to Iowa Code section 97B.8B.

“*Internal Revenue Code*” means the Internal Revenue Code as defined in Iowa Code section 422.3.

“*IPERS*” means the agency or the system as the context requires.

“*System*” means the Iowa public employees’ retirement system created pursuant to Iowa Code chapter 97B.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

**495—1.3(97B) Administration.** The chief executive officer, through the chief investment officer and the chief benefits officer, shall administer Iowa Code chapters 97, 97B, and 97C. The chief executive officer shall execute contracts on behalf of IPERS and shall, after consultation with the board and other agency staff, establish and administer the budget, funding policy and such other duties as are required or permitted in Iowa Code section 97B.4. The chief executive officer may make expenditures, reports, and investigations as necessary to carry out the powers and duties created in Iowa Code chapter 97B and may obtain, as necessary, the specialized services of individuals or organizations on a contract-for-service basis. The chief executive officer shall be the agency’s statutory designee with respect to rule-making power.

**1.3(1) Location.** IPERS’ headquarters is located at 7401 Register Drive, Des Moines, Iowa. General correspondence, inquiries, requests for information or assistance, complaints, or petitions shall be addressed to: Chief Executive Officer, Iowa Public Employees’ Retirement System, P.O. Box 9117, Des Moines, Iowa 50306-9117.

**1.3(2) Business hours.** Business hours are 8 a.m. to 4:30 p.m., Monday through Friday, excluding officially designated holidays.

These rules are intended to implement Iowa Code chapter 97B.

[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]

[Filed 4/7/06, Notice 3/1/06—published 4/26/06, effective 5/31/06]

[Filed ARC 2981C (Notice ARC 2892C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3684C (Notice ARC 3537C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

CHAPTER 2  
INVESTMENT BOARD  
[Prior to 1/7/04, see 581—21.1]

**495—2.1(97B) Investment board.** The principal place of business of the board is IPERS' headquarters, 7401 Register Drive, Des Moines, Iowa.

1. Effective July 1, 2002, the board shall be the trustee of the retirement fund. The board shall meet annually, and may meet more often, to review its investment policies.

2. At the first meeting in each fiscal year, the voting members shall elect a chair and vice chair. Future meeting dates for the year shall also be decided at the first meeting. Advance notice of time, date, tentative agenda, and place of each meeting shall be given in compliance with Iowa Code chapter 21. All meetings of the board are open to the public and shall be held in accordance with Robert's Rules of Order, Newly Revised.

3. Parties wishing to present items for the agenda of the next meeting shall file a written request with the board chair at least five business days prior to the meeting.

4. Four members eligible to vote shall constitute a quorum. A simple majority vote of the full voting membership shall be the vote of the board.

5. Members of the board shall file financial statements pursuant to Iowa Code section 68B.35(2) "e."

6. In the event that it should become necessary to fill the chief investment officer position, the board may consult with, and make hiring recommendations to, the chief executive officer that are consistent with the requirements of Iowa Code chapter 8A, subchapter IV.

7. The board shall set the salary of the CEO pursuant to Iowa Code section 97B.3.

8. The board shall participate in the annual performance evaluation of the chief investment officer. [ARC 0017C, IAB 2/22/12, effective 3/28/12; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

**495—2.2(97B) Group trusts.** Assets of the fund may be invested in a tax-exempt group trust that has been determined by the Internal Revenue Service to be a pooled fund arrangement pursuant to Revenue Ruling 81-100, as modified by Revenue Rulings 2004-67 and 2011-1, and that is operated or maintained exclusively for the commingling and collective investment of moneys. In such case, the terms of the group trust shall be adopted as part of this plan.

[ARC 1348C, IAB 2/19/14, effective 3/26/14]

These rules are intended to implement Iowa Code chapter 97B.

[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]

[Filed 12/1/05, Notice 10/26/05—published 12/21/05, effective 1/25/06]

[Filed 4/7/06, Notice 3/1/06—published 4/26/06, effective 5/31/06]

[Filed emergency 6/25/08—published 7/16/08, effective 6/25/08]

[Filed 8/20/08, Notice 7/16/08—published 9/10/08, effective 10/15/08]

[Filed ARC 0017C (Notice ARC 9951B, IAB 12/28/11), IAB 2/22/12, effective 3/28/12]

[Filed ARC 1348C (Notice ARC 1256C, IAB 12/25/13), IAB 2/19/14, effective 3/26/14]

[Filed ARC 2981C (Notice ARC 2892C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3684C (Notice ARC 3537C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]



CHAPTER 3  
BENEFITS ADVISORY COMMITTEE

[Prior to 1/7/04, see 581—21.33]

**495—3.1(97B) Benefits advisory committee.**

**3.1(1) Scope.** These rules shall govern the conduct of business by the IPERS benefits advisory committee (BAC) pursuant to Iowa Code section 97B.8B.

**3.1(2) Purpose.** The BAC shall be an advisory committee that serves as a channel for employers and employees to help formulate policies and recommendations regarding the provision of benefits and services to members of the system.

**3.1(3) Governmental body.** The BAC is a governmental body as defined by Iowa Code section 21.2(1).

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

**495—3.2(97B) Membership organizations and representatives.**

**3.2(1)** The BAC membership shall number no less than 9 and no more than 14, and the composition of the BAC must at all times meet the specific membership and voting requirements of Iowa Code section 97B.8B. A current list of organizations, appointees, terms and voting status is maintained on IPERS' Internet site.

**3.2(2)** Appointment of BAC representatives. Each membership organization shall appoint a representative to serve on the BAC. All BAC representatives shall provide in writing to IPERS or the chairperson the name, address, and telephone number of and other information about the representative as required by IPERS or the chairperson. The BAC shall not entertain petitions disputing a membership organization's choice of its representative. In addition, a citizen representative who is not a member of IPERS will also serve, pursuant to subrule 3.3(3).

**3.2(3)** Attendance. Any representative shall be deemed to have submitted a resignation from participation in the BAC if either of the following events occurs:

- a. The representative does not attend three or more consecutive regularly scheduled meetings.
- b. The representative attends fewer than one-half of the regularly scheduled meetings of the BAC each fiscal year.

This provision applies only to a period beginning on or after the date when the person assumes the position of representative. In the event that a representative is deemed to have resigned under this provision, the chairperson shall immediately notify the representative's organization and require the appointment of a different representative within 30 days.

If a representative is unable to attend a meeting, an alternate designated by the membership organization may attend the meeting. Attendance by an alternate shall not relieve the regular representative of the responsibility of attendance at regularly scheduled meetings.

**3.2(4)** Replacement of membership organizations due to nonparticipation. If a membership organization, after receiving written notice from the BAC under subrule 3.2(3), fails to appoint a new representative to serve on the BAC, the chairperson shall send a second written notice to that membership organization again requiring that the organization appoint its representative within the next 30 days. The notice shall further state that, in order for the appointment to become effective, the newly appointed representative must also attend the next regularly scheduled BAC meeting. The attendance of an alternative representative at said meeting shall not fulfill the requirements of this subrule.

If the organization does not timely appoint a new representative, or its newly appointed representative does not attend the next regularly scheduled BAC meeting, the organization shall be deemed to have relinquished its seat on the BAC.

When a membership organization has relinquished its seat on the BAC for nonparticipation, the subcommittee on membership shall, as soon as practicable, meet to consider a replacement organization. If a seat relinquished for nonparticipation was not filled and the subcommittee on membership determines that the composition of the BAC would continue to satisfy subrule 3.2(1), the subcommittee on membership may recommend any type of qualified interested organization as a replacement, or it may recommend leaving the seat open. However, if the subcommittee determines that the composition

of the BAC would not satisfy subrule 3.2(1) if a seat relinquished for nonparticipation was not filled, the subcommittee must recommend a replacement, and the replacement must be one that permits the BAC to meet the requirements of subrule 3.2(1).

Any qualified, interested organization may file a petition for consideration as a replacement membership organization. The subcommittee shall review all such petitions, if any, which have been filed after the most recent formal review under this rule. The subcommittee may also solicit petitions for BAC membership from any qualified interested organization.

The subcommittee shall make its recommendation for a replacement membership organization, if any, at the next regularly scheduled BAC meeting or as soon as practicable. The BAC, by a majority vote of the nine voting representatives, shall approve or reject the subcommittee's recommendation.

If the subcommittee's recommendation is rejected and the seat must be filled, the subcommittee shall reconvene as soon as practicable and the foregoing process shall be repeated until such time as the subcommittee's recommendation is approved.

In order to be considered for BAC membership under this rule, an organization must be a "qualified, interested organization." "Qualified, interested organization" means a unit of the executive branch or a formally organized corporation or association representing a viable and identifiable group of covered employers or covered employees as determined by the BAC in its sole discretion.

This subrule shall not be construed to affect the BAC positions reserved for the director of the department of administrative services or the position reserved for a citizen who is not a member of IPERS.

**3.2(5)** Replacement of current membership organizations other than through nonparticipation. A qualified, interested organization that wishes to replace an existing membership organization may petition the BAC to do so. Such petitions for BAC membership must be submitted in writing to the BAC as set forth in this rule and will be considered according to the schedule established below.

An organization petitioning for membership on the BAC must include the official name of the organization, a description of its organizational structure, the number of employers or employees represented, a description of prior activities by that organization regarding IPERS issues, and a brief explanation of the reasons why the organization should be selected as a replacement organization. The petition should also include the name and contact information for the organization's proposed representative and the name and contact information of the person completing the petition.

A formal review of petitions under this rule shall be conducted every three years. IPERS shall provide 60 days' prior written notice of the next formal review session to members who have indicated in writing that they wish to file such a petition. IPERS will provide 60 days' prior written notice of the next formal review to all other potential petitioners through its Internet site.

The subcommittee chosen to make recommendations regarding the replacement of a current membership organization shall not include the individual representing that organization on the BAC. However, any membership organization whose seat is being contested under this rule shall have the opportunity to submit written materials and make oral presentations to the subcommittee in support of its continued existence as a BAC membership organization.

For each formal review, the subcommittee on membership shall review all petitions for membership, if any, that have been filed after the most recent formal review under this rule. The subcommittee may also solicit petitions for BAC membership from any qualified, interested organization.

When one or more qualified, interested organizations have filed a petition to replace a current membership organization, the subcommittee on membership shall meet at least 30 days prior to the next formal review session to determine whether to recommend approval or rejection.

If the subcommittee on membership determines that the composition of the BAC would continue to satisfy subrule 3.2(1) regardless of the type of qualified, interested organization recommended, the subcommittee on membership may recommend any type of qualified, interested organization for a seat being sought under this rule.

However, if the subcommittee on membership determines that the composition of the BAC will only continue to satisfy subrule 3.2(1) if a current membership organization's seat is filled by a certain specific type of organization, the subcommittee on membership must limit its recommendations for approval to

the types of organizations that would permit the composition of the BAC to continue to satisfy subrule 3.2(1).

The subcommittee shall present its recommendation regarding the replacement of a current membership organization at the next regularly scheduled formal review of petitions under this rule. The BAC, by a majority vote of the nine voting representatives, shall approve or reject the subcommittee's recommendation.

If the subcommittee determines that two qualified, interested organizations are competing for the same seat, the subcommittee shall, in its sole discretion, evaluate the competing organizations and make a recommendation that meets the requirements of this rule and takes into consideration the following factors: the number of employers or employees represented, the diversity of the representation, the degree to which the applicable constituents already have BAC representation through other BAC membership organizations, prior involvement in BAC activities, and prior activities as an IPERS advocate in other forums.

If the BAC votes to replace a current membership organization that holds a voting seat with a new membership organization, the replacement membership organization shall complete the remainder of the term for that voting seat. Otherwise, the new membership organization shall be seated as a nonvoting organization. Thereafter, if a vacancy occurs in a voting seat and the new membership organization is qualified to fill that voting seat, the new membership organization may compete for the vacant voting seat.

An organization that petitions for a seat under this rule and after a formal review is not selected must resubmit its petition for membership in order to receive consideration for a seat during the next scheduled formal review.

This subrule shall not be construed to affect the BAC position reserved for the director of the department of administrative services or the position reserved for a citizen who is not a member of IPERS.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

**495—3.3(97B) Voting representatives.** The BAC shall have nine voting representatives. Four shall represent employers, four shall represent members of the system, and one shall be a citizen who is not a member of IPERS.

**3.3(1) Employer voting representatives.** One voting representative shall be the director of the department of administrative services. The remaining employer voting representatives shall be elected by the full membership of the BAC as follows: one shall be a representative of an employer group representing cities, one shall be a representative of an employer group representing counties, and one shall be a representative of an employer group representing local school districts.

**3.3(2) Employee voting representatives.** One voting representative shall be elected by the full membership of the BAC from a membership organization that represents teachers. The other three voting representatives who represent members of the system shall be elected by the full membership of the BAC, with no more than one being the representative of an employee group that solely represents the public safety protection classes.

**3.3(3) Citizen representative.** The citizen representative shall be elected by the eight voting representatives who serve under subrules 3.3(1) and 3.3(2).

**3.3(4) Voting rights.** A membership organization shall be permitted to designate a substitute voting representative to cast the vote of the membership organization at a meeting in the event that the named representative cannot attend the meeting. No membership organization shall have more than one vote on a matter brought before the BAC.

**3.3(5) Terms of voting representatives.** The term of each voting representative shall be three years, beginning and ending as provided in Iowa Code section 97B.8B, except as otherwise indicated in this subrule.

The terms of the voting representatives shall be staggered, so as to maintain an acceptable level of continuity and experience on the BAC.

If a voting representative resigns or is replaced by the appointing organization, the appointing organization shall appoint a successor who shall be a voting member for the remainder of the term in question.

If an organization that is not currently a membership organization successfully petitions to replace a membership organization that is represented by a voting representative, the representative of the replacement membership organization shall complete the remainder of the term of the voting representative in question.

**3.3(6) *Quorum, voting requirements and voting procedures.***

*a. Quorum.* Five voting representatives of the BAC constitute a quorum.

*b. Voting requirements.* A quorum of the BAC must be present, whether the representatives are attending in person or remotely, at the time any vote is taken.

*c. Voting procedures.* The chairperson shall rule as to whether the vote will be by voice or roll call. A roll-call vote shall be taken anytime a voice vote is not unanimous. Minutes of the BAC shall indicate the vote of each voting member if a roll-call vote is taken.

**3.3(7) *Officers and elections.***

*a. Officers.* The officers of the BAC are the chairperson and vice chairperson and shall be elected by a vote of the full membership of the BAC.

*b. Elections.* Election of officers shall take place at the first BAC meeting held at the beginning of each fiscal year. If an officer does not serve out the elected term, a special election shall be held at the first meeting after notice is provided to the BAC to elect a representative to serve out the remainder of the term.

[ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

**495—3.4(97B) Duties.** The BAC shall review and advise on the following matters insofar as they impact benefits and services provided to members and employers under Iowa Code chapter 97B: overall plan design, benefits policy and goals, budget, benchmarking and quality assessment efforts, research and strategic planning. The BAC shall also participate in annual performance evaluations of the chief benefits officer and, when that position becomes vacant, assist the chief executive officer in the process of selecting a replacement. In addition, the BAC shall recommend to the governor at least two nominees for each vacant position on the investment board reserved for active or retired members of the system. The chairperson of the BAC shall solicit nominations for such vacancies from the entire BAC membership and, through a meeting of the BAC, select the names to be forwarded to the governor.

At least every two years, the BAC shall review the benefits and services provided to members; and the voting representatives shall make recommendations to the system, the governor, and the general assembly concerning the benefits and services provided to members and the system's benefits policies and benefits goals. All of the membership of the BAC, including nonvoting representatives, may have input into formulating such recommendations.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

**495—3.5(97B) Meetings.** The BAC shall meet at least quarterly, or at the call of the chairperson, or upon the written request by the chief executive officer. The chairperson shall establish the dates of all regularly scheduled meetings. Unless otherwise specified in the agenda, meetings will be held at IPERS' headquarters, 7401 Register Drive, Des Moines, Iowa.

**3.5(1) *Meeting agenda and minutes.***

*a. Meeting agenda.* The agenda for each meeting will be posted at IPERS' headquarters at least 24 hours prior to the meeting unless, for good cause, notice is impossible or impractical, in which case as much notice as is reasonably possible will be given.

*b. Minutes.* Minutes shall be reviewed and approved by the BAC and maintained by IPERS.

**3.5(2) *Attendance and participation by the public.***

*a. Attendance.* All meetings of the BAC are open to the public and shall be held in accordance with Robert's Rules of Order, Newly Revised. The BAC may exclude the public from portions of the meeting in accordance with Iowa Code section 21.5 (closed session).

*b. Participation.*

(1) Items on agenda. Persons who wish to address the BAC on a matter on the agenda should notify IPERS or the chairperson in writing at least 24 hours prior to the meeting.

(2) Items not on agenda. Persons who wish to address the BAC on a matter not on the agenda should notify IPERS or the chairperson in writing at least five days prior to the meeting.

*c. Coverage by press.* Cameras and recording devices may be used during meetings provided they do not interfere with the orderly conduct of the meeting.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

These rules are intended to implement Iowa Code chapter 97B.

[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]

[Filed 12/1/05, Notice 10/26/05—published 12/21/05, effective 1/25/06]

[Filed 4/7/06, Notice 3/1/06—published 4/26/06, effective 5/31/06]

[Filed 5/3/07, Notice 3/28/07—published 5/23/07, effective 6/27/07]

[Filed ARC 2981C (Notice ARC 2892C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3684C (Notice ARC 3537C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]



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) Patient advocates.** 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.

[ARC 3684C, IAB 3/14/18, effective 4/18/18]

#### **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) Required information.** 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. The Iowa department of administrative services and the Iowa department of corrections shall notify IPERS prior to adding additional job classifications to the protection occupation class. The notification shall include the effective date, names and social security numbers of the employees involved.

**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; ARC 2981C, IAB 3/15/17, effective 4/19/17]

#### **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 state-observed holiday, the wage report is due on the next regularly scheduled business day.

Effective August 1, 2008, IPERS shall accept wage reports electronically via IPERS' employer self-service Internet application or as a paper report. However, for those employers submitting reports other than via IPERS' employer self-service Internet application, 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 state-observed 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 state-observed holiday, the contribution or wage 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 wage report or timely pay a contribution 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 Internet 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 Internet 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

sections 97B.9 and 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 state-observed 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; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

**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<br>July 1, 2007 | Effective<br>July 1, 2008 | Effective<br>July 1, 2009 | Effective<br>July 1, 2010 | Effective<br>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<br>July 1, 2014 | Effective<br>July 1, 2015 | Effective<br>July 1, 2016 | Effective<br>July 1, 2017 | Effective<br>July 1, 2018 |
|---------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| Combined rate | 14.88%                    | 14.88%                    | 14.88%                    | 14.88%                    | 15.73%                    |
| Employer      | 8.93%                     | 8.93%                     | 8.93%                     | 8.93%                     | 9.44%                     |
| Employee      | 5.95%                     | 5.95%                     | 5.95%                     | 5.95%                     | 6.29%                     |

**4.6(2)** Contribution rates for sheriffs and deputy sheriffs are as follows.

|               | Effective<br>July 1, 2014 | Effective<br>July 1, 2015 | Effective<br>July 1, 2016 | Effective<br>July 1, 2017 | Effective<br>July 1, 2018 |
|---------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| Combined rate | 19.76%                    | 19.76%                    | 19.26%                    | 18.76%                    | 19.52%                    |
| Employer      | 9.88%                     | 9.88%                     | 9.63%                     | 9.38%                     | 9.76%                     |
| Employee      | 9.88%                     | 9.88%                     | 9.63%                     | 9.38%                     | 9.76%                     |

**4.6(3)** Contribution rates for protection occupations are as follows.

|               | Effective<br>July 1, 2014 | Effective<br>July 1, 2015 | Effective<br>July 1, 2016 | Effective<br>July 1, 2017 | Effective<br>July 1, 2018 |
|---------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| Combined rate | 16.90%                    | 16.40%                    | 16.40%                    | 16.40%                    | 17.02%                    |
| Employer      | 10.14%                    | 9.84%                     | 9.84%                     | 9.84%                     | 10.21%                    |
| Employee      | 6.76%                     | 6.56%                     | 6.56%                     | 6.56%                     | 6.81%                     |

**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.

*p.* Effective July 1, 2016, a peace officer employed by an institution under the control of the state board of regents whose position requires law enforcement certification pursuant to Iowa Code section 262.13.

*q.* Effective July 1, 2016, a person employed by the department of human services as a psychiatric security specialist at a civil commitment unit for sexually violent offenders facility.

**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; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

**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 using IPERS' employer self-service Internet application. 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, and employer identification number. When an employee terminates employment with a covered employer, the employer shall provide the termination date and the date of the employee's final paycheck.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

**495—4.8(97B) Additional employer contributions from employer-mandated reduction in hours or by the exercise of bumping rights to avoid a layoff.** Rescinded ARC 2981C, IAB 3/15/17, effective 4/19/17.

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.

[Filed 5/21/04, Notice 4/14/04—published 6/9/04, effective 7/14/04]

[Filed emergency 6/4/04—published 6/23/04, effective 7/1/04]

[Filed 7/30/04, Notice 6/23/04—published 8/18/04, effective 9/22/04]

[Filed 11/5/04, Notice 9/15/04—published 11/24/04, effective 12/29/04]

[Filed 5/6/05, Notice 3/30/05—published 5/25/05, effective 7/1/05]

[Filed 12/1/05, Notice 10/26/05—published 12/21/05, effective 1/25/06]

[Filed 4/7/06, Notice 3/1/06—published 4/26/06, effective 5/31/06]

[Filed 11/3/06, Notice 9/27/06—published 11/22/06, effective 12/27/06]

[Filed 5/3/07, Notice 3/28/07—published 5/23/07, effective 6/27/07]

[Filed 3/7/08, Notice 1/2/08—published 3/26/08, effective 4/30/08]

[Filed emergency 6/25/08—published 7/16/08, effective 6/25/08]

[Filed 8/20/08, Notice 7/16/08—published 9/10/08, effective 10/15/08]

[Filed ARC 7591B (Notice ARC 7453B, IAB 12/31/08), IAB 2/25/09, effective 7/1/09]

[Filed Emergency ARC 7759B, IAB 5/6/09, effective 4/17/09]

[Filed ARC 7916B (Notice ARC 7760B, IAB 5/6/09), IAB 7/1/09, effective 8/5/09]

[Filed ARC 8601B (Notice ARC 8477B, IAB 1/13/10), IAB 3/10/10, effective 4/14/10]

[Filed Emergency ARC 8929B, IAB 7/14/10, effective 6/21/10]

[Filed ARC 9068B (Notice ARC 8928B, IAB 7/14/10), IAB 9/8/10, effective 10/13/10]

[Filed ARC 9397B (Notice ARC 9310B, IAB 12/29/10), IAB 2/23/11, effective 3/30/11]  
[Filed ARC 0017C (Notice ARC 9951B, IAB 12/28/11), IAB 2/22/12, effective 3/28/12]  
[Filed ARC 0662C (Notice ARC 0598C, IAB 2/6/13), IAB 4/3/13, effective 5/8/13]  
[Filed ARC 1348C (Notice ARC 1256C, IAB 12/25/13), IAB 2/19/14, effective 3/26/14]  
[Filed ARC 1887C (Notice ARC 1800C, IAB 12/24/14), IAB 2/18/15, effective 3/25/15]  
[Filed ARC 2402C (Notice ARC 2331C, IAB 12/23/15), IAB 2/17/16, effective 3/23/16]  
[Filed ARC 2981C (Notice ARC 2892C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]  
[Filed ARC 3684C (Notice ARC 3537C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

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.

IPERS makes employment determinations based on a common law test, which factors in behavior control, financial control and relationship of the parties. Once this decision is made, if any party disagrees with the decision, the party in disagreement will be required to submit an SS-8 Determination of Workers Status form directly to the Internal Revenue Service (IRS). Upon receipt of the determination by the IRS, IPERS will review this hiring arrangement a second time. A Final Agency Determination will be made at that time.

Further, if a person is performing essential governmental functions that can only be performed by a governmental employee, that person shall be IPERS-covered.

**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.

[ARC 3684C, IAB 3/14/18, effective 4/18/18]

**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.

*g.* An emergency medical care provider who provides emergency medical services, as defined in Iowa Code section 147A.1, and who is not a member of the retirement systems established in Iowa Code chapter 401 or 411 shall 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)** Full-time or part-time students employed part-time by the educational institution where they are enrolled shall not be IPERS-covered. 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. If the employer is not the institution where the college student is enrolled, the college student is not exempt from IPERS coverage and employers would determine IPERS coverage by applying the usual permanent or temporary rules.

High school and lower grade students continue to be exempt from IPERS coverage.

**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 they elect coverage in an alternative retirement system qualified by the state board of regents. An employee must make an election in the alternative retirement system within 60 days of the employee's first day of employment.

**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. An employee must make an election in the alternative retirement system within 60 days of the employee's first day of employment.

**5.2(41)** Volunteer emergency personnel, such as ambulance drivers and emergency medical technicians, 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.1A.

**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; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

**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 the same position held.

[ARC 3684C, IAB 3/14/18, effective 4/18/18]

These rules are intended to implement Iowa Code sections 97B.1A, 97B.4, 97B.42, 97B.42A, 97B.49B, 97B.49C, and 97B.49G.

[Filed 5/21/04, Notice 4/14/04—published 6/9/04, effective 7/14/04]

[Filed 4/7/06, Notice 3/1/06—published 4/26/06, effective 5/31/06]

[Filed 3/7/08, Notice 1/2/08—published 3/26/08, effective 4/30/08]

[Filed ARC 0662C (Notice ARC 0598C, IAB 2/6/13), IAB 4/3/13, effective 5/8/13]

[Filed ARC 2402C (Notice ARC 2331C, IAB 12/23/15), IAB 2/17/16, effective 3/23/16]

[Filed ARC 2981C (Notice ARC 2892C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3684C (Notice ARC 3537C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

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, an identification card or driver's license issued by the state of Iowa, 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; ARC 2981C, IAB 3/15/17, effective 4/19/17]

#### **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 verbal or written 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 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 retirement benefit. Such an elected official or legislator may remain in the elective office and receive an IPERS retirement without violating IPERS' bona fide retirement rules. If such elected official or legislator 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 retirement as of the date of hire, the retirement shall not be made. Furthermore, if such elected official or legislator is reemployed in covered employment, the election to revoke IPERS coverage for the elective position shall remain in effect, and the elected official or legislator 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 or legislator is reelected to the same position without an intervening term out of office.

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.

Effective July 1, 2018, a member will not have a bona fide retirement if the member enters into a verbal or written arrangement to perform duties for the member's former employer(s) as an independent contractor prior to or during the member's first month of entitlement or performs any duties for the member's former employer(s) as an independent contractor prior to receiving four months of retirement benefits.

**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; ARC 3684C, IAB 3/14/18, effective 4/18/18]

#### **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 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 CEO or CEO's designee. 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; ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

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.

[Filed 11/5/04, Notice 9/15/04—published 11/24/04, effective 12/29/04]

[Filed 12/1/05, Notice 10/26/05—published 12/21/05, effective 1/25/06]

[Filed 4/7/06, Notice 3/1/06—published 4/26/06, effective 5/31/06]

[Filed 11/3/06, Notice 9/27/06—published 11/22/06, effective 12/27/06]

[Filed 5/3/07, Notice 3/28/07—published 5/23/07, effective 6/27/07]

[Filed 8/10/07, Notice 7/4/07—published 8/29/07, effective 10/3/07]

[Filed 3/7/08, Notice 1/2/08—published 3/26/08, effective 4/30/08]

[Filed ARC 8601B (Notice ARC 8477B, IAB 1/13/10), IAB 3/10/10, effective 4/14/10]

[Filed Emergency ARC 8929B, IAB 7/14/10, effective 6/21/10]

[Filed ARC 9068B (Notice ARC 8928B, IAB 7/14/10), IAB 9/8/10, effective 10/13/10]

[Filed ARC 0017C (Notice ARC 9951B, IAB 12/28/11), IAB 2/22/12, effective 3/28/12]

[Filed ARC 0662C (Notice ARC 0598C, IAB 2/6/13), IAB 4/3/13, effective 5/8/13]

[Filed ARC 1348C (Notice ARC 1256C, IAB 12/25/13), IAB 2/19/14, effective 3/26/14]

[Filed ARC 1887C (Notice ARC 1800C, IAB 12/24/14), IAB 2/18/15, effective 3/25/15]

[Filed ARC 2402C (Notice ARC 2331C, IAB 12/23/15), IAB 2/17/16, effective 3/23/16]

[Filed ARC 2981C (Notice ARC 2892C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3684C (Notice ARC 3537C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]



CHAPTER 31  
AGENCY PROCEDURE FOR RULE MAKING

**495—31.1(17A) Applicability.** Except to the extent otherwise expressly provided by statute, all rules adopted by the Iowa Public Employees' Retirement System are subject to the provisions of Iowa Code chapter 17A, the Iowa administrative procedure Act, and the provisions of this chapter.

**495—31.2(17A,ExecOrd80) Advice on possible rules before notice of proposed rule adoption.**

**31.2(1)** IPERS shall designate the benefits advisory committee (BAC), and investment board as applicable, as the stakeholder rule-making group, pursuant to the rules for creation, public notice, procedures, public input, and results as outlined in Executive Order Number 80. The stakeholder group shall review and comment on any proposed rule changes before the rules are considered to be pending, as defined in subrule 31.3(2).

**31.2(2)** In addition to seeking information by other methods, the agency may, before publication of a Notice of Intended Action under Iowa Code section 17A.4(1) "a," solicit comments from the public by any reasonable means on a subject matter of possible rule making by the agency. Notwithstanding the foregoing, except as otherwise provided by law, the agency may use its own experience, specialized knowledge, and judgment in the adoption of a law.

[ARC 2981C, IAB 3/15/17, effective 4/19/17; ARC 3684C, IAB 3/14/18, effective 4/18/18]

**495—31.3(17A) Public rule-making docket.**

**31.3(1)** *Docket maintained.* The agency shall maintain a current public rule-making docket.

**31.3(2)** *Pending rule-making proceedings.* 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 of a Notice of Intended Action pursuant to Iowa Code section 17A.4(1) "a," to the time it is terminated, by publication of a Notice of Termination in the Iowa Administrative Bulletin or the effective date of the rule. 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 the 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 and any agency determinations with respect thereto;
- h. Any known timetable for agency decisions or other action in the proceeding;
- i. The date of the rule's adoption;
- j. The dates of the rule's filing, indexing, and publication;
- k. The date on which the rule will become effective; and
- l. Where the rule-making record may be inspected.

**31.3(3)** *Rule-making Internet site.* The agency will maintain a page on its Internet site, and its rules filings will appear on the state of Iowa's Iowa administrative rules Internet site, pursuant to the requirements of Iowa Code section 17A.6A.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

**495—31.4(17A) Notice of proposed rule making.**

**31.4(1)** *Contents.*

a. At least 35 days before the adoption of a rule, the agency shall cause Notice of Intended Action to be published in the Iowa Administrative Bulletin. The Notice of Intended Action shall include:

- (1) A brief explanation of the purpose of and the reason for the proposed rule;
- (2) A brief explanation of the principal reasons for the agency's failure to provide for a waiver in a rule and the reasons for overruling considerations urged against the rule;
- (3) The specific legal authority for the proposed rule;
- (4) Except to the extent impracticable, the text of the proposed rule;
- (5) Where, when, and how persons may present their views on the proposed rule;
- (6) Where, when, and how persons may request an oral proceeding on the proposed rule if the notice does not already provide for one; and
- (7) A fiscal impact statement as described under rule 495—31.7(17A,25B).

Where inclusion of the complete text of a proposed rule in the Notice of Intended Action is impracticable, the agency 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 agency for the resolution of each of those issues.

*b.* If requested by an interested person, the agency shall issue a concise statement of the principal reasons for and against the rule adopted, pursuant to Iowa Code section 17A.4(2).

**31.4(2) *Incorporation by reference.*** A proposed rule may incorporate other materials by reference only if it complies with all of the requirements applicable to the incorporation by reference of other materials in an adopted rule that are contained in subrule 31.12(2).

**31.4(3) *Copies of notices.*** The agency shall submit a copy of the notice to the chairpersons and ranking members of the appropriate standing committees of the general assembly as required by Iowa Code section 17A.4(1) "a."

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

#### **495—31.5(17A) Public participation.**

**31.5(1) *Written comments.*** For at least 20 days after publication of a Notice of Intended Action, persons may submit arguments, data, and views, in writing, on the subject matter of the published notice. Such written submissions should identify each proposed rule to which they relate and should be submitted to the person and address designated in the Notice of Intended Action.

**31.5(2) *Oral proceedings.*** The agency may, at any time, schedule an oral proceeding on a Notice of Intended Action. The agency shall schedule an oral proceeding 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 agency 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 additional information:

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

*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.

*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.

**31.5(3) *Conduct of oral proceedings.***

*a. Applicability.* This subrule 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," or this chapter.

*b. Scheduling and notice.* An oral proceeding on a Notice of Intended Action may be held at IPERS, 7401 Register Drive, Des Moines, Iowa, 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 applicable Notice of Intended Action by ARC number and citation to the Iowa Administrative Bulletin.

*c. Presiding officer.* The agency, through an employee of the agency, who is familiar with the substance of the rules proposed in the Notice of Intended Action, shall preside at the oral proceeding. The presiding officer shall record the oral proceeding and archive the recorded record at IPERS.

*d. Conduct of proceeding.* At an oral proceeding on a Notice of Intended Action, persons may make oral statements and make documentary and physical submissions, which may include data, views, comments or arguments concerning the subject matter of the rules proposed in the Notice of Intended Action. Persons wishing to make oral presentations at such a proceeding are encouraged to notify the agency 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 electronic means.

(1) At the beginning of an oral proceeding, the presiding officer shall give a brief synopsis of the subject matter of the rules proposed in the Notice of Intended Action, a statement of the statutory authority for each proposed rule, and the reasons for the agency's decision to propose each rule. The presiding officer may place time limitations on individual oral presentations when necessary to ensure the orderly and expeditious conduct of an 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 views.

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

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

(4) The presiding officer shall have the authority to take any reasonable action necessary for the orderly conduct of a meeting.

(5) Physical and documentary submissions presented by participants in an oral proceeding shall be submitted to the presiding officer. Such submissions become the property of the agency.

(6) An oral proceeding may be continued by the presiding officer to a later time without notice other than by announcement at the hearing.

(7) 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.

(8) 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.

**31.5(4) Additional information.** In addition to receiving written comments and oral presentations according to the provisions of this rule, the agency may obtain information concerning its proposed rules through any other lawful means deemed appropriate under the circumstances.

**31.5(5) Accessibility.** The agency shall schedule oral proceedings in rooms accessible to and functional for persons with physical disabilities. Persons who have special requirements should contact the person designated in the Notice of Intended Action at the telephone number or address provided in the Notice of Intended Action in advance of the proceeding to arrange access or other needed services.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

#### **495—31.6(17A) Regulatory analysis.**

**31.6(1) Definition of small business.** A “small business” is defined in Iowa Code section 17A.4A(8)“a.”

**31.6(2) Mailing list.** Small businesses or organizations of small businesses may be registered on the agency's small business impact list by making a written application addressed to IPERS, 7401 Register Dr., P.O. Box 9117, Des Moines, Iowa 50306-9117. 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 qualify as a small business shall indicate that fact; and
- e. Whether the registrant desires copies of Notices of Intended Action at cost, or desires advance notice of the subject of all or some specific category of proposed rule making affecting small business.

The agency 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 agency may periodically send a letter to each registered small business 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.

**31.6(3) *Time of mailing.*** Within seven days after submission of a Notice of Intended Action to the administrative rules coordinator for publication in the Iowa Administrative Bulletin, the agency 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. In the case of a rule that may have an impact on small business adopted in reliance upon Iowa Code section 17A.4(2), the agency 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.

**31.6(4) *Qualified requesters for regulatory analysis—economic impact.*** The agency shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4A(2) "a" after a proper request from:

- a. The administrative rules coordinator;
- b. The administrative rules review committee.

**31.6(5) *Qualified requesters for regulatory analysis—business impact.*** The agency shall issue a regulatory analysis of a proposed rule that conforms to the requirements of Iowa Code section 17A.4A(2) "b" 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;
- d. An organization representing at least 25 small businesses. That organization shall list the name, address and telephone number of not less than 25 small businesses it represents.

**31.6(6) *Time period for analysis.*** Upon receipt of a timely request for a regulatory analysis, the agency shall adhere to the time lines described in Iowa Code section 17A.4A(4).

**31.6(7) *Contents of request.*** A request for a regulatory analysis is made when it is mailed or delivered to the agency. The request shall be in writing and satisfy the requirements of Iowa Code section 17A.4A(1).

**31.6(8) *Contents of concise summary.*** The contents of the concise summary shall conform to the requirements of Iowa Code sections 17A.4A(2), 17A.4A(5) and 17A.4A(6).

**31.6(9) *Publication of a concise summary.*** The agency shall make available, to the maximum extent feasible, copies of the published summary in conformance with Iowa Code section 17A.4A(5).

**31.6(10) *Regulatory analysis contents—rules review committee or rules coordinator.*** 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 Iowa Code section 17A.4A(2) "a," unless a written request expressly waives one or more of the items listed in the section.

**31.6(11) *Regulatory analysis contents—substantial impact on small business.*** 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, the regulatory analysis shall conform to the requirements of Iowa Code section 17A.4A(2) “b.”  
[ARC 2981C, IAB 3/15/17, effective 4/19/17]

**495—31.7(17A,25B) Fiscal impact statement.**

**31.7(1)** A proposed rule that mandates additional combined expenditures exceeding \$100,000 or combined expenditures of at least \$500,000 within five years by all affected political subdivisions, the agency itself, or agencies and entities which contract with political subdivisions to provide services shall be accompanied by a fiscal impact statement outlining the costs associated with the rule. A fiscal impact statement shall satisfy the requirements of Iowa Code section 25B.6.

**31.7(2)** If the agency determines at the time it adopts a rule that the fiscal impact statement upon which the rule is based contains errors, the agency shall, at the same time, issue a corrected fiscal impact statement and publish the corrected fiscal impact statement in the Iowa Administrative Bulletin.

**495—31.8(17A) Time and manner of rule adoption.**

**31.8(1)** *Time of adoption.* The agency 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 agency shall adopt a rule pursuant to the rule-making proceeding or terminate the proceeding by publication of a notice to that effect in the Iowa Administrative Bulletin.

**31.8(2)** *Consideration of public comment.* Before the adoption of a rule, the agency shall consider fully all of the written submissions and oral submissions received in that rule-making proceeding or any memorandum summarizing such oral submissions, and any regulatory analysis or fiscal impact statement issued in that rule-making proceeding.

**31.8(3)** *Reliance on agency expertise.* Except as otherwise provided by law, the agency may use its own experience, technical competence, specialized knowledge, and judgment in the adoption of a rule.

**495—31.9(17A) Variance between adopted rule and published notice of proposed rule adoption.**

**31.9(1)** The agency shall not adopt a rule that differs from the rule proposed in a Notice of Intended Action on which the rule is based unless:

- a. 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
- b. The differences are a logical outgrowth of the contents of that Notice of Intended Action and the comments submitted in response thereto; and
- c. The Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question.

**31.9(2)** In determining whether a Notice of Intended Action provided fair warning that the outcome of that rule-making proceeding could be the rule in question, the agency shall consider the following factors:

- a. The extent to which persons who will be affected should have understood that the rule making on which it is based could affect their interests;
- b. The extent to which the subject matter or the issues determined by the adopted rule are different from the subject matter or issues contained in the Notice of Intended Action; and
- c. The extent to which the effects of the adopted rule differ from the effects of the proposed rule contained in the Notice of Intended Action.

**31.9(3)** The agency shall commence a rule-making proceeding within 60 days of its receipt of a petition for rule making seeking the amendment or repeal of an adopted rule that differs from the proposed rule contained in the Notice of Intended Action upon which the adopted rule is based, unless the agency finds that the differences are so insubstantial as to make such a rule-making proceeding wholly unnecessary. A copy of any such finding and the petition to which it responds shall be sent to petitioner, the administrative rules coordinator, and the administrative rules review committee, within three days of its issuance.

**31.9(4)** Concurrent rule-making proceedings. Nothing in this rule sets aside the discretion of the agency to initiate, concurrently, several different rule-making proceedings on the same subject each with its appropriate Notice of Intended Action.

**495—31.10(17A) Exemptions from public rule-making procedures.**

**31.10(1)** *Omission of notice and comment.* To the extent the agency 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 or set of rules, the agency may adopt that rule or set of rules without publishing advance Notice of Intended Action in the Iowa Administrative Bulletin and without providing for written or oral public submissions prior to adoption. The agency shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

**31.10(2)** *Categories exempt.* The following narrowly tailored categories of rules are exempted from the usual public notice and participation requirements because those requirements are unnecessary, impracticable, or contrary to the public interest with respect to each category:

- a. Rules that implement nondiscretionary federal law;
- b. Rules that implement nondiscretionary state law;
- c. Rules implementing contribution rates recommended by IPERS;
- d. Minor changes such as grammar, punctuation, spelling and other scrivener's errors that are otherwise nonsubstantive and serve only to make a correction; and
- e. Any other categories added to this list by rule making where such an exemption is justified.

**31.10(3)** *Public proceedings on rules adopted without them.* The agency may, at any time, commence a standard rule-making proceeding for the adoption of a rule that is identical or similar to a rule adopted in reliance upon subrule 31.10(1). Upon written petition by a governmental subdivision, the administrative rules review committee, an agency, the administrative rules coordinator, an association having not less than 25 members, or at least 25 persons, the agency shall commence a standard rule-making proceeding for any rule specified in the petition that was adopted in reliance upon subrule 31.10(1). Such a petition must be filed within one year of the publication of the specified rule in the Iowa Administrative Bulletin as an adopted rule. A rule-making proceeding on that rule must be commenced within 60 days of the receipt of such a petition. After a standard rule-making proceeding commenced pursuant to this subrule, the agency may either readopt the rule it adopted without benefit of all usual procedures on the basis of subrule 31.10(1), or may take any other lawful action, including the amendment or repeal of the rule in question, with whatever further proceedings are appropriate.

**495—31.11(17A) Concise statement of reasons.**

**31.11(1)** *General.* 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 agency shall issue a concise statement of reasons for the rule. Requests for such a statement must be in writing and be delivered to the person designated in the Notice of Intended Action at the address designated in the Notice of Intended Action. 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.

**31.11(2)** *Contents.* The concise statement of reasons shall contain:

- a. The reasons for adopting the particular 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 agency's reasons for overruling the arguments made against the rule.

**31.11(3)** *Time of issuance.* After a proper request, the agency 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.

**495—31.12(17A) Contents, style, and form of rules.**

**31.12(1) Contents.** Each rule making by the agency shall contain the text of each rule and, in addition:

- a.* The date the agency adopted the rule;
- b.* A brief explanation of the principal reasons for the rule-making action if such reasons are required by Iowa Code section 17A.4A(1)“b,” or the agency in its discretion decides to include such reasons;
- 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.* Effective July 1, 1999, if the agency has not included the subject matter of the proposed rule in a separate rule listing categories of rules for which no waiver provision will be included, a brief explanation of the principal reasons for the failure to provide for waivers to the rule if no waiver provision is included and a brief explanation of any waivers or special exceptions provided in the rule if such reasons are required by Iowa Code section 17A.4A(1)“b,” or the agency in its discretion decides to include such reasons; and
- g.* The effective date of the rule.

**31.12(2) Incorporation by reference.** The agency may incorporate by reference in a proposed or adopted rule, and without causing publication of the incorporated material in full, all or any part of a code, standard, rule, or other matter if the agency finds that the incorporation of its text in the agency proposed or adopted rule would be unduly cumbersome, expensive, or otherwise inexpedient. The reference in the agency proposed or adopted rule shall fully and precisely identify the incorporated material by location, title, citation, date, and edition, if any; and may state that the proposed or adopted rule includes any later amendments or editions of the proposed material that are binding on the agency by state or federal law or regulation. The agency may incorporate such material by reference in a proposed or adopted rule if copies are readily available to the public at the agency’s headquarters. The agency shall retain permanently a copy of materials that are incorporated by reference in a rule. Copies of incorporated material may be obtained at cost from the agency.

**31.12(3) References to materials not published in full.** When the administrative code editor decides to omit the full text of a proposed or adopted rule because publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient, the agency shall prepare and submit to the administrative code editor for inclusion in the Iowa Administrative Bulletin and Iowa Administrative Code a summary statement describing the specific subject matter of 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 agency. The agency will provide a copy of that full text at actual cost upon request and shall ensure that copies of the full text are available for review at the state law library and may make the standards available electronically.

At the request of the administrative code editor, the agency shall provide a statement explaining why publication of the full text would be unduly cumbersome, expensive, or otherwise inexpedient.

**31.12(4) Style and form.** In preparing its rules, the agency shall follow the uniform numbering system, form, and style prescribed by the administrative rules coordinator.

**495—31.13(17A) Agency rule-making record.**

**31.13(1) Requirement.** The agency shall maintain for each separate rule making an index listing and summarizing the rules being proposed, adopted, amended or repealed. In addition, the agency shall maintain a rule-making record as described in subrule 31.13(2) for each separate rule making that it proposes, adopts, or terminates under the provisions of Iowa Code chapter 17A and this chapter. These

indices and rule-making records, including materials incorporated by reference, are available for public inspection at IPERS' headquarters.

**31.13(2) Contents of rule-making record.** The agency shall maintain a file containing the indices from each separate rule making that it proposes, adopts, or terminates under the provisions of Iowa Code chapter 17A and this chapter. This file shall also include information showing the date of publication in the Iowa Administrative Bulletin and ARC number where each applicable rule making was published. Each separate rule-making record shall contain:

*a.* Copies of all publications in the Iowa Administrative Bulletin with respect to a rule making and any file-stamped copies of agency submissions to the administrative rules coordinator concerning the rule making;

*b.* All written petitions for declaratory orders, all requests for rule makings, all submissions by a governmental subdivision, the administrative rules review committee, an agency, the administrative rules coordinator, an association having not less than 25 members, or at least 25 persons, 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 agency and considered in connection with the formulation, proposal, or adoption of a rule or the proceeding upon which a rule is based, except to the extent the agency 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 agency shall identify in the record the particular materials deleted and state the reasons for that deletion;

*c.* Any official transcript of oral presentations made in the rule-making proceedings 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;

*d.* A copy of any regulatory analysis or fiscal impact statement prepared for the rule-making proceedings;

*e.* A copy of the rule and any concise statement of reasons prepared for the rule;

*f.* All petitions for amendment, repeal or suspension of the rule;

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

*h.* A copy of any objection to a rule filed by the administrative rules review committee, the governor, or the attorney general pursuant to Iowa Code section 17A.4(4), and any agency response to such objection;

*i.* A copy of any significant criticism of the rule, including a summary of any petitions for waiver of a rule; and

*j.* A copy of any executive order concerning the rule.

**31.13(3) Effect of record.** Except as otherwise required by a provision of law, the agency rule-making record required by this rule need not constitute the exclusive basis for agency action on a rule.

**31.13(4) Maintenance of record.** The agency shall maintain the rule-making record for a period of not less than five years from the date the rules to which it pertains became effective.

**495—31.14(17A) Filing of rules.** The agency shall file each rule it adopts in the office of the administrative rules coordinator. The filing must be executed as soon after adoption of 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 were issued with respect to that rule. If a fiscal impact statement or statement of reasons for that rule was not issued until a time subsequent to 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 agency shall use the standard form prescribed by the administrative rules coordinator.

**495—31.15(17A) Effectiveness of rules prior to publication.**

**31.15(1) *Grounds.*** The agency 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 it 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 agency shall incorporate the required finding and a brief statement of its supporting reasons in each rule adopted in reliance upon this subrule.

**31.15(2) *Special notice.*** When the agency 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 agency 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 agency 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 agency of utilizing each of those alternatives, and the harm suffered by affected persons from any lack of notice concerning the contents of the rule prior to its indexing and publication. 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 one or more 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.

**495—31.16(17A) General statements of policy.**

**31.16(1) *Compilation, indexing, public inspection.*** The agency 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(11)“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(11)“f,” or otherwise authorized by law to be kept confidential, the compilation must be made available for public inspection and copying.

**31.16(2) *Enforcement of requirements.*** A general statement of policy subject to the requirements of this subrule shall not be relied on by the agency to the detriment of any person who does not have actual, timely knowledge of the contents of the statement until the requirements of subrule 31.16(1) are satisfied. This provision is inapplicable to the extent necessary to avoid imminent peril to the public health, safety, or welfare.

**495—31.17(17A) Review by agency of rules.**

**31.17(1) *Periodic comprehensive reviews.*** Beginning July 1, 2012, over each five-year period of time, the agency shall conduct an ongoing and comprehensive review of all of its rules, to identify and eliminate all rules of the agency that are outdated, redundant, or inconsistent or incompatible with the federal tax law requirements for a qualified plan, statute or its own rules or that of other agencies, pursuant to Iowa Code section 17A.7(2).

**31.17(2) *Petition for adoption, amendment or repeal of rules.***

*a.* Any interested person may petition the agency requesting the adoption, amendment, or repeal of a rule. The agency shall prescribe by rule the form for petitions and the procedure for their submission, consideration, and disposition, pursuant to Iowa Code section 17A.7(1).

*b.* Any interested person, association, agency, or political subdivision may submit a written request to the administrative rules coordinator requesting the agency to conduct a formal review of a specified rule. Upon approval of that request by the administrative rules coordinator, the agency shall conduct a formal review of a specified rule to determine whether a new rule should be adopted or the rule should

be amended or repealed. The agency 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.

**31.17(3) Report responsive to request for review.** In conducting the formal review, the agency shall prepare within a reasonable time a written report summarizing its findings, its supporting reasons, and any proposed course of action. The report must include a concise statement of the agency's findings regarding the rule's effectiveness in achieving its objectives, including a summary of any available supporting data. The report shall also concisely describe significant written criticisms of the rule received during the previous five years, including a summary of any petitions for waiver of the rule received by the agency or granted by the agency. The report shall describe alternative solutions to resolve the criticisms of the rule, the reasons any were rejected, and any changes made in the rule in response to the criticisms as well as the reasons for the changes. A copy of the agency's report shall be sent to the administrative rules review committee and the administrative rules coordinator. The report must also be available for public inspection.

[ARC 2981C, IAB 3/15/17, effective 4/19/17]

These rules are intended to implement Iowa Code chapter 17A and Executive Order Number 80 of 2012.

[Filed 12/17/03, Notice 11/12/03—published 1/7/04, effective 2/11/04]

[Filed ARC 2981C (Notice ARC 2892C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3684C (Notice ARC 3537C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

## **ENVIRONMENTAL PROTECTION COMMISSION[567]**

Former Water, Air and Waste Management[900], renamed by 1986 Iowa Acts, chapter 1245, Environmental Protection Commission under the “umbrella” of the Department of Natural Resources.

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TITLE II  
AIR QUALITY

## CHAPTER 20

## SCOPE OF TITLE—DEFINITIONS

[Prior to 12/3/86, Water, Air and Waste Management[900]]

**567—20.1(455B,17A) Scope of title.** The department has jurisdiction over the atmosphere of the state to prevent, abate and control air pollution, by establishing standards for air quality and by regulating potential sources of air pollution through a system of general rules or specific permits. The construction and operation of any new or existing stationary source which emits or may emit any air pollutant requires a specific permit from the department, unless exempted by the department.

This chapter provides general definitions applicable to this title.

Chapter 21 contains the provisions requiring compliance schedules, allowing for variances, and setting forth the emission reduction program. Chapter 22 contains the standards and procedures for the permitting of emission sources. Chapter 23 contains the air emission standards for contaminants. Chapter 24 provides for the reporting of excess emissions and the equipment maintenance and repair requirements. Chapter 25 contains the testing and sampling requirements for new and existing sources. Chapter 26 identifies air pollution emergency episodes and the preplanned abatement strategies. Chapter 27 sets forth the conditions political subdivisions must meet in order to secure acceptance of a local air pollution control program. Chapter 28 identifies the state ambient air quality standards. Chapter 29 sets forth the qualifications for an observer for reading visible emissions. Chapter 30 sets forth requirements to pay fees for specified activities. Chapter 31 contains rules for the nonattainment major new source review (NSR) program and general conformity. Chapter 32 specifies requirements for conducting the animal feeding operations field study. Chapter 33 contains special regulations and construction permit requirements for major stationary sources and includes the requirements for prevention of significant deterioration (PSD). Chapter 34 contains provisions for air quality emissions trading programs. Chapter 35 specifies the requirements for the department to provide financial assistance to eligible applicants for the purpose of reducing air pollution emissions.

All dates specified in reference to the Code of Federal Regulations (CFR) are the dates of publication of the last amendments to the portion of the CFR being cited.

[ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 2949C, IAB 2/15/17, effective 3/22/17]

**567—20.2(455B) Definitions.** For the purpose of these rules, the following terms shall have the meaning indicated in this chapter. The definitions set out in Iowa Code section 455B.411 shall be considered to be incorporated verbatim in these rules.

*“Air pollution alert”* means that action condition declared when the concentrations of air contaminants reach the level at which the first stage control actions are to begin.

*“Air pollution emergency”* means that action condition declared when the air quality is continuing to degrade to a level that should never be reached, and that the most stringent control actions are necessary.

*“Air pollution episode”* means a combination of forecast or actual meteorological conditions and emissions of air contaminants which may or do present an imminent and substantial endangerment to the health of persons, during which the chief meteorological factors are the absence of winds that disperse air contaminants horizontally and a stable atmospheric layer which tends to inhibit vertical mixing through relatively deep layers.

*“Air pollution forecast”* means an air stagnation advisory issued to the department, the commission, and to appropriate air pollution control agencies by an authorized Air Stagnation Advisory Office of the National Weather Service predicting that meteorological conditions conducive to an air pollution episode may be imminent. This advisory may be followed by a prediction of the duration and termination of such meteorological conditions.

*“Air pollution warning”* means that action condition declared when the air quality is continuing to degrade from the levels classified as an air pollution alert, and where control actions in addition to those conducted under an air pollution alert are necessary.

“*Air quality standard*” means an allowable level of air contaminant or atmospheric air concentration established by the commission.

“*Ambient air*” means that portion of the atmosphere, external to buildings, to which the general public has access. Ambient air does not include the atmosphere over land owned or controlled by the source and to which public access is precluded by a fence or other physical barriers.

“*Anaerobic lagoon*” means an impoundment, the primary function of which is to store and stabilize organic wastes. The impoundment is designed to receive wastes on a regular basis and the design waste loading rates are such that the predominant biological activity in the impoundment will be anaerobic. An anaerobic lagoon does not include:

a. A runoff control basin which collects and stores only precipitation induced runoff from an open feedlot feeding operation; or

b. A waste slurry storage basin which receives waste discharges from confinement feeding operations and which is designed for complete removal of accumulated wastes from the basin at least semiannually; or

c. Any anaerobic treatment system which includes collection and treatment facilities for all off gases.

“*ASME*” means the American Society of Mechanical Engineers.

“*ASTM*” means the American Society for Testing and Materials.

“*Auxiliary fuel firing equipment*” means equipment to supply additional heat, by the combustion of an auxiliary fuel, for the purpose of attaining temperatures sufficient to dry and ignite the waste material, to maintain ignition thereof, and to promote complete combustion of combustible gases, solids and vapors.

“*Backyard burning*” means the disposal of residential waste by open burning on the premises of the property where such waste is generated.

“*Biodiesel fuel*” means a renewable, biodegradable, mono alkyl ester combustible liquid fuel derived from agricultural plant oils or animal fat such as, but not limited to, soybean oil. For purposes of this definition, “biodiesel fuel” must also meet the specifications of American Society for Testing and Material Specifications (ASTM) D 6751-02, “Standard Specification for Biodiesel Fuel (B100) Blend Stock for Distillate Fuels,” and be registered with the U.S. Environmental Protection Agency as a fuel and a fuel additive under Section 211(b) of the Clean Air Act, 42 U.S.C. Sections 7401, et seq. as amended through November 15, 1990.

“*Btu*” means British thermal unit, the quantity of heat required to raise the temperature of one pound of water from 59°F to 60°F.

“*Carbonaceous fuel*” means any form of combustible matter (whether solid, liquid, vapor or gas) consisting primarily of carbon-containing compounds in either fixed or volatile form, and which is burned primarily for its heat content.

“*Chimney or stack*” means any flue, conduit or duct permitting the discharge or passage of air contaminants into the open air, or constructed or arranged for this purpose.

“*COH/1,000 linear feet*” means coefficient of haze per 1,000 linear feet, which is a measure of the optical density of a filtered deposit of particulate matter as given in ASTM Standard D-1704-61, and indicated by the following formula:

$$\text{COH/1,000 linear feet} = \frac{(\text{Area tape, ft}^2)(100,000)}{(\text{Volume of air sample, ft}^3)} \log \frac{100}{\% \text{ transmission}}$$

“*Combustion for indirect heating*” means the combustion of fuel to produce usable heat that is to be transferred through a heat-conducting materials barrier or by a heat storage medium to a material to be heated so that the material being heated is not contacted by, and adds no substance to, the products of combustion.

“*Control equipment*” means any equipment that has the function to prevent the formation of or the emission to the atmosphere of air contaminants from any fuel burning, incinerator or process equipment.

“*Country grain elevator*” shall have the same definition as “country grain elevator” set forth in 567—subrule 22.10(1).

“*Criteria*” means information used as guidelines for decisions when establishing air quality goals, air quality standards and the various air quality levels, and which in no case is to be confused or used interchangeably with air quality goals or standards.

“*Diesel fuel*” means a low sulfur fuel oil that complies with the specifications for grade 1-D or 2-D, as defined by the American Society of Testing and Materials (ASTM) D 975-02, “Standard Specification for Diesel Fuel Oils,” grade 1-GT or 2-GT, as defined by ASTM D 2880-00, “Standard Specification for Gas Turbine Fuel Oils,” or grade 1 or 2, as defined by ASTM D 396-02, “Standard Specification for Fuel Oils.”

1. For purposes of the air quality rules contained in Title II, and unless otherwise specified, diesel fuel may contain a blend of up to 2.0 percent biodiesel fuel, by volume, as “biodiesel fuel” is defined in this rule.

2. The department shall consider air pollutant emissions calculations for the biodiesel fuel blends specified in numbered paragraph “1” to be equivalent to the air pollutant emissions calculations for unblended diesel fuel.

3. Construction permits or operating permits issued under 567—Chapter 22 which restrict equipment fuel use to diesel fuel shall be considered by the department to include the biodiesel fuel blends specified in numbered paragraph “1,” unless otherwise specified in 567—Chapter 22 or in a permit issued under 567—Chapter 22.

“*Director*” means the director of the department of natural resources or the director’s designee.

“*Electric furnace*” means a furnace in which the melting and refining of metals are accomplished by means of electrical energy.

“*Emergency generator*” means any generator of which the sole function is to provide emergency backup power during an interruption of electrical power from the electric utility. An emergency generator does not include:

1. Peaking units at electric utilities; or
2. Generators at industrial facilities that typically operate at low rates, but are not confined to emergency purposes; or
3. Any standby generators that are used during time periods when power is available from the electric utility.

An emergency is an unforeseeable condition that is beyond the control of the owner or operator.

“*Emission limitation*” and “*emission standard*” mean a requirement established by a state, local government, or the administrator which limits the quantity, rate or concentration of emissions of air pollutants on a continuous basis, including any requirements which limit the level of opacity, prescribe equipment, set fuel specifications or prescribe operation or maintenance procedures for a source to ensure continuous emission reduction.

“*EPA conditional method*” means any method of sampling and analyzing for air pollutants that has been validated by the administrator but that has not been published as an EPA reference method.

“*EPA reference method*” means the following methods used for performance tests and continuous monitoring systems:

1. Performance test (stack test). A stack test shall be conducted according to EPA reference methods specified in 40 CFR 51, Appendix M (as amended through August 30, 2016); 40 CFR 60, Appendix A (as amended through August 30, 2016); 40 CFR 61, Appendix B (as amended through August 30, 2016); and 40 CFR 63, Appendix A (as amended through August 30, 2016).

2. Continuous monitoring systems. Minimum performance specifications and quality assurance procedures for performance evaluations of continuous monitoring systems are as specified in 40 CFR 60, Appendix B (as amended through August 30, 2016); 40 CFR 60, Appendix F (as amended through August 30, 2016); 40 CFR 75, Appendix A (as amended through August 30, 2016); 40 CFR 75, Appendix B (as amended through August 30, 2016); and 40 CFR 75, Appendix F (as amended through August 30, 2016).

*“Equipment”* means equipment capable of emitting air contaminants to produce air pollution such as fuel burning, combustion or process devices or apparatus including but not limited to fuel-burning equipment, refuse burning equipment used for the burning of fuel or other combustible material from which the products of combustion are emitted; and including but not limited to apparatus, equipment or process devices which generate heat and may emit products of combustion, and manufacturing, chemical, metallurgical or mechanical apparatus or process devices which may emit smoke, particulate matter or other air contaminants.

*“Excess air”* means that amount of air supplied in addition to the theoretical quantity necessary for complete combustion of all fuel or combustible waste material present.

*“Excess emission”* means any emission which exceeds any applicable emission standard prescribed in 567—Chapter 23 or rule 567—22.4(455B), 567—22.5(455B), 567—31.3(455B), or 567—33.3(455B) or any emission limit specified in a permit or order.

*“Existing equipment”* means equipment, machines, devices or installations that are in operation prior to September 23, 1970.

*“Foundry cupola”* means a stack-type furnace used for melting of metals consisting of, but not limited to, the furnace proper, tuyeres, fans or blowers, tapping spout, charging equipment, gas cleaning devices and other auxiliaries.

*“Fugitive dust”* means any airborne solid particulate matter emitted from any source other than a flue or stack.

*“Garbage”* means all solid and semisolid putrescible and nonputrescible animal and vegetable wastes resulting from the handling, preparing, cooking, storing and serving of food or of material intended for use as food, but excluding recognized industrial by-products.

*“Gas cleaning device”* means a facility designed to remove air contaminants from gases exhausted from equipment as defined herein.

*“Goal”* means a level of air quality which is expected to be obtained.

*“Grain processing”* means the equipment, or the combination of different types of equipment, used in the processing of grain to produce a product primarily for wholesale or retail sale for human or animal consumption, including the processing of grain for production of biofuels, except for “feed mill equipment,” as “feed mill equipment” is defined in rule 567—22.10(455B).

*“Grain storage elevator”* means any plant or installation at which grain is unloaded, handled, cleaned, dried, stored, or loaded and that is located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant which has a permanent grain storage capacity (grain storage capacity which is inside a building, bin, or silo) of more than 35,200 m<sup>3</sup> (ca. 1 million U.S. bushels).

*“Greenhouse gas”* means carbon dioxide, methane, nitrous oxide, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride.

*“Heating value”* means the heat released by combustion of one pound of waste or fuel measured in Btu on an as received basis. For solid fuels, the heating value shall be determined by use of ASTM Standard D2015-66.

*“Incinerator”* means a combustion apparatus designed for high temperature operation in which solid, semisolid, liquid or gaseous combustible refuse is ignited and burned efficiently, and from which the solid residues contain little or no combustible material.

*“Initiation of construction, installation or alteration”* means significant permanent modification of a site to install equipment, control equipment or permanent structures. Not included are activities incident to preliminary engineering, environmental studies, or acquisition of a site for a facility.

*“Landscape waste”* means any vegetable or plant wastes except garbage. The term includes trees, tree trimmings, branches, stumps, brush, weeds, leaves, grass, shrubbery and yard trimmings.

*“Level”* means a certain specified degree, quality or characteristic.

*“Malfunction”* means any sudden and unavoidable failure of control equipment or of a process to operate in a normal manner. Any failure that is caused entirely or in part by poor maintenance, careless operation, lack of an adequate maintenance program, or any other preventable upset condition or preventable equipment breakdown shall not be considered a malfunction.

*“Maximum achievable control technology (MACT)”* means the following regarding regulated hazardous air pollutant sources:

1. For existing sources, the emissions limitation reflecting the maximum degree of reduction in emissions that the administrator or the department, taking into consideration the cost of achieving such emission reduction, and any non-air quality health and environmental impacts and energy requirements, determines is achievable by sources in the category of stationary sources, that shall not be less stringent than the MACT floor.

2. For new sources, the emission limitation which is not less stringent than the emission limitation achieved in practice by the best-controlled similar source and which reflects the maximum degree of reduction in emissions that the administrator or the department, taking into consideration the cost of achieving such emission reduction, and any non-air quality health and environmental impacts and energy requirements, determines is achievable by the affected source.

*“Maximum achievable control technology (MACT) floor”* means the following:

1. For existing sources, the average emission limitation achieved by the best 12 percent of the existing sources in the United States (for which the administrator or the department has or could reasonably obtain emissions information), excluding those sources that have, within 18 months before the emission standard is proposed or within 30 months before such standard is promulgated, whichever is later, first achieved a level of emission rate or emission reduction which complies, or would comply if the source is not subject to such standard, with the lowest achievable emission rate applicable to the source category and prevailing at the time, for categories and subcategories of stationary sources with 30 or more sources in the category or subcategory, or the average emission limitation achieved by the best-performing five sources in the United States (for which the administrator or the department has or could reasonably obtain emissions information), for a category or subcategory of stationary sources with fewer than 30 sources in the category or subcategory.

2. For new sources, the emission limitation achieved in practice by the best-controlled similar source.

*“New equipment”* means except for any equipment or modified equipment to which 567—subrule 23.1(2) applies, any equipment or control equipment not under construction or for which components have not been purchased on or before September 23, 1970, and any equipment which is altered or modified after such date, which may cause the emission of air contaminants or eliminate, reduce or control the emission of air contaminants.

*“Number 1 fuel oil”* and *“number 2 fuel oil,”* also known as “distillate oil,” mean fuel oil that complies with the specifications for fuel oil number 1 or fuel oil number 2, as defined by the American Society of Testing and Materials (ASTM) D 396-02, “Standard Specification for Fuel Oils.”

1. For purposes of the air quality rules contained in Title II, and unless otherwise specified, number 1 fuel oil or number 2 fuel oil may contain a blend of up to 2.0 percent biodiesel fuel, by volume, as “biodiesel fuel” is defined in this rule.

2. The department shall consider air pollutant emissions calculations for the biodiesel fuel blends specified in numbered paragraph “1” to be equivalent to the air pollutant emissions calculations for unblended number 1 fuel oil or unblended number 2 fuel oil.

3. Construction permits or operating permits issued under 567—Chapter 22 which restrict equipment fuel use to number 1 fuel oil or number 2 fuel oil shall be considered by the department to include the biodiesel fuel blends specified in numbered paragraph “1,” unless otherwise specified in 567—Chapter 22 or in a permit issued under 567—Chapter 22.

*“Objective”* means a certain specified degree, quality or characteristic expected to be attained.

*“Odor”* means that which produces a response of the human sense of smell to an odorous substance.

*“Odorous substance”* means a gaseous, liquid, or solid material that elicits a physiological response by the human sense of smell.

*“Odorous substance source”* means any equipment, installation operation, or material which emits odorous substances; such as, but not limited to, a stack, chimney, vent, window, opening, basin, lagoon, pond, open tank, storage pile, or inorganic or organic discharges.

*“One-hour period”* means any 60-minute period commencing on the hour.

“*Opacity*” means the degree to which emissions reduce the transmission of light and obscure the view of an object in the background (See 567—Chapter 29).

“*Open burning*” means any burning of combustible materials where the products of combustion are emitted into the open air without passing through a chimney or stack.

“*Particulate matter*” (except for the purposes of new source performance standards as defined in 40 CFR 60) means any material, except uncombined water, that exists in a finely divided form as a liquid or solid at standard conditions and includes gaseous emissions that condense to liquid or solid form as measured by EPA-approved reference methods.

“*Parts per million (PPM)*” means a term which expresses the volumetric concentration of one material in one million unit volumes of a carrier material.

“*Plan documents*” means the reports, proposals, preliminary plans, survey and basis of design data, general and detail construction plans, profiles, specifications and all other information pertaining to equipment.

“*PM<sub>10</sub>*” means particulate matter with an aerodynamic diameter less than or equal to a nominal 10 micrometers as measured by an EPA-approved reference method.

“*PM<sub>2.5</sub>*” means particulate matter as defined in this rule with an aerodynamic diameter less than or equal to a nominal 2.5 micrometers as measured by an EPA-approved reference method.

“*Potential to emit*” means the maximum capacity of a stationary source to emit any air pollutant under its physical and operational design. Any physical or operational limitation on the capacity of a source to emit an air pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design if the limitation is enforceable by the administrator. This term does not alter or affect the use of this term for any other purposes under the Act, or the term “capacity factor” as used in Title IV of the Act or the regulations relating to acid rain.

For the purpose of determining potential to emit for country grain elevators, the provisions set forth in 567—subrule 22.10(2) shall apply.

For purposes of calculating potential to emit for emergency generators, “maximum capacity” means one of the following:

1. 500 hours of operation annually, if the generator has actually been operated less than 500 hours per year for the past five years;
2. 8,760 hours of operation annually, if the generator has actually been operated more than 500 hours in one of the past five years; or
3. The number of hours specified in a state or federally enforceable limit.

If the source is subject to new source construction permit review, then potential to emit is defined as stated above or as established in a federally enforceable permit.

“*Privileged communication*” means information other than air pollutant emissions data the release of which would tend to affect adversely the competitive position of the owner or operator of the equipment.

“*Process*” means any action, operation or treatment, and all methods and forms of manufacturing or processing, that may emit smoke, particulate matter, gaseous matter or other air contaminant.

“*Process weight*” means the total weight of all materials introduced into any source operation. Solid fuels charged will be considered as part of the process weight, but liquid and gaseous fuels and combustion air will not.

“*Process weight rate*” means continuous or long-run steady-state source operations, the total process weight for the entire period of continuous operation or for a typical portion thereof, divided by the number of hours of such period or portion thereof; or for a cyclical or batch source operation, the total process weight for a period that covers a complete operation or an integral number of cycles, divided by the number of hours of actual process operation during such a period. Where the nature of any process or operation, or the design of any equipment is such as to permit more than one interpretation of this definition, the interpretation that results in the minimum value for allowable emission shall apply.

“*Refuse*” means garbage, rubbish and all other putrescible and nonputrescible wastes, except sewage and water-carried trade wastes.

“*Residential waste*” means any refuse generated on the premises as a result of residential activities. The term includes landscape waste grown on the premises or deposited thereon by the elements, but excludes garbage, tires, trade wastes, and any locally recyclable goods or plastics.

“*Rubbish*” means all waste materials of nonputrescible nature.

“*Salvage operations*” means any business, industry or trade engaged wholly or in part in salvaging or reclaiming any product or material, including, but not limited to, chemicals, drums, metals, motor vehicles or shipping containers.

“*Shutdown*” means the cessation of operation of any control equipment or process equipment or process for any purpose.

“*Six-minute period*” means any one of the ten equal parts of a one-hour period.

“*Smoke*” means gas-borne particles resulting from incomplete combustion, consisting predominantly, but not exclusively, of carbon, and other combustible material, or ash, that form a visible plume in the air.

“*Smoke monitor*” means a device using a light source and a light detector which can automatically measure and record the light-obscuring power of smoke at a specific location in the flue or stack of a source.

“*Source operation*” means the last operation preceding the emission of an air contaminant, and which results in the separation of the air contaminant from the process materials or in the conversion of the process materials into air contaminants, but is not an air pollution control operation.

“*Standard conditions*” means a temperature of 68°F and a pressure of 29.92 inches of mercury absolute.

“*Standard cubic foot (SCF)*” means the volume of one cubic foot of gas at standard conditions.

“*Standard metropolitan statistical area (SMSA)*” means an area which has at least one city with a population of at least 50,000 and such surrounding areas as geographically defined by the U.S. Bureau of the Budget (Department of Commerce).

“*Startup*” means the setting into operation of any control equipment or process equipment or process for any purpose.

“*Stationary source*” means any building, structure, facility or installation which emits or may emit any air pollutant.

“*Theoretical air*” means the exact amount of air required to supply the required oxygen for complete combustion of a given quantity of a specific fuel or waste.

“*Total suspended particulate*” means particulate matter as defined in this rule.

“*Trade waste*” means any refuse resulting from the prosecution of any trade, business, industry, commercial venture (including farming and ranching), or utility or service activity, and any governmental or institutional activity, whether or not for profit.

“*12-month rolling period*” means a period of 12 consecutive months determined on a rolling basis with a new 12-month period beginning on the first day of each calendar month.

“*Untreated*” as it refers to wood or wood products includes only wood or wood products that have not been treated with compounds such as, but not limited to, paint, pigment-stain, adhesive, varnish, lacquer, or resin or that have not been pressure treated with compounds such as, but not limited to, chromate copper acetate, pentachlorophenol or creosote. “*Untreated*” as it refers to seeds, pellets or other vegetative matter includes only seeds, pellets or other vegetative matter that has not been treated with pesticides or fungicides.

“*Urban area*” means any Iowa city of 100,000 or more population in the current census and all Iowa cities contiguous to such city.

“*Variance*” means a temporary waiver from rules or standards governing the quality, nature, duration or extent of emissions granted by the commission for a specified period of time.

“*Volatile organic compounds*” or “*VOC*” means any compound included in the definition of “volatile organic compounds” found at 40 CFR Section 51.100(s) as amended through August 1, 2016. [ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 0330C, IAB 9/19/12, effective 10/24/12; ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 1913C, IAB 3/18/15, effective 4/22/15; ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—20.3(455B) Air quality forms generally.** Rescinded **ARC 1913C**, IAB 3/18/15, effective 4/22/15.

These rules are intended to implement Iowa Code section 17A.3 and chapter 455B.

- [Filed emergency 6/3/83—published 6/22/83, effective 7/1/83]
- [Filed 8/24/84, Notice 5/9/84—published 9/12/84, effective 10/18/84]
- [Filed emergency 11/14/86—published 12/3/86, effective 12/3/86]
- [Filed emergency 9/22/87—published 10/21/87, effective 9/22/87]
- [Filed 10/28/88, Notice 7/27/88—published 11/16/88, effective 12/21/88]
- [Filed emergency 10/25/91 after Notice 9/18/91—published 11/13/91, effective 11/13/91]
- [Filed 12/30/92, Notice 9/16/92—published 1/20/93, effective 2/24/93]
- [Filed 9/23/94, Notice 6/22/94—published 10/12/94, effective 11/16/94]
- [Filed 12/30/94, Notice 10/12/94—published 1/18/95, effective 2/22/95]
- [Filed 5/19/95, Notice 3/15/95—published 6/7/95, effective 7/12/95]
- [Filed 8/25/95, Notice 6/7/95—published 9/13/95, effective 10/18/95]<sup>1</sup>
- [Filed 4/19/96, Notice 1/17/96—published 5/8/96, effective 6/12/96]
- [Filed 8/23/96, Notice 5/8/96—published 9/11/96, effective 10/16/96]
- [Filed 3/20/97, Notice 10/9/96—published 4/9/97, effective 5/14/97]
- [Filed 3/19/98, Notice 1/14/98—published 4/8/98, effective 5/13/98]
- [Filed emergency 5/29/98—published 6/17/98, effective 6/29/98]
- [Filed 8/21/98, Notice 6/17/98—published 9/9/98, effective 10/14/98]
- [Filed 5/28/99, Notice 3/10/99—published 6/16/99, effective 7/21/99]
- [Filed 2/28/02, Notice 12/12/01—published 3/20/02, effective 4/24/02]
- [Filed 5/18/05, Notice 3/16/05—published 6/8/05, effective 7/13/05]
- [Filed 7/28/05, Notice 5/11/05—published 8/17/05, effective 9/21/05]
- [Filed 5/17/06, Notice 1/18/06—published 6/7/06, effective 7/12/06]
- [Filed 8/25/06, Notice 6/7/06—published 9/27/06, effective 11/1/06]
- [Filed 1/23/08, Notice 8/29/07—published 2/13/08, effective 3/19/08]
- [Filed 4/18/08, Notice 1/2/08—published 5/7/08, effective 6/11/08]
- [Filed 8/20/08, Notice 6/4/08—published 9/10/08, effective 10/15/08]
- [Filed ARC 8215B (Notice ARC 7855B, IAB 6/17/09), IAB 10/7/09, effective 11/11/09]
- [Filed ARC 0330C (Notice ARC 0087C, IAB 4/18/12; Amended Notice ARC 0162C, IAB 6/13/12), IAB 9/19/12, effective 10/24/12]
- [Filed ARC 1227C (Notice ARC 1016C, IAB 9/18/13), IAB 12/11/13, effective 1/15/14]
- [Filed ARC 1913C (Notice ARC 1795C, IAB 12/24/14), IAB 3/18/15, effective 4/22/15]
- [Filed Emergency After Notice ARC 2352C (Notice ARC 2222C, IAB 10/28/15), IAB 1/6/16, effective 12/16/15]
- [Filed ARC 2949C (Notice ARC 2799C, IAB 11/9/16), IAB 2/15/17, effective 3/22/17]
- [Filed ARC 3679C (Notice ARC 3520C, IAB 12/20/17), IAB 3/14/18, effective 4/18/18]

<sup>1</sup> Effective date of 20.2(455B), definition of “12-month rolling period,” delayed 70 days by the Administrative Rules Review Committee at its meeting held October 10, 1995; delay lifted by this Committee December 13, 1995, effective December 14, 1995.

CHAPTER 22  
CONTROLLING POLLUTION

[Prior to 7/1/83, DEQ Ch 3]

[Prior to 12/3/86, Water, Air and Waste Management[900]]

**567—22.1(455B) Permits required for new or existing stationary sources.**

**22.1(1) Permit required.** Unless exempted in subrule 22.1(2) or to meet the parameters established in paragraph “c” of this subrule, no person shall construct, install, reconstruct or alter any equipment, control equipment or anaerobic lagoon without first obtaining a construction permit, or permit pursuant to rule 567—22.8(455B), or permits required pursuant to rules 567—22.4(455B), 567—22.5(455B), 567—31.3(455B), and 567—33.3(455B) as required in this subrule. A permit shall be obtained prior to the initiation of construction, installation or alteration of any portion of the stationary source or anaerobic lagoon.

*a.* Existing sources. Sources built prior to September 23, 1970, are not subject to this subrule, unless they have been modified, reconstructed, or altered on or after September 23, 1970.

*b.* New or reconstructed major sources of hazardous air pollutants. No person shall construct or reconstruct a major source of hazardous air pollutants, as defined in 40 CFR 63.2 and 40 CFR 63.41 as adopted by reference in 567—subrule 23.1(4), unless a construction permit has been obtained from the department, which requires maximum achievable control technology for new sources to be applied. The permit shall be obtained prior to the initiation of construction or reconstruction of the major source.

*c.* New, reconstructed, or modified sources may initiate construction prior to issuance of the construction permit by the department if they meet the eligibility requirements stated in subparagraph (1) below. The applicant must assume any liability for construction conducted on a source before the permit is issued. In no case will the applicant be allowed to hook up the equipment to the exhaust stack or operate the equipment in any way that may emit any pollutant prior to receiving a construction permit.

(1) Eligibility.

1. The applicant has submitted a construction permit application to the department, as specified in subrule 22.1(3);

2. The applicant has notified the department of the applicant’s intentions in writing five working days prior to initiating construction; and

3. The source is not subject to rule 567—22.4(455B), 567—subrule 23.1(2), 567—subrule 23.1(3), 567—subrule 23.1(4), 567—subrule 23.1(5), or paragraph “b” of this subrule. Prevention of significant deterioration (PSD) provisions and prohibitions remain applicable until a proposed project legally obtains PSD synthetic minor status (i.e., obtains permitted limits which limit the source below the PSD thresholds).

(2) The applicant must cease construction if the department’s evaluation demonstrates that the construction, reconstruction or modification of the source will interfere with the attainment or maintenance of the national ambient air quality standards or will result in a violation of a control strategy required by 40 CFR Part 51, Subpart G, as amended through February 19, 2015.

(3) The applicant will be required to make any modification to the source that may be imposed in the issued construction permit.

(4) The applicant must notify the department of the date that construction or reconstruction actually started. All notifications shall be submitted to the department in writing no later than 30 days after construction or reconstruction started. All notifications shall include all of the information listed in 22.3(3) “b.”

*d.* Permit requirements for country grain elevators, country grain terminal elevators, grain terminal elevators, and feed mill equipment. The owner or operator of a country grain elevator, country grain terminal elevator, grain terminal elevator or feed mill equipment, as “country grain elevator,” “country grain terminal elevator,” “grain terminal elevator,” and “feed mill equipment” are defined in subrule 22.10(1), may elect to comply with the requirements specified in rule 567—22.10(455B) for equipment at these facilities.

**22.1(2) Exemptions.** The requirement to obtain a permit in subrule 22.1(1) is not required for the equipment, control equipment, and processes listed in this subrule. The permitting exemptions in this subrule do not relieve the owner or operator of any source from any obligation to comply with any other applicable requirements. Equipment, control equipment, or processes subject to rule 567—22.4(455B) and 567—Chapter 33 (except rule 567—33.9(455B)), prevention of significant deterioration requirements, or rule 567—22.5(455B) or 567—31.3(455B), requirements for nonattainment areas, may not use the exemptions from construction permitting listed in this subrule. Equipment, control equipment, or processes subject to 567—subrule 23.1(2), new source performance standards (40 CFR Part 60 NSPS); 567—subrule 23.1(3), emission standards for hazardous air pollutants (40 CFR Part 61 NESHAP); 567—subrule 23.1(4), emission standards for hazardous air pollutants for source categories (40 CFR Part 63 NESHAP); or 567—subrule 23.1(5), emission guidelines, may still use the exemptions from construction permitting listed in this subrule provided that a permit is not needed to create federally enforceable limits that restrict potential to emit. If equipment is permitted under the provisions of rule 567—22.8(455B), then no other exemptions shall apply to that equipment.

Records shall be kept at the facility for exemptions that have been claimed under the following paragraphs: 22.1(2)“a” (for equipment > 1 million Btu per hour input), 22.1(2)“b,” 22.1(2)“e,” 22.1(2)“r” or 22.1(2)“s.” The records shall contain the following information: the specific exemption claimed and a description of the associated equipment. These records shall be made available to the department upon request.

The following paragraphs are applicable to paragraphs 22.1(2)“g” and “i.” A facility claiming to be exempt under the provisions of paragraph 22.1(2)“g” or “i” shall provide to the department the information listed below. If the exemption is claimed for a source not yet constructed or modified, the information shall be provided to the department at least 30 days in advance of the beginning of construction on the project. If the exemption is claimed for a source that has already been constructed or modified and that does not have a construction permit for that construction or modification, the information listed below shall be provided to the department within 60 days of March 20, 1996. After that date, if the exemption is claimed by a source that has already been constructed or modified and that does not have a construction permit for that construction or modification, the source shall not operate until the information listed below is provided to the department:

- A detailed emissions estimate of the actual and potential emissions, specifically noting increases or decreases, for the project for all regulated pollutants (as defined in rule 567—22.100(455B)), accompanied by documentation of the basis for the emissions estimate;
  - A detailed description of each change being made;
  - The name and location of the facility;
  - The height of the emission point or stack and the height of the highest building within 50 feet;
  - The date for beginning actual construction and the date that operation will begin after the changes are made;
- A statement that the provisions of rules 567—22.4(455B), 567—22.5(455B), and 567—31.3(455B) and 567—Chapter 33 (except rule 567—33.9(455B)) do not apply; and
- A statement that the accumulated emissions increases associated with each change under paragraph 22.1(2)“i,” when totaled with other net emissions increases at the facility contemporaneous with the proposed change (occurring within five years before construction on the particular change commences), have not exceeded significant levels, as defined in 40 CFR 52.21(b)(23) as amended through October 20, 2010, and adopted in rules 567—22.4(455B) and 567—33.3(455B), and will not prevent the attainment or maintenance of the ambient air quality standards specified in 567—Chapter 28. This statement shall be accompanied by documentation for the basis of these statements.

The written statement shall contain certification by a responsible official as defined in rule 567—22.100(455B) of truth, accuracy, and completeness. This certification shall state that, based on information and belief formed after reasonable inquiry, the statements and information in the document are true, accurate, and complete.

*a.* Fuel-burning equipment for indirect heating and reheating furnaces or cooling units using natural gas or liquefied petroleum gas with a capacity of less than ten million Btu per hour input per combustion unit.

*b.* Fuel-burning equipment for indirect heating or indirect cooling with a capacity of less than 1 million Btu per hour input per combustion unit when burning untreated wood, untreated seeds or pellets, other untreated vegetative materials, or fuel oil, provided that the equipment and the fuel meet the conditions specified in this paragraph. Used oils meeting the specification from 40 CFR 279.11 as amended through July 14, 2006, are acceptable fuels for this exemption. When combusting used oils, the equipment must have a maximum rated capacity of 50,000 Btu or less per hour of heat input or a maximum throughput of 3,600 gallons or less of used oils per year. When combusting untreated wood, untreated seeds or pellets, or other untreated vegetative materials, the equipment must have a maximum rated capacity of 265,600 Btu or less per hour or a maximum throughput of 378,000 pounds or less per year of each fuel or any combination of fuels. Records shall be maintained on site by the owner or operator for at least two calendar years to demonstrate that fuel usage is less than the exemption thresholds. Owners or operators initiating construction, installation, reconstruction, or alteration of equipment (as defined in rule 567—20.2(455B)) on or before October 23, 2013, burning coal, used oils, untreated wood, untreated seeds or pellets, or other untreated vegetative materials that qualified for this exemption may continue to claim this exemption after October 23, 2013, without being restricted to the maximum heat input or throughput specified in this paragraph.

*c.* Mobile internal combustion and jet engines, marine vessels and locomotives.

*d.* Equipment used for cultivating land, harvesting crops, or raising livestock other than anaerobic lagoons. This exemption is not applicable if the equipment is used to remove substances from grain which were applied to the grain by another person. This exemption is also not applicable to equipment used by a person to manufacture commercial feed, as defined in Iowa Code section 198.3, which is normally not fed to livestock, owned by the person or another person, in a feedlot, as defined in Iowa Code section 172D.1(6), or a confinement building owned or operated by that person and located in this state.

*e.* Incinerators and pyrolysis cleaning furnaces with a rated refuse burning capacity of less than 25 pounds per hour for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013. Pyrolysis cleaning furnace exemption is limited to those units that use only natural gas or propane. Salt bath units are not included in this exemption. Incinerators or pyrolysis cleaning furnaces for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall not qualify for this exemption. After October 23, 2013, only paint clean-off ovens with a maximum rated capacity of less than 25 pounds per hour that do not combust lead-containing materials shall qualify for this exemption.

*f.* Fugitive dust controls unless a control efficiency can be assigned to the equipment or control equipment.

*g.* Equipment or control equipment which reduces or eliminates all emission to the atmosphere. If a source wishes to obtain credit for emission reductions, a permit must be obtained for the reduction prior to the time the reduction is made. If a construction permit has been previously issued for the equipment or control equipment, all other conditions of the construction permit remain in effect.

*h.* Equipment (other than anaerobic lagoons) or control equipment which emits odors unless such equipment or control equipment also emits particulate matter, or any other regulated air contaminant (as defined in rule 567—22.100(455B)).

*i.* Initiation of construction, installation, reconstruction, or alteration (modification) to equipment (as defined in rule 567—20.2(455B)) on or before October 23, 2013, which will not result in a net emissions increase (as defined in 567—subrule 31.3(1)) of more than 1.0 lb/hr of any regulated air pollutant (as defined in rule 567—22.100(455B)). Emission reduction achieved through the installation of control equipment, for which a construction permit has not been obtained, does not establish a limit to potential emissions.

Hazardous air pollutants (as defined in rule 567—22.100(455B)) are not included in this exemption except for those listed in Table 1. Further, the net emissions rate INCREASE must not equal or exceed the values listed in Table 1.

Table 1

| Pollutant      | Ton/year |
|----------------|----------|
| Lead           | 0.6      |
| Asbestos       | 0.007    |
| Beryllium      | 0.0004   |
| Vinyl Chloride | 1        |
| Fluorides      | 3        |

This exemption is ONLY applicable to vertical discharges with the exhaust stack height 10 or more feet above the highest building within 50 feet. If a construction permit has been previously issued for the equipment or control equipment, the conditions of the construction permit remain in effect. In order to use this exemption, the facility must comply with the information submission to the department as described above.

The department reserves the right to require proof that the expected emissions from the source which is being exempted from the air quality construction permit requirement, in conjunction with all other emissions, will not prevent the attainment or maintenance of the ambient air quality standards specified in 567—Chapter 28. If the department finds, at any time after a change has been made pursuant to this exemption, evidence of violations of any of the department's rules, the department may require the source to submit to the department sufficient information to determine whether enforcement action should be taken. This information may include, but is not limited to, any information that would have been submitted in an application for a construction permit for any changes made by the source under this exemption, and air quality dispersion modeling.

Equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall not qualify for this exemption.

*j.* Residential heaters, cookstoves, or fireplaces, which burn untreated wood, untreated seeds or pellets, or other untreated vegetative materials.

*k.* Asbestos demolition and renovation projects subject to 40 CFR 61.145 as amended through January 16, 1991.

*l.* The equipment in laboratories used exclusively for nonproduction chemical and physical analyses. Nonproduction analyses means analyses incidental to the production of a good or service and includes analyses conducted for quality assurance or quality control activities, or for the assessment of environmental impact.

*m.* Storage tanks with a capacity of less than 19,812 gallons and an annual throughput of less than 200,000 gallons.

*n.* Stack or vents to prevent escape of sewer gases through plumbing traps. Systems which include any industrial waste are not exempt.

*o.* A nonproduction surface coating process that uses only hand-held aerosol spray cans.

*p.* Brazing, soldering or welding equipment or portable cutting torches used only for nonproduction activities.

*q.* Cooling and ventilating equipment: Comfort air conditioning not designed or used to remove air contaminants generated by, or released from, specific units of equipment.

*r.* An internal combustion engine with a brake horsepower rating of less than 400 measured at the shaft, provided that the owner or operator meets all of the conditions in this paragraph. For the purposes of this exemption, the manufacturer's nameplate rated capacity at full load shall be defined as the brake horsepower output at the shaft. The owner or operator of an engine that was manufactured, ordered, modified or reconstructed after March 18, 2009, may use this exemption only if the owner or operator, prior to installing, modifying or reconstructing the engine, submits to the department a

completed registration on forms provided by the department (unless the engine is exempted from registration, as specified in this paragraph or on the registration form), certifying that the engine is in compliance with the following federal regulations:

- (1) New source performance standards (NSPS) for stationary compression ignition internal combustion engines (40 CFR Part 60, Subpart IIII); or
- (2) New source performance standards (NSPS) for stationary spark ignition internal combustion engines (40 CFR Part 60, Subpart JJJJ); and
- (3) National emission standards for hazardous air pollutants (NESHAP) for reciprocating internal combustion engines (40 CFR Part 63, Subpart ZZZZ).

Use of this exemption does not relieve an owner or operator from any obligation to comply with NSPS or NESHAP requirements. An engine that meets the definition of a nonroad engine as specified in 40 CFR 1068.30 is exempt from the registration requirements of this paragraph (22.1(2) “r”).

s. Equipment that is not related to the production of goods or services and used exclusively for academic purposes, located at educational institutions (as defined in Iowa Code section 455B.161). The equipment covered under this exemption is limited to: lab hoods, art class equipment, wood shop equipment in classrooms, wood fired pottery kilns, and fuel-burning units with a capacity of less than one million Btu per hour fuel capacity. This exemption does not apply to incinerators.

t. Any container, storage tank, or vessel that contains a fluid having a maximum true vapor pressure of less than 0.75 psia. “Maximum true vapor pressure” means the equilibrium partial pressure of the material considering:

- For material stored at ambient temperature, the maximum monthly average temperature as reported by the National Weather Service, or
- For material stored above or below the ambient temperature, the temperature equal to the highest calendar-month average of the material storage temperature.

u. Equipment for carving, cutting, routing, turning, drilling, machining, sawing, surface grinding, sanding, planing, buffing, sandblast cleaning, shot blasting, shot peening, or polishing ceramic artwork, leather, metals (other than beryllium), plastics, concrete, rubber, paper stock, and wood or wood products, where such equipment is either used for nonproduction activities or exhausted inside a building.

v. Manually operated equipment, as defined in rule 567—22.100(455B), used for buffing, polishing, carving, cutting, drilling, machining, routing, sanding, sawing, scarfing, surface grinding, or turning.

w. Small unit exemption.

(1) “Small unit” means any emission unit and associated control (if applicable) that emits less than the following:

1. 2 pounds per year of lead and lead compounds expressed as lead (40 pounds per year of lead or lead compounds for equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013);
2. 5 tons per year of sulfur dioxide;
3. 5 tons per year of nitrogen oxides;
4. 5 tons per year of volatile organic compounds;
5. 5 tons per year of carbon monoxide;
6. 5 tons per year of particulate matter (particulate matter as defined in 40 CFR Part 51.100(pp));
7. 2.5 tons per year of PM<sub>10</sub>;
8. 0.52 tons per year of PM<sub>2.5</sub> (does not apply to equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013); and
9. 5 tons per year of hazardous air pollutants (as defined in rule 567—22.100(455B)).

For the purposes of this exemption, “emission unit” means any part or activity of a stationary source that emits or has the potential to emit any pollutant subject to regulation under the Act. This exemption applies to existing and new or modified “small units.”

An emission unit that emits hazardous air pollutants (as defined in rule 567—22.100(455B)) is not eligible for this exemption if the emission unit is required to be reviewed for compliance with

567—subrule 23.1(3), emission standards for hazardous air pollutants (40 CFR 61, NESHAP), or 567—subrule 23.1(4), emission standards for hazardous air pollutants for source categories (40 CFR 63, NESHAP).

An emission unit that emits air pollutants that are not regulated air pollutants as defined in rule 567—22.100(455B) shall not be eligible to use this exemption.

(2) Permit requested. If requested in writing by the owner or operator of a small unit, the director may issue a construction permit for the emission point associated with that emission unit.

(3) An owner or operator that utilizes the small unit exemption must maintain on site an “exemption justification document.” The exemption justification document must document conformance and compliance with the emission rate limits contained in the definition of “small unit” for the particular emission unit or group of similar emission units obtaining the exemption. Controls which may be part of the exemption justification document include, but are not limited to, the following: emission control devices, such as cyclones, filters, or baghouses; restricted hours of operation or fuel; and raw material or solvent substitution. The exemption justification document for an emission unit or group of similar emission units must be made available for review during normal business hours and for state or EPA on-site inspections, and shall be provided to the director or the director’s representative upon request. If an exemption justification document does not exist, the applicability of the small unit exemption is voided for that particular emission unit or group of similar emission units. The controls described in the exemption justification document establish a limit on the potential emissions. An exemption justification document shall include the following for each applicable emission unit or group of similar emission units:

1. A narrative description of how the emissions from the emission unit or group of similar emission units were determined and maintained at or below the annual small unit exemption levels.

2. If air pollution control equipment is used, a description of the air pollution control equipment used on the emission unit or group of similar emission units and a statement that the emission unit or group of similar emission units will not be operated without the pollution control equipment operating.

3. If air pollution control equipment is used, applicant shall maintain a copy of any report of manufacturer’s testing results of any emissions test, if available. The department may require a test if it believes that a test is necessary for the exemption claim.

4. A description of all production limits required for the emission unit or group of similar emission units to comply with the exemption levels.

5. Detailed calculations of emissions reflecting the use of any air pollution control devices or production or throughput limitations, or both, for applicable emission unit or group of similar emission units.

6. Records of actual operation that demonstrate that the annual emissions from the emission unit or group of similar emission units were maintained below the exemption levels.

7. Facilities designated as major sources with respect to rules 567—22.4(455B) and 567—22.101(455B), or subject to any applicable federal requirements, shall retain all records demonstrating compliance with the exemption justification document for five years. The record retention requirements supersede any retention conditions of an individual exemption.

8. A certification from the responsible official that the emission unit or group of similar emission units have complied with the exemption levels specified in 22.1(2) “w”(1).

(4) Requirement to apply for a construction permit. An owner or operator of a small unit will be required to obtain a construction permit or take the unit out of service if the emission unit exceeds the small unit emission levels.

1. If, during an inspection or other investigation of a facility, the department believes that the emission unit exceeds the emission levels that define a “small unit,” then the department will submit calculations and detailed information in a letter to the owner or operator. The owner or operator shall have 60 days to respond with detailed calculations and information to substantiate a claim that the small unit does not exceed the emission levels that define a small unit.

2. If the owner or operator is unable to substantiate a claim to the satisfaction of the department, then the owner or operator that has been using the small unit exemption must cease operation of that small

unit or apply for a construction permit for that unit within 90 days after receiving a letter of notice from the department. The emission unit and control equipment may continue operation during this period and the associated initial application review period.

3. If the notification of nonqualification as a small unit is made by the department following the process described above, the owner or operator will be deemed to have constructed an emission unit without the required permit and may be subject to applicable penalties.

(5) Required notice for construction or modification of a “substantial small unit.” The owner or operator shall notify the department in writing at least 10 days prior to commencing construction of any new or modified “substantial small unit” as defined in 22.1(2) “w”(6). The owner or operator shall notify the department within 30 days after determining an existing small unit meets the criteria of the “substantial small unit” as defined in 22.1(2) “w”(6). Notification shall include the name of the business, the location where the unit will be installed, and information describing the unit and quantifying its emissions. The owner or operator shall notify the department within 90 days of the end of the calendar year for which the aggregate emissions from substantial small units at the facility have reached any of the cumulative notice thresholds listed below.

(6) For the purposes of this paragraph, “substantial small unit” means a small unit which emits more than the following amounts, as documented in the exemption justification document:

1. 2 pounds per year of lead and lead compounds expressed as lead (30 pounds per year of lead or lead compounds for equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013);

2. 3.75 tons per year of sulfur dioxide;

3. 3.75 tons per year of nitrogen oxides;

4. 3.75 tons per year of volatile organic compounds;

5. 3.75 tons per year of carbon monoxide;

6. 3.75 tons per year of particulate matter (particulate matter as defined in 40 CFR Part 51.100(pp));

7. 1.875 tons per year of PM<sub>10</sub>;

8. 0.4 tons per year of PM<sub>2.5</sub> (does not apply to equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013); or

9. 3.75 tons per year of any hazardous air pollutant or 3.75 tons per year of any combination of hazardous air pollutants.

An emission unit is a “substantial small unit” only for those substances for which annual emissions exceed the above-indicated amounts.

(7) Required notice that a cumulative notice threshold has been reached. Once a “cumulative notice threshold,” as defined in 22.1(2) “w”(8), has been reached for any of the listed pollutants, the owner or operator at the facility must apply for air construction permits for all substantial small units for which the cumulative notice threshold for the pollutant(s) in question has been reached. The owner or operator shall have 90 days from the date it determines that the cumulative notice threshold has been reached in which to apply for construction permit(s). The owner or operator shall submit a letter to the department, within 5 working days of making this determination, establishing the date the owner or operator determined that the cumulative notice threshold had been reached.

(8) “Cumulative notice threshold” means the total combined emissions from all substantial small units using the small unit exemption which emit at the facility the following amounts, as documented in the exemption justification document:

1. 0.6 tons per year of lead and lead compounds expressed as lead;

2. 40 tons per year of sulfur dioxide;

3. 40 tons per year of nitrogen oxides;

4. 40 tons per year of volatile organic compounds;

5. 100 tons per year of carbon monoxide;

6. 25 tons per year of particulate matter (particulate matter as defined in 40 CFR Part 51.100(pp));

7. 15 tons per year of PM<sub>10</sub>;

8. 10 tons per year of PM<sub>2.5</sub> (does not apply to equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013); or

9. 10 tons per year of any hazardous air pollutant or 25 tons per year of any combination of hazardous air pollutants.

x. The following equipment, processes, and activities:

(1) Cafeterias, kitchens, and other facilities used for preparing food or beverages primarily for consumption at the source.

(2) Consumer use of office equipment and products, not including printers or businesses primarily involved in photographic reproduction.

(3) Janitorial services and consumer use of janitorial products.

(4) Internal combustion engines used for lawn care, landscaping, and groundskeeping purposes.

(5) Laundry activities located at a stationary source that uses washers and dryers to clean, with water solutions of bleach or detergents, or to dry clothing, bedding, and other fabric items used on site. This exemption does not include laundry activities that use dry cleaning equipment or steam boilers.

(6) Bathroom vent emissions, including toilet vent emissions.

(7) Blacksmith forges.

(8) Plant maintenance and upkeep activities and repair or maintenance shop activities (e.g., groundskeeping, general repairs, cleaning, painting, welding, plumbing, retarring roofs, installing insulation, and paving parking lots), provided that these activities are not conducted as part of manufacturing process, are not related to the source's primary business activity, and do not otherwise trigger a permit modification. Cleaning and painting activities qualify if they are not subject to control requirements for volatile organic compounds or hazardous air pollutants as defined in rule 567—22.100(455B).

(9) Air compressors and vacuum pumps, including hand tools.

(10) Batteries and battery charging stations, except at battery manufacturing plants.

(11) Equipment used to store, mix, pump, handle or package soaps, detergents, surfactants, waxes, glycerin, vegetable oils, greases, animal fats, sweetener, corn syrup, and aqueous salt or caustic solutions, provided that appropriate lids and covers are utilized and that no organic solvent has been mixed with such materials.

(12) Equipment used exclusively to slaughter animals, but not including other equipment at slaughterhouses, such as rendering cookers, boilers, heating plants, incinerators, and electrical power generating equipment.

(13) Vents from continuous emissions monitors and other analyzers.

(14) Natural gas pressure regulator vents, excluding venting at oil and gas production facilities.

(15) Equipment used by surface coating operations that apply the coating by brush, roller, or dipping, except equipment that emits volatile organic compounds or hazardous air pollutants as defined in rule 567—22.100(455B).

(16) Hydraulic and hydrostatic testing equipment.

(17) Environmental chambers not using gases which are hazardous air pollutants as defined in rule 567—22.100(455B).

(18) Shock chambers, humidity chambers, and solar simulators.

(19) Fugitive dust emissions related to movement of passenger vehicles on unpaved road surfaces, provided that the emissions are not counted for applicability purposes and that any fugitive dust control plan or its equivalent is submitted as required by the department.

(20) Process water filtration systems and demineralizers, demineralized water tanks, and demineralizer vents.

(21) Boiler water treatment operations, not including cooling towers or lime silos.

(22) Oxygen scavenging (deaeration) of water.

(23) Fire suppression systems.

(24) Emergency road flares.

(25) Steam vents, safety relief valves, and steam leaks.

(26) Steam sterilizers.

(27) Application of hot melt adhesives from closed-pot systems using polyolefin compounds, polyamides, acrylics, ethylene vinyl acetate and urethane material when stored and applied at the manufacturer's recommended temperatures. Equipment used to apply hot melt adhesives shall have a safety device that automatically shuts down the equipment if the hot melt temperature exceeds the manufacturer's recommended application temperature.

y. Direct-fired equipment burning natural gas, propane, or liquefied propane with a capacity of less than 10 million Btu per hour input, and direct-fired equipment burning fuel oil with a capacity of less than 1 million Btu per hour input, with emissions that are attributable only to the products of combustion. Emissions other than those attributable to the products of combustion shall be accounted for in an enforceable permit condition or shall otherwise be exempt under this subrule.

z. Closed refrigeration systems, including storage tanks used in refrigeration systems, but excluding any combustion equipment associated with such systems.

aa. Pretreatment application processes that use aqueous-based chemistries designed to clean a substrate, provided that the chemical concentrate contains no more than 5 percent organic solvents by weight. This exemption includes pretreatment processes that use aqueous-based cleaners, cleaner-phosphatizers, and phosphate conversion coating chemistries.

bb. Indoor-vented powder coating operations with filters or powder recovery systems.

cc. Electric curing ovens or curing ovens that run on natural gas or propane with a maximum heat input of less than 10 million Btu per hour and that are used for powder coating operations, provided that the total cured powder usage is less than 75 tons of powder per year at the stationary source. Records shall be maintained on site by the owner or operator for a period of at least two calendar years to demonstrate that cured powder usage is less than the exemption threshold.

dd. Each production painting, adhesive or coating unit using an application method other than a spray system and associated cleaning operations that use 1,000 gallons or less of coating and solvents annually, unless the production painting, adhesive or coating unit and associated cleaning operations are subject to work practice, process limits, emissions limits, stack testing, record-keeping or reporting requirements under 567—subrule 23.1(2), 567—subrule 23.1(3), or 567—subrule 23.1(4). Records shall be maintained on site by the owner or operator for a period of at least two calendar years to demonstrate that paint, adhesive, or solvent usage is at or below the exemption threshold.

ee. Any production surface coating activity that uses only nonrefillable hand-held aerosol cans, where the total volatile organic compound emissions from all these activities at a stationary source do not exceed 5.0 tons per year.

ff. Production welding.

(1) Consumable electrode.

1. Welding operations for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013, using a consumable electrode, provided that the consumable electrode used falls within American Welding Society specification A5.18/A5.18M for Gas Metal Arc Welding (GMAW), A5.1 or A5.5 for Shielded Metal Arc Welding (SMAW), and A5.20 for Flux Core Arc Welding (FCAW), and provided that the quantity of all electrodes used at the stationary source of the acceptable specifications is below 200,000 pounds per year for GMAW and 28,000 pounds per year for SMAW or FCAW. Records that identify the type and annual amount of welding electrode used shall be maintained on site by the owner or operator for a period of at least two calendar years. For stationary sources where electrode usage exceeds these levels, the welding activity at the stationary source may be exempted if the amount of electrode used (Y) is less than:

Y = the greater of  $1380x - 19,200$  or 200,000 for GMAW, or

Y = the greater of  $187x - 2,600$  or 28,000 for SMAW or FCAW

Where "x" is the minimum distance to the property line in feet and "Y" is the annual electrode usage in pounds per year.

If the stationary source has welding processes that fit into both of the specified exemptions, the most stringent limits must be applied.

2. Welding operations for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, using a consumable electrode, provided that the consumable electrode used falls within American Welding Society specification A5.18/A5.18M for Gas Metal Arc Welding (GMAW), A5.1 or A5.5 for Shielded Metal Arc Welding (SMAW), and A5.20 for Flux Core Arc Welding (FCAW), and provided that the quantity of all electrodes used at the stationary source of the acceptable specifications is below 12,500 pounds per year for GMAW and 1,600 pounds per year for SMAW or FCAW. Records that identify the type and annual amount of welding electrode used shall be maintained on site by the owner or operator for a period of at least two calendar years. For stationary sources where electrode usage exceeds these levels, the welding activity at the stationary source may be exempted if the amount of electrode used (Y) is less than:

Y = the greater of  $84x - 1,200$  or 12,500 for GMAW, or

Y = the greater of  $11x - 160$  or 1,600 for SMAW or FCAW

Where “x” is the minimum distance to the property line in feet and “Y” is the annual electrode usage in pounds per year.

If the stationary source has welding processes that fit into both of the specified exemptions, the most stringent limits must be applied.

(2) Resistance welding, submerged arc welding, or arc welding that does not use a consumable electrode, provided that the base metals do not include stainless steel, alloys of lead, alloys of arsenic, or alloys of beryllium and provided that the base metals are uncoated, excluding manufacturing process lubricants.

*gg.* Electric hand soldering, wave soldering, and electric solder paste reflow ovens for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013. Electric hand soldering, wave soldering, and electric solder paste reflow ovens for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall be limited to 37,000 pounds or less per year of lead-containing solder. Records shall be maintained on site by the owner or operator for at least two calendar years to demonstrate that use of lead-containing solder is less than the exemption thresholds.

*hh.* Pressurized piping and storage systems for natural gas, propane, liquefied petroleum gas (LPG), and refrigerants, where emissions could only result from an upset condition.

*ii.* Emissions from the storage and mixing of paints and solvents associated with the painting operations, provided that the emissions from the storage and mixing are accounted for in an enforceable permit condition or are otherwise exempt.

*jj.* Product labeling using laser and ink-jet printers with target distances less than or equal to six inches and an annual material throughput of less than 1,000 gallons per year as calculated on a stationary sourcewide basis.

*kk.* Equipment related to research and development activities at a stationary source, provided that:

(1) Actual emissions from all research and development activities at the stationary source based on a 12-month rolling total are less than the following levels:

2 pounds per year of lead and lead compounds expressed as lead (40 pounds per year for research and development activities that commenced on or before October 23, 2013);

5 tons per year of sulfur dioxide;

5 tons per year of nitrogen oxides;

5 tons per year of volatile organic compounds;

5 tons per year of carbon monoxide;

5 tons per year of particulate matter (particulate matter as defined in 40 CFR Part 51.100(pp) as amended through November 29, 2004);

2.5 tons per year of  $PM_{10}$ ;

0.52 tons per year of  $PM_{2.5}$  (does not apply to research and development activities that commenced on or before October 23, 2013); and

5 tons per year of hazardous pollutants (as defined in rule 567—22.100(455B)); and

(2) The owner or operator maintains records of actual operations demonstrating that the annual emissions from all research and development activities conducted under this exemption are below the levels listed in subparagraph (1) above. These records shall:

1. Include a list of equipment that is included under the exemption;
2. Include records of actual operation and detailed calculations of actual annual emissions, reflecting the use of any control equipment and demonstrating that the emissions are below the levels specified in the exemption;
3. Include, if air pollution equipment is used in the calculation of emissions, a copy of any report of manufacturer's testing, if available. The department may require a test if it believes that a test is necessary for the exemption claim; and
4. Be maintained on site for a minimum of two years, be made available for review during normal business hours and for state and EPA on-site inspections, and be provided to the director or the director's designee upon request. Facilities designated as major sources pursuant to rules 567—22.4(455B) and 567—22.101(455B), or subject to any applicable federal requirements, shall retain all records demonstrating compliance with this exemption for five years.

(3) An owner or operator using this exemption obtains a construction permit or ceases operation of equipment if operation of the equipment would cause the emission levels listed in this exemption to be exceeded.

For the purposes of this exemption, "research and development activities" shall be defined as activities:

1. That are operated under the close supervision of technically trained personnel; and
2. That are conducted for the primary purpose of theoretical research or research and development into new or improved processes and products; and
3. That do not manufacture more than de minimis amounts of commercial products; and
4. That do not contribute to the manufacture of commercial products by collocated sources in more than a de minimis manner.

*ll.* A regional collection center (RCC), as defined in 567—Chapter 211, involved in the processing of permitted hazardous materials from households and conditionally exempt small quantity generators (CESQG), not to exceed 1,200,000 pounds of VOC containing material in a 12-month rolling period. Latex paint drying may not exceed 120,000 pounds per year on a 12-month rolling total. Other nonprocessing emission units (e.g., standby generators and waste oil heaters) shall not be eligible to use this exemption.

*mm.* Cold solvent cleaning machines that are not in-line cleaning machines, where the maximum vapor pressure of the solvents used shall not exceed 0.7 kPa (5 mmHg or 0.1 psi) at 20°C (68°F). The machine must be equipped with a tightly fitted cover or lid that shall be closed at all times except during parts entry and removal. This exemption cannot be used for cold solvent cleaning machines that use solvent containing methylene chloride (CAS # 75-09-2), perchloroethylene (CAS # 127-18-4), trichloroethylene (CAS # 79-01-6), 1,1,1-trichloroethane (CAS # 71-55-6), carbon tetrachloride (CAS # 56-23-5) or chloroform (CAS # 67-66-3), or any combination of these halogenated HAP solvents in a total concentration greater than 5 percent by weight.

*nn.* Emissions from mobile over-the-road trucks, and mobile agricultural and construction internal combustion engines that are operated only for repair or maintenance purposes at equipment repair shops or equipment dealerships, and only when the repair shops or equipment dealerships are not major sources as defined in rule 567—22.100(455B).

*oo.* A non-road diesel fueled engine, as defined in 40 CFR 1068.30 as amended through April 30, 2010, with a brake horsepower rating of less than 1,100 at full load measured at the shaft, used to conduct periodic testing and maintenance on natural gas pipelines. For the purposes of this exemption, the manufacturer's nameplate rating shall be defined as the brake horsepower output at the shaft at full load.

(1) To qualify for the exemption, the engine must:

1. Be used for periodic testing and maintenance on natural gas pipelines outside the compressor station, which shall not exceed 330 hours in any 12-month consecutive period at a single location; or

2. Be used for periodic testing and maintenance on natural gas pipelines within the compressor station, which shall not exceed 330 hours in any 12-month consecutive period.

(2) The owner or operator shall maintain a monthly record of the number of hours the engine operated and a record of the rolling 12-month total of the number of hours the engine operated for each location outside the compressor station and within the compressor station. These records shall be maintained for two years. Records shall be made available to the department upon request.

(3) This exemption shall not apply to the replacement or substitution of engines for backup power generation at a pipeline compressor station.

**22.1(3) Construction permits.** The owner or operator of a new or modified stationary source shall apply for a construction permit. One copy of a construction permit application for a new or modified stationary source shall be presented or mailed to Department of Natural Resources, Air Quality Bureau, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324. Alternatively, the owner or operator may apply for a construction permit for a new or modified stationary source through the electronic submittal format specified by the department. An owner or operator applying for a permit as required pursuant to rule 567—31.3(455B) (nonattainment new source review) or 567—33.3(455B) (prevention of significant deterioration (PSD)) shall present or mail to the department one hard copy of a construction permit application to the address specified above and, upon request from the department, shall also submit one electronic copy and one additional hard copy of the application. Application submission methods may include, but are not limited to, U.S. Postal Service, private parcel delivery services, and hand delivery. Applications are not required to be submitted by certified mail. The owner or operator of any new or modified industrial anaerobic lagoon shall apply for a construction permit as specified in this subrule and as provided in 567—Chapter 22. The owner or operator of a new or modified anaerobic lagoon for an animal feeding operation shall apply for a construction permit as provided in 567—Chapter 65.

*a. Regulatory applicability determinations.* If requested in writing, the director will review the design concepts of equipment and associated control equipment prior to application for a construction permit. The purpose of the review would be to determine the acceptability of the location of the equipment. If the review is requested, the requester shall supply the following information and submit a fee as required in 567—Chapter 30:

- (1) Preliminary plans and specifications of equipment and related control equipment.
- (2) The exact site location and a plot plan of the immediate area, including the distance to and height of nearby buildings and the estimated location and elevation of the emission points.
- (3) The estimated emission rates of any air contaminants which are to be considered.
- (4) The estimated exhaust gas temperature, velocity at the point of discharge, and stack diameter at the point of discharge.
- (5) An estimate of when construction would begin and when construction would be completed.

*b. Construction permit applications.* Each application for a construction permit shall be submitted to the department on the permit application forms available on the department's website. Final plans and specifications for the proposed equipment or related control equipment shall be submitted with the application for a permit and shall be prepared by or under the direct supervision of a professional engineer licensed in the state of Iowa in conformance with Iowa Code section 542B.1, or consistent with the provisions of Iowa Code section 542B.26 for any full-time employee of any corporation while the employee is doing work for that corporation. The application for a permit to construct shall include the following information:

- (1) A description of the equipment or control equipment covered by the application;
- (2) A scaled plot plan, including the distance and height of nearby buildings, and the location and elevation of existing and proposed emission points;
- (3) The composition of the effluent stream, both before and after any control equipment with estimates of emission rates, concentration, volume and temperature;
- (4) The physical and chemical characteristics of the air contaminants;
- (5) The proposed dates and description of any tests to be made by the owner or operator of the completed installation to verify compliance with applicable emission limits or standards of performance;

(6) Information pertaining to sampling port locations, scaffolding, power sources for operation of appropriate sampling instruments, and pertinent allied facilities for making tests to ascertain compliance;

(7) Any additional information deemed necessary by the department to determine compliance with or applicability of rules 567—22.4(455B), 567—22.5(455B), 567—31.3(455B) and 567—33.3(455B);

(8) Application for a case-by-case MACT determination. If the source meets the definition of construction or reconstruction of a major source of hazardous air pollutants, as defined in paragraph 22.1(1)“b,” then the owner or operator shall submit an application for a case-by-case MACT determination, as required in 567—subparagraph 23.1(4)“b”(1), with the construction permit application. In addition to this paragraph, an application for a case-by-case MACT determination shall include the following information:

1. The hazardous air pollutants (HAP) emitted by the constructed or reconstructed major source, and the estimated emission rate for each HAP, to the extent this information is needed by the permitting authority to determine MACT;

2. Any federally enforceable emission limitations applicable to the constructed or reconstructed major source;

3. The maximum and expected utilization of capacity of the constructed or reconstructed major source, and the associated uncontrolled emission rates for that source, to the extent this information is needed by the permitting authority to determine MACT;

4. The controlled emissions for the constructed or reconstructed major source in tons/yr at expected and maximum utilization of capacity to the extent this information is needed by the permitting authority to determine MACT;

5. A recommended emission limitation for the constructed or reconstructed major source consistent with the principles set forth in 40 CFR Part 63.43(d) as amended through December 27, 1996;

6. The selected control technology to meet the recommended MACT emission limitation, including technical information on the design, operation, size, estimated control efficiency of the control technology (and the manufacturer’s name, address, telephone number, and relevant specifications and drawings, if requested by the permitting authority);

7. Supporting documentation including identification of alternative control technologies considered by the applicant to meet the emission limitation, and analysis of cost and non-air quality health environmental impacts or energy requirements for the selected control technology;

8. An identification of any listed source category or categories in which the major source is included;

(9) A signed statement that ensures the applicant’s legal entitlement to install and operate equipment covered by the permit application on the property identified in the permit application. A signed statement shall not be required for rock crushers, portable concrete or asphalt equipment used in conjunction with specific identified construction projects which are intended to be located at a site only for the duration of the specific, identified construction project;

(10) Application fee.

1. The owner or operator shall submit a fee as required in 567—Chapter 30 to obtain a permit under subrule 22.1(1), rule 567—22.4(455B), rule 567—22.5(455B), rule 567—22.8(455B), rule 567—22.10(455B), 567—Chapter 31 or 567—Chapter 33;

2. For application submittals from a minor source as defined in 567—Chapter 30, the department shall not initiate review and processing of a permit application submittal until all required application fees have been paid to the department; and

(11) Quantity of greenhouse gas emissions for all applications for projects that will or do have greenhouse gas emissions. For all applications for projects that will not or do not have greenhouse gas emissions, the applicant shall indicate in the application that no greenhouse gases will be emitted, and the applicant will not be required to file an inventory of greenhouse gases with that application, unless requested by the department.

*c. Application requirements for anaerobic lagoons.* The application for a permit to construct an anaerobic lagoon shall include the following information:

(1) The source of the water being discharged to the lagoon;

- (2) A plot plan, including distances to nearby residences or occupied buildings, local land use zoning maps of the vicinity, and a general description of the topography in the vicinity of the lagoon;
- (3) In the case of an animal feeding operation, the information required in rule 567—65.15(455B);
- (4) In the case of an industrial source, a chemical description of the waste being discharged to the lagoon;
- (5) A report of sulfate analyses conducted on the water to be used for any purpose in a livestock operation proposing to use an anaerobic lagoon. The report shall be prepared by using standard methods as defined in 567—60.2(455B);
- (6) A description of available water supplies to prove that adequate water is available for dilution;
- (7) In the case of an animal feeding operation, a waste management plan describing the method of waste collection and disposal and the land to be used for disposal. Evidence that the waste disposal equipment is of sufficient size to dispose of the wastes within a 20-day period per year shall also be provided;
- (8) Any additional information needed by the department to determine compliance with these rules.

**22.1(4) Conditional permits.** Rescinded IAB 3/18/15, effective 4/22/15.

This rule is intended to implement Iowa Code section 455B.133.

[ARC 7565B, IAB 2/11/09, effective 3/18/09; ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 1013C, IAB 9/18/13, effective 10/23/13; ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 1913C, IAB 3/18/15, effective 4/22/15; ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3440C, IAB 11/8/17, effective 12/13/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

#### **567—22.2(455B) Processing permit applications.**

**22.2(1) Incomplete applications.** The department will notify the applicant whether the application is complete or incomplete. If the application is found by the department to be incomplete upon receipt, the applicant will be notified within 30 days of that fact and of the specific deficiencies. Sixty days following such notification, the application may be denied for lack of information. When this schedule would cause undue hardship to an applicant, or the applicant has a compelling need to proceed promptly with the proposed installation, modification or location, a request for priority consideration and the justification therefor shall be submitted to the department.

**22.2(2) Public notice and participation.** A notice of intent to issue a construction permit to a major stationary source shall be published by the department in a newspaper having general circulation in the area affected by the emissions of the proposed source. The notice and supporting documentation shall be made available for public inspection upon request from the department's central office. Publication of the notice shall be made at least 30 days prior to issuing a permit and shall include the department's evaluation of ambient air impacts. The public may submit written comments or request a public hearing. If the response indicates significant interest, a public hearing may be held after due notice.

**22.2(3) Final notice.** The department shall notify the applicant in writing of the issuance or denial of a construction permit as soon as practicable and at least within 120 days of receipt of the completed application. This shall not apply to applicants for electric generating facilities subject to Iowa Code chapter 476A.

This rule is intended to implement Iowa Code section 455B.133.

[ARC 1913C, IAB 3/18/15, effective 4/22/15]

#### **567—22.3(455B) Issuing permits.**

**22.3(1) Stationary sources other than anaerobic lagoons.** In no case shall a construction permit which results in an increase in emissions be issued to any facility which is in violation of any condition found in a permit involving PSD, NSPS, NESHAP or a provision of the Iowa state implementation plan. If the facility is in compliance with a schedule for correcting the violation and that schedule is contained in an order or permit condition, the department may consider issuance of a construction permit. A construction permit shall be issued when the director concludes that the preceding requirement has been met and:

- a. That the required plans and specifications represent equipment which reasonably can be expected to comply with all applicable emission standards, and

*b.* That the expected emissions from the proposed source or modification in conjunction with all other emissions will not prevent the attainment or maintenance of the ambient air quality standards specified in 567—Chapter 28, and

*c.* That the applicant has not relied on emission limits based on stack height that exceeds good engineering practice or any other dispersion techniques as defined in 567—subrule 23.1(6), and

*d.* That the applicant has met all other applicable requirements.

**22.3(2) *Anaerobic lagoons.*** A construction permit for an industrial anaerobic lagoon shall be issued when the director concludes that the application for permit represents an approach to odor control that can reasonably be expected to comply with the criteria in 567—subrule 23.5(2). A construction permit for an animal feeding operation using an anaerobic lagoon shall be issued when the director concludes that the application has met the requirements of rule 567—65.15(455B).

**22.3(3) *Conditions of approval.*** A permit may be issued subject to conditions which shall be specified in writing. Such conditions may include but are not limited to emission limits, operating conditions, fuel specifications, compliance testing, continuous monitoring, and excess emission reporting.

*a.* Each permit shall specify the date on which it becomes void if work on the installation for which it was issued has not been initiated.

*b.* Each permit shall list the requirements for notifying the department of the dates of intended startup, start of construction and actual equipment startup. All notifications shall be in writing and include the following information:

- (1) The date or dates required by 22.3(3) “*b*” for which the notice is being submitted.
- (2) Facility name.
- (3) Facility address.
- (4) DNR facility number.
- (5) DNR air construction permit number.
- (6) The name or the number of the emission unit or units in the notification.
- (7) The emission point number or numbers in the notification.
- (8) The name and signature of a company official.
- (9) The date the notification was signed.

*c.* Each permit shall specify that no review has been undertaken on the various engineering aspects of the equipment other than the potential of the equipment for reducing air contaminant emissions.

*d.* Rescinded IAB 3/18/15, effective 4/22/15.

*e.* If changes in the final plans and specifications are proposed by the permittee after a construction permit has been issued, a supplemental permit shall be obtained.

*f.* A permit is not transferable from one location to another or from one piece of equipment to another unless the equipment is portable. When portable equipment for which a permit has been issued is to be transferred from one location to another, the department shall be notified in writing at least 7 days prior to the transfer of the portable equipment to the new location. Written notification shall be submitted to the department through one of the following methods: electronic mail (email), mail delivery service (including U.S. Mail), hand delivery, facsimile (fax), or by electronic format specified by the department (at such time as an Internet-based submittal system or other, similar electronic submittal system becomes available). However, if the owner or operator is relocating the portable equipment to an area currently classified as nonattainment for ambient air quality standards or to an area under a maintenance plan for ambient air quality standards, the owner or operator shall notify the department at least 14 days prior to transferring the portable equipment to the new location. A list of nonattainment and maintenance areas may be obtained from the department, upon request, or on the department’s Internet website. The owner or operator will be notified by the department at least 10 days prior to the scheduled relocation if said relocation will prevent the attainment or maintenance of ambient air quality standards and thus require a more stringent emission standard and the installation of additional control equipment. In such a case, the owner or operator shall obtain a supplemental permit prior to the initiation of construction, installation, or alteration of such additional control equipment.

g. The issuance of a permit (approval to construct) shall not relieve any owner or operator of the responsibility to comply fully with applicable provisions of the state implementation plan and any other requirement under local, state or federal law.

**22.3(4) Denial of a permit.**

a. When an application for a construction permit is denied, the applicant shall be notified in writing of the reasons therefor. A denial shall be without prejudice to the right of the applicant to file a further application after revisions are made to meet the objections specified as reasons for the denial.

b. The department may deny an application based upon the applicant's failure to provide a signed statement of the applicant's legal entitlement to install and operate equipment covered by the permit application on the property identified in the permit application.

**22.3(5) Modification of a permit.** The director may, after public notice of such decision, modify a condition of approval of an existing permit for a major stationary source or an emission limit contained in an existing permit for a major stationary source if necessary to attain or maintain an ambient air quality standard, or to mitigate excessive deposition of mercury.

**22.3(6) Limits on hazardous air pollutants.** The department may limit a source's hazardous air pollutant potential to emit, as defined at rule 567—22.100(455B), in the source's construction permit for the purpose of establishing federally enforceable limits on the source's hazardous air pollutant potential to emit.

**22.3(7) Revocation of a permit.** The department may revoke a permit upon obtaining knowledge that a permit holder has lost legal entitlement to use the property identified in the permit to install and operate equipment covered by the permit, upon notice that the property owner does not wish to have continued the operation of the permitted equipment, or upon notice that the owner of the permitted equipment no longer wishes to retain the permit for future operation.

**22.3(8) Ownership change of permitted equipment.** The new owner shall notify the department in writing no later than 30 days after the change in ownership of equipment covered by a construction permit pursuant to rule 567—22.1(455B). The notification to the department shall be mailed to the Air Quality Bureau, Iowa Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324, and shall include the following information:

- a. The date of ownership change;
- b. The name, address and telephone number of the responsible official, the contact person and the owner of the equipment both before and after ownership change; and
- c. The construction permit number of the equipment changing ownership.

This rule is intended to implement Iowa Code section 455B.133.

[ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 0330C, IAB 9/19/12, effective 10/24/12; ARC 1913C, IAB 3/18/15, effective 4/22/15]

**567—22.4(455B) Special requirements for major stationary sources located in areas designated attainment or unclassified (PSD).** As applicable, the owner or operator of a stationary source shall comply with the rules for prevention of significant deterioration (PSD) as set forth in 567—Chapter 33. An owner or operator required to apply for a construction permit under this rule shall submit all required fees as required in 567—Chapter 30.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.5(455B) Special requirements for nonattainment areas.** As applicable, the owner or operator of a stationary source shall comply with the requirements for the nonattainment major NSR program as set forth in rule 567—31.20(455B). An owner or operator required to apply for a construction permit under this rule shall submit all required fees as required in 567—Chapter 30.

[ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.6(455B) Nonattainment area designations.** Rescinded ARC 1227C, IAB 12/11/13, effective 1/15/14.

**567—22.7(455B) Alternative emission control program.**

**22.7(1) Applicability.** The owner or operator of any source located in an area with attainment or unclassified status (as published at 40 CFR §81.316 amended August 5, 2013) or located in an area with an approved state implementation plan (SIP) demonstrating attainment by the statutory deadline may apply for an alternative set of emission limits if:

- a. The applicant is presently in compliance with EPA approved SIP requirements, or
- b. The applicant is subject to a consent order to meet an EPA approved compliance schedule and the final compliance date will not be delayed by the use of alternative emission limits.

**22.7(2) Demonstration requirements.** The applicant for the alternative emission control program shall have the burden of demonstrating that:

- a. The alternative emission control program will not interfere with the attainment and maintenance of ambient air quality standards, including the reasonable further progress or prevention of significant deterioration requirements of the Clean Air Act;
- b. The alternative emission limits are equivalent to existing emission limits in pollution reduction, enforceability, and environmental impact; (In the case of a particulate nonattainment area, the difference between the allowable emission rate and the actual emission rate, as of January 1, 1978, cannot be credited in the emissions tradeoff.)
- c. The pollutants being exchanged are comparable and within the same pollutant category;
- d. Hazardous air pollutants designated in 40 CFR Part 61, as amended through July 20, 2004, will not be exchanged for nonhazardous air pollutants;
- e. The alternative program will not result in any delay in compliance by any source.

Specific situations may require additional demonstration as specified at 44 FR 71780-71788, December 11, 1979, or as requested by the director.

**22.7(3) Approval process.**

- a. The director shall review all alternative emission control program proposals and shall make recommendations on all completed demonstrations to the commission.
- b. After receiving recommendations from the director and public comments made available through the hearing process, the commission may approve or disapprove the alternative emission control program proposal.
- c. If approved by the commission, the program will be forwarded to the EPA regional administrator as a revision to the State Implementation Plan. The alternative emission control program must receive the approval of the EPA regional administrator prior to becoming effective.

[ARC 1227C, IAB 12/11/13, effective 1/15/14]

**567—22.8(455B) Permit by rule.**

**22.8(1) Permit by rule for spray booths.** Spray booths which comply with the requirements contained in this rule will be deemed to be in compliance with the requirements to obtain an air construction permit and an air operating permit. Spray booths which comply with this rule will be considered to have federally enforceable limits so that their potential emissions are less than the major source limits for regulated air pollutants and hazardous air pollutants as defined in rule 567—22.100(455B). An owner or operator required to apply for a permit by rule under this subrule shall submit fees as required in 567—Chapter 30.

a. Definition. “Sprayed material” is material applied by spray equipment when used in a surface coating process in a spray booth, including but not limited to paint, solvents, and mixtures of paint and solvents. Powder coatings applied in an indoor-vented spray booth equipped with filters or overspray powder recovery systems are not considered sprayed material for purposes of this rule (567—22.8(455B)).

b. Facilities which facilitywide spray one gallon per day or less of sprayed material are exempt from all other requirements in 567—Chapter 22, except that they must submit the certification in 22.8(1)“e” to the department and keep records of daily sprayed material use. Any spray booth or associated equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall use sprayed material with

a maximum lead content of 0.35 pounds or less per gallon if the booth or associated equipment is subject to the following NESHAP: 40 CFR Part 63, Subpart HHHHHH or Subpart XXXXXX. Any spray booth or associated equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, that is not subject to the NESHAP or is otherwise exempt from the NESHAP shall use sprayed material with a maximum lead content of 0.02 pounds or less per gallon. The owner or operator must keep the records of daily sprayed material use for 18 months from the date to which the records apply and shall keep safety data sheets (SDS) or equivalent records for at least two calendar years to demonstrate that the sprayed materials contain lead at less than the exemption thresholds. The owner or operator must also certify that the facility is in compliance with or otherwise exempt from the federal regulations specified in 22.8(1) “e.”

c. Facilities which facilitywide spray more than one gallon per day but never more than three gallons per day are exempt from all other requirements in 567—Chapter 22, except that they must submit the certification in 22.8(1) “e” to the department, keep records of daily sprayed material use, and vent emissions from a spray booth(s) through a stack(s) which is at least 22 feet tall, measured from ground level. Any spray booth or associated equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall use sprayed material with a maximum lead content of 0.35 pounds or less per gallon if the booth or associated equipment is subject to the following NESHAP: 40 CFR Part 63, Subpart HHHHHH or Subpart XXXXXX. Any spray booth or associated equipment for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, that is not subject to the NESHAP or is otherwise exempt from the NESHAP shall use sprayed material with a maximum lead content of 0.02 pounds or less per gallon. The owner or operator must keep the records of daily sprayed material use for 18 months from the date to which the records apply and shall keep safety data sheets (SDS) or equivalent records for at least two calendar years to demonstrate that the sprayed materials contain lead at less than the exemption thresholds. The owner or operator must also certify that the facility is in compliance with or otherwise exempt from the federal regulations specified in 22.8(1) “e.”

d. Facilities which facilitywide spray more than three gallons per day are not eligible to use the permit by rule for spray booths and must apply for a construction permit as required by subrules 22.1(1) and 22.1(3) unless otherwise exempt.

e. Notification letter.

(1) Facilities which claim to be permitted by provisions of this rule must submit to the department a written notification letter, on forms provided by the department, certifying that the facility meets the following conditions:

1. All paint booths and associated equipment are in compliance with the provisions of subrule 22.8(1);

2. All paint booths and associated equipment are in compliance with all applicable requirements including, but not limited to, the allowable particulate emission rate for painting and surface coating operations of 0.01 gr/scf of exhaust gas as specified in 567—subrule 23.4(13); and

3. All paint booths and associated equipment currently are or will be in compliance with or otherwise exempt from the national emissions standards for hazardous air pollutants (NESHAP) for paint stripping and miscellaneous surface coating at area sources (40 CFR Part 63, Subpart HHHHHH) and the NESHAP for metal fabricating and finishing at area sources (40 CFR Part 63, Subpart XXXXXX) by the applicable NESHAP compliance dates.

(2) The certification must be signed by one of the following individuals:

1. For corporations, a principal executive officer of at least the level of vice president, or a responsible official as defined at rule 567—22.100(455B).

2. For partnerships, a general partner.

3. For sole proprietorships, the proprietor.

4. For municipal, state, county, or other public facilities, the principal executive officer or the ranking elected official.

**22.8(2) Reserved.**

[ARC 7565B, IAB 2/11/09, effective 3/18/09; ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 1013C, IAB 9/18/13, effective 10/23/13; ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—22.9(455B) Special requirements for visibility protection.**

**22.9(1) Definitions.** Definitions included in this subrule apply to the provisions set forth in rule 567—22.9(455B).

“*Best available retrofit technology (BART)*” means an emission limitation based on the degree of reduction achievable through the application of the best system of continuous emission reduction for each pollutant which is emitted by an existing stationary facility. The emission limitation must be established, on a case-by-case basis, taking into consideration the technology available, the costs of compliance, the energy and non-air quality environmental impacts of compliance, any pollution control equipment in use or in existence at the source, the remaining useful life of the source, and the degree of improvement in visibility which may reasonably be anticipated to result from the use of such technology.

“*Deciview*” means a haze index derived from calculated light extinction, such that uniform changes in haziness correspond to uniform incremental changes in perception across the entire range of conditions, from pristine to highly impaired. The deciview haze index is calculated based on an equation found in 40 CFR 51.301, as amended on July 1, 1999.

“*Mandatory Class I area*” means any Class I area listed in 40 CFR Part 81, Subpart D, as amended through October 5, 1989.

**22.9(2) Best available retrofit technology (BART) applicability.** A source shall comply with the provisions of subrule 22.9(3) if the source falls within numbers 1 through 20 or 22 through 26 of the “stationary source categories” of air pollutants listed in rule 22.100(455B) or is a fossil-fuel fired boiler individually totaling more than 250 million Btu’s per hour heat input and meets the following criteria:

- a. Any emission unit for which startup began after August 7, 1962; and
- b. Construction of the emission unit commenced on or before August 7, 1977; and
- c. The sum of the potential to emit, as “potential to emit” is defined in 567—20.2(455B), from emission units identified above is equal to or greater than 250 tons per year or more of one of the following pollutants: nitrogen oxides, sulfur dioxide, particulate matter (PM<sub>10</sub>), or volatile organic compounds.

**22.9(3) Duty to self-identify.** The owner or operator or designated representative of a facility meeting the conditions of subrule 22.9(2) shall submit two copies of a completed BART Eligibility Certification Form #542-8125, which shall include all information necessary for the department to complete eligibility determinations. The information submitted shall include source identification, description of processes, potential emissions, emission unit and emission point characteristics, date construction commenced and date of startup, and other information required by the department. The completed form was required to be submitted to the Air Quality Bureau, Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324, by September 1, 2005.

**22.9(4) Notification.** The department shall notify in writing the owner or operator or designated representative of a source of the department’s determination that either:

- a. A source meets the conditions listed in 22.9(2) (a source that meets these conditions is BART-eligible); or
- b. For the purposes of the regional haze program, a source may cause or contribute to visibility impairment in any mandatory Class I area, as identified during either:
  - (1) Regional haze plan development required by 40 CFR 51.308(d) as amended on July 6, 2005; or
  - (2) A five-year periodic review on the progress toward the reasonable progress goals required by 40 CFR 51.308(g) as amended on July 6, 2005; or
  - (3) A ten-year comprehensive periodic revision of the implementation plan required by 40 CFR 51.308(f) as amended on July 6, 2005.

**22.9(5) Analysis.** The department may request in writing an analysis from the owner or operator or designated representative of a source that the department has determined may be causing or contributing to visibility impairment in a mandatory Class I area.

*a. BART control analysis.* For the purposes of BART, a source that is responsible for an impact of 1.0 deciview or more at a mandatory Class I area is considered to cause visibility impairment. A source that is responsible for an impact of 0.5 deciview or more at a mandatory Class I area is considered to contribute to visibility impairment. If a source meets either of these criteria, the owner or operator or designated representative shall prepare the BART analysis in accordance with Section IV of Appendix Y of 40 CFR Part 51 as amended through July 5, 2005, and shall submit the BART analysis 180 days after receipt of written notification by the department that a BART analysis is required.

*b. Regional haze analysis.* The owner or operator or designated representative of a source subject to 22.9(4)“b” shall prepare and submit an analysis after receipt of written notification by the department that an analysis is required.

**22.9(6) Control technology implementation.** Following the department’s review of the analysis submitted pursuant to 22.9(5), an owner or operator of a source identified in 22.9(4) shall:

*a.* Submit all necessary permit applications to achieve the emissions requirements established following the completion of analysis performed in accordance with 22.9(5).

*b.* Install, operate, and maintain the control technology as required by permits issued by the department.

**22.9(7) BART exemption.** The owner or operator of a source subject to the BART emission control requirements may apply for an exemption from subrule 22.9(5) in accordance with 40 CFR 51.303 as amended on July 1, 1999.

[ARC 8215B, IAB 10/7/09, effective 11/11/09]

**567—22.10(455B) Permitting requirements for country grain elevators, country grain terminal elevators, grain terminal elevators and feed mill equipment.** The requirements of this rule apply only to country grain elevators, country grain terminal elevators, grain terminal elevators and feed mill equipment, as these terms are defined in subrule 22.10(1). The requirements of this rule do not apply to equipment located at grain processing plants or grain storage elevators, as “grain processing” and “grain storage elevator” are defined in rule 567—20.2(455B). Compliance with the requirements of this rule does not alleviate any affected person’s duty to comply with any applicable state or federal regulations. In particular, the emission standards set forth in 567—Chapter 23, including the regulations for grain elevators contained in 40 CFR Part 60, Subpart DD (as adopted by reference in 567—paragraph 23.1(2)“ooo”), may apply. An owner or operator subject to this rule shall submit fees as required in 567—Chapter 30.

**22.10(1) Definitions.** For purposes of rule 567—22.10(455B), the following terms shall have the meanings indicated in this subrule.

“*Country grain elevator*” means any plant or installation at which grain is unloaded, handled, cleaned, dried, stored, or loaded and which meets the following criteria:

1. Receives more than 50 percent of its grain, as “grain” is defined in this subrule, from farmers in the immediate vicinity during harvest season;
2. Is not located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant.

“*Country grain terminal elevator*” means any plant or installation at which grain is unloaded, handled, cleaned, dried, stored, or loaded and which meets the following criteria:

1. Receives 50 percent or less of its grain, as “grain” is defined in this subrule, from farmers in the immediate vicinity during harvest season;
2. Has a permanent storage capacity of less than or equal to 2.5 million U.S. bushels, as “permanent storage capacity” is defined in this subrule;
3. Is not located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant.

“*Feed mill equipment,*” for purposes of rule 567—22.10(455B), means grain processing equipment that is used to make animal feed including, but not limited to, grinders, crackers, hammermills, and pellet coolers, and that is located at a country grain elevator, country grain terminal elevator or grain terminal elevator.

“*Grain*,” as set forth in Iowa Code section 203.1(9), means any grain for which the United States Department of Agriculture has established standards including, but not limited to, corn, wheat, oats, soybeans, rye, barley, grain sorghum, flaxseeds, sunflower seed, spelt (emmer), and field peas.

“*Grain processing*” shall have the same definition as “grain processing” set forth in rule 567—20.2(455B).

“*Grain storage elevator*” shall have the same definition as “grain storage elevator” set forth in rule 567—20.2(455B).

“*Grain terminal elevator*,” for purposes of rule 567—22.10(455B), means any plant or installation at which grain is unloaded, handled, cleaned, dried, stored, or loaded and which meets the following criteria:

1. Receives 50 percent or less of its grain, as “grain” is defined in this subrule, from farmers in the immediate vicinity during harvest season;
2. Has a permanent storage capacity of more than 88,100 m<sup>3</sup> (2.5 million U.S. bushels), as “permanent storage capacity” is defined in this subrule;
3. Is not located at an animal food manufacturer, pet food manufacturer, cereal manufacturer, brewery, or livestock feedlot;
4. Is not located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant.

“*Permanent storage capacity*” means grain storage capacity which is inside a building, bin, or silo.

**22.10(2) Methods for determining potential to emit (PTE).** The owner or operator of a country grain elevator, country grain terminal elevator, grain terminal elevator or feed mill equipment shall use the following methods for calculating the potential to emit (PTE) for particulate matter (PM) and for particulate matter with an aerodynamic diameter less than or equal to 10 microns (PM<sub>10</sub>).

*a. Country grain elevators.* The owner or operator of a country grain elevator shall calculate the PTE for PM and PM<sub>10</sub> as specified in the definition of “potential to emit” in rule 567—20.2(455B), except that “maximum capacity” means the greatest amount of grain received at the country grain elevator during one calendar, 12-month period of the previous five calendar, 12-month periods, multiplied by an adjustment factor of 1.2. The owner or operator may make additional adjustments to the calculations for air pollution control of PM and PM<sub>10</sub> if the owner or operator submits the calculations to the department using the PTE calculation tool provided by the department, and only if the owner or operator fully implements the applicable air pollution control measures no later than March 31, 2009, or upon startup of the equipment, whichever event first occurs. Credit for the application of some best management practices, as specified in subrule 22.10(3) or in a permit issued by the department, may also be used to make additional adjustments in the PTE for PM and PM<sub>10</sub> if the owner or operator submits the calculations to the department using the PTE calculation tool provided by the department, and only if the owner or operator fully implements the applicable best management practices no later than March 31, 2009, or upon startup of the equipment, whichever event first occurs.

*b. Country grain terminal elevators.* The owner or operator of a country grain terminal elevator shall calculate the PTE for PM and PM<sub>10</sub> as specified in the definition of “potential to emit” in rule 567—20.2(455B).

*c. Grain terminal elevators.* For purposes of the permitting and other requirements specified in subrule 22.10(3), the owner or operator of a grain terminal elevator shall calculate the PTE for PM and PM<sub>10</sub> as specified in the definition of “potential to emit” in rule 567—20.2(455B). For purposes of determining whether the stationary source is subject to the prevention of significant deterioration (PSD) requirements set forth in 567—Chapter 33, or for determining whether the source is subject to the operating permit requirements set forth in rules 567—22.100(455B) through 567—22.300(455B), the owner or operator of a grain terminal elevator shall include fugitive emissions, as “fugitive emissions” is defined in 567—subrule 33.3(1) and in rule 567—22.100(455B), in the PTE calculation.

*d. Feed mill equipment.* The owner or operator of feed mill equipment, as “feed mill equipment” is defined in subrule 22.10(1), shall calculate the PTE for PM and PM<sub>10</sub> for the feed mill equipment as specified in the definition of “potential to emit” in rule 567—20.2(455B). For purposes of determining whether the stationary source is subject to the prevention of significant deterioration (PSD) requirements

set forth in 567—Chapter 33, or for determining whether the stationary source is subject to the operating permit requirements set forth in rules 567—22.100(455B) through 567—22.300(455B), the owner or operator of feed mill equipment shall sum the PTE of the feed mill equipment with the PTE of the country grain elevator, country grain terminal elevator or grain terminal elevator.

**22.10(3)** *Classification and requirements for permits, emissions controls, record keeping and reporting for Group 1, Group 2, Group 3 and Group 4 grain elevators.* The requirements for construction permits, operating permits, emissions controls, record keeping and reporting for a stationary source that is a country grain elevator, country grain terminal elevator or grain terminal elevator are set forth in this subrule.

*a. Group 1 facilities.* A country grain elevator, country grain terminal elevator or grain terminal elevator may qualify as a Group 1 facility if the PTE at the stationary source is less than 15 tons of PM<sub>10</sub> per year, as PTE is specified in subrule 22.10(2). For purposes of this paragraph, an “existing” Group 1 facility is one that commenced construction or reconstruction before February 6, 2008. A “new” Group 1 facility is one that commenced construction or reconstruction on or after February 6, 2008.

(1) Group 1 registration. The owner or operator of a Group 1 facility shall submit to the department a Group 1 registration, including PTE calculations, on forms provided by the department, certifying that the facility’s PTE is less than 15 tons of PM<sub>10</sub> per year. The owner or operator of an existing facility shall provide the Group 1 registration to the department on or before March 31, 2008. The owner or operator of a new facility shall provide the Group 1 registration to the department prior to initiating construction or reconstruction of a facility. The registration becomes effective upon the department’s receipt of the signed registration form and the PTE calculations.

1. If the owner or operator registers with the department as specified in subparagraph 22.10(3) “a”(1), the owner or operator is exempt from the requirement to obtain a construction permit as specified under subrule 22.1(1).

2. Upon department receipt of a Group 1 registration and PTE calculations, the owner or operator is allowed to add, remove and modify the emissions units or change throughput or operations at the facility without modifying the Group 1 registration, provided that the owner or operator calculates the PTE for PM<sub>10</sub> on forms provided by the department prior to making any additions to, removals of or modifications to equipment, and only if the facility continues to meet the emissions limits and operating limits (including restrictions on material throughput and hours of operation, if applicable, as specified in the PTE for PM<sub>10</sub> calculations) specified in the Group 1 registration.

3. If equipment at a Group 1 facility currently has an air construction permit issued by the department, that permit shall remain in full force and effect, and the permit shall not be invalidated by the subsequent submittal of a registration made pursuant to subparagraph 22.10(3) “a”(1).

(2) Best management practices (BMP). The owner or operator of a Group 1 facility shall implement best management practices (BMP) for controlling air pollution at the facility and for limiting fugitive dust at the facility from crossing the property line. The owner or operator shall implement BMP according to the department manual, Best Management Practices (BMP) for Grain Elevators (December 2007; revised July 15, 2014), as adopted by the commission on January 15, 2008, and July 15, 2014, and adopted by reference herein (available from the department, upon request, and on the department’s Internet website). No later than March 31, 2009, the owner or operator of an existing Group 1 facility shall fully implement applicable BMP, except that BMPs for grain vacuuming operations shall be fully implemented no later than September 10, 2014. Upon startup of equipment at the facility, the owner or operator of a new Group 1 facility shall fully implement applicable BMP.

(3) Record keeping. The owner or operator of a Group 1 facility shall retain a record of the previous five calendar years of total annual grain handled and shall calculate the facility’s potential PM<sub>10</sub> emissions annually by January 31 for the previous calendar year. These records shall be kept on site for a period of five years and shall be made available to the department upon request.

(4) Emissions increases. The owner or operator of a Group 1 facility shall calculate any emissions increases prior to making any additions to, removals of or modifications to equipment. If the owner or operator determines that PM<sub>10</sub> emissions at a Group 1 facility will increase to 15 tons per year or more,

the owner or operator shall comply with the requirements set forth for Group 2, Group 3 or Group 4 facilities, as applicable, prior to making any additions to, removals of or modifications to equipment.

(5) Changes to facility classification or permanent grain storage capacity. If the owner or operator of a Group 1 facility plans to change the facility's operations or increase the facility's permanent grain storage capacity to more than 2.5 million U.S. bushels, the owner or operator, prior to making any changes, shall reevaluate the facility's classification and the allowed method for calculating PTE to determine if any increases to the PTE for PM<sub>10</sub> will occur. If the proposed change will alter the facility's classification or will increase the facility's PTE for PM<sub>10</sub> such that the facility PTE increases to 15 tons per year or more, the owner or operator shall comply with the requirements set forth for Group 2, Group 3 or Group 4 facilities, as applicable, prior to making the change.

*b. Group 2 facilities.* A country grain elevator, country grain terminal elevator or grain terminal elevator may qualify as a Group 2 facility if the PTE at the stationary source is greater than or equal to 15 tons of PM<sub>10</sub> per year and is less than or equal to 50 tons of PM<sub>10</sub> per year, as PTE is specified in subrule 22.10(2). For purposes of this paragraph, an "existing" Group 2 facility is one that commenced construction, modification or reconstruction before February 6, 2008. A "new" Group 2 facility is one that commenced construction or reconstruction on or after February 6, 2008.

(1) Group 2 permit for grain elevators. The owner or operator of a Group 2 facility may, in lieu of obtaining air construction permits for each piece of emissions equipment at the facility, submit to the department a completed Group 2 permit application for grain elevators, including PTE calculations, on forms provided by the department. Alternatively, the owner or operator may obtain an air construction permit as specified under subrule 22.1(1). The owner or operator of an existing facility shall provide the appropriate completed Group 2 permit application for grain elevators or the appropriate construction permit applications to the department on or before March 31, 2008. The owner or operator of a new facility shall provide the appropriate, completed Group 2 permit application for grain elevators or the appropriate construction permit applications to the department prior to initiating construction or reconstruction of a facility.

1. Upon department issuance of a Group 2 permit to a facility, the owner or operator is allowed to add, remove and modify the emissions units at the facility, or change throughput or operations, without modifying the Group 2 permit, provided that the owner or operator calculates the PTE for PM<sub>10</sub> prior to making any additions to, removals of or modifications to equipment, and only if the facility continues to meet the emissions limits and operating limits (including restrictions on material throughput and hours of operation, if applicable, as specified in the PTE for PM<sub>10</sub> calculations) specified in the Group 2 permit.

2. If a Group 2 facility currently has an air construction permit issued by the department, that permit shall remain in full force and effect, and the permit shall not be invalidated by the subsequent submittal of a Group 2 permit application for grain elevators made pursuant to this rule. However, the owner or operator of a Group 2 facility may request that the department incorporate any equipment with a previously issued construction permit into the Group 2 permit for grain elevators. The department will grant such requests on a case-by-case basis. If the department grants the request to incorporate previously permitted equipment into the Group 2 permit for grain elevators, the owner or operator of the Group 2 facility is responsible for requesting that the department rescind any previously issued construction permits.

(2) Best management practices (BMP). The owner or operator shall implement BMP, as specified in the Group 2 permit, for controlling air pollution at the source and for limiting fugitive dust at the source from crossing the property line. If the department revises the BMP requirements for Group 2 facilities after a facility is issued a Group 2 permit, the owner or operator of the Group 2 facility may request that the department modify the facility's Group 2 permit to incorporate the revised BMP requirements. The department will issue permit modifications to incorporate BMP revisions on a case-by-case basis. No later than March 31, 2009, the owner or operator of an existing Group 2 facility shall fully implement BMP, as specified in the Group 2 permit. Upon startup of equipment at the facility, the owner or operator of a new Group 2 facility shall fully implement BMP, as specified in the Group 2 permit.

(3) Record keeping. The owner or operator of a Group 2 facility shall retain all records as specified in the Group 2 permit.

(4) Emissions inventory. The owner or operator of a Group 2 facility shall submit an emissions inventory for the facility for all regulated air pollutants as specified under 567—subrule 21.1(3).

(5) Emissions increases. The owner or operator of a Group 2 facility shall calculate any emissions increases prior to making any additions to, removals of or modifications to equipment. If the owner or operator determines that potential PM<sub>10</sub> emissions at a Group 2 facility will increase to more than 50 tons per year, the owner or operator shall comply with the requirements set forth for Group 3 or Group 4 facilities, as applicable, prior to making any additions to, removals of or modifications to equipment.

(6) Changes to facility classification or permanent grain storage capacity. If the owner or operator of a Group 2 facility plans to change the facility's operations or increase the facility's permanent grain storage capacity to more than 2.5 million U.S. bushels, the owner or operator, prior to making any changes, shall reevaluate the facility's classification and the allowed method for calculating PTE to determine if any increases to the PTE for PM<sub>10</sub> will occur. If the proposed change will increase the facility's PTE for PM<sub>10</sub> such that the facility PTE increases to more than 50 tons per year, the owner or operator shall comply with the requirements set forth for Group 3 or Group 4 facilities, as applicable, prior to making the change.

*c. Group 3 facilities.* A country grain elevator, country grain terminal elevator or grain terminal elevator may qualify as a Group 3 facility if the PTE for PM<sub>10</sub> at the stationary source is greater than 50 tons per year, but is less than 100 tons of PM<sub>10</sub> per year, as PTE is specified in subrule 22.10(2). For purposes of this paragraph, an "existing" Group 3 facility is one that commenced construction, modification or reconstruction before February 6, 2008. A "new" Group 3 facility is one that commenced construction or reconstruction on or after February 6, 2008.

(1) Air construction permit. The owner or operator of a Group 3 facility shall obtain the required construction permits as specified under subrule 22.1(1). The owner or operator of an existing facility shall provide the construction permit applications, as specified in subrule 22.1(3), to the department on or before March 31, 2008. The owner or operator of a new facility shall obtain the required permits, as specified in subrule 22.1(1), from the department prior to initiating construction or reconstruction of a facility.

(2) Permit conditions. Construction permit conditions for a Group 3 facility shall include, but are not limited to, the following:

1. The owner or operator shall implement BMP, as specified in the permit, for controlling air pollution at the source and for limiting fugitive dust at the source from crossing the property line. If the department revises the BMP requirements for Group 3 facilities after a facility is issued a permit, the owner or operator of the Group 3 facility may request that the department modify the facility's permit to incorporate the revised BMP requirements. The department will issue permit modifications to incorporate BMP revisions on a case-by-case basis.

2. The owner or operator shall retain all records as specified in the permit.

(3) Emissions inventory. The owner or operator shall submit an emissions inventory for the facility for all regulated air pollutants as specified under 567—subrule 21.1(3).

(4) Changes to facility classification or permanent grain storage capacity. If the owner or operator of a Group 3 facility plans to change its operations or increase the facility's permanent grain storage capacity to more than 2.5 million U.S. bushels, the owner or operator, prior to making any changes, shall reevaluate the facility's classification and the allowed method for calculating PTE to determine if any increases to the PTE for PM<sub>10</sub> will occur. If the proposed change will alter the facility's classification or will increase the facility's PTE for PM<sub>10</sub> such that the facility PTE increases to greater than or equal to 100 tons per year, the owner or operator shall comply with the requirements set forth for Group 4 facilities, as applicable, prior to making the change.

(5) PSD applicability. If the PTE for PM or PM<sub>10</sub> at the Group 3 facility is greater than or equal to 250 tons per year, the owner or operator shall comply with requirements specified in 567—Chapter 33, as applicable. The owner or operator of a Group 3 facility that is a grain terminal elevator shall include fugitive emissions, as "fugitive emissions" is defined in 567—subrule 33.3(1), in the PTE calculation for determining PSD applicability.

(6) Record keeping. The owner or operator shall keep the records of annual grain handled at the facility and annual PTE for PM and PM<sub>10</sub> emissions on site for a period of five years, and the records shall be made available to the department upon request.

*d. Group 4 facilities.* A facility qualifies as a Group 4 facility if the facility is a stationary source with a PTE equal to or greater than 100 tons of PM<sub>10</sub> per year, as PTE is specified in subrule 22.10(2). For purposes of this paragraph, an “existing” Group 4 facility is one that commenced construction, modification or reconstruction before February 6, 2008. A “new” Group 4 facility is one that commenced construction or reconstruction on or after February 6, 2008.

(1) Air construction permit. The owner or operator of a Group 4 facility shall obtain the required construction permits as specified under subrule 22.1(1). The owner or operator of an existing facility shall provide the construction permit applications, as specified by subrule 22.1(3), to the department on or before March 31, 2008. The owner or operator of a new facility shall obtain the required permits, as specified by subrule 22.1(1), from the department prior to initiating construction or reconstruction of a facility.

(2) Permit conditions. Construction permit conditions for a Group 4 facility shall include, but are not limited to, the following:

1. The owner or operator shall implement BMP, as specified in the permit, for controlling air pollution at the facility and for limiting fugitive dust at the facility from crossing the property line. If the department revises the BMP requirements for Group 4 facilities after a facility is issued a permit, the owner or operator of the Group 4 facility may request that the department modify the facility’s permit to incorporate the revised BMP requirements. The department will issue permit modifications to incorporate BMP revisions on a case-by-case basis.

2. The owner or operator shall retain all records as specified in the permit.

(3) PSD applicability. If the PTE for PM or PM<sub>10</sub> at the facility is equal to or greater than 250 tons per year, the owner or operator shall comply with requirements specified in 567—Chapter 33, as applicable. The owner or operator of a Group 4 facility that is a grain terminal elevator shall include fugitive emissions, as “fugitive emissions” is defined in 567—subrule 33.3(1), in the PTE calculation for determining PSD applicability.

(4) Record keeping. The owner or operator shall keep the records of annual grain handled at the facility and annual PTE for PM and PM<sub>10</sub> emissions on site for a period of five years, and the records shall be made available to the department upon request.

(5) Operating permits. The owner or operator of a Group 4 facility shall apply for an operating permit for the facility if the facility’s annual PTE for PM<sub>10</sub> is equal to or greater than 100 tons per year as specified in rules 567—22.100(455B) through 567—22.300(455B). The owner or operator of a Group 4 facility that is a grain terminal elevator shall include fugitive emissions in the calculations to determine if the PTE for PM<sub>10</sub> is greater than or equal to 100 tons per year. The owner or operator also shall submit annual emissions inventories and fees, as specified in rule 567—22.106(455B).

**22.10(4) Feed mill equipment.** This subrule sets forth the requirements for construction permits, operating permits, and emissions inventories for an owner or operator of feed mill equipment as “feed mill equipment” is defined in subrule 22.10(1). For purposes of this subrule, the owner or operator of “existing” feed mill equipment shall have commenced construction or reconstruction of the feed mill equipment before February 6, 2008. The owner or operator of “new” feed mill equipment shall have commenced construction or reconstruction of the feed mill equipment on or after February 6, 2008.

*a. Air construction permit.* The owner or operator of feed mill equipment shall obtain an air construction permit as specified under subrule 22.1(1) for each piece of feed mill equipment that emits a regulated air pollutant. The owner or operator of “existing” feed mill equipment shall provide the appropriate permit applications to the department on or before March 31, 2008. The owner or operator of “new” feed mill equipment shall provide the appropriate permit applications to the department prior to initiating construction or reconstruction of feed mill equipment.

*b. Emissions inventory.* The owner or operator shall submit an emissions inventory for the feed mill equipment for all regulated air pollutants as specified under 567—subrule 21.1(3).

*c. Operating permits.* The owner or operator shall sum the PTE of the feed mill equipment with the PTE of the equipment at the country grain elevator, country grain terminal elevator or grain terminal elevator, as PTE is specified in subrule 22.10(2), to determine if operating permit requirements specified in rules 567—22.100(455B) through 567—22.300(455B) apply to the stationary source. If the operating permit requirements apply, then the owner or operator shall apply for an operating permit as specified in rules 567—22.100(455B) through 567—22.300(455B). The owner or operator also shall begin submitting annual emissions inventories and fees, as specified under rule 567—22.106(455B).

*d. PSD applicability.* For purposes of determining whether the stationary source is subject to the prevention of significant deterioration (PSD) requirements set forth in 567—Chapter 33, the owner or operator shall sum the PTE of the feed mill equipment with the PTE of the equipment at the country grain elevator, country grain terminal elevator or grain terminal elevator. If the PTE for PM or PM<sub>10</sub> for the stationary source is equal to or greater than 250 tons per year, the owner or operator shall comply with requirements for PSD specified in 567—Chapter 33, as applicable.

[ARC 1561C, IAB 8/6/14, effective 9/10/14; ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—22.11 to 22.99** Reserved.

**567—22.100(455B) Definitions for Title V operating permits.** For purposes of rules 567—22.100(455B) to 567—22.116(455B), the following terms shall have the meaning indicated in this rule:

“*Act*” means the Clean Air Act, 42 U.S.C. Sections 7401, et seq.

“*Actual emissions*” means the actual rate of emissions of a pollutant from an emissions unit, as determined in accordance with the following:

1. In general, actual emissions as of a particular date shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during a two-year period which immediately precedes that date and which is representative of normal source operations. The director may allow the use of a different time period upon a demonstration that it is more representative of normal source operations. Actual emissions shall be calculated using the unit’s actual operating hours, production rates, and types of materials processed, stored or combusted during the selected time period. Actual emissions for acid rain affected sources are calculated using a one-year period.

2. Lacking specific information to the contrary, the director may presume that source-specific allowable emissions for the unit are equivalent to the actual emissions of the unit.

3. For any emissions unit which has not begun normal operations on a particular date, actual emissions shall equal the potential to emit of the unit on that date.

4. For purposes of calculating early reductions of hazardous air pollutants, actual emissions shall not include excess emissions resulting from a malfunction or from startups and shutdowns associated with a malfunction.

Actual emissions for purposes of determining fees shall be the actual emissions calculated over a period of one year.

“*Administrator*” means the administrator for the United States Environmental Protection Agency (EPA) or designee.

“*Affected facility*” means, with reference to a stationary source, any apparatus which emits or may emit any regulated air pollutant or contaminant.

“*Affected source*” means a source that includes one or more affected units subject to any emissions reduction requirement or limitation under Title IV of the Act.

“*Affected state*” means any state which is contiguous to the permitting state and whose air quality may be affected through the modification, renewal or issuance of a Title V permit; or which is within 50 miles of the permitted source.

“*Affected unit*” means a unit that is subject to any acid rain emissions reduction requirement or acid rain emissions limitation under Title IV of the Act.

“*Allowable emissions*” means the emission rate of a stationary source calculated using both the maximum rated capacity of the source, unless the source is subject to federally enforceable limits which restrict the operating rate or hours of operation, and the most stringent of the following:

1. The applicable new source performance standards or national emissions standards for hazardous air pollutants, contained in 567—subrules 23.1(2) and 23.1(3);
2. The applicable existing source emission standard contained in 567—Chapter 23; or
3. The emissions rate specified in the air construction permit for the source.

“*Allowance*” means an authorization by the administrator under Title IV of the Act or rules promulgated thereunder to emit during or after a specified calendar year up to one ton of sulfur dioxide.

“*Applicable requirement*” includes the following:

1. Any standard or other requirement provided for in the applicable implementation plan approved or promulgated by EPA through rule making under Title I of the Act that implements the relevant requirements of the Act, including any revisions to that plan promulgated in 40 CFR 52;
2. Any term or condition of any preconstruction permits issued pursuant to regulations approved or promulgated through rule making under Title I, including Parts C and D, of the Act;
3. Any standard or other requirement under Section 111 of the Act (subrule 23.1(2)), including Section 111(d);
4. Any standard or other requirement under Section 112 of the Act, including any requirement concerning accident prevention under Section 112(r)(7) of the Act;
5. Any standard or other requirement of the acid rain program under Title IV of the Act or the regulations promulgated thereunder;
6. Any requirements established pursuant to Section 504(b) or Section 114(a)(3) of the Act;
7. Any standard or other requirement governing solid waste incineration, under Section 129 of the Act;
8. Any standard or other requirement for consumer and commercial products, under Section 183(e) of the Act;
9. Any standard or other requirement for tank vessels under Section 183(f) of the Act;
10. Any standard or other requirement of the program to control air pollution from outer continental shelf sources, under Section 328 of the Act;
11. Any standard or other requirement of the regulations promulgated to protect stratospheric ozone under Title VI of the Act, unless the administrator has determined that such requirements need not be contained in a Title V permit; and
12. Any national ambient air quality standard or increment or visibility requirement under Part C of Title I of the Act, but only as it would apply to temporary sources permitted pursuant to Section 504(e) of the Act.

“*Area source*” means any stationary source of hazardous air pollutants that is not a major source as defined in rule 567—22.100(455B).

“*CFR*” means the Code of Federal Regulations, with standard references in this chapter by Title and Part, so that “40 CFR 51” means “Title 40 of the Code of Federal Regulations, Part 51.”

“*Consumer Price Index*” means for any calendar year the average of the Consumer Price Index for all urban consumers published by the United States Department of Labor, as of the close of the 12-month period ending on August 31 of each calendar year.

“*Country grain elevator*” shall have the same definition as “country grain elevator” set forth in subrule 22.10(1).

“*Designated representative*” means a responsible natural person authorized by the owner(s) or operator(s) of an affected source and of all affected units at the source, as evidenced by a certificate of representation submitted in accordance with Subpart B of 40 CFR Part 72 as amended through April 28, 2006, to represent and legally bind each owner and operator, as a matter of federal law, in matters pertaining to the acid rain program. Whenever the term “responsible official” is used in Chapter 22, it shall be deemed to refer to the designated representative with regard to all matters under the acid rain program.

“*Draft Title V permit*” means the version of a Title V permit for which the department offers public participation or affected state review.

“*Emergency generator*” means any generator of which the sole function is to provide emergency backup power during an interruption of electrical power from the electric utility. An emergency generator does not include:

1. Peaking units at electric utilities;
2. Generators at industrial facilities that typically operate at low rates, but are not confined to emergency purposes; or
3. Any standby generators that are used during time periods when power is available from the electric utility.

An emergency is an unforeseeable condition that is beyond the control of the owner or operator.

“*Emissions allowable under the permit*” means a federally enforceable permit term or condition determined at issuance to be required by an applicable requirement that establishes an emissions limit (including a work practice standard) or a federally enforceable emissions cap that the source has assumed to avoid an applicable requirement to which the source would otherwise be subject.

“*Emissions unit*” means any part or activity of a stationary source that emits or has the potential to emit any regulated air pollutant or any pollutant listed under Section 112(b) of the Act. This term is not meant to alter or affect the definition of the term “unit” for purposes of Title IV of the Act or any related regulations.

“*EPA conditional method*” means any method of sampling and analyzing for air pollutants that has been validated by the administrator but that has not been published as an EPA reference method.

“*EPA reference method*” means the following methods used for performance tests and continuous monitoring systems:

1. Performance test (stack test). A stack test shall be conducted according to EPA reference methods specified in 40 CFR 51, Appendix M (as amended through August 30, 2016); 40 CFR 60, Appendix A (as amended through August 30, 2016); 40 CFR 61, Appendix B (as amended through August 30, 2016); and 40 CFR 63, Appendix A (as amended through August 30, 2016).
2. Continuous monitoring systems. Minimum performance specifications and quality assurance procedures for performance evaluations of continuous monitoring systems are as specified in 40 CFR 60, Appendix B (as amended through August 30, 2016); 40 CFR 60, Appendix F (as amended through August 30, 2016); 40 CFR 75, Appendix A (as amended through August 30, 2016); 40 CFR 75, Appendix B (as amended through August 30, 2016); and 40 CFR 75, Appendix F (as amended through August 30, 2016).

“*Equipment leaks*” means leaks from pumps, compressors, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, connectors, agitators, accumulator vessels, and instrumentation systems.

“*Existing hazardous air pollutant source*” means any source as defined in 40 CFR 61 as adopted by reference in 567—subrule 23.1(3) and 40 CFR 63.72 as adopted by reference in 567—subrule 23.1(4) with respect to Section 112(i)(5) of the Act, the construction or reconstruction of which commenced prior to proposal of an applicable Section 112(d) standard.

“*Facility*” means, with reference to a stationary source, any apparatus which emits or may emit any air pollutant or contaminant.

“*Federal implementation plan*” means a plan promulgated by the administrator to fill all or a portion of a gap or otherwise correct all or a portion of an inadequacy in a state implementation plan, and which includes enforceable emission limitations or other control measures, means or techniques, and provides for attainment of the relevant national ambient air quality standard.

“*Federally enforceable*” means all limitations and conditions which are enforceable by the administrator including, but not limited to, the requirements of the new source performance standards and national emission standards for hazardous air pollutants contained in 567—subrules 23.1(2) and 23.1(3); the requirements of such other state rules or orders approved by the administrator for inclusion in the SIP; and any construction, Title V or other federally approved operating permit conditions.

“*Final Title V permit*” means the version of a Title V permit issued by the department that has completed all required review procedures.

“*Fugitive emissions*” are those emissions which could not reasonably pass through a stack, chimney, vent or other functionally equivalent opening.

“*Hazardous air pollutant*” means any of the following air pollutants listed in Section 112 of the Act:

| cas #   | chemical name                               |
|---------|---|
| 75343   | 1,1-Dichloroethane                          |
| 57147   | 1,1-Dimethyl hydrazine                      |
| 71556   | 1,1,1-Trichloroethane                       |
| 79005   | 1,1,2-Trichloroethane                       |
| 79345   | 1,1,2,2-Tetrachloroethane                   |
| 106887  | 1,2-Butylene oxide                          |
| 96128   | 1,2-Dibromo-3-chloropropane                 |
| 106934  | 1,2-Dibromoethane                           |
| 107062  | 1,2-Dichloroethane                          |
| 78875   | 1,2-Dichloropropane                         |
| 122667  | 1,2-Diphenylhydrazine                       |
| 120821  | 1,2,4-Trichlorobenzene                      |
| 106990  | 1,3-Butadiene                               |
| 542756  | 1,3-Dichloropropylene                       |
| 106467  | 1,4-Dichlorobenzene                         |
| 123911  | 1,4-Dioxane                                 |
| 53963   | 2-Acetylaminofluorene                       |
| 532274  | 2-Chloroacetophenone                        |
| 79469   | 2-Nitropropane                              |
| 540841  | 2,2,4-Trimethylpentane                      |
| 1746016 | 2,3,7,8-Tetrachlorodibenzo-p-dioxin (TC-DD) |
| 94757   | 2,4-D salts and esters                      |
| 95807   | 2,4-Diaminotoluene                          |
| 51285   | 2,4-Dinitrophenol                           |
| 121142  | 2,4-Dinitrotoluene                          |
| 95954   | 2,4,5-Trichlorophenol                       |
| 88062   | 2,4,6-Trichlorophenol                       |
| 91941   | 3,3'-Dichlorobenzidine                      |
| 119904  | 3,3'-Dimethoxybenzidine                     |
| 119937  | 3,3'-Dimethylbenzidine                      |
| 92671   | 4-Aminobiphenyl                             |
| 60117   | 4-Dimethylaminoazobenzene                   |
| 92933   | 4-Nitrobiphenyl                             |
| 100027  | 4-Nitrophenol                               |
| 101144  | 4,4'-Methylenebis(2-chloroaniline)          |
| 101779  | 4,4'-methylenedianiline                     |
| 534521  | 4,6-Dinitro-o-cresol, and salts             |

| cas #   | chemical name                                  |
|---------|--|
| 75070   | Acetaldehyde                                   |
| 60355   | Acetamide                                      |
| 75058   | Acetonitrile                                   |
| 98862   | Acetophenone                                   |
| 107028  | Acrolein                                       |
| 79061   | Acrylamide                                     |
| 79107   | Acrylic acid                                   |
| 107131  | Acrylonitrile                                  |
| 107051  | Allyl chloride                                 |
| 62533   | Aniline  |
| 0       | Antimony Compounds                             |
| 0       | Arsenic Compounds (inorganic including arsine) |
| 1332214 | Asbestos (friable)                             |
| 71432   | Benzene  |
| 92875   | Benzidine                                      |
| 98077   | Benzoic trichloride                            |
| 100447  | Benzyl chloride                                |
| 0       | Beryllium Compounds                            |
| 57578   | Beta-Propiolactone                             |
| 92524   | Biphenyl                                       |
| 111444  | Bis(2-chloroethyl) ether                       |
| 542881  | Bis(chloromethyl) ether                        |
| 75252   | Bromoform                                      |
| 74839   | Bromomethane                                   |
| 0       | Cadmium Compounds                              |
| 156627  | Calcium cyanamide                              |
| 133062  | Captan   |
| 63252   | Carbaryl                                       |
| 75150   | Carbon disulfide                               |
| 56235   | Carbon tetrachloride                           |
| 463581  | Carbonyl sulfide                               |
| 120809  | Catechol                                       |
| 133904  | Chloramben                                     |
| 57749   | Chlordane                                      |
| 7782505 | Chlorine                                       |
| 79118   | Chloroacetic acid                              |
| 108907  | Chlorobenzene                                  |
| 510156  | Chlorobenzilate                                |
| 75003   | Chloroethane                                   |
| 67663   | Chloroform                                     |
| 74873   | Chloromethane                                  |

| cas #   | chemical name  |
|---------|--|
| 107302  | Chloromethyl methyl ether  |
| 126998  | Chloroprene  |
| 0       | Chromium Compounds   |
| 0       | Cobalt Compounds   |
| 0       | Coke Oven Emissions  |
| 1319773 | Cresol/Cresylic acid (isomers & mixture)   |
| 98828   | Cumene   |
| 0       | Cyanide Compounds <sup>1</sup>   |
| 72559   | DDE  |
| 117817  | Di(2-ethylhexyl) phthalate   |
| 334883  | Diazomethane   |
| 132649  | Dibenzofuran   |
| 84742   | Dibutyl phthalate  |
| 75092   | Dichloromethane  |
| 62737   | Dichlorvos   |
| 111422  | Diethanolamine   |
| 64675   | Diethyl sulfate  |
| 68122   | Dimethyl formamide   |
| 131113  | Dimethyl phthalate   |
| 77781   | Dimethyl sulfate   |
| 79447   | Dimethylcarbamyl chloride  |
| 106898  | Epichlorohydrin  |
| 140885  | Ethyl acrylate   |
| 100414  | Ethylbenzene   |
| 107211  | Ethylene glycol  |
| 75218   | Ethylene oxide   |
| 96457   | Ethylene thiourea  |
| 151564  | Ethyleneimine  |
| 0       | Fine Mineral Fibers <sup>3</sup>   |
| 50000   | Formaldehyde   |
| 0       | Glycol Ethers <sup>2</sup> , except cas #111-76-2, ethylene glycol mono-butyl ether, also known as EGBE or 2-Butoxyethanol |
| 76448   | Heptachlor   |
| 87683   | Hexachloro-1,3-butadiene   |
| 118741  | Hexachlorobenzene  |
| 77474   | Hexachlorocyclopentadiene  |
| 67721   | Hexachloroethane   |
| 822060  | Hexamethylene-1,6-diisocyanate   |
| 680319  | Hexamethylphosphoramide  |
| 110543  | Hexane   |
| 302012  | Hydrazine  |

| cas #   | chemical name                   |
|---------|---------------------------------|
| 7647010 | Hydrochloric acid               |
| 7664393 | Hydrogen fluoride               |
| 123319  | Hydroquinone                    |
| 78591   | Isophorone                      |
| 0       | Lead Compounds                  |
| 58899   | Lindane (all isomers)           |
| 108394  | m-Cresol                        |
| 108383  | m-Xylene                        |
| 108316  | Maleic anhydride                |
| 0       | Manganese Compounds             |
| 0       | Mercury Compounds               |
| 67561   | Methanol                        |
| 72435   | Methoxychlor                    |
| 60344   | Methyl hydrazine                |
| 74884   | Methyl iodide                   |
| 108101  | Methyl isobutyl ketone          |
| 624839  | Methyl isocyanate               |
| 80626   | Methyl methacrylate             |
| 1634044 | Methyl tertbutyl ether          |
| 101688  | Methylene bis(phenylisocyanate) |
| 684935  | N-Nitroso-N-methylurea          |
| 62759   | N-Nitrosodimethylamine          |
| 59892   | N-Nitrosomorpholine             |
| 91203   | Naphthalene                     |
| 0       | Nickel Compounds                |
| 98953   | Nitrobenzene                    |
| 121697  | N,N-Dimethylaniline             |
| 90040   | o-Anisidine                     |
| 95487   | o-Cresol                        |
| 95534   | o-Toluidine                     |
| 95476   | o-Xylene                        |
| 106445  | p-Cresol                        |
| 106503  | p-Phenylenediamine              |
| 106423  | p-Xylene                        |
| 56382   | Parathion                       |
| 87865   | Pentachlorophenol               |
| 108952  | Phenol                          |
| 75445   | Phosgene                        |
| 7803512 | Phosphine                       |
| 7723140 | Phosphorus (yellow or white)    |
| 85449   | Phthalic anhydride              |

| cas #   | chemical name                                |
|---------|--|
| 1336363 | Polychlorinated biphenyls                    |
| 0       | Polycyclic Organic Matter <sup>4</sup>       |
| 1120714 | Propane sultone                              |
| 123386  | Propionaldehyde                              |
| 114261  | Propoxur                                     |
| 75569   | Propylene oxide                              |
| 75558   | Propyleneimine                               |
| 91225   | Quinoline                                    |
| 106514  | Quinone                                      |
| 82688   | Quintozene                                   |
| 0       | Radionuclides (including Radon) <sup>5</sup> |
| 0       | Selenium Compounds                           |
| 100425  | Styrene                                      |
| 96093   | Styrene oxide                                |
| 127184  | Tetrachloroethylene                          |
| 7550450 | Titanium tetrachloride                       |
| 108883  | Toluene                                      |
| 584849  | Toluene-2,4-diisocyanate                     |
| 8001352 | Toxaphene                                    |
| 79016   | Trichloroethylene                            |
| 121448  | Triethylamine                                |
| 1582098 | Trifluralin                                  |
| 51796   | Urethane                                     |
| 108054  | Vinyl acetate                                |
| 593602  | Vinyl bromide                                |
| 75014   | Vinyl chloride                               |
| 75354   | Vinylidene chloride                          |
| 1330207 | Xylene (mixed isomers)                       |

NOTE: For all listings above which contain the word “compounds” and for glycol ethers, the following applies: Unless otherwise specified, these listings are defined as including any unique chemical substance that contains the named chemical (i.e., antimony, arsenic, etc.) as part of that chemical’s infrastructure.

<sup>1</sup>X’CN where X=H’ or any other group where a formal dissociation may occur. For example KCN or Ca(CN)<sub>2</sub>

<sup>2</sup>Includes mono- and di-ethers of ethylene glycol, diethylene glycol, and triethylene glycol R(OCH<sub>2</sub>CH<sub>2</sub>)<sub>n</sub>-OR’ where n=1,2, or 3; R=alkyl or aryl groups; R’=R,H, or groups which, when removed, yield glycol ethers with the structure R(OCH<sub>2</sub>CH<sub>2</sub>)<sub>n</sub>-OH. Polymers are excluded from the glycol category.

<sup>3</sup>Includes mineral fiber emissions from facilities manufacturing or processing glass, rock, or slag fibers (or other mineral derived fibers) of average diameter 1 micrometer or less.

<sup>4</sup>Includes organic compounds with more than one benzene ring, and which have a boiling point greater than or equal to 100 degrees C.

<sup>5</sup>A type of atom which spontaneously undergoes radioactive decay.

“*High-risk pollutant*” means one of the following hazardous air pollutants listed in Table 1 in 40 CFR 63.74 as adopted by reference in 567—subrule 23.1(4).

| cas #   | chemical name                                 | weighting factor |
|---------|---|------------------|
| 53963   | 2-Acetylaminofluorene                         | 100              |
| 107028  | Acrolein                                      | 100              |
| 79061   | Acrylamide                                    | 10               |
| 107131  | Acrylonitrile                                 | 10               |
| 0       | Arsenic compounds                             | 100              |
| 1332214 | Asbestos                                      | 100              |
| 71432   | Benzene                                       | 10               |
| 92875   | Benzidine                                     | 1000             |
| 0       | Beryllium compounds                           | 10               |
| 542881  | Bis(chloromethyl) ether                       | 1000             |
| 106990  | 1,3-Butadiene                                 | 10               |
| 0       | Cadmium compounds                             | 10               |
| 57749   | Chlordane                                     | 100              |
| 532274  | 2-Chloroacetophenone                          | 100              |
| 0       | Chromium compounds                            | 100              |
| 107302  | Chloromethyl methyl ether                     | 10               |
| 0       | Coke oven emissions                           | 10               |
| 334883  | Diazomethane                                  | 10               |
| 132649  | Dibenzofuran                                  | 10               |
| 96128   | 1,2-Dibromo-3-chloropropane                   | 10               |
| 111444  | Dichloroethyl ether(Bis(2-chloroethyl) ether) | 10               |
| 79447   | Dimethylcarbamoyl chloride                    | 100              |
| 122667  | 1,2-Diphenylhydrazine                         | 10               |
| 106934  | Ethylene dibromide                            | 10               |
| 151564  | Ethylenimine (Aziridine)                      | 100              |
| 75218   | Ethylene oxide                                | 10               |
| 76448   | Heptachlor                                    | 100              |
| 118741  | Hexachlorobenzene                             | 100              |
| 77474   | Hexachlorocyclopentadiene                     | 100              |
| 302012  | Hydrazine                                     | 100              |
| 0       | Manganese compounds                           | 10               |
| 0       | Mercury compounds                             | 100              |
| 60344   | Methyl hydrazine                              | 10               |
| 624839  | Methyl isocyanate                             | 10               |
| 0       | Nickel compounds                              | 10               |
| 62759   | N-Nitrosodimethylamine                        | 100              |
| 684935  | N-Nitroso-N-methylurea                        | 1000             |
| 56382   | Parathion                                     | 10               |
| 75445   | Phosgene                                      | 10               |

| cas #   | chemical name                       | weighting factor |
|---------|-------------------------------------|------------------|
| 7803512 | Phosphine                           | 10               |
| 7723140 | Phosphorus                          | 10               |
| 75558   | 1,2-Propylenimine                   | 100              |
| 1746016 | 2,3,7,8-Tetrachlorodibenzo-p-dioxin | 100,000          |
| 8001352 | Toxaphene (chlorinated camphene)    | 100              |
| 75014   | Vinyl chloride                      | 10               |

“*Major source*” means any stationary source (or any group of stationary sources located on one or more contiguous or adjacent properties and under common control of the same person or of persons under common control) belonging to a single major industrial grouping that is any of the following:

1. A major stationary source of air pollutants, as defined in Section 302 of the Act, that directly emits or has the potential to emit 100 tons per year (tpy) or more of any air pollutant subject to regulation (including any major source of fugitive emissions of any such pollutant). The fugitive emissions of a stationary source shall not be considered in determining whether it is a major stationary source for the purposes of Section 302(j) of the Act, unless the source belongs to one of the stationary source categories listed in this chapter.

2. A major source of hazardous air pollutants according to Section 112 of the Act as follows:

For pollutants other than radionuclides, any stationary source or group of stationary sources located within a contiguous area and under common control that emits or has the potential to emit, in the aggregate, 10 tpy or more of any hazardous air pollutant which has been listed pursuant to Section 112(b) of the Act and these rules or 25 tpy or more of any combination of such hazardous air pollutants. Notwithstanding the previous sentence, emissions from any oil or gas exploration or production well (with its associated equipment) and emission from any pipeline compressor or pump station shall not be aggregated with emissions from other similar units, whether or not such units are in a contiguous area or under common control, to determine whether such units or stations are major sources.

For Title V purposes, all fugitive emissions of hazardous air pollutants are to be considered in determining whether a stationary source is a major source.

For radionuclides, “major source” shall have the meaning specified by the administrator by rule.

3. A major stationary source as defined in Part D of Title I of the Act, including:

For ozone nonattainment areas, sources with the potential to emit 100 tpy or more of volatile organic compounds or oxides of nitrogen in areas classified or treated as classified as “marginal” or “moderate,” 50 tpy or more in areas classified or treated as classified as “serious,” 25 tpy or more in areas classified or treated as classified as “severe” and 10 tpy or more in areas classified or treated as classified as “extreme”; except that the references in this paragraph to 100, 50, 25, and 10 tpy of nitrogen oxides shall not apply with respect to any source for which the administrator has made a finding, under Section 182(f)(1) or (2) of the Act, that requirements under Section 182(f) of the Act do not apply;

For ozone transport regions established pursuant to Section 184 of the Act, sources with potential to emit 50 tpy or more of volatile organic compounds;

For carbon monoxide nonattainment areas (1) that are classified or treated as classified as “serious” and (2) in which stationary sources contribute significantly to carbon monoxide levels, and sources with the potential to emit 50 tpy or more of carbon monoxide;

For particulate matter (PM<sub>10</sub>), nonattainment areas classified or treated as classified as “serious,” sources with the potential to emit 70 tpy or more of PM<sub>10</sub>.

For the purposes of defining “major source,” a stationary source or group of stationary sources shall be considered part of a single industrial grouping if all of the pollutant emitting activities at such source or group of sources on contiguous or adjacent properties belong to the same major group (i.e., all have the same two-digit code) as described in the Standard Industrial Classification Manual, 1987.

“*Manually operated equipment*” means a machine or tool that is handheld, such as a handheld circular saw or compressed air chisel; a machine or tool for which the work piece is held or manipulated

by hand, such as a bench grinder; a machine or tool for which the tool or bit is manipulated by hand, such as a lathe or drill press; and any dust collection system which is part of such machine or tool; but not including any machine or tool for which the extent of manual operation is to control power to the machine or tool and not including any central dust collection system serving more than one machine or tool.

*“Maximum achievable control technology (MACT)”* means the following regarding regulated hazardous air pollutant sources:

1. For existing sources, the emissions limitation reflecting the maximum degree of reduction in emissions that the administrator or the department, taking into consideration the cost of achieving such emission reduction, and any nonair quality health and environmental impacts and energy requirements, determines is achievable by sources in the category of stationary sources, that shall not be less stringent than the MACT floor.

2. For new sources, the emission limitation which is not less stringent than the emission limitation achieved in practice by the best-controlled similar source, and which reflects the maximum degree of reduction in emissions that the administrator or the department, taking into consideration the cost of achieving such emission reduction, and any nonair quality health and environmental impacts and energy requirements, determines is achievable by sources in the Title IV affected source category.

*“Maximum achievable control technology (MACT) floor”* means the following:

1. For existing sources, the average emission limitation achieved by the best 12 percent of the existing sources in the United States (for which the administrator or the department has or could reasonably obtain emission information), excluding those sources that have, within 18 months before the emission standard is proposed or within 30 months before such standard is promulgated, whichever is later, first achieved a level of emission rate or emission reduction which complies, or would comply if the source is not subject to such standard, with the lowest achievable emission rate applicable to the source category and prevailing at the time, for categories and subcategories of stationary sources with 30 or more sources in the category or subcategory, or the average emission limitation achieved by the best performing 5 sources in the United States (for which the administrator or the department has or could reasonably obtain emissions information) for a category or subcategory or stationary source with fewer than 30 sources in the category or subcategory.

2. For new sources, the emission limitation achieved in practice by the best-controlled similar source.

*“New Title IV affected source or unit”* means a unit that commences commercial operation on or after November 15, 1990, including any such unit that serves a generator with a nameplate capacity of 25 MWe or less or that is a simple combustion turbine.

*“Nonattainment area”* means an area so designated by the administrator, acting pursuant to Section 107 of the Act.

*“Permit modification”* means a revision to a Title V operating permit that cannot be accomplished under the provisions for administrative permit amendments found at rule 567—22.111(455B). A permit modification for purposes of the acid rain portion of the permit shall be governed by the regulations pertaining to acid rain found at rules 567—22.120(455B) to 567—22.147(455B). This definition of “permit modification” shall be used solely for purposes of this chapter governing Title V operating permits.

*“Permit revision”* means any permit modification or administrative permit amendment.

*“Permitting authority”* means the Iowa department of natural resources or the director thereof.

*“Potential to emit”* means the maximum capacity of a stationary source to emit any air pollutant under its physical and operational design. Any physical or operational limitation on the capacity of a source to emit an air pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design if the limitation is enforceable by the administrator. This term does not alter or affect the use of this term for any other purposes under the Act, or the term “capacity factor” as used in Title IV of the Act or the regulations relating to acid rain.

For the purpose of determining potential to emit for country grain elevators, the provisions set forth in subrule 22.10(2) shall apply.

For purposes of calculating potential to emit for emergency generators, “maximum capacity” means one of the following:

1. 500 hours of operation annually, if the generator has actually been operated less than 500 hours per year for the past five years;
2. 8,760 hours of operation annually, if the generator has actually been operated more than 500 hours in one of the past five years; or
3. The number of hours specified in a state or federally enforceable limit.

“*Proposed Title V permit*” means the version of a permit that the permitting authority proposes to issue and forwards to the administrator for review in compliance with 22.107(7) “a.”

“*Regulated air contaminant*” shall mean the same thing as “regulated air pollutant.”

“*Regulated air pollutant*” means the following:

1. Nitrogen oxides or any volatile organic compounds;
2. Any pollutant for which a national ambient air quality standard has been promulgated;
3. Any pollutant that is subject to any standard promulgated under Section 111 of the Act;
4. Any Class I or II substance subject to a standard promulgated under or established by Title VI of the Act; or

5. Any pollutant subject to a standard promulgated under Section 112 or other requirements established under Section 112 of the Act, including Sections 112(g), (j), and (r) of the Act, including the following:

- Any pollutant subject to requirements under Section 112(j) of the Act. If the administrator fails to promulgate a standard by the date established pursuant to Section 112(e) of the Act, any pollutant for which a subject source would be major shall be considered to be regulated on the date 18 months after the applicable date established pursuant to Section 112(e) of the Act; and

- Any pollutant for which the requirements of Section 112(g)(2) of the Act have been met, but only with respect to the individual source subject to the Section 112(g)(2) requirement.

6. With respect to Title V, particulate matter, except for PM<sub>10</sub>, is not considered a regulated air pollutant for the purpose of determining whether a source is considered to be a major source.

“*Regulated air pollutant or contaminant (for fee calculation)*,” which is used only for purposes of 567—Chapter 30, means any “regulated air pollutant or contaminant” except the following:

1. Carbon monoxide;
2. Particulate matter, excluding PM<sub>10</sub>;
3. Any pollutant that is a regulated air pollutant solely because it is a Class I or II substance subject to a standard promulgated under or established by Title VI of the Act;
4. Any pollutant that is a regulated pollutant solely because it is subject to a standard or regulation under Section 112(r) of the Act;
5. Greenhouse gas, as defined in rule 567—20.2(455B).

“*Renewal*” means the process by which a permit is reissued at the end of its term.

“*Responsible official*” means one of the following:

1. For a corporation: a president, secretary, treasurer, or vice-president of the corporation in charge of a principal business function, or any other person who performs similar policy or decision-making functions for the corporation, or a duly authorized representative of such person if the representative is responsible for the overall operation of one or more manufacturing, production, or operating facilities applying for or subject to a permit and either:
  - The facilities employ more than 250 persons or have gross annual sales or expenditures exceeding \$25 million (in second quarter 1980 dollars); or
  - The delegation of authority to such representative is approved in advance by the permitting authority.

2. For a partnership or sole proprietorship: a general partner or the proprietor, respectively;

3. For a municipality, state, federal, or other public agency: either a principal executive officer or ranking elected official. For the purposes of this chapter, a principal executive officer of a federal

agency includes the chief executive officer having responsibility for the overall operations of a principal geographic unit of the agency (e.g., a regional administrator of EPA); or

4. For Title IV affected sources:

- The designated representative insofar as actions, standards, requirements, or prohibitions under Title IV of the Act or the regulations promulgated thereunder are concerned; and
- The designated representative for any other purposes under this chapter or the Act.

“*Section 502(b)(10) changes*” are changes that contravene an express permit term and which are made pursuant to rule 567—22.110(455B). Such changes do not include changes that would violate applicable requirements or contravene federally enforceable permit terms and conditions that are monitoring (including test methods), record keeping, reporting, or compliance certification requirements.

“*State implementation plan (SIP)*” means the plan adopted by the state of Iowa and approved by the administrator which provides for implementation, maintenance, and enforcement of such primary and secondary ambient air quality standards as are adopted by the administrator, pursuant to the Act.

“*Stationary source*” means any building, structure, facility, or installation that emits or may emit any regulated air pollutant or any pollutant listed under Section 112(b) of the Act.

“*Stationary source categories*” means any of the following classes of sources:

1. Coal cleaning plants with thermal dryers;
2. Kraft pulp mills;
3. Portland cement plants;
4. Primary zinc smelters;
5. Iron and steel mills;
6. Primary aluminum ore reduction plants;
7. Primary copper smelters;
8. Municipal incinerators capable of charging more than 250 tons of refuse per day;
9. Hydrofluoric, sulfuric, or nitric acid plants;
10. Petroleum refineries;
11. Lime plants;
12. Phosphate rock processing plants;
13. Coke oven batteries;
14. Sulfur recovery plants;
15. Carbon black plants using the furnace process;
16. Primary lead smelters;
17. Fuel conversion plants;
18. Sintering plants;
19. Secondary metal production plants;
20. Chemical process plants — The term chemical processing plant shall not include ethanol production facilities that produce ethanol by natural fermentation included in NAICS code 325193 or 312140;
21. Fossil-fuel boilers, or combinations thereof, totaling more than 250 million Btu’s per hour heat input;
22. Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels;
23. Taconite ore processing plants;
24. Glass fiber processing plants;
25. Charcoal production plants;
26. Fossil fuel-fired steam electric plants of more than 250 million Btu’s per hour heat input;
27. Any other stationary source category, which as of August 7, 1980, is regulated under Section 111 or 112 of the Act.

“*Subject to regulation*” means, for any air pollutant, that the pollutant is subject to either a provision in the Clean Air Act, or a nationally applicable regulation codified by the Administrator in 40 CFR Subchapter C (Air Programs) that requires actual control of the quantity of emissions of that pollutant,

and that such a control requirement has taken effect and is operative to control, limit or restrict the quantity of emissions of that pollutant released from the regulated activity, except that:

1. Greenhouse gases (GHGs), the air pollutant defined in 40 CFR §86.1818-12(a) (as amended on May 7, 2010) as the aggregate group of six greenhouse gases that includes carbon dioxide, nitrous oxide, methane, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride, shall not be subject to regulation unless, as of July 1, 2011, the GHG emissions are at a stationary source emitting or having the potential to emit 100,000 tpy CO<sub>2</sub> equivalent emissions.

2. The term “tpy CO<sub>2</sub> equivalent emissions (CO<sub>2</sub>e)” shall represent an amount of GHGs emitted and shall be computed by multiplying the mass amount of emissions (tpy) for each of the six greenhouse gases in the pollutant GHGs by the associated global warming potential of the gas published at 40 CFR Part 98, Subpart A, Table A-1, “Global Warming Potentials,” (as amended through December 24, 2014) and summing the resultant value for each to compute a tpy CO<sub>2</sub>e.

For purposes of this definition, prior to July 21, 2014, the mass of the greenhouse gas carbon dioxide shall not include carbon dioxide emissions resulting from the combustion or decomposition of non-fossilized and biodegradable organic material originating from plants, animals, or micro-organisms (including products, by-products, residues and waste from agriculture, forestry and related industries as well as the non-fossilized and biodegradable organic fractions of industrial and municipal wastes, including gases and liquids recovered from the decomposition of non-fossilized and biodegradable organic material).

“Title V permit” means an operating permit under Title V of the Act.

“12-month rolling period” means a period of 12 consecutive months determined on a rolling basis with a new 12-month period beginning on the first day of each calendar month.

[ARC 9224B, IAB 11/17/10, effective 12/22/10; ARC 9906B, IAB 12/14/11, effective 11/16/11; ARC 0330C, IAB 9/19/12, effective 10/24/12; ARC 1913C, IAB 3/18/15, effective 4/22/15; ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

#### **567—22.101(455B) Applicability of Title V operating permit requirements.**

**22.101(1)** Except as provided in rule 567—22.102(455B), any person who owns or operates any of the following sources shall obtain a Title V operating permit and shall submit fees as required in 567—Chapter 30:

- a. Any affected source subject to the provisions of Title IV of the Act;
- b. Any major source;
- c. Any source, including any nonmajor source, subject to a standard, limitation, or other requirement under Section 111 of the Act (567—subrule 23.1(2), new source performance standards; 567—subrule 23.1(5), emission guidelines);
- d. Any source, including any area source, subject to a standard or other requirement under Section 112 of the Act (567—subrules 23.1(3) and 23.1(4), emission standards for hazardous air pollutants), except that a source is not required to obtain a Title V permit solely because it is subject to regulations or requirements under Section 112(r) of the Act;
- e. Any solid waste incinerator unit required to obtain a Title V permit under Section 129(e) of the Act;
- f. Any source category designated by the Administrator pursuant to 40 CFR 70.3 as amended through December 19, 2005.

**22.101(2)** Any nonmajor source required to obtain a Title V operating permit pursuant to subrule 22.101(1) is required to obtain a Title V permit only for the emissions units and related equipment causing the source to be subject to the Title V program.

**22.101(3)** Election to apply for permit. Rescinded IAB 7/19/06, effective 8/23/06.  
[ARC 2352C, IAB 1/6/16, effective 12/16/15]

#### **567—22.102(455B) Source category exemptions.**

**22.102(1)** All sources listed in subrule 22.101(1) that are not major sources, affected sources subject to the provisions of Title IV of the Act or solid waste incineration units required to obtain a permit pursuant to Section 129(e) of the Act are exempt from the obligation to obtain a Title V permit until such time as the Administrator completes a rule making to determine how the program should be structured

for nonmajor sources and the appropriateness of any permanent exemptions in addition to those provided for in subrule 22.102(3).

**22.102(2)** In the case of nonmajor sources subject to a standard or other requirement under either Section 111 or Section 112 of the Act after July 21, 1992, publication, the Administrator will determine at the time the new or amended standard is promulgated whether to exempt any or all such applicable sources from the requirement to obtain a Title V permit.

**22.102(3)** The following source categories are exempt from the obligation to obtain a Title V permit:

*a.* All sources and source categories that would be required to obtain a Title V permit solely because they are subject to 40 CFR 60, Subpart AAA, Standards of Performance for New Residential Wood Heaters, as amended through March 16, 2015;

*b.* All sources and source categories that would be required to obtain a Title V permit solely because they are subject to 40 CFR 61, Subpart M, National Emission Standard for Hazardous Air Pollutants for Asbestos, Section 61.145, Standard for Demolition and Renovation, as adopted by reference in 567—subrule 23.1(3);

*c.* All sources and source categories that would be required to obtain a Title V permit solely because they are subject to any of the following subparts from 40 CFR 63:

(1) Subpart M, National Perchloroethylene Air Emission Standards for Dry Cleaning Facilities, as adopted by reference in 567—subrule 23.1(4).

(2) Subpart N, National Emission Standards for Chromium Emissions from Hard and Decorative Chromium Electroplating and Chromium Anodizing Tanks, as adopted by reference in 567—subrule 23.1(4).

(3) Subpart O, Ethylene Oxide Emissions Standards for Sterilization Facilities, as adopted by reference in 567—subrule 23.1(4).

(4) Subpart T, National Emission Standards for Halogenated Solvent Cleaning, as adopted by reference in 567—subrule 23.1(4).

(5) Subpart RRR, National Emission Standards for Hazardous Air Pollutants for Secondary Aluminum Production, as adopted by reference in 567—subrule 23.1(4).

(6) Subpart VVV, National Emission Standards for Hazardous Air Pollutants: Publicly Owned Treatment Works, as adopted by reference in 567—subrule 23.1(4).

[ARC 2949C, IAB 2/15/17, effective 3/22/17]

**567—22.103(455B) Insignificant activities.** The following are insignificant activities for purposes of the Title V application if not needed to determine the applicability of or to impose any applicable requirement. Title V permit emissions fees are not required from insignificant activities pursuant to 567—paragraph 30.4(2)“f.”

**22.103(1)** *Insignificant activities excluded from Title V operating permit application.* In accordance with 40 CFR 70.5 (as amended through October 6, 2009), these activities need not be included in the Title V permit application.

*a.* Mobile internal combustion and jet engines, marine vessels, and locomotives.

*b.* Equipment, other than anaerobic lagoons, used for cultivating land, harvesting crops, or raising livestock. This exemption is not applicable if the equipment is used to remove substances from grain which were applied to the grain by another person. This exemption also is not applicable to equipment used by a person to manufacture commercial feed, as defined in Iowa Code section 198.3, when that feed is normally not fed to livestock:

(1) Owned by that person or another person, and

(2) Located in a feedlot, as defined in Iowa Code section 172D.1(6), or in a confinement building owned or operated by that person, and

(3) Located in this state.

*c.* Equipment or control equipment which eliminates all emissions to the atmosphere.

*d.* Equipment (other than anaerobic lagoons) or control equipment which emits odors unless such equipment or control equipment also emits particulate matter or any other air pollutant or contaminant.

- e.* Air conditioning or ventilating equipment not designed to remove air contaminants generated by or released from associated equipment.
- f.* Residential wood heaters, cookstoves, or fireplaces.
- g.* The equipment in laboratories used exclusively for nonproduction chemical and physical analyses. Nonproduction analyses means analyses incidental to the production of a good or service and includes analyses conducted for quality assurance or quality control activities, or for the assessment of environmental impact.
- h.* Recreational fireplaces.
- i.* Barbecue pits and cookers except at a meat packing plant or a prepared meat manufacturing facility.
- j.* Stacks or vents to prevent escape of sewer gases through plumbing traps for systems handling domestic sewage only. Systems which include any industrial waste are not exempt.
- k.* Retail gasoline and diesel fuel handling facilities.
- l.* Photographic process equipment by which an image is reproduced upon material sensitized to radiant energy.
- m.* Equipment used for hydraulic or hydrostatic testing.
- n.* General vehicle maintenance and servicing activities at the source, other than gasoline fuel handling.
- o.* Cafeterias, kitchens, and other facilities used for preparing food or beverages primarily for consumption at the source.
- p.* Equipment using water, water and soap or detergent, or a suspension of abrasives in water for purposes of cleaning or finishing provided no organic solvent has been added to the water, the boiling point of the additive is not less than 100°C (212°F), and the water is not heated above 65.5°C (150°F).
- q.* Administrative activities including, but not limited to, paper shredding, copying, photographic activities, and blueprinting machines. This does not include incinerators.
- r.* Laundry dryers, extractors, and tumblers processing clothing, bedding, and other fabric items used at the source that have been cleaned with water solutions of bleach or detergents provided that any organic solvent present in such items before processing that is retained from cleanup operations shall be addressed as part of the volatile organic compound emissions from use of cleaning materials.
- s.* Housekeeping activities for cleaning purposes, including collecting spilled and accumulated materials at the source, but not including use of cleaning materials that contain organic solvent.
- t.* Refrigeration systems, including storage tanks used in refrigeration systems, but excluding any combustion equipment associated with such systems.
- u.* Activities associated with the construction, on-site repair, maintenance or dismantlement of buildings, utility lines, pipelines, wells, excavations, earthworks and other structures that do not constitute emission units.
- v.* Storage tanks of organic liquids with a capacity of less than 500 gallons, provided the tank is not used for storage of any material listed as a hazardous air pollutant pursuant to Section 112(b) of the Clean Air Act.
- w.* Piping and storage systems for natural gas, propane, and liquified petroleum gas, excluding pipeline compressor stations and associated storage facilities.
- x.* Water treatment or storage systems, as follows:
  - (1) Systems for potable water or boiler feedwater.
  - (2) Systems, including cooling towers, for process water provided that such water has not been in direct or indirect contact with process steams that contain volatile organic material or materials listed as hazardous air pollutants pursuant to Section 112(b) of the Clean Air Act.
- y.* Lawn care, landscape maintenance, and groundskeeping activities.
- z.* Containers, reservoirs, or tanks used exclusively in dipping operations to coat objects with oils, waxes, or greases, provided no organic solvent has been mixed with such materials.
- aa.* Cold cleaning degreasers that are not in-line cleaning machines, where the vapor pressure of the solvents used never exceeds 2 kPa (15 mmHg or 0.3 psi) measured at 38°C (100°F) or 0.7 kPa (5

mmHg or 0.1 psi) at 20°C (68°F). (Note: Cold cleaners subject to 40 CFR Part 63 Subpart T are not considered insignificant activities.)

*bb.* Manually operated equipment used for buffing, polishing, carving, cutting, drilling, machining, routing, sanding, sawing, scarfing, surface grinding or turning.

*cc.* Use of consumer products, including hazardous substances as that term is defined in the Federal Hazardous Substances Act (15 U.S.C. 1261 et seq.), when the product is used at a source in the same manner as normal consumer use.

*dd.* Activities directly used in the diagnosis and treatment of disease, injury or other medical condition.

*ee.* Firefighting activities and training in preparation for fighting fires conducted at the source. (Note: Written notification pursuant to 567—paragraph 23.2(3) “g” is required at least ten working days before such action commences.)

*ff.* Activities associated with the construction, repair or maintenance of roads or other paved or open areas, including operation of street sweepers, vacuum trucks, spray trucks and other vehicles related to the control of fugitive emissions of such roads or other areas.

*gg.* Storage and handling of drums or other transportable containers when the containers are sealed during storage and handling.

*hh.* Individual points of emission or activities as follows:

(1) Individual flanges, valves, pump seals, pressure relief valves and other individual components that have the potential for leaks.

(2) Individual sampling points, analyzers, and process instrumentation, whose operation may result in emissions.

(3) Individual features of an emission unit such as each burner and sootblower in a boiler or each use of cleaning materials on a coating or printing line.

*ii.* Construction activities at a source solely associated with the modification or building of a facility, an emission unit or other equipment at the source. (Note: Notwithstanding the status of this activity as insignificant, a particular activity that entails modification or construction of an emission unit or construction of air pollution control equipment may require a construction permit pursuant to 22.1(455B) and may subsequently require a revised Title V operating permit. A revised Title V operating permit may also be necessary for operation of an emission unit after completion of a particular activity if the existing Title V operating permit does not accommodate the new state of the emission unit.)

*jj.* Activities at a source associated with the maintenance, repair, or dismantlement of an emission unit or other equipment installed at the source, including preparation for maintenance, repair or dismantlement, and preparation for subsequent startup, including preparation of a shutdown vessel for entry, replacement of insulation, welding and cutting, and steam purging of a vessel prior to startup.

**22.103(2)** *Insignificant activities which must be included in Title V operating permit applications.*

*a.* The following are insignificant activities based on potential emissions:

An emission unit which has the potential to emit less than:

5 tons per year of any regulated air pollutant, except:

2.5 tons per year of PM<sub>10</sub>,

0.52 tons per year of PM<sub>2.5</sub> (does not apply to emission units for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013),

2 lbs per year of lead or lead compounds (40 lbs per year for emission units for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013),

2500 lbs per year of any combination of hazardous air pollutants except high-risk pollutants,

1000 lbs per year of any individual hazardous air pollutant except high-risk pollutants,

250 lbs per year of any combination of high-risk pollutants, or

100 lbs per year of any individual high-risk pollutant.

The definition of “high-risk pollutant” is found in rule 567—22.100(455B).

*b.* The following are insignificant activities:

(1) Fuel-burning equipment for indirect heating and reheating furnaces or indirect cooling units using natural or liquefied petroleum gas with a capacity of less than 10 million Btu per hour input per combustion unit.

(2) Fuel-burning equipment for indirect heating or indirect cooling for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013, with a capacity of less than 1 million Btu per hour input per combustion unit when burning coal, untreated wood, or fuel oil.

Fuel-burning equipment for indirect heating or indirect cooling for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, with a capacity of less than 1 million Btu per hour input per combustion unit when burning untreated wood, untreated seeds or pellets, other untreated vegetative materials, or fuel oil provided that the equipment and the fuel meet the condition specified in this subparagraph (22.103(2)“b”(2)). Used oils meeting the specification from 40 CFR 279.11 as amended through July 14, 2006, are acceptable fuels. When combusting used oils, the equipment must have a maximum rated capacity of 50,000 Btu or less per hour of heat input or a maximum throughput of 3600 gallons or less of used oils per year. When combusting untreated wood, untreated seeds or pellets, or other untreated vegetative materials, the equipment must have a maximum rated capacity of 265,600 Btu or less per hour or a maximum throughput of 378,000 pounds or less per year of each fuel or any combination of fuels.

(3) Incinerators with a rated refuse burning capacity of less than 25 pounds per hour for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred on or before October 23, 2013. Incinerators for which initiation of construction, installation, reconstruction, or alteration (as defined in rule 567—20.2(455B)) occurred after October 23, 2013, shall not qualify as an insignificant activity. After October 23, 2013, only paint clean-off ovens with a maximum rated capacity of less than 25 pounds per hour that do not combust lead-containing materials shall qualify as an insignificant activity.

(4) Gasoline, diesel fuel, or oil storage tanks with a capacity of 1,000 gallons or less and an annual throughput of less than 40,000 gallons.

(5) A storage tank which contains no volatile organic compounds above a vapor pressure of 0.75 pounds per square inch at the normal operating temperature of the tank when other emissions from the tank do not exceed the levels in paragraph 22.103(2)“a.”

(6) Internal combustion engines that are used for emergency response purposes with a brake horsepower rating of less than 400 measured at the shaft. The manufacturer’s nameplate rating at full load shall be defined as the brake horsepower output at the shaft. Emergency engines that are subject to any of the following federal regulations are not considered to be insignificant activities for purposes of this rule (567—22.103(455B)):

1. New source performance standards (NSPS) for stationary compression ignition internal combustion engines (40 CFR Part 60, Subpart IIII);

2. New source performance standards (NSPS) for stationary spark ignition internal combustion engines (40 CFR Part 50, Subpart JJJJ); or

3. National emission standards for hazardous air pollutants (NESHAP) for reciprocating internal combustion engines (40 CFR Part 63, Subpart ZZZZ).

[ARC 1013C, IAB 9/18/13, effective 10/23/13; ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—22.104(455B) Requirement to have a Title V permit.** No source may operate after the time that it is required to submit a timely and complete application, except in compliance with a properly issued Title V operating permit. However, if a source submits a timely and complete application for permit issuance (including renewal), the source’s failure to have a permit is not a violation of this chapter until the director takes final action on the permit application, except as noted in this rule. In that case, all terms and conditions of the permit shall remain in effect until the renewal permit has been issued or denied.

**22.104(1)** This protection shall cease to apply if, subsequent to the completeness determination, the applicant fails to submit, by the deadline specified in writing by the director, any additional information identified as being needed to process the application.

**22.104(2)** Sources making permit revisions pursuant to rule 567—22.110(455B) shall not be in violation of this rule.

**567—22.105(455B) Title V permit applications.**

**22.105(1) Duty to apply.** For each source required to obtain a Title V operating permit, the owner or operator or designated representative, where applicable, shall present or mail a complete and timely permit application in accordance with this rule to the following locations: Iowa Department of Natural Resources, Air Quality Bureau, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324 (one copy); and U.S. EPA Region VII, 11201 Renner Boulevard, Lenexa, Kansas 66219 (one copy); and, if applicable, the local permitting authority, which is either Linn County Public Health Department, Air Quality Division, 501 13th Street NW, Cedar Rapids, Iowa 52405 (one copy); or Polk County Public Works, Air Quality Division, 5885 NE 14th Street, Des Moines, Iowa 50313 (one copy). Application submission methods may include, but are not limited to, U.S. Postal Service, private parcel delivery services, or hand delivery. Applications are not required to be submitted by certified mail. Alternatively, an owner or operator may submit a complete and timely application through the electronic submittal format specified by the department. An owner or operator of a source required to obtain a Title V permit pursuant to subrule 22.101(1) shall submit all required fees as required in 567—Chapter 30.

*a. Timely application.* Each owner or operator applying for a Title V permit shall submit an application as follows:

(1) Initial application for an existing source. The owner or operator of a stationary source that was existing on or before April 20, 1994, shall make the first time submittals of a Title V permit application to the department by November 15, 1994. However, the owner or operator may choose to defer submittal of Part 2 of the permit application until December 31, 1995. The department will mail notice of the deadline for Part 2 of the permit application to all applicants who have filed Part 1 of the application by October 17, 1995.

(2) Initial application for a new source. The owner or operator of a stationary source that commenced construction or reconstruction after April 20, 1994, or that otherwise became subject to the requirement to obtain a Title V permit after April 20, 1994, shall submit an application to the department within 12 months of becoming subject to the Title V permit requirements.

(3) Application related to 112(g), PSD or nonattainment. The owner or operator of a stationary source that is subject to Section 112(g) of the Act, that is subject to rule 567—22.4(455B) or 567—33.3(455B) (prevention of significant deterioration (PSD)), or that is subject to rule 567—22.5(455B) or 567—31.3(455B) (nonattainment area permitting) shall submit an application to the department within 12 months of commencing operation. In cases in which an existing Title V permit would prohibit such construction or change in operation, the owner or operator must obtain a Title V permit revision before commencing operation.

(4) Renewal application. The owner or operator of a stationary source with a Title V permit shall submit an application to the department for a permit renewal at least 6 months prior to, but not more than 18 months prior to, the date of permit expiration.

(5) Changes allowed without a permit revision (off-permit revision). The owner or operator of a stationary source with a Title V permit who is proposing a change that is allowed without a Title V permit revision (an off-permit revision) as specified in rule 567—22.110(455B) shall submit to the department a written notification as specified in rule 567—22.110(455B) at least 30 days prior to the proposed change.

(6) Application for an administrative permit amendment. Prior to implementing a change that satisfies the requirements for an administrative permit amendment as set forth in rule 567—22.111(455B), the owner or operator shall submit to the department an application for an administrative amendment as specified in rule 567—22.111(455B).

(7) Application for a minor permit modification. Prior to implementing a change that satisfies the requirements for a minor permit modification as set forth in rule 567—22.112(455B), the owner or

operator shall submit to the department an application for a minor permit modification as specified in rule 567—22.112(455B).

(8) Application for a significant permit modification. The owner or operator of a source that satisfies the requirements for a significant permit modification as set forth in rule 567—22.113(455B) shall submit to the department an application for a significant permit modification as specified in rule 567—22.113(455B) within three months after the commencing operation of the changed source. However, if the existing Title V permit would prohibit such construction or change in operation, the owner or operator shall not commence operation of the changed source until the department issues a revised Title V permit that allows the change.

(9) Application for an acid rain permit. The owner or operator of a source subject to the acid rain program, as set forth in rules 567—22.120(455B) through 567—22.148(455B), shall submit an application for an initial Phase II acid rain permit by January 1, 1996 (for sulfur dioxide), or by January 1, 1998 (for nitrogen oxides).

*b. Complete application.* To be deemed complete, an application must provide all information required pursuant to subrule 22.105(2), except that applications for permit revision need supply such information only if it is related to the proposed change.

**22.105(2) Standard application form and required information.** To apply for a Title V permit, applicants shall complete the standard permit application form available only from the department and supply all information required by the filing instructions found on that form. The information submitted must be sufficient to evaluate the source and its application and to determine all applicable requirements and to evaluate the fee amount required by rule 567—30.4(455B). If a source is not a major source and is applying for a Title V operating permit solely because of a requirement imposed by paragraphs 22.101(1)“c” and “d,” then the information provided in the operating permit application may cover only the emissions units that trigger Title V applicability. The applicant shall submit the information called for by the application form for each emissions unit to be permitted, except for activities which are insignificant according to the provisions of rule 567—22.103(455B). The applicant shall provide a list of all insignificant activities and specify the basis for the determination of insignificance for each activity. Nationally standardized forms shall be used for the acid rain portions of permit applications and compliance plans, as required by regulations promulgated under Title IV of the Act. The standard application form and any attachments shall require that the following information be provided:

*a.* Identifying information, including company name and address (or plant or source name if different from the company name), owner’s name and agent, and telephone number and names of plant site manager/contact.

*b.* A description of the source’s processes and products (by two-digit Standard Industrial Classification Code) including any associated with each alternate scenario identified by the applicant.

*c.* The following emissions-related information shall be submitted to the department on the emissions inventory portion of the application, unless the department notifies the applicant that the emissions-related information is not required because it has already been submitted:

(1) All emissions of pollutants for which the source is major, and all emissions of regulated air pollutants. The permit application shall describe all emissions of regulated air pollutants emitted from any emissions unit except where such units are exempted. The source shall submit additional information related to the emissions of air pollutants sufficient to verify which requirements are applicable to the source, and other information necessary to collect any permit fees owed under the approved fee schedule.

(2) Identification and description of all points of emissions in sufficient detail to establish the basis for fees and the applicability of any and all requirements.

(3) Emissions rates in tons per year and in such terms as are necessary to establish compliance consistent with the applicable standard reference test method, if any.

(4) The following information to the extent it is needed to determine or regulate emissions: fuels, fuel use, raw materials, production rates, and operating schedules.

(5) Identification and description of air pollution control equipment.

(6) Identification and description of compliance monitoring devices or activities.

(7) Limitations on source operations affecting emissions or any work practice standards, where applicable, for all regulated pollutants.

(8) Other information required by any applicable requirement (including information related to stack height limitations developed pursuant to Section 123 of the Act).

(9) Calculations on which the information in subparagraphs (1) to (8) above is based.

(10) Fugitive emissions from a source shall be included in the permit application in the same manner as stack emissions, regardless of whether the source category in question is included in the list of sources contained in the definition of major source.

*d.* The following air pollution control requirements:

(1) Citation and description of all applicable requirements, and

(2) Description of or reference to any applicable test method for determining compliance with each applicable requirement.

*e.* Other specific information that may be necessary to implement and enforce other applicable requirements of the Act or of these rules or to determine the applicability of such requirements.

*f.* An explanation of any proposed exemptions from otherwise applicable requirements.

*g.* Additional information as determined to be necessary by the director to define alternative operating scenarios identified by the source pursuant to subrule 22.108(12) or to define permit terms and conditions relating to operational flexibility and emissions trading pursuant to subrule 22.108(11) and rule 567—22.112(455B).

*h.* A compliance plan that contains the following:

(1) A description of the compliance status of the source with respect to all applicable requirements.

(2) The following statements regarding compliance status: For applicable requirements with which the stationary source is in compliance, a statement that the stationary source will continue to comply with such requirements. For applicable requirements that will become effective during the permit term, a statement that the stationary source will meet such requirements on a timely basis. For requirements for which the stationary source is not in compliance at the time of permit issuance, a narrative description of how the stationary source will achieve compliance with such requirements.

(3) A compliance schedule that contains the following:

1. For applicable requirements with which the stationary source is in compliance, a statement that the stationary source will continue to comply with such requirements. For applicable requirements that will become effective during the permit term, a statement that the stationary source will meet such requirements on a timely basis. A statement that the stationary source will meet in a timely manner applicable requirements that become effective during the permit term shall satisfy this provision, unless a more detailed schedule is expressly required by the applicable requirement.

2. A compliance schedule for sources that are not in compliance with all applicable requirements at the time of permit issuance. Such a schedule shall include a schedule of remedial measures, including an enforceable sequence of actions with milestones, leading to compliance with any applicable requirements for which the stationary source will be in noncompliance at the time of permit issuance.

3. This compliance schedule shall resemble and be at least as stringent as any compliance schedule contained in any judicial consent decree or administrative order to which the source is subject. Any compliance schedule shall be supplemental to, and shall not sanction noncompliance with, the applicable requirements on which it is based.

(4) A schedule for submission of certified progress reports no less frequently than every six months for sources required to have a compliance schedule in the permit.

*i.* Requirements for compliance certification, including the following:

(1) A certification of compliance for the prior year with all applicable requirements certified by a responsible official consistent with subrule 22.107(4) and Section 114(a)(3) of the Act.

(2) A statement of methods used for determining compliance, including a description of monitoring, record keeping, and reporting requirements and test methods.

(3) A schedule for submission of compliance certifications for each compliance period (one year unless required for a shorter time period by an applicable requirement) during the permit term, which

shall be submitted annually, or more frequently if required by an underlying applicable requirement or by the director.

(4) A statement indicating the source's compliance status with any applicable enhanced monitoring and compliance certification requirements of the Act.

(5) Notwithstanding any other provisions of these rules, for the purposes of submission of compliance certifications, an owner or operator is not prohibited from using monitoring as required by subrules 22.108(3), 22.108(4) or 22.108(5) and incorporated into a Title V operating permit in addition to any specified compliance methods.

*j.* The compliance plan content requirements specified in these rules shall apply and be included in the acid rain portion of a compliance plan for a Title IV affected source, except as specifically superseded by regulations promulgated under Title IV of the Act, with regard to the schedule and method(s) the source shall use to achieve compliance with the acid rain emissions limitations.

**22.105(3) Hazardous air pollutant early reduction application.** Anyone requesting a compliance extension from a standard issued under Section 112(d) of the Act must submit with its Title V permit application information that complies with the requirements established in 567—paragraph 23.1(4) “d.”

**22.105(4) Acid rain application content.** The acid rain application content shall be as prescribed in the acid rain rules found at rules 567—22.128(455B) and 567—22.129(455B).

**22.105(5) More than one Title V operating permit for a stationary source.** Following application made pursuant to subrule 22.105(1), the department may, at its discretion, issue more than one Title V operating permit for a stationary source, provided that the owner or operator does not have, and does not propose to have, a sourcewide emission limit or a sourcewide alternative operating scenario.

[ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3440C, IAB 11/8/17, effective 12/13/17]

#### **567—22.106(455B) Annual Title V emissions inventory.**

**22.106(1) Emissions fee.** Fees shall be paid as set forth in 567—Chapter 30.

**22.106(2) Emissions inventory and documentation due dates.** The emissions inventory shall be submitted with forms specified by the department. For emissions located in Polk County or Linn County, three copies of the forms documenting actual emissions for the previous calendar year shall be submitted annually by March 31. For emissions in all other counties, two copies of the forms documenting actual emissions for the previous calendar year shall be submitted annually by March 31.

Alternatively, an owner or operator may submit the required emissions inventory information through the electronic submittal format specified by the department.

If there are any changes to the emission calculation form, the department shall make revised forms available to the public by January 1. If revised forms are not available by January 1, forms from the previous year may be used and the year of emissions documented changed. The department shall calculate the total statewide Title V emissions for the prior calendar year and make this information available to the public no later than April 30 of each year.

**22.106(3) Correction of errors.** If an owner or operator, or the department, finds an error in a Title V emissions inventory, the owner or operator shall submit to the department revised forms making the necessary corrections to the Title V emissions inventory. Corrected forms shall be submitted as soon as possible after the errors are discovered or upon notification by the department.

[ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 3679C, IAB 3/14/18, effective 4/18/18]

#### **567—22.107(455B) Title V permit processing procedures.**

**22.107(1) Action on application.**

*a. Conditions for action on application.* A permit, permit modification, or renewal may be issued only if all of the following conditions have been met:

(1) The permitting authority has received a complete application for a permit, permit modification, or permit renewal, except that a complete application need not be received before issuance of a general permit under rule 567—22.109(455B);

(2) Except for modifications qualifying for minor permit modification procedures under rule 22.112(455B), the permitting authority has complied with the requirements for public participation under subrule 22.107(6);

(3) The permitting authority has complied with the requirements for notifying and responding to affected states under subrule 22.107(7);

(4) The conditions of the permit provide for compliance with all applicable requirements and the requirements of this chapter;

(5) The administrator has received a copy of the proposed permit and any notices required under subrule 22.107(7), and has not objected to issuance of the permit under subrule 22.107(7) within the time period specified therein;

(6) If the administrator has properly objected to the permit pursuant to the provisions of 40 CFR 70.8(d) as amended to July 21, 1992, or subrule 22.107(7), then the permitting authority may issue a permit only after the administrator's objection has been resolved; and

(7) No permit for a solid waste incineration unit combusting municipal waste subject to the provisions of Section 129(e) of the Act may be issued by an agency, instrumentality or person that is also responsible, in whole or part, for the design and construction or operation of the unit.

*b. Time for action on application.* The permitting authority shall take final action on each complete permit application (including a request for permit modification or renewal) within 18 months of receiving a complete application, except in the following instances:

(1) When otherwise provided under Title V or Title IV of the Act for the permitting of affected sources under the acid rain program.

(2) In the case of initial permit applications, the permitting authority may take up to three years from the effective date of the program to take final action on an application.

(3) Any complete permit applications containing an early reduction demonstration under Section 112(i)(5) of the Act shall be acted upon within nine months of receipt of the complete application.

*c. Prioritization of applications.* The director shall give priority to action on Title V applications involving construction or modification for which a construction permit pursuant to subrule 22.1(1) or Title I of the Act, Parts C and D, is also required. The director also shall give priority to action on Title V applications involving early reduction of hazardous air pollutants pursuant to 567—paragraph 23.1(4) "d."

*d. Completeness of applications.* The department shall promptly provide notice to the applicant of whether the application is complete. Unless the permitting authority requests additional information or otherwise notifies the applicant of incompleteness within 60 days of receipt of an application, the application shall be deemed complete. If, while processing an application that has been determined to be complete, the permitting authority determines that additional information is necessary to evaluate or take final action on that application, the permitting authority may request in writing such information and set a reasonable deadline for a response. The source's ability to operate without a permit, as set forth in rule 567—22.104(455B), shall be in effect from the date the application is determined to be complete until the final permit is issued, provided that the applicant submits any requested additional information by the deadline specified by the permitting authority. For modifications processed through minor permit modification procedures, a completeness determination shall not be required.

*e. Decision to deny a permit application.* The director shall decide to issue or deny the permit. The director shall notify the applicant as soon as practicable that the application has been denied. Upon denial of the permit the provisions of paragraph 22.107(1) "d" shall no longer be applicable. The new application shall be regarded as an entirely separate application containing all the required information and shall not depend on references to any documents contained in the previous denied application.

*f. Fact sheet.* A draft permit and fact sheet shall be prepared by the permitting authority. The fact sheet shall include the rationale for issuance or denial of the permit; a brief description of the type of facility; a summary of the type and quantity of air pollutants being emitted; a brief summary of the legal and factual basis for the draft permit conditions, including references to applicable statutes and rules; a description of the procedures for reaching final decision on the draft permit including the comment period, the address where comments will be received, and procedures for requesting a hearing

and the nature of the hearing; and the name and telephone number for a person to contact for additional information. The permitting authority shall provide the fact sheet to EPA and to any other person who requests it.

*g. Relation to construction permits.* The submittal of a complete application shall not affect the requirement that any source have a construction permit under Title I of the Act and subrule 22.1(1).

**22.107(2) Confidential information.** If a source has submitted information with an application under a claim of confidentiality to the department, the source shall also submit a copy of such information directly to the administrator. Requests for confidentiality must comply with 561—Chapter 2.

**22.107(3) Duty to supplement or correct application.** Any applicant who fails to submit any relevant facts or who has submitted incorrect information in a permit application shall, upon becoming aware of such failure or incorrect submittal, promptly submit such supplementary facts or corrected information. In addition, an applicant shall provide additional information as necessary to address any requirements that become applicable to the source after the date the source filed a complete application but prior to release of a draft permit. Applicants who have filed a complete application shall have 60 days following notification by the department to file any amendments. Any MACT determinations in permit applications will be evaluated based on the standards, limitations or levels of technology existing on the date the initial application is deemed complete.

**22.107(4) Certification of truth, accuracy, and completeness.** Any application form, report, or compliance certification submitted pursuant to these rules shall contain certification by a responsible official of truth, accuracy, and completeness. This certification and any other certification required under these rules shall state that, based on information and belief formed after reasonable inquiry, the statements and information in the document are true, accurate, and complete.

**22.107(5) Early reduction application evaluation.** Hazardous air pollutant early reduction application evaluation review shall follow the procedures established in 567—paragraph 23.1(4) “d.”

**22.107(6) Public notice and public participation.**

*a.* The permitting authority shall provide public notice and an opportunity for public comments, including an opportunity for a hearing, before taking any of the following actions: issuance, denial or renewal of a permit; or significant modification or revocation or reissuance of a permit.

*b.* Notice shall be given by posting of the notice, including the draft permit, for the duration of the public comment period on a public website identified by the permitting authority and designed to give general public notice. Notice also shall be given to persons on a mailing list developed by the permitting authority, including those who request in writing to be on the list. The department may use other means if necessary to ensure adequate notice to the affected public.

*c.* The public notice shall include the following:

- (1) Identification of the Title V source.
- (2) Name and address of the permittee.
- (3) Name and address of the permitting authority processing the permit.
- (4) The activity or activities involved in the permit action.
- (5) The emissions change involved in any permit modification.
- (6) The air pollutants or contaminants to be emitted.
- (7) The time and place of any possible public hearing.
- (8) A statement that any person may submit written and signed comments, or may request a public hearing, or both, on the proposed permit. A statement of procedures to request a public hearing shall be included.

(9) The name, address, and telephone number of a person from whom additional information may be obtained. Information entitled to confidential treatment pursuant to Section 114(c) of the Act or state law shall not be released pursuant to this provision. However, the contents of a Title V permit shall not be entitled to protection under Section 114(c) of the Act.

(10) Locations where copies of the permit application and the proposed permit may be reviewed, including the closest department office, and the times at which they shall be available for public inspection.

d. At least 30 days shall be provided for public comment. Notice of any public hearing shall be given at least 30 days in advance of the hearing.

e. Any person may request a public hearing. A request for a public hearing shall be in writing and shall state the person's interest in the subject matter and the nature of the issues proposed to be raised at the hearing. The director shall hold a public hearing upon finding, on the basis of requests, a significant degree of relevant public interest in a draft permit. A public hearing also may be held at the director's discretion.

f. The director shall keep a record of the commenters and of the issues raised during the public participation process and shall prepare written responses to all comments received. At the time a final decision is made, the record and copies of the director's responses shall be made available to the public.

g. The permitting authority shall provide notice and opportunity for participation by affected states as provided by subrule 22.107(7).

**22.107(7) Permit review by EPA and affected states.**

a. *Transmission of information to the administrator.* Except as provided in subrule 22.107(2) or waived by the administrator, the director shall provide to the administrator a copy of each permit application or modification application, including any attachments and compliance plans; each proposed permit; and each final permit. For purposes of this subrule, the application information may be submitted in a computer-readable format compatible with the administrator's national database management system.

b. *Review by affected states.* The director shall provide notice of each draft permit to any affected state on or before the time that public notice is provided to the public pursuant to subrule 22.107(6), except to the extent that subrule 22.112(3) requires the timing of the notice to be different. If the director refuses to accept a recommendation of any affected state, submitted during the public or affected state review period, then the director shall notify the administrator and the affected state in writing. The notification shall include the director's reasons for not accepting the recommendation(s). The director shall not be required to accept recommendations that are not based on applicable requirements.

c. *EPA objection.* No permit for which an application must be transmitted to the administrator shall be issued if the administrator objects in writing to its issuance as not in compliance with the applicable requirements within 45 days after receiving a copy of the proposed permit and necessary supporting information under 22.107(7) "a." Within 90 days after the date of an EPA objection made pursuant to this rule, the director shall submit a response to the objection, if the objection has not been resolved.

**22.107(8) Public petitions to the administrator regarding Title V permits.**

a. If the administrator does not object to a proposed permit, any person may petition the administrator within 60 days after the expiration of the administrator's 45-day review period to make an objection pursuant to 40 CFR 70.8(d) as amended to July 21, 1992.

b. Any person who petitions the administrator pursuant to the provisions of 40 CFR 70.8(d) as amended to July 21, 1992, shall notify the department by certified mail of such petition immediately, and in no case more than 10 days following the date the petition is submitted to EPA. Such notice shall include a copy of the petition submitted to EPA and a separate written statement detailing the grounds for the objection(s) and whether the objection(s) was raised during the public comment period. A petition for review shall not stay the effectiveness of a permit or its requirements if the permit was issued after the end of the 45-day EPA review period and prior to the administrator's objection.

c. If the administrator objects to the permit as a result of a petition filed pursuant to 40 CFR 70.8(d) as amended to July 21, 1992, then the director shall not issue a permit until the administrator's objection has been resolved. However, if the director has issued a permit prior to receipt of the administrator's objection, and the administrator modifies, terminates, or revokes such permit, consistent with the procedures in 40 CFR 70.7 as amended to July 21, 1992, then the director may thereafter issue only a revised permit that satisfies the administrator's objection. In any case, the source shall not be in violation of the requirement to have submitted a timely and complete application.

**22.107(9) A Title V permit application may be denied if:**

a. The director finds that a source is not in compliance with any applicable requirement; or

*b.* An applicant knowingly submits false information in a permit application.

**22.107(10) Retention of permit records.** The director shall keep all records associated with each permit for a minimum of five years.  
[ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—22.108(455B) Permit content.** Each Title V permit shall include the following elements:

**22.108(1) Enforceable emission limitations and standards.** Each permit issued pursuant to this chapter shall include emissions limitations and standards, including those operational requirements and limitations that ensure compliance with all applicable requirements at the time of permit issuance.

*a.* The permit shall specify and reference the origin of and authority for each term or condition and identify any difference in form as compared to the applicable requirement upon which the term or condition is based.

*b.* The permit shall state that, where an applicable requirement of the Act is more stringent than an applicable requirement of regulations promulgated under Title IV of the Act, both provisions shall be incorporated into the permit and shall be enforceable by the administrator.

*c.* If an applicable implementation plan allows a determination of an alternative emission limit at a Title V source, equivalent to that contained in the plan, to be made in the permit issuance, renewal, or significant modification process, and the state elects to use such process, then any permit containing such equivalency determination shall contain provisions to ensure that any resulting emissions limit has been demonstrated to be quantifiable, accountable, enforceable, and based on replicable procedures.

*d.* If an early reduction demonstration is approved as part of the Title V permit application, the permit shall include enforceable alternative emissions limitations for the source reflecting the reduction which qualified the source for the compliance extension.

*e.* Fugitive emissions from a source shall be included in the permit in the same manner as stack emissions, regardless of whether the source category in question is included in the list of sources contained in the definition of major source.

*f.* For all major sources, all applicable requirements for all relevant emissions units in the major source shall be included in the permit.

**22.108(2) Permit duration.** The permit shall specify a fixed term not to exceed five years except:

*a.* Permits issued to Title IV affected sources shall have a fixed term of five years.

*b.* Permits issued to solid waste incineration units combusting municipal waste subject to standards under Section 129(e) of the Act shall have a term not to exceed 12 years. Such permits shall be reviewed every five years.

**22.108(3) Monitoring.** Each permit shall contain the following requirements with respect to monitoring:

*a.* All emissions monitoring and analysis procedures or test methods required under the applicable requirements, including any procedures and methods promulgated pursuant to Section 114(a)(3) or 504(b) of the Act;

*b.* Where the applicable requirement does not require periodic testing or instrumental or noninstrumental monitoring (which may consist of record keeping designed to serve as monitoring), periodic monitoring sufficient to yield reliable data from the relevant time period that are representative of the source's compliance with the permit, as reported pursuant to subrule 22.108(5). Such monitoring shall be determined by application of the "Periodic Monitoring Guidance" (as amended through October 24, 2012) available from the department;

*c.* As necessary, requirements concerning the use, maintenance, and, where appropriate, installation of monitoring equipment or methods; and

*d.* As required, Compliance Assurance Monitoring (CAM) consistent with 40 CFR Part 64 (as amended through October 22, 1997).

**22.108(4) Record keeping.** With respect to record keeping, the permit shall incorporate all applicable record-keeping requirements and require, where applicable, the following:

*a.* Records of required monitoring information that include the following:

(1) The date, place as defined in the permit, and time of sampling or measurements;

- (2) The date(s) the analyses were performed;
- (3) The company or entity that performed the analyses;
- (4) The analytical techniques or methods used;
- (5) The results of such analyses; and
- (6) The operating conditions as existing at the time of sampling or measurement; and

*b.* Retention of records of all required monitoring data and support information for a period of at least five years from the date of the monitoring sample, measurement, report, or application. Support information includes all calibration and maintenance records and all original strip-chart and other recordings for continuous monitoring instrumentation, and copies of all reports required by the permit.

**22.108(5)** Reporting. With respect to reporting, the permit shall incorporate all applicable reporting requirements and shall require the following:

*a.* Submittal of reports of any required monitoring at least every six months. All instances of deviations from permit requirements must be clearly identified in such reports. All required reports must be certified by a responsible official consistent with subrule 22.107(4).

*b.* Prompt reporting of deviations from permit requirements, including those attributable to upset conditions as defined in the permit, the probable cause of such deviations, and any corrective actions or preventive measures taken. The director shall define “prompt” in relation to the degree and type of deviation likely to occur and the applicable requirements.

**22.108(6)** Risk management plan. Pursuant to Section 112(r)(7)(E) of the Act, if the source is required to develop and register a risk management plan pursuant to Section 112(r) of the Act, the permit shall state the requirement for submission of the plan to the air quality bureau of the department. The permit shall also require filing the plan with appropriate authorities and an annual certification to the department that the plan is being properly implemented.

**22.108(7)** A permit condition prohibiting emissions exceeding any allowances that the affected source lawfully holds under Title IV of the Act or the regulations promulgated thereunder.

*a.* No permit revision shall be required for increases in emissions that are authorized by allowances acquired pursuant to the acid rain program, provided that such increases do not require a permit revision under any other applicable requirement.

*b.* No limit shall be placed on the number of allowances held by the Title IV affected source. The Title IV affected source may not, however, use allowances as a defense to noncompliance with any other applicable requirement.

*c.* Any such allowances shall be accounted for according to the procedures established in regulations promulgated under Title IV of the Act.

*d.* Any permit issued pursuant to the requirements of these rules and Title V of the Act to a unit subject to the provisions of Title IV of the Act shall include conditions prohibiting all of the following:

- (1) Annual emissions of sulfur dioxide in excess of the number of allowances to emit sulfur dioxide held by the owners or operators of the unit or the designated representative of the owners or operators.
- (2) Exceedences of applicable emission rates.
- (3) The use of any allowance prior to the year for which it was allocated.
- (4) Contravention of any other provision of the permit.

**22.108(8)** Severability clause. The permit shall contain a severability clause to ensure the continued validity of the various permit requirements in the event of a challenge to any portions of the permit.

**22.108(9)** Other provisions. The Title V permit shall contain provisions stating the following:

*a.* The permittee must comply with all conditions of the Title V permit. Any permit noncompliance constitutes a violation of the Act and is grounds for enforcement action; for a permit termination, revocation and reissuance, or modification; or for denial of a permit renewal application.

*b.* Need to halt or reduce activity not a defense. It shall not be a defense for a permittee in an enforcement action that it would have been necessary to halt or reduce the permitted activity in order to maintain compliance with the conditions of the permit.

*c.* The permit may be modified, revoked, reopened, and reissued, or terminated for cause. The filing of a request by the permittee for a permit modification, revocation and reissuance, or termination, or of a notification of planned changes or anticipated noncompliance does not stay any permit condition.

- d.* The permit does not convey any property rights of any sort, or any exclusive privilege.
- e.* The permittee shall furnish to the director, within a reasonable time, any information that the director may request in writing to determine whether cause exists for modifying, revoking and reissuing, or terminating the permit or to determine compliance with the permit. Upon request, the permittee also shall furnish to the director copies of records required to be kept by the permit or, for information claimed to be confidential, the permittee shall furnish such records directly to the administrator of EPA along with a claim of confidentiality.

**22.108(10) Fees.** The permit shall include a provision to ensure that the Title V permittee pays fees to the director pursuant to rule 567—30.4(455B).

**22.108(11) Emissions trading.** A provision of the permit shall state that no permit revision shall be required, under any approved economic incentives, marketable permits, emissions trading and other similar programs or processes for changes that are provided for in the permit.

**22.108(12) Terms and conditions for reasonably anticipated operating scenarios identified by the source in its application and as approved by the director.** Such terms and conditions:

- a.* Shall require the source, contemporaneously with making a change from one operating scenario to another, to record in a log at the permitted facility a record of the scenario under which it is operating; and

- b.* Must ensure that the terms and conditions of each such alternative scenario meet all applicable requirements and the requirements of the department's rules.

**22.108(13) Terms and conditions, if the permit applicant requests them, for the trading of emissions increases and decreases in the permitted facility, to the extent that the applicable requirements provide for trading such increases and decreases without a case-by-case approval of each emissions trade.** Such terms and conditions:

- a.* Shall include all terms required under subrules 22.108(1) to 22.108(13) and subrule 22.108(15) to determine compliance;

- b.* Must meet all applicable requirements of the Act and regulations promulgated thereunder and all requirements of this chapter; and

- c.* May extend the permit shield described in subrule 22.108(18) to all terms and conditions that allow such increases and decreases in emissions.

**22.108(14) Federally enforceable requirements.**

- a.* All terms and conditions in a Title V permit, including any provisions designed to limit a source's potential to emit, are enforceable by the administrator and citizens under the Act.

- b.* Notwithstanding paragraph "a" of this subrule, the director shall specifically designate as not being federally enforceable under the Act any terms and conditions included in the permit that are not required under the Act or under any of its applicable requirements. Terms and conditions so designated are not subject to the requirements of 40 CFR 70.7 or 70.8 (as amended through July 21, 1992).

**22.108(15) Compliance requirements.** All Title V permits shall contain the following elements with respect to compliance:

- a.* Consistent with the provisions of subrules 22.108(3) to 22.108(5), compliance certification, testing, monitoring, reporting, and record-keeping requirements sufficient to ensure compliance with the terms and conditions of the permit. Any documents, including reports, required by a permit shall contain a certification by a responsible official that meets the requirements of subrule 22.107(4).

- b.* Inspection and entry provisions which require that, upon presentation of proper credentials, the permittee shall allow the director or the director's authorized representative to:

- (1) Enter upon the permittee's premises where a Title V source is located or emissions-related activity is conducted, or where records must be kept under the conditions of the permit;

- (2) Have access to and copy, at reasonable times, any records that must be kept under the conditions of the permit;

- (3) Inspect, at reasonable times, any facilities, equipment (including monitoring and air pollution control equipment), practices, or operations regulated or required under the permit; and

- (4) Sample or monitor, at reasonable times, substances or parameters for the purpose of ensuring compliance with the permit or other applicable requirements.

*c.* A schedule of compliance consistent with subparagraphs 22.105(2) “*h*” and “*j*” and subrule 22.105(3).

*d.* Progress reports, consistent with an applicable schedule of compliance and with the provisions of paragraphs 22.105(2) “*h*” and “*j*,” to be submitted at least every six months, or more frequently if specified in the applicable requirement or by the department in the permit. Such progress reports shall contain the following:

(1) Dates for achieving the activities, milestones or compliance required in the schedule of compliance, and dates when such activities, milestones or compliance were achieved; and

(2) An explanation of why any dates in the schedule of compliance were not or will not be met, and any preventive or corrective measures adopted.

*e.* Requirements for compliance certification with terms and conditions contained in the permit, including emission limitations, standards, or work practices. Permits shall include each of the following:

(1) The frequency of submissions of compliance certifications, which shall not be less than annually.

(2) The means to monitor the compliance of the source with its emissions limitations, standards, and work practices, in accordance with the provisions of all applicable department rules.

(3) A requirement that the compliance certification include: the identification of each term or condition of the permit that is the basis of the certification; the compliance status; whether compliance was continuous or intermittent; the method(s) used for determining the compliance status of the source, currently and over the reporting period consistent with all applicable department rules; and other facts as the director may require to determine the compliance status of the source.

(4) A requirement that all compliance certifications be submitted to the administrator and the director.

*f.* Such additional provisions as the director may require.

*g.* Such additional provisions as may be specified pursuant to Sections 114(a)(3) and 504(b) of the Act.

*h.* If there is a federal implementation plan applicable to the source, a provision that compliance with the federal implementation plan is required.

**22.108(16) Emergency provisions.**

*a.* For the purposes of a Title V permit, an “emergency” means any situation arising from sudden and reasonably unforeseeable events beyond the control of the source, including acts of God, which situation requires immediate corrective action to restore normal operation, and that causes the source to exceed a technology-based emission limitation under the permit, due to unavoidable increases in emissions attributable to the emergency. An emergency shall not include noncompliance to the extent caused by improperly designed equipment, lack of preventive maintenance, careless or improper operation, or operator error.

*b.* An emergency constitutes an affirmative defense to an action brought for noncompliance with such technology-based emission limitations if the conditions of paragraph 22.108(16) “*c*” are met.

*c.* Requirements for affirmative defense. The affirmative defense of emergency shall be demonstrated by the source through properly signed, contemporaneous operating logs, or other relevant evidence that:

(1) An emergency occurred and that the permittee can identify the cause(s) of the emergency;

(2) The permitted facility was at the time being properly operated;

(3) During the period of the emergency the permittee took all reasonable steps to minimize levels of emissions that exceeded the emissions standards or other requirements of the permit; and

(4) The permittee submitted notice of the emergency to the director by certified mail within two working days of the time when emission limitations were exceeded due to the emergency. This notice fulfills the requirement of paragraph 22.108(5) “*b*.” This notice must contain a description of the emergency, any steps taken to mitigate emissions, and corrective actions taken.

*d.* In any enforcement proceeding, the permittee seeking to establish the occurrence of an emergency has the burden of proof.

*e.* This provision is in addition to any emergency or upset provision contained in any applicable requirement.

**22.108(17) Permit reopenings.**

*a.* A Title V permit issued to a major source shall require that revisions be made to incorporate applicable standards and regulations adopted by the administrator pursuant to the Act, provided that:

(1) The reopening and revision on this ground is not required if the permit has a remaining term of less than three years;

(2) The reopening and revision on this ground is not required if the effective date of the requirement is later than the date on which the permit is due to expire, unless the original permit or any of its terms and conditions have been extended pursuant to 40 CFR 70.4(b)(10)(i) or (ii) as amended through October 6, 2009; or

(3) The additional applicable requirements are implemented in a general permit that is applicable to the source and the source receives approval for coverage under that general permit.

*b.* The revisions shall be made as expeditiously as practicable, but not later than 18 months after the promulgation of such standards and regulations. Any permit revision required pursuant to this subrule shall be treated as a permit renewal.

**22.108(18) Permit shield.**

*a.* The director may expressly include in a Title V permit a provision stating that compliance with the conditions of the permit shall be deemed compliance with any applicable requirements as of the date of permit issuance, provided that:

(1) Such applicable requirements are included and are specifically identified in the permit; or

(2) The director, in acting on the permit application or revision, determines in writing that other requirements specifically identified are not applicable to the source, and the permit includes the determination or a concise summary thereof.

*b.* A Title V permit that does not expressly state that a permit shield exists shall be presumed not to provide such a shield.

*c.* A permit shield shall not alter or affect the following:

(1) The provisions of Section 303 of the Act (emergency orders), including the authority of the administrator under that section;

(2) The liability of an owner or operator of a source for any violation of applicable requirements prior to or at the time of permit issuance;

(3) The applicable requirements of the acid rain program, consistent with Section 408(a) of the Act;

(4) The ability of the department or the administrator to obtain information from the facility pursuant to Section 114 of the Act.

**22.108(19) Emission trades.** For emission trades at facilities solely for the purpose of complying with a federally enforceable emissions cap that is established in the permit independent of otherwise applicable requirements, permit applications under this provision are required to include proposed replicable procedures and proposed permit terms that ensure the emission trades are quantifiable and enforceable.

[ARC 0330C, IAB 9/19/12, effective 10/24/12; ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 2949C, IAB 2/15/17, effective 3/22/17]

**567—22.109(455B) General permits.**

**22.109(1) Applicability.** The director may issue a general permit for multiple sources that contain a number of operations and processes which emit pollutants with similar characteristics and that have substantially similar requirements regarding emissions, operations, monitoring and record keeping. General permits shall not be issued to Title IV affected sources except as provided in regulations promulgated by the administrator under Title IV of the Act.

**22.109(2) Issuance of general permits.** General permits may be issued by the director and codified in this chapter following notice and opportunity for public participation consistent with the procedures contained in subrule 22.107(6). Public participation shall be provided for a new general permit, for any revision of an existing general permit, and for renewal of an existing general permit. Permit review by

the administrator and affected states shall be provided consistent with subrule 22.107(7). Each general permit shall identify criteria by which sources may qualify to operate under the general permit and shall comply with all requirements applicable to other Title V permits.

**22.109(3) Applications.** Any source that would qualify for a general permit must apply for either (a) coverage under the terms of the general permit or (b) an individual Title V permit. Applications for authority to operate under the terms of a general permit shall be made on the “General Permit Application Form” and shall specify the general permit concerned by citing the subrule containing that general permit. These applications may deviate from the Title V individual permit application but shall include all information necessary to determine qualification for, and to ensure compliance with, the general permit. If a source is later determined not to qualify for the terms and conditions of the general permit, then the source shall be subject to enforcement action for operation without a Title V operating permit.

**22.109(4) General permit content.** A general permit shall include all of the following:

- a. The terms and conditions required for all sources authorized to operate under the permit;
- b. Emission limitations and standards, including those operational requirements and limitations that ensure compliance with all applicable requirements at the time of the permit issuance;
- c. A compliance plan;
- d. Monitoring, record keeping, and reporting requirements to ensure compliance with the terms and conditions of the general permit. These requirements shall ensure the use of consistent terms, test methods, units, averaging periods, and other statistical conventions consistent with the applicable emissions limitations, standards, and other requirements contained in the general permit;
- e. The requirement to submit at least every six months the results of any required monitoring;
- f. References to the authority for the term or condition;
- g. A provision specifying permit duration as a fixed term not to exceed five years;
- h. A severability clause provision pursuant to subrule 22.108(8);
- i. A provision for payment of fees pursuant to subrule 22.108(10);
- j. A provision for emissions trading pursuant to subrules 22.108(11) and 22.108(13);
- k. Other provisions pursuant to subrule 22.108(9);
- l. Statement that the Title V permit is to be kept at the site of the source as well as at the corporate offices; and
- m. The process for individual sources to apply for coverage under the general permit.

**22.109(5) Action on general permit application.**

a. Once the director has issued a general permit, any source which is a member of the class of sources covered by the general permit may apply to the director for authority to operate under the general permit.

b. Review of a general permit application. The director shall grant the conditions and terms of a general permit to all sources that apply and qualify under the identified criteria.

c. The director may grant a source’s request for authorization to operate under a general permit without repeating the public participation procedures followed in subrule 22.109(2). However, such a grant shall not be a final permit action for purposes of judicial review.

**22.109(6) General permit renewal.** The director shall review and may renew general permits every five years. A source’s authorization to operate under a general permit shall expire when the general permit expires regardless of when the authorization began during the five-year period.

**22.109(7) Relationship to individual permits.** Any source covered by a general permit may request to be excluded from coverage by applying for an individual Title V permit. Coverage under the general permit shall terminate on the date the individual Title V permit is issued.

**22.109(8) Permit shield for general permit.** Each general permit issued under this chapter shall specifically identify all federal, state, and local air pollution control requirements applicable to the source at the time the permit is issued. The permit shall state that compliance with the conditions of the permit shall be deemed compliance with any applicable requirements as of the date of permit issuance. Any permit under this chapter that does not expressly state that a permit shield exists shall be presumed not to provide such a shield. Notwithstanding the above provisions, the source shall be subject to enforcement

action for operation without a permit if the source is later determined not to qualify for the conditions and terms of the general permit.

**22.109(9) Revocations of authority to operate.**

*a.* The director may require any source or a class of sources authorized to operate under a general permit to individually apply for and obtain a Title V permit at any time if:

- (1) The source is not in compliance with the terms and conditions of the general permit;
- (2) The director has determined that the emissions from the source or class of sources is contributing significantly to ambient air quality standard violations and that these emissions are not adequately addressed by the terms and conditions of the general permit; or
- (3) The director has information which indicates that the cumulative effects on human health and the environment from the sources covered under the general permit are unacceptable.

*b.* The director shall provide written notice to all sources operating under that general permit of the proposed revocation of that general permit. Such notice shall include an explanation of the basis for the proposed action.

**567—22.110(455B) Changes allowed without a Title V permit revision (off-permit revisions).**

**22.110(1)** A source with a Title V permit may make Section 502(b)(10) changes to the permitted installation/facility without a Title V permit revision if:

*a.* The changes are not major modifications under any provision of any program required by Section 110 of the Act, modifications under Section 111 of the Act, modifications under Section 112 of the Act, or major modifications of this chapter;

*b.* The changes do not exceed the emissions allowable under the permit (whether expressed therein as a rate of emissions or in terms of total emissions);

*c.* The changes are not modifications under any provision of Title I of the Act and the changes do not exceed the emissions allowable under the permit (whether expressed therein as a rate of emissions or in terms of total emissions);

*d.* The changes are not subject to any requirement under Title IV of the Act (revisions affecting Title IV permitting are addressed in rules 567—22.140(455B) through 567—22.144(455B));

*e.* The changes comply with all applicable requirements; and

*f.* For each such change, the permitted source provides to the department and the administrator by certified mail, at least 30 days in advance of the proposed change, a written notification, including the following, which shall be attached to the permit by the source, the department, and the administrator:

- (1) A brief description of the change within the permitted facility,
- (2) The date on which the change will occur,
- (3) Any change in emission as a result of the change,
- (4) The pollutants emitted subject to the emissions trade,
- (5) If the emissions trading provisions of the state implementation plan are invoked, then the Title V permit requirements with which the source shall comply; a description of how the emission increases and decreases will comply with the terms and conditions of the Title V permit;
- (6) A description of the trading of emissions increases and decreases for the purpose of complying with a federally enforceable emissions cap as specified in and in compliance with the Title V permit; and
- (7) Any permit term or condition no longer applicable as a result of the change.

**22.110(2)** Such changes do not include changes that would violate applicable requirements or contravene federally enforceable permit terms and conditions that are monitoring (including test methods), record keeping, reporting, or compliance certification requirements.

**22.110(3)** Notwithstanding any other part of this rule, the director may, upon review of a notice, require a stationary source to apply for a Title V permit if the change does not meet the requirements of subrule 22.110(1).

**22.110(4)** The permit shield provided in subrule 22.108(18) shall not apply to any change made pursuant to this rule. Compliance with the permit requirements that the source will meet using the emissions trade shall be determined according to requirements of the state implementation plan authorizing the emissions trade.

**567—22.111(455B) Administrative amendments to Title V permits.**

**22.111(1)** An administrative permit amendment is a permit revision that does any of the following:

- a.* Corrects typographical errors;
- b.* Identifies a change in the name, address, or telephone number of any person identified in the permit, or provides a similar minor administrative change at the source;
- c.* Requires more frequent monitoring or reporting by the permittee; or
- d.* Allows for a change in ownership or operational control of a source where the director determines that no other change in the permit is necessary, provided that a written agreement containing a specific date for transfer of permit responsibility, coverage, and liability between the current and new permittee has been submitted to the director.

**22.111(2)** Administrative permit amendments to portions of permits containing provisions pursuant to Title IV of the Act shall be governed by regulations promulgated by the administrator under Title IV of the Act.

**22.111(3)** The director shall take no more than 60 days from receipt of a request for an administrative permit amendment to take final action on such request, and may incorporate such changes without providing notice to the public or affected states provided that the director designates any such permit revisions as having been made pursuant to this rule.

**22.111(4)** The director shall submit to the administrator a copy of each Title V permit revised under this rule.

**22.111(5)** The source may implement the changes addressed in the request for an administrative amendment immediately upon submittal of the request.

**567—22.112(455B) Minor Title V permit modifications.**

**22.112(1)** Minor Title V permit modification procedures may be used only for those permit modifications that satisfy all of the following:

- a.* Do not violate any applicable requirement;
- b.* Do not involve significant changes to existing monitoring, reporting, or record-keeping requirements in the Title V permit;
- c.* Do not require or change a case-by-case determination of an emission limitation or other standard, or an increment analysis;
- d.* Do not seek to establish or change a permit term or condition for which there is no corresponding underlying applicable requirement and that the source has assumed in order to avoid an applicable requirement to which the source would otherwise be subject. Such terms and conditions include any federally enforceable emissions caps which the source would assume to avoid classification as a modification under any provision of Title I of the Act; and an alternative emissions limit approved pursuant to regulations promulgated under Section 112(i)(5) of the Act;
- e.* Are not modifications under any provision of Title I of the Act; and
- f.* Are not required to be processed as a significant modification under rule 567—22.113(455B).

**22.112(2)** An application for minor permit revision shall be on the minor Title V modification application form and shall include at least the following:

- a.* A description of the change, the emissions resulting from the change, and any new applicable requirements that will apply if the change occurs;
- b.* The source's suggested draft permit;
- c.* Certification by a responsible official, pursuant to subrule 22.107(4), that the proposed modification meets the criteria for use of minor permit modification procedures and a request that such procedures be used; and
- d.* Completed forms to enable the department to notify the administrator and affected states as required by subrule 22.107(7).

**22.112(3)** The department shall notify the administrator and affected states within five working days of receipt of a complete permit modification application. Notification shall be in accordance with the provisions of subrule 22.107(7). The department shall promptly send to the administrator any notification required by subrule 22.107(7).

**22.112(4)** The director shall not issue a final Title V permit modification until after the administrator's 45-day review period or until the administrator has notified the director that the administrator will not object to issuance of the Title V permit modification, whichever is first. Within 90 days of the director's receipt of an application under the minor permit modification procedures, or 15 days after the end of the administrator's 45-day review period provided for in subrule 22.107(7), whichever is later, the director shall:

- a. Issue the permit modification as proposed;
- b. Deny the permit modification application;
- c. Determine that the requested permit modification does not meet the minor permit modification criteria and should be reviewed under the significant modification procedures; or
- d. Revise the draft permit modification and transmit to the administrator the proposed permit modification, as required by subrule 22.107(7).

**22.112(5)** Source's ability to make change. The source may make the change proposed in its minor permit modification application immediately after it files the application. After the source makes the change allowed by the preceding sentence, and until the director takes any of the actions specified in paragraphs 22.112(4) "a" to "c," the source must comply with both the applicable requirements governing the change and the proposed permit terms and conditions. During this time, the source need not comply with the existing permit terms and conditions it seeks to modify. However, if the source fails to comply with its proposed permit terms and conditions during this time period, the existing permit terms and conditions it seeks to modify may be enforced against it.

**22.112(6)** Permit shield. The permit shield under subrule 22.108(18) shall not extend to minor Title V permit revisions.

**567—22.113(455B) Significant Title V permit modifications.**

**22.113(1)** Significant Title V modification procedures shall be used for applications requesting Title V permit modifications that do not qualify as minor Title V modifications or as administrative amendments. These include, but are not limited to, all significant changes in monitoring permit terms, every relaxation of reporting or record-keeping permit terms, and any change in the method of measuring compliance with existing requirements.

**22.113(2)** Significant Title V permit modifications shall meet all requirements of this chapter, including those for applications, public participation, review by affected states, and review by the administrator, as those requirements that apply to Title V permit issuance and renewal.

**22.113(3)** Unless the director determines otherwise, review of significant Title V permit modification applications shall be completed within nine months of receipt of a complete application.

**22.113(4)** For a change that is subject to the requirements for a significant permit modification (see rule 567—22.113(455B)), the permittee shall submit to the department an application for a significant permit modification not later than three months after commencing operation of the changed source unless the existing Title V permit would prohibit such construction or change in operation, in which event the operation of the changed source may not commence until the department revises the permit.

**567—22.114(455B) Title V permit reopenings.**

**22.114(1)** Each issued Title V permit shall include provisions specifying the conditions under which the permit may be reopened and revised prior to the expiration of the permit. A permit shall be reopened and revised under any of the following circumstances:

a. The department receives notice that the administrator has granted a petition for disapproval of a permit pursuant to 40 CFR 70.8(d) as amended to July 21, 1992, provided that the reopening may be stayed pending judicial review of that determination;

b. The department or the administrator determines that the Title V permit contains a material mistake or that inaccurate statements were made in establishing the emissions standards or other terms or conditions of the Title V permit;

c. Additional applicable requirements under the Act become applicable to a Title V source, provided that the reopening on this ground is not required if the permit has a remaining term of less

than three years, the effective date of the requirement is later than the date on which the permit is due to expire, or the additional applicable requirements are implemented in a general permit that is applicable to the source and the source receives approval for coverage under that general permit. Such a reopening shall be complete not later than 18 months after promulgation of the applicable requirement.

*d.* Additional requirements, including excess emissions requirements, become applicable to a Title IV affected source under the acid rain program. Upon approval by the administrator, excess emissions offset plans shall be deemed to be incorporated into the permit.

*e.* The department or the administrator determines that the permit must be revised or revoked to ensure compliance by the source with the applicable requirements.

**22.114(2)** Proceedings to reopen and reissue a Title V permit shall follow the procedures applicable to initial permit issuance and shall affect only those parts of the permit for which cause to reopen exists.

**22.114(3)** A notice of intent shall be provided to the Title V source at least 30 days in advance of the date the permit is to be reopened, except that the director may provide a shorter time period in the case of an emergency.

**22.114(4)** Within 90 days of receipt of a notice from the administrator that cause exists to reopen a permit, the director shall forward to the administrator and the source a proposed determination of termination, modification, revocation, or reissuance of the permit, as appropriate.

**567—22.115(455B) Suspension, termination, and revocation of Title V permits.**

**22.115(1)** Permits may be terminated, modified, revoked, or reissued for cause. The following examples shall be considered cause for the suspension, modification, revocation, or reissuance of a Title V permit:

*a.* The director has reasonable cause to believe that the permit was obtained by fraud or misrepresentation.

*b.* The person applying for the permit failed to disclose a material fact required by the permit application form or the rules applicable to the permit, of which the applicant had or should have had knowledge at the time the application was submitted.

*c.* The terms and conditions of the permit have been or are being violated.

*d.* The permittee has failed to pay the Title V permit fees.

*e.* The permittee has failed to pay an administrative, civil or criminal penalty imposed for violations of the permit.

**22.115(2)** If the director suspends, terminates or revokes a Title V permit under this rule, the notice of such action shall be served on the applicant or permittee by certified mail, return receipt requested. The notice shall include a statement detailing the grounds for the action sought, and the proceeding shall in all other respects comply with the requirements of rule 561—7.16(17A,455A).

**567—22.116(455B) Title V permit renewals.**

**22.116(1)** An application for Title V permit renewal shall be subject to the same procedural requirements that apply to initial permit issuance, including those for public participation and review by the administrator and affected states.

**22.116(2)** Except as provided in rule 567—22.104(455B), permit expiration terminates a source's right to operate unless a timely and complete application for renewal has been submitted in accordance with rule 567—22.105(455B).

**567—22.117 to 22.119** Reserved.

**567—22.120(455B) Acid rain program—definitions.** The terms used in rules 567—22.120(455B) through 567—22.147(455B) shall have the meanings set forth in Title IV of the Clean Air Act, 42 U.S.C. 7401, et seq., as amended through November 15, 1990, and in this rule. The definitions set forth in 40 CFR Part 72 as amended through March 28, 2011, and 40 CFR Part 76 as amended through October 15, 1999, are adopted by reference.

“40 CFR Part 72,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 72, or the cited provision therein, as amended through March 28, 2011.

“40 CFR Part 73,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 73, or the cited provision therein, as amended through April 28, 2006.

“40 CFR Part 74,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 74, or the cited provision therein, as amended through April 28, 2006.

“40 CFR Part 75,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 75, or the cited provision therein, as amended through August 30, 2016.

“40 CFR Part 76,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 76, or the cited provision therein, as amended through October 15, 1999.

“40 CFR Part 77,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 77, or the cited provision therein, as amended through May 12, 2005.

“40 CFR Part 78,” or any cited provision therein, shall mean 40 Code of Federal Regulations Part 78, or the cited provision therein, as amended through August 8, 2011.

“Acid rain permit” means the legally binding written document, or portion of such document, issued by the department (following an opportunity for appeal as set forth in 561—Chapter 7, as adopted by reference at 567—Chapter 7), including any permit revisions, specifying the acid rain program requirements applicable to an affected source, to each affected unit at an affected source, and to the owner and operators and the designated representative of the affected source or the affected unit.

“Department” means the department of natural resources and is the state acid rain permitting authority.

“Draft acid rain permit” means the version of the acid rain permit, or the acid rain portion of a Title V operating permit, that the department offers for public comment.

“Permit revision” means a permit modification, fast-track modification, administrative permit amendment, or automatic permit amendment, as provided in rules 567—22.140(455B) through 567—22.144(455B).

“Proposed acid rain permit” means the version of the acid rain permit that the department submits to the Administrator after the public comment period, but prior to completion of the EPA permit review under 40 CFR 70.8(c) as amended through July 21, 1992.

“Title V operating permit” means a permit issued under rules 567—22.100(455B) through 567—22.116(455B) implementing Title V of the Act.

“Ton” or “tonnage” means any short ton (i.e., 2,000 pounds). For purposes of determining compliance with the acid rain emissions limitations and reduction requirements, total tons for a year shall be calculated as the sum of all recorded hourly emissions (or the tonnage equivalent of the recorded hourly emissions) in accordance with rule 567—25.2(455B), with any remaining fraction of a ton equal to or greater than 0.50 ton deemed to equal one ton and any fraction of a ton less than 0.50 ton deemed not equal to a ton.

[ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—22.121(455B) Measurements, abbreviations, and acronyms.** Measurements, abbreviations, and acronyms used in rules 567—22.120(455B) to 567—22.147(455B) are defined as follows:

“ASTM” means American Society for Testing and Materials.

“Btu” means British thermal unit.

“CFR” means Code of Federal Regulations.

“DOE” means Department of Energy.

“EPA” means Environmental Protection Agency.

“mmBtu” means million Btu.

“MWe” means megawatt electrical.

“SO<sub>2</sub>” means sulfur dioxide.

**567—22.122(455B) Applicability.**

**22.122(1)** Each of the following units shall be an affected unit, and any source that includes such a unit shall be an affected source, subject to the requirements of the acid rain program:

- a.* A unit listed in Table 1 of 40 CFR 73.10(a).
- b.* An existing unit that is identified in Table 2 or 3 of 40 CFR 73.10, and any other existing utility unit, except a unit under subrule 22.122(2).
- c.* A utility unit, except a unit under subrule 22.122(2), that:
  - (1) Is a new unit;
  - (2) Did not serve a generator with a nameplate capacity greater than 25 MWe on November 15, 1990, but serves such a generator after November 15, 1990;
  - (3) Was a simple combustion turbine on November 15, 1990, but adds or uses auxiliary firing after November 15, 1990;
  - (4) Was an exempt cogeneration facility under paragraph 22.122(2)“*d*” but during any three-calendar-year period after November 15, 1990, sold, to a utility power distribution system, an annual average of more than one-third of its potential electrical output capacity and more than 219,000 MWe-hrs electric output, on a gross basis;
  - (5) Was an exempt qualifying facility under paragraph 22.122(2)“*e*” but, at any time after the later of November 15, 1990, or the date the facility commences commercial operation, fails to meet the definition of qualifying facility;
  - (6) Was an exempt independent power production facility under paragraph 22.122(2)“*f*” but, at any time after the later of November 15, 1990, or the date the facility commences commercial operation, fails to meet the definition of independent power production facility; or
  - (7) Was an exempt solid waste incinerator under paragraph 22.122(2)“*g*” but during any three-calendar-year period after November 15, 1990, consumes 20 percent or more (on a Btu basis) fossil fuel.
- (8) Is a coal-fired substitution unit that is designated in a substitution plan that was not approved and not active as of January 1, 1995, or is a coal-fired compensating unit.

**22.122(2)** The following types of units are not affected units subject to the requirements of the acid rain program:

- a.* A simple combustion turbine that commenced operation before November 15, 1990.
- b.* Any unit that commenced commercial operation before November 15, 1990, and that did not, as of November 15, 1990, and does not currently, serve a generator with a nameplate capacity of greater than 25 MWe.
- c.* Any unit that, during 1985, did not serve a generator that produced electricity for sale and that did not, as of November 15, 1990, and does not currently, serve a generator that produces electricity for sale.
- d.* A cogeneration facility which:
  - (1) For a unit that commenced construction on or prior to November 15, 1990, was constructed for the purpose of supplying equal to or less than one-third its potential electrical output capacity or equal to or less than 219,000 MWe-hrs actual electric output on an annual basis to any utility power distribution system for sale (on a gross basis). If the purpose of construction is not known, it will be presumed to be consistent with the actual operation from 1985 through 1987. However, if in any three-calendar-year period after November 15, 1990, such unit sells to a utility power distribution system an annual average of more than one-third of its potential electrical output capacity and more than 219,000 MWe-hrs actual electric output (on a gross basis), that unit shall be an affected unit, subject to the requirements of the acid rain program; or
  - (2) For units that commenced construction after November 15, 1990, supplies equal to or less than one-third its potential electrical output capacity or equal to or less than 219,000 MWe-hrs actual electric output on an annual basis to any utility power distribution system for sale (on a gross basis). However, if in any three-calendar-year period after November 15, 1990, such unit sells to a utility power distribution system an annual average of more than one-third of its potential electrical output capacity and more than

219,000 MWe-hrs actual electric output (on a gross basis), that unit shall be an affected unit, subject to the requirements of the acid rain program.

*e.* A qualifying facility that:

(1) Has, as of November 15, 1990, one or more qualifying power purchase commitments to sell at least 15 percent of its total planned net output capacity; and

(2) Consists of one or more units designated by the owner or operator with total installed net output capacity not exceeding 130 percent of the total planned net output capacity. If the emissions rates of the units are not the same, the administrator may exercise discretion to designate which units are exempt.

*f.* An independent power production facility that:

(1) Has, as of November 15, 1990, one or more qualifying power purchase commitments to sell at least 15 percent of its total planned net output capacity; and

(2) Consists of one or more units designated by the owner or operator with total installed net output capacity not exceeding 130 percent of its total planned net output capacity. If the emissions rates of the units are not the same, the administrator may exercise discretion to designate which units are exempt.

*g.* A solid waste incinerator, if more than 80 percent (on a Btu basis) of the annual fuel consumed at such incinerator is other than fossil fuels. For a solid waste incinerator which began operation before January 1, 1985, the average annual fuel consumption of nonfossil fuels for calendar years 1985 through 1987 must be greater than 80 percent for such an incinerator to be exempt. For a solid waste incinerator which began operation after January 1, 1985, the average annual fuel consumption of nonfossil fuels for the first three years of operation must be greater than 80 percent for such an incinerator to be exempt. If, during any three-calendar-year period after November 15, 1990, such incinerator consumes 20 percent or more (on a Btu basis) fossil fuel, such incinerator will be an affected source under the acid rain program.

*h.* A nonutility unit.

**22.122(3)** A certifying official of any unit may petition the administrator for a determination of applicability under 40 CFR 72.6(c). The administrator's determination of applicability shall be binding upon the department, unless the petition is found to have contained significant errors or omissions.

**567—22.123(455B) Acid rain exemptions.**

**22.123(1)** *New unit exemption.* The new unit exemption, as specified in 40 CFR §72.7, except for 40 CFR §72.7(c)(1)(i), is adopted by reference. This exemption applies to new utility units.

**22.123(2)** *Retired unit exemption.* The retired unit exemption, as specified in 40 CFR §72.8, is adopted by reference. This exemption applies to any affected unit that is permanently retired.

**22.123(3)** *Industrial utility-unit exemption.* The industrial utility-unit exemption, as specified in 40 CFR §72.14, is adopted by reference. This exemption applies to any noncogeneration utility unit.

**567—22.124(455B) Retired units exemption.** Rescinded IAB 9/9/98, effective 10/14/98.

**567—22.125(455B) Standard requirements.**

**22.125(1)** *Permit requirements.*

*a.* The designated representative of each affected source and each affected unit at the source shall:

(1) Submit a complete acid rain permit application under this chapter in accordance with the deadlines specified in rule 567—22.128(455B);

(2) Submit in a timely manner any supplemental information that the department determines is necessary in order to review an acid rain permit application and issue or deny an acid rain permit.

*b.* The owners and operators of each affected source and each affected unit at the source shall:

(1) Operate the unit in compliance with a complete acid rain permit application or a superseding acid rain permit issued by the department; and

(2) Have an acid rain permit.

**22.125(2)** *Monitoring requirements.*

*a.* The owners and operators and, to the extent applicable, designated representative of each affected source and each affected unit at the source shall comply with the monitoring requirements as

provided in rule 567—25.2(455B) and Section 407 of the Act and regulations implementing Section 407 of the Act.

*b.* The emissions measurements recorded and reported in accordance with rule 567—25.2(455B) and Section 407 of the Act and regulations implementing Section 407 of the Act shall be used to determine compliance by the unit with the acid rain emissions limitations and emissions reduction requirements for sulfur dioxide and nitrogen oxides under the acid rain program.

*c.* The requirements of rule 567—25.2(455B) and regulations implementing Section 407 of the Act shall not affect the responsibility of the owners and operators to monitor emissions of other pollutants or other emissions characteristics at the unit under other applicable requirements of the Act and other provisions of the operating permit for the source.

**22.125(3) Sulfur dioxide requirements.**

*a.* The owners and operators of each source and each affected unit at the source shall:

(1) Hold allowances, as of the allowance transfer deadline, in the unit's compliance subaccount (after deductions under 40 CFR 73.34(c)) not less than the total annual emissions of sulfur dioxide for the previous calendar year from the unit; and

(2) Comply with the applicable acid rain emissions limitation for sulfur dioxide.

*b.* Each ton of sulfur dioxide emitted in excess of the acid rain emissions limitations for sulfur dioxide shall constitute a separate violation of the Act.

*c.* An affected unit shall be subject to the requirements under paragraph 22.125(3) "a" as follows: starting January 1, 2000, an affected unit under paragraph 22.122(1) "b"; or starting on the later of January 1, 2000, or the deadline for monitor certification under rule 567—25.2(455B), an affected unit under paragraph 22.122(1) "c."

*d.* Allowances shall be held in, deducted from, or transferred among allowance tracking system accounts in accordance with the acid rain program.

*e.* An allowance shall not be deducted, in order to comply with the requirements under paragraph 22.125(3) "a," prior to the calendar year for which the allowance was allocated.

*f.* An allowance allocated by the administrator under the acid rain program is a limited authorization to emit sulfur dioxide in accordance with the acid rain program. No provision of the acid rain program, the acid rain permit application, the acid rain permit, or the written exemption under rules 567—22.123(455B) and 567—22.124(455B) and no provision of law shall be construed to limit the authority of the United States to terminate or limit such authorization.

*g.* An allowance allocated by the administrator under the acid rain program does not constitute a property right.

**22.125(4) Nitrogen oxides requirements.** The owners and operators of the source and each affected unit at the source shall comply with the applicable acid rain emission limitation for nitrogen oxides, as specified in 40 CFR Sections 76.5 and 76.7; 76.6; and 76.8, 76.11, 76.12, and 76.15; or by alternative emission limitations provided for by 40 CFR 76.10, as long as the alternative emission limitation has been petitioned and demonstrated according to 40 CFR 76.14 and approved by the department.

**22.125(5) Excess emissions requirements.**

*a.* The designated representative of an affected unit that has excess emissions in any calendar year shall submit a proposed offset plan to the administrator, as required under 40 CFR Part 77, and submit a copy to the department.

*b.* The owners and operators of an affected unit that has excess emissions in any calendar year shall:

(1) Pay to the administrator without demand the penalty required, and pay to the administrator upon demand the interest on that penalty, as required by 40 CFR Part 77; and

(2) Comply with the terms of an approved offset plan, as required by 40 CFR Part 77.

**22.125(6) Record-keeping and reporting requirements.**

*a.* Unless otherwise provided, the owners and operators of the source and each affected unit at the source shall keep on site at the source each of the following documents for a period of five years from the date the document is created. This period may be extended for cause, at any time prior to the end of five years, in writing by the administrator or the department.

(1) The certificate of representation for the designated representative for the source and each affected unit at the source and all documents that demonstrate the truth of the statements in the certificate of representation, in accordance with 40 CFR 72.24; provided that the certificate and documents shall be retained on site at the source beyond such five-year period until such documents are superseded because of the submission of a new certificate of representation changing the designated representative.

(2) All emissions monitoring information, in accordance with rule 567—25.2(455B).

(3) Copies of all reports, compliance certifications, and other submissions and all records made or required under the acid rain program.

(4) Copies of all documents used to complete an acid rain permit application and any other submission under the acid rain program or to demonstrate compliance with the requirements of the acid rain program.

*b.* The designated representative of an affected source and each affected unit at the source shall submit the reports and compliance certifications required under the acid rain program, including those under rules 567—22.146(455B) and 567—22.147(455B) and rule 567—25.2(455B).

**22.125(7) Liability.**

*a.* Any person who knowingly violates any requirement or prohibition of the acid rain program, a complete acid rain permit application, an acid rain permit, or a written exemption under rules 567—22.123(455B) or 567—22.124(455B), including any requirement for the payment of any penalty owed to the United States, shall be subject to enforcement by the administrator pursuant to Section 113(c) of the Act and by the department pursuant to Iowa Code section 455B.146.

*b.* Any person who knowingly makes a false, material statement in any record, submission, or report under the acid rain program shall be subject to criminal enforcement by the administrator pursuant to Section 113(c) of the Act and 18 U.S.C. 1001 and by the department pursuant to Iowa Code section 455B.146.

*c.* No permit revision shall excuse any violation of the requirements of the acid rain program that occurs prior to the date that the revision takes effect.

*d.* Each affected source and each affected unit shall meet the requirements of the acid rain program.

*e.* Any provision of the acid rain program that applies to an affected source (including a provision applicable to the designated representative of an affected source) shall also apply to the owners and operators of such source and of the affected units at the source.

*f.* Any provision of the acid rain program that applies to an affected unit (including a provision applicable to the designated representative of an affected unit) shall also apply to the owners and operators of such unit. Except as provided under rule 567—22.132(455B) (Phase II repowering extension plans), Section 407 of the Act and regulations implementing Section 407 of the Act, and except with regard to the requirements applicable to units with a common stack under rule 567—25.2(455B), the owners and operators and the designated representative of one affected unit shall not be liable for any violation by any other affected unit of which they are not owners or operators or the designated representative and that is located at a source of which they are not owners or operators or the designated representative.

*g.* Each violation of a provision of rules 567—22.120(455B) to 567—22.146(455B) and 40 CFR Parts 72, 73, 75, 76, 77, and 78 and regulations implementing Sections 407 and 410 of the Act by an affected source or affected unit, or by an owner or operator or designated representative of such source or unit, shall be a separate violation of the Act.

**22.125(8) Effect on other authorities.** No provision of the acid rain program, an acid rain permit application, an acid rain permit, or a written exemption under rule 567—22.123(455B) or 567—22.124(455B) shall be construed as:

*a.* Except as expressly provided in Title IV of the Act, exempting or excluding the owners and operators and, to the extent applicable, the designated representative of an affected source or affected unit from compliance with any other provision of the Act, including the provisions of Title I of the Act relating to applicable National Ambient Air Quality Standards or State Implementation Plans;

*b.* Limiting the number of allowances a unit can hold; provided that the number of allowances held by the unit shall not affect the source's obligation to comply with any other provisions of the Act;

- c.* Requiring a change of any kind in any state law regulating electric utility rates and charges, affecting any state law regarding such state rule, or limiting such state rule, including any prudence review requirements under such state law;
- d.* Modifying the Federal Power Act or affecting the authority of the Federal Energy Regulatory Commission under the Federal Power Act; or
- e.* Interfering with or impairing any program for competitive bidding for power supply in a state in which such program is established.

**567—22.126(455B) Designated representative—submissions.**

**22.126(1)** The designated representative shall submit a certificate of representation, and any superseding certificate of representation, to the administrator in accordance with Subpart B of 40 CFR Part 72, and, concurrently, shall submit a copy to the department. Whenever the term “designated representative” is used in this rule, the term shall be construed to include the alternate designated representative.

**22.126(2)** Each submission under the acid rain program shall be submitted, signed, and certified by the designated representative for all sources on behalf of which the submission is made.

**22.126(3)** In each submission under the acid rain program, the designated representative shall certify by signature:

*a.* The following statement, which shall be included verbatim in such submission: “I am authorized to make this submission on behalf of the owners and operators of the affected source or affected units for which the submission is made.”

*b.* The following statement, which shall be included verbatim in such submission: “I certify under penalty of law that I have personally examined, and am familiar with, the statements and information submitted in this document and all its attachments. Based on my inquiry of those individuals with primary responsibility for obtaining the information, I certify that the statements and information are to the best of my knowledge and belief true, accurate, and complete. I am aware that there are significant penalties for submitting false statements and information or omitting required statements and information, including the possibility of fine or imprisonment.”

**22.126(4)** The department will accept or act on a submission made on behalf of owners or operators of an affected source and an affected unit only if the submission has been made, signed, and certified in accordance with subrules 22.126(2) and 22.126(3).

**22.126(5)** The designated representative of a source shall serve notice on each owner and operator of the source and of an affected unit at the source:

*a.* By the date of submission, of any acid rain program submissions by the designated representative;

*b.* Within ten business days of receipt of a determination, of any written determination by the administrator or the department; and

*c.* Provided that the submission or determination covers the source or the unit.

**22.126(6)** The designated representative of a source shall provide each owner and operator of an affected unit at the source a copy of any submission or determination under subrule 22.126(5), unless the owner or operator expressly waives the right to receive such a copy.

**567—22.127(455B) Designated representative—objections.**

**22.127(1)** Except as provided in 40 CFR 72.23, no objection or other communication submitted to the administrator or the department concerning the authorization, or any submission, action or inaction, of the designated representative shall affect any submission, action, or inaction of the designated representative, or the finality of any decision by the department, under the acid rain program. In the event of such communication, the department is not required to stay any submission or the effect of any action or inaction under the acid rain program.

**22.127(2)** The department will not adjudicate any private legal dispute concerning the authorization or any submission, action, or inaction of any designated representative, including private legal disputes concerning the proceeds of allowance transfers.

**567—22.128(455B) Acid rain applications—requirement to apply.**

**22.128(1) Duty to apply.** The designated representative of any source with an affected unit shall submit a complete acid rain permit application by the applicable deadline in subrules 22.128(2) and 22.128(3), and the owners and operators of such source and any affected unit at the source shall not operate the source or unit without a permit that states its acid rain program requirements.

**22.128(2) Deadlines.**

*a.* For any source with an existing unit described under paragraph 22.122(1) “*b*,” the designated representative shall submit a complete acid rain permit application governing such unit to the department on or before January 1, 1996.

*b.* For any source with a new unit described under subparagraph 22.122(1) “*c*”(1), the designated representative shall submit a complete acid rain permit application governing such unit to the department at least 24 months before the later of January 1, 2000, or the date on which the unit commences operation.

*c.* For any source with a unit described under subparagraph 22.122(1) “*c*”(2), the designated representative shall submit a complete acid rain permit application governing such unit to the department at least 24 months before the later of January 1, 2000, or the date on which the unit begins to serve a generator with a nameplate capacity greater than 25 MWe.

*d.* For any source with a unit described under subparagraph 22.122(1) “*c*”(3), the designated representative shall submit a complete acid rain permit application governing such unit to the department at least 24 months before the later of January 1, 2000, or the date on which the auxiliary firing commences operation.

*e.* For any source with a unit described under subparagraph 22.122(1) “*c*”(4), the designated representative shall submit a complete acid rain permit application governing such unit to the department before the later of January 1, 1998, or March 1 of the year following the three-calendar-year period in which the unit sold to a utility power distribution system an annual average of more than one-third of its potential electrical output capacity and more than 219,000 MWe-hrs actual electric output (on a gross basis).

*f.* For any source with a unit described under subparagraph 22.122(1) “*c*”(5), the designated representative shall submit a complete acid rain permit application governing such unit to the department before the later of January 1, 1998, or March 1 of the year following the calendar year in which the facility fails to meet the definition of qualifying facility.

*g.* For any source with a unit described under subparagraph 22.122(1) “*c*”(6), the designated representative shall submit a complete acid rain permit application governing such unit to the department before the later of January 1, 1998, or March 1 of the year following the calendar year in which the facility fails to meet the definition of an independent power production facility.

*h.* For any source with a unit described under subparagraph 22.122(1) “*c*”(7), the designated representative shall submit a complete acid rain permit application governing such unit to the department before the later of January 1, 1998, or March 1 of the year following the three-calendar-year period in which the incinerator consumed 20 percent or more fossil fuel (on a Btu basis).

*i.* For a Phase II unit with a Group 1 or a Group 2 boiler, the designated representative shall submit a complete permit application and compliance plan for NO<sub>x</sub> emissions to the department no later than January 1, 1998.

**22.128(3) Duty to reapply.** The designated representative shall submit a complete acid rain permit application for each source with an affected unit at least six months prior to the expiration of an existing acid rain permit governing the unit.

**22.128(4) Submission of copies.** Two copies of all permit applications shall be presented or mailed to the Air Quality Bureau, Iowa Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324.

[ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 2949C, IAB 2/15/17, effective 3/22/17]

**567—22.129(455B) Information requirements for acid rain permit applications.** A complete acid rain permit application shall be submitted on a form approved by the department, which includes the following elements:

**22.129(1)** Identification of the affected source for which the permit application is submitted;

**22.129(2)** Identification of each affected unit at the source for which the permit application is submitted;

**22.129(3)** A complete compliance plan for each unit, in accordance with rules 567—22.131(455B) and 567—22.132(455B);

**22.129(4)** The standard requirements under rule 567—22.125(455B); and

**22.129(5)** If the unit is a new unit, the date that the unit has commenced or will commence operation and the deadline for monitor certification.

**567—22.130(455B) Acid rain permit application shield and binding effect of permit application.**

**22.130(1)** Once a designated representative submits a timely and complete acid rain permit application, the owners and operators of the affected source and the affected units covered by the permit application shall be deemed in compliance with the requirement to have an acid rain permit under paragraph 22.125(1)“*b*” and subrule 22.128(1); provided that any delay in issuing an acid rain permit is not caused by the failure of the designated representative to submit in a complete and timely fashion supplemental information, as required by the department, necessary to issue a permit.

**22.130(2)** Prior to the date on which an acid rain permit is issued as a final agency action subject to judicial review, an affected unit governed by and operated in accordance with the terms and requirements of a timely and complete acid rain permit application shall be deemed to be operating in compliance with the acid rain program.

**22.130(3)** A complete acid rain permit application shall be binding on the owners and operators and the designated representative of the affected source and the affected units covered by the permit application and shall be enforceable as an acid rain permit from the date of submission of the permit application until the issuance or denial of such permit as a final agency action subject to judicial review.

**567—22.131(455B) Acid rain compliance plan and compliance options—general.**

**22.131(1)** For each affected unit included in an acid rain permit application, a complete compliance plan shall include:

*a.* For sulfur dioxide emissions, a certification that, as of the allowance transfer deadline, the designated representative will hold allowances in the unit’s compliance subaccount (after deductions under 40 CFR 73.34(c)) not less than the total annual emissions of sulfur dioxide from the unit. The compliance plan may also specify, in accordance with rule 567—22.131(455B), one or more of the acid rain compliance options.

*b.* For nitrogen oxides emissions, a certification that the unit will comply with the applicable limitation established by subrule 22.125(4) or shall specify one or more acid rain compliance options, in accordance with Section 407 of the Act, and 40 CFR Section 76.9.

**22.131(2)** The compliance plan may include a multiunit compliance option under rule 567—22.132(455B) or Section 407 of the Act or regulations implementing Section 407.

*a.* A plan for a compliance option that includes units at more than one affected source shall be complete only if:

(1) Such plan is signed and certified by the designated representative for each source with an affected unit governed by such plan; and

(2) A complete permit application is submitted covering each unit governed by such plan.

*b.* The department’s approval of a plan under paragraph 22.131(2)“*a*” that includes units in more than one state shall be final only after every permitting authority with jurisdiction over any such unit has approved the plan with the same modifications or conditions, if any.

**22.131(3)** Conditional approval. In the compliance plan, the designated representative of an affected unit may propose, in accordance with rules 567—22.131(455B) and 567—22.132(455B), any acid rain compliance option for conditional approval; provided that an acid rain compliance option under Section 407 of the Act may be conditionally proposed only to the extent provided in regulations implementing Section 407 of the Act.

*a.* To activate a conditionally approved acid rain compliance option, the designated representative shall notify the department in writing that the conditionally approved compliance option will actually be pursued beginning January 1 of a specified year. If the conditionally approved compliance option includes a plan described in paragraph 22.131(2)“*a*,” the designated representative of each source governed by the plan shall sign and certify the notification. Such notification shall be subject to the limitations on activation under rule 567—22.132(455B) and regulations implementing Section 407 of the Act.

*b.* The notification under paragraph 22.131(3)“*a*” shall specify the first calendar year and the last calendar year for which the conditionally approved acid rain compliance option is to be activated. A conditionally approved compliance option shall be activated, if at all, before the date of any enforceable milestone applicable to the compliance option. The date of activation of the compliance option shall not be a defense against failure to meet the requirements applicable to that compliance option during each calendar year for which the compliance option is activated.

*c.* Upon submission of a notification meeting the requirements of paragraphs 22.131(3)“*a*” and “*b*,” the conditionally approved acid rain compliance option becomes binding on the owners and operators and the designated representative of any unit governed by the conditionally approved compliance option.

*d.* A notification meeting the requirements of paragraphs 22.131(3)“*a*” and “*b*” will revise the unit’s permit in accordance with rule 567—22.143(455B) (administrative permit amendment).

**22.131(4) Termination of compliance option.**

*a.* The designated representative for a unit may terminate an acid rain compliance option by notifying the department in writing that an approved compliance option will be terminated beginning January 1 of a specified year. Such notification shall be subject to the limitations on termination under rule 567—22.132(455B) and regulations implementing Section 407 of the Act. If the compliance option includes a plan described in paragraph 22.131(2)“*a*,” the designated representative for each source governed by the plan shall sign and certify the notification.

*b.* The notification under paragraph 22.131(4)“*a*” shall specify the calendar year for which the termination will take effect.

*c.* Upon submission of a notification meeting the requirements of paragraphs 22.131(4)“*a*” and “*b*,” the termination becomes binding on the owners and operators and the designated representative of any unit governed by the acid rain compliance option to be terminated.

*d.* A notification meeting the requirements of paragraphs 22.131(4)“*a*” and “*b*” will revise the unit’s permit in accordance with rule 567—22.143(455B) (administrative permit amendment).

**567—22.132(455B) Repowering extensions.** Rescinded IAB 4/8/98, effective 5/13/98.

**567—22.133(455B) Acid rain permit contents—general.**

**22.133(1)** Each acid rain permit (including any draft acid rain permit) will contain the following elements:

*a.* All elements required for a complete acid rain permit application under rule 567—22.129(455B), as approved or adjusted by the department;

*b.* The applicable acid rain emissions limitation for sulfur dioxide; and

*c.* The applicable acid rain emissions limitation for nitrogen oxides.

**22.133(2)** Each acid rain permit is deemed to incorporate the definitions of terms under rule 567—22.120(455B).

**567—22.134(455B) Acid rain permit shield.** Each affected unit operated in accordance with the acid rain permit that governs the unit and that was issued in compliance with Title IV of the Act, as provided in rules 567—22.120(455B) to 567—22.146(455B), rule 567—25.2(455B), or 40 CFR Parts 72, 73, 75, 76, 77, and 78, and the regulations implementing Section 407 of the Act, shall be deemed to be operating in compliance with the acid rain program, except as provided in paragraph 22.125(7)“*f*.”

**567—22.135(455B) Acid rain permit issuance procedures—general.** The department will issue or deny all acid rain permits in accordance with rules 567—22.100(455B) to 567—22.116(455B), including the completeness determination, draft permit, administrative record, statement of basis, public notice and comment period, public hearing, proposed permit, permit issuance, permit revision, and appeal procedures as amended by rules 567—22.135(455B) to 567—22.145(455B).

**567—22.136(455B) Acid rain permit issuance procedures—completeness.** The department will submit a written notice of application completeness to the administrator within ten working days following a determination by the department that the acid rain permit application is complete.

**567—22.137(455B) Acid rain permit issuance procedures—statement of basis.**

**22.137(1)** The statement of basis will briefly set forth significant factual, legal, and policy considerations on which the department relied in issuing or denying the draft acid rain permit.

**22.137(2)** The statement of basis will include the reasons, and supporting authority, for approval or disapproval of any compliance options requested in the permit application, including references to applicable statutory or regulatory provisions and to the administrative record.

**22.137(3)** The department will submit to the administrator a copy of the draft acid rain permit and the statement of basis and all other relevant portions of the Title V operating permit that may affect the draft acid rain permit.

**567—22.138(455B) Issuance of acid rain permits.**

**22.138(1)** Proposed permit. After the close of the public comment and EPA 45-day review period (pursuant to subrules 22.107(6) and 22.107(7)), the department will address any objections by the administrator, incorporate all necessary changes and issue or deny the acid rain permit.

**22.138(2)** The department will submit the proposed acid rain permit or denial of a proposed acid rain permit to the administrator in accordance with rules 567—22.100(455B) to 567—22.116(455B), the provisions of which shall be treated as applying to the issuance or denial of a proposed acid rain permit.

**22.138(3)** Following the administrator's review of the proposed acid rain permit or denial of a proposed acid rain permit, the department, or under 40 CFR 70.8(c) as amended to July 21, 1992, the administrator, will incorporate any required changes and issue or deny the acid rain permit in accordance with rules 567—22.133(455B) and 567—22.134(455B).

**22.138(4)** No acid rain permit including a draft or proposed permit shall be issued unless the administrator has received a certificate of representation for the designated representative of the source in accordance with Subpart B of 40 CFR Part 72.

**22.138(5)** Permit issuance deadline and effective date.

*a.* On or before December 31, 1997, the department will issue an acid rain permit to each affected source whose designated representative submitted a timely and complete acid rain permit application by January 1, 1996, in accordance with rule 567—22.126(455B) and meets the requirements of rules 567—22.135(455B) to 567—22.139(455B) and rules 567—22.100(455B) to 567—22.116(455B).

*b.* Nitrogen oxides. Not later than January 1, 1999, the department will reopen the acid rain permit to add the acid rain program nitrogen oxides requirements; provided that the designated representative of the affected source submitted a timely and complete acid rain permit application for nitrogen oxides in accordance with rule 567—22.126(455B). Such reopening shall not affect the term of the acid rain portion of a Title V operating permit.

*c.* Each acid rain permit issued in accordance with paragraph 22.138(5) "a" shall take effect by the later of January 1, 2000, or, where the permit governs a unit under paragraph 22.122(1) "c," the deadline for monitor certification under rule 567—25.2(455B).

*d.* Each acid rain permit shall have a term of five years commencing on its effective date.

*e.* An acid rain permit shall be binding on any new owner or operator or designated representative of any source or unit governed by the permit.

**22.138(6)** Each acid rain permit shall contain all applicable acid rain requirements, shall be a portion of the Title V operating permit that is complete and segregable from all other air quality requirements, and shall not incorporate information contained in any other documents, other than documents that are readily available.

**22.138(7)** Invalidation of the acid rain portion of a Title V operating permit shall not affect the continuing validity of the rest of the Title V operating permit, nor shall invalidation of any other portion of the Title V operating permit affect the continuing validity of the acid rain portion of the permit.

**567—22.139(455B) Acid rain permit appeal procedures.**

**22.139(1)** Appeals of the acid rain portion of a Title V operating permit issued by the department that do not challenge or involve decisions or actions of the administrator under 40 CFR Parts 72, 73, 75, 76, 77, and 78 and Sections 407 and 410 of the Act and regulations implementing Sections 407 and 410 shall be conducted according to the procedures in Iowa Code chapter 17A and 561—Chapter 7, as adopted by reference at 567—Chapter 7. Appeals of the acid rain portion of such a permit that challenge or involve such decisions or actions of the administrator shall follow the procedures under 40 CFR Part 78 and Section 307 of the Act. Such decisions or actions include, but are not limited to, allowance allocations, determinations concerning alternative monitoring systems, and determinations of whether a technology is a qualifying repowering technology.

**22.139(2)** No administrative appeal or judicial appeal of the acid rain portion of a Title V operating permit shall be allowed more than 30 days following respective issuance of the acid rain portion of the permit that is subject to administrative appeal or issuance of the final agency action subject to judicial appeal.

**22.139(3)** The administrator may intervene as a matter of right in any state administrative appeal of an acid rain permit or denial of an acid rain permit.

**22.139(4)** No administrative appeal concerning an acid rain requirement shall result in a stay of the following requirements:

- a. The allowance allocations for any year during which the appeal proceeding is pending or is being conducted;
- b. Any standard requirement under rule 567—22.125(455B);
- c. The emissions monitoring and reporting requirements applicable to the affected units at an affected source under rule 567—25.2(455B);
- d. Uncontested provisions of the decision on appeal; and
- e. The terms of a certificate of representation submitted by a designated representative under Subpart B of 40 CFR Part 72.

**22.139(5)** The department will serve written notice on the administrator of any state administrative or judicial appeal concerning an acid rain provision of any Title V operating permit or denial of an acid rain portion of any Title V operating permit within 30 days of the filing of the appeal.

**22.139(6)** The department will serve written notice on the administrator of any determination or order in a state administrative or judicial proceeding that interprets, modifies, voids, or otherwise relates to any portion of an acid rain permit. Following any such determination or order, the administrator will have an opportunity to review and veto the acid rain permit or revoke the permit for cause in accordance with subrules 22.107(7) and 22.107(8).

**567—22.140(455B) Permit revisions—general.**

**22.140(1)** Rules 567—22.140(455B) to 567—22.145(455B) shall govern revisions to any acid rain permit issued by the department.

**22.140(2)** A permit revision may be submitted for approval at any time. No permit revision shall affect the term of the acid rain permit to be revised. No permit revision shall excuse any violation of an acid rain program requirement that occurred prior to the effective date of the revision.

**22.140(3)** The terms of the acid rain permit shall apply while the permit revision is pending.

**22.140(4)** Any determination or interpretation by the state (including the department or a state court) modifying or voiding any acid rain permit provision shall be subject to review by the administrator in

accordance with 40 CFR 70.8(c) as amended to July 21, 1992, as applied to permit modifications, unless the determination or interpretation is an administrative amendment approved in accordance with rule 567—22.143(455B).

**22.140(5)** The standard requirements of rule 567—22.125(455B) shall not be modified or voided by a permit revision.

**22.140(6)** Any permit revision involving incorporation of a compliance option that was not submitted for approval and comment during the permit issuance process, or involving a change in a compliance option that was previously submitted, shall meet the requirements for applying for such compliance option under rule 567—22.132(455B) and Section 407 of the Act and regulations implementing Section 407 of the Act.

**22.140(7)** For permit revisions not described in rules 567—22.141(455B) and 567—22.142(455B), the department may, in its discretion, determine which of these rules is applicable.

**567—22.141(455B) Permit modifications.**

**22.141(1)** Permit modifications shall follow the permit issuance requirements of rules 567—22.135(455B) to 567—22.139(455B) and subrules 22.113(2) and 22.113(3).

**22.141(2)** For purposes of applying subrule 22.141(1), a permit modification shall be treated as an acid rain permit application, to the extent consistent with rules 567—22.140(455B) to 567—22.145(455B).

**22.141(3)** The following permit revisions are permit modifications:

- a.* Relaxation of an excess emission offset requirement after approval of the offset plan by the administrator;
- b.* Incorporation of a final nitrogen oxides alternative emissions limitation following a demonstration period;
- c.* Determinations concerning failed repowering projects under subrule 22.132(6); and
- d.* At the option of the designated representative submitting the permit revision, the permit revisions listed in subrule 22.142(2).

**567—22.142(455B) Fast-track modifications.**

**22.142(1)** Fast-track modifications shall follow the following procedures:

*a.* The designated representative shall serve a copy of the fast-track modification on the administrator, the department, and any person entitled to a written notice under subrules 22.107(6) and 22.107(7). Within five business days of serving such copies, the designated representative shall also give public notice by publication in a newspaper of general circulation in the area where the source is located or in a state publication designed to give general public notice.

*b.* The public shall have a period of 30 days, commencing on the date of publication of the notice, to comment on the fast-track modification. Comments shall be submitted in writing to the air quality bureau of the department and to the designated representative.

*c.* The designated representative shall submit the fast-track modification to the department on or before commencement of the public comment period.

*d.* Within 30 days of the close of the public comment period, the department will consider the fast-track modification and the comments received and approve, in whole or in part or with changes or conditions as appropriate, or disapprove the modification. A fast-track modification shall be effective immediately upon issuance, in accordance with subrule 22.113(2) as applied to significant modifications.

**22.142(2)** The following permit revisions are, at the option of the designated representative submitting the permit revision, either fast-track modifications under this rule or permit modifications under rule 567—22.141(455B):

- a.* Incorporation of a compliance option that the designated representative did not submit for approval and comment during the permit issuance process;
- b.* Addition of a nitrogen oxides averaging plan to a permit; and
- c.* Changes in a repowering plan, nitrogen oxides averaging plan, or nitrogen oxides compliance deadline extension.

**567—22.143(455B) Administrative permit amendment.**

**22.143(1)** Administrative amendments shall follow the procedures set forth at rule 567—22.111(455B). The department will submit the revised portion of the permit to the administrator within ten working days after the date of final action on the request for an administrative amendment.

**22.143(2)** The following permit revisions are administrative amendments:

*a.* Activation of a compliance option conditionally approved by the department; provided that all requirements for activation under subrule 22.131(3) and rule 567—22.132(455B) are met;

*b.* Changes in the designated representative or alternative designated representative; provided that a new certificate of representation is submitted to the administrator in accordance with Subpart B of 40 CFR Part 72;

*c.* Correction of typographical errors;

*d.* Changes in names, addresses, or telephone or facsimile numbers;

*e.* Changes in the owners or operators; provided that a new certificate of representation is submitted within 30 days to the administrator and the department in accordance with Subpart B of 40 CFR Part 72;

*f.* Termination of a compliance option in the permit; provided that all requirements for termination under subrule 22.131(4) shall be met and this procedure shall not be used to terminate a repowering plan after December 31, 1999;

*g.* Changes in the date, specified in a new unit's acid rain permit, of commencement of operation or the deadline for monitor certification; provided that they are in accordance with rule 567—22.125(455B);

*h.* The addition of or change in a nitrogen oxides alternative emissions limitation demonstration period; provided that the requirements of regulations implementing Section 407 of the Act are met; and

*i.* Incorporation of changes that the administrator has determined to be similar to those in paragraphs "a" through "h" of this subrule.

**567—22.144(455B) Automatic permit amendment.** The following permit revisions shall be deemed to amend automatically, and become a part of the affected unit's acid rain permit by operation of law without any further review:

**22.144(1)** Upon recordation by the administrator under 40 CFR Part 73, all allowance allocations to, transfers to, and deductions from an affected unit's allowance tracking system account; and

**22.144(2)** Incorporation of an offset plan that has been approved by the administrator under 40 CFR Part 77.

**567—22.145(455B) Permit reopenings.**

**22.145(1)** As provided in rule 567—22.114(455B), the department will reopen an acid rain permit for cause, including whenever additional requirements become applicable to any affected unit governed by the permit.

**22.145(2)** In reopening an acid rain permit for cause, the department will issue a draft permit changing the provisions, or adding the requirements, for which the reopening was necessary. The draft permit shall be subject to the requirements of rules 567—22.135(455B) to 567—22.139(455B).

**22.145(3)** Any reopening of an acid rain permit shall not affect the term of the permit.

**567—22.146(455B) Compliance certification—annual report.**

**22.146(1)** Applicability and deadline. For each calendar year in which a unit is subject to the acid rain emissions limitations, the designated representative of the source at which the unit is located shall submit to the administrator and the department, within 60 days after the end of the calendar year, an annual compliance certification report for the unit in compliance with 40 CFR 72.90.

**22.146(2)** The submission of complete compliance certifications in accordance with subrule 22.146(1) and rule 567—25.2(455B) shall be deemed to satisfy the requirement to submit compliance certifications under paragraph 22.108(15) "e" with regard to the acid rain portion of the source's Title V operating permit.

**567—22.147(455B) Compliance certification—units with repowering extension plans.** Rescinded IAB 4/8/98, effective 5/13/98.

**567—22.148(455B) Sulfur dioxide opt-ins.** The department adopts by reference the provisions of 40 CFR Part 74, Acid Rain Opt-Ins.

**567—22.149 to 22.199** Reserved.

**567—22.200(455B) Definitions for voluntary operating permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.201(455B) Eligibility for voluntary operating permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.202(455B) Requirement to have a Title V permit.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.203(455B) Voluntary operating permit applications.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.204(455B) Voluntary operating permit fees.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.205(455B) Voluntary operating permit processing procedures.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.206(455B) Permit content.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.207(455B) Relation to construction permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.208(455B) Suspension, termination, and revocation of voluntary operating permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.209(455B) Change of ownership for facilities with voluntary operating permits.** Rescinded ARC 1913C, IAB 3/18/15, effective 4/22/15.

**567—22.210 to 22.299** Reserved.

**567—22.300(455B) Operating permit by rule for small sources.** Except as provided in subrule 22.300(11), any source which otherwise would be required to obtain a Title V operating permit may instead register for an operation permit by rule for small sources. Sources which comply with the requirements contained in this rule will be deemed to have an operating permit by rule for small sources. Sources which comply with this rule will be considered to have federally enforceable limits so that their potential emissions are less than the major source thresholds for regulated air pollutants and hazardous air pollutants as defined in rule 567—22.100(455B).

**22.300(1) Definitions for operating permit by rule for small sources.** For the purposes of rule 567—22.300(455B), the definitions shall be the same as the definitions found at rule 567—22.100(455B).

**22.300(2) Registration for operating permit by rule for small sources.**

*a.* Except as provided in subrules 22.300(3) and 22.300(11), any person who owns or operates a stationary source and meets the following criteria may register for an operating permit by rule for small sources:

(1) The potential to emit air contaminants is equal to or in excess of the threshold for a major stationary source of regulated air pollutants or hazardous air pollutants, and

(2) For every 12-month rolling period, the actual emissions of the stationary source are less than or equal to the emission limitations specified in subrule 22.300(6).

*b.* Eligibility for an operating permit by rule for small sources does not eliminate the source's responsibility to meet any and all applicable federal requirements including, but not limited to, a maximum achievable control technology (MACT) standard.

*c.* Nothing in this rule shall prevent any stationary source which has had a Title V operating permit from qualifying to comply with this rule in the future in lieu of maintaining an application for a Title V operating permit or upon rescission of a Title V operating permit if the owner or operator demonstrates that the stationary source is in compliance with the emissions limitations in subrule 22.300(6).

*d.* The department reserves the right to require proof that the expected emissions from the stationary source, in conjunction with all other emissions, will not prevent the attainment or maintenance of the ambient air quality standards specified in 567—Chapter 28.

**22.300(3) Exceptions to eligibility.**

*a.* Any affected source subject to the provisions of Title IV of the Act or any solid waste incinerator unit required to obtain a Title V operating permit under Section 129(e) of the Act is not eligible for an operating permit by rule for small sources.

*b.* Sources which meet the registration criteria established in 22.300(2)“*a*” and meet all applicable requirements of rule 567—22.300(455B), and are subject to a standard or other requirement under 567—subrule 23.1(2) (standards of performance for new stationary sources) or Section 111 of the Act are eligible for an operating permit by rule for small sources. These sources shall be required to obtain a Title V operating permit when the exemptions specified in subrule 22.102(1) or 22.102(2) no longer apply.

*c.* Sources which meet the registration criteria established in 22.300(2)“*a*” and meet all applicable requirements of rule 567—22.300(455B), and are subject to a standard or other requirement under 567—subrule 23.1(3) (emissions standards for hazardous air pollutants), 567—subrule 23.1(4) (emissions standards for hazardous air pollutants for source categories) or Section 112 of the Act are eligible for an operating permit by rule for small sources. These sources shall be required to obtain a Title V operating permit when the exemptions specified in subrule 22.102(1) or 22.102(2) no longer apply.

**22.300(4) Stationary source with de minimus emissions.** Stationary sources with de minimus emissions must submit the standard registration form and must meet and fulfill all registration and reporting requirements as found in 22.300(8). Only the record-keeping and reporting provisions listed in 22.300(4)“*b*” shall apply to a stationary source with de minimus emissions or operations as specified in 22.300(4)“*a*”:

*a. De minimus emission and usage limits.* For the purpose of this rule a stationary source with de minimus emissions means:

(1) In every 12-month rolling period, the stationary source emits less than or equal to the following quantities of emissions:

1. 5 tons per year of a regulated air pollutant (excluding HAPs), and
2. 2 tons per year of a single HAP, and
3. 5 tons per year of any combination of HAPs.

(2) In every 12-month rolling period, at least 90 percent of the stationary source's emissions are associated with an operation for which the throughput is less than or equal to one of the quantities specified in paragraphs “1” to “9” below:

1. 1,400 gallons of any combination of solvent-containing materials but no more than 550 gallons of any one solvent-containing material, provided that the materials do not contain the following: methyl chloroform (1,1,1-trichloroethane), methylene chloride (dichloromethane), tetrachloroethylene (perchloroethylene), or trichloroethylene;

2. 750 gallons of any combination of solvent-containing materials where the materials contain the following: methyl chloroform (1,1,1-trichloroethane), methylene chloride (dichloromethane), tetrachloroethylene (perchloroethylene), or trichloroethylene, but not more than 300 gallons of any one solvent-containing material;

3. 365 gallons of solvent-containing material used at a paint spray unit(s);
4. 4,400,000 gallons of gasoline dispensed from equipment with Phase I and II vapor recovery systems;
5. 470,000 gallons of gasoline dispensed from equipment without Phase I and II vapor recovery systems;
6. 1,400 gallons of gasoline combusted;
7. 16,600 gallons of diesel fuel combusted;
8. 500,000 gallons of distillate oil combusted; or
9. 71,400,000 cubic feet of natural gas combusted.

*b. Record keeping for de minimis sources.* Upon registration with the department the owner or operator of a stationary source eligible to register for an operating permit by rule for small sources shall comply with all applicable record-keeping requirements of this rule. The record-keeping requirements of this rule shall not replace any record-keeping requirement contained in a construction permit or in a local, state, or federal rule or regulation.

(1) De minimis sources shall always maintain an annual log of each raw material used and its amount. The annual log and all related material safety data sheets (MSDS) for all materials shall be maintained for a period of not less than the most current five years. The annual log will begin on the date the small source operating permit application is submitted, then on an annual basis, based on a calendar year.

(2) Within 30 days of a written request by the state or the U.S. EPA, the owner or operator of a stationary source not maintaining records pursuant to subrule 22.300(7) shall demonstrate that the stationary source's emissions or throughput is not in excess of the applicable quantities set forth in paragraph "a" above.

**22.300(5) Provision for air pollution control equipment.** The owner or operator of a stationary source may take into account the operation of air pollution control equipment on the capacity of the source to emit an air contaminant if the equipment is required by federal, state, or local air pollution control agency rules and regulations or permit terms and conditions that are federally enforceable. The owner or operator of the stationary source shall maintain and operate such air pollution control equipment in a manner consistent with good air pollution control practice for minimizing emissions.

**22.300(6) Emission limitations.**

*a.* No stationary source subject to this rule shall emit in every 12-month rolling period more than the following quantities of emissions:

- (1) 50 percent of the major source thresholds for regulated air pollutants (excluding hazardous air pollutants), and
- (2) 5 tons per year of a single hazardous air pollutant, and
- (3) 12.5 tons per year of any combination of hazardous air pollutants.

*b.* The owner or operator of a stationary source subject to this rule shall obtain any necessary permits prior to commencing any physical or operational change or activity which will result in actual emissions that exceed the limits specified in paragraph "a" of this subrule.

**22.300(7) Record-keeping requirements for non-de minimis sources.** Upon registration with the department the owner or operator of a stationary source eligible to register for an operating permit by rule for small stationary sources shall comply with all applicable record-keeping requirements in this rule. The record-keeping requirements of this rule shall not replace any record-keeping requirement contained in any operating permit, a construction permit, or in a local, state, or federal rule or regulation.

*a.* A stationary source previously covered by the provisions in 22.300(4) shall comply with the applicable provisions of subrule 22.300(7) (record-keeping requirements) and subrule 22.300(8) (reporting requirements) if the stationary source exceeds the quantities specified in paragraph 22.300(4) "a."

*b.* The owner or operator of a stationary source subject to this rule shall keep and maintain records, as specified in 22.300(7) "c" below, for each permitted emission unit and each piece of emission control equipment sufficient to determine actual emissions. Such information shall be maintained on site for five years, and be made available to local, state, or U.S. EPA staff upon request.

c. Record-keeping requirements for emission units and emission control equipment. Record-keeping requirements for emission units are specified below in 22.300(7)“c”(1) through 22.300(7)“c”(4). Record-keeping requirements for emission control equipment are specified in 22.300(7)“c”(5).

(1) Coating/solvent emission unit. The owner or operator of a stationary source subject to this rule that contains a coating/solvent emission unit not permitted under 22.8(1) (permit by rule for spray booths) or uses a coating, solvent, ink or adhesive shall keep and maintain the following records:

1. A current list of all coatings, solvents, inks and adhesives in use. This list shall include: material safety data sheets (MSDS), manufacturer’s product specifications, and material VOC content reports for each solvent (including solvents used in cleanup and surface preparation), coating, ink, and adhesive used showing at least the product manufacturer, product name and code, VOC and hazardous air pollutant content;

2. A description of any equipment used during and after coating/solvent application, including type, make and model; maximum design process rate or throughput; and control device(s) type and description (if any);

3. A monthly log of the consumption of each solvent (including solvents used in cleanup and surface preparation), coating, ink, and adhesive used; and

4. All purchase orders, invoices, and other documents to support information in the monthly log.

(2) Organic liquid storage unit. The owner or operator of a stationary source subject to this rule that contains an organic liquid storage unit shall keep and maintain the following records:

1. A monthly log identifying the liquid stored and monthly throughput; and

2. Information on the tank design and specifications including control equipment.

(3) Combustion emission unit. The owner or operator of a stationary source subject to this rule that contains a combustion emission unit shall keep and maintain the following records:

1. Information on equipment type, make and model, maximum design process rate or maximum power input/output, minimum operating temperature (for thermal oxidizers) and capacity and all source test information; and

2. A monthly log of fuel type, fuel usage, fuel heating value (for nonfossil fuels; in terms of Btu/lb or Btu/gal), and percent sulfur for fuel oil and coal.

(4) General emission unit. The owner or operator of a stationary source subject to this rule that contains an emission unit not included in subparagraph (1), (2), or (3) above shall keep and maintain the following records:

1. Information on the process and equipment including the following: equipment type, description, make and model; and maximum design process rate or throughput;

2. A monthly log of operating hours and each raw material used and its amount; and

3. Purchase orders, invoices, or other documents to support information in the monthly log.

(5) Emission control equipment. The owner or operator of a stationary source subject to this rule that contains emission control equipment shall keep and maintain the following records:

1. Information on equipment type and description, make and model, and emission units served by the control equipment;

2. Information on equipment design including, where applicable: pollutant(s) controlled; control effectiveness; and maximum design or rated capacity; other design data as appropriate including any available source test information and manufacturer’s design/repair/maintenance manual; and

3. A monthly log of hours of operation including notation of any control equipment breakdowns, upsets, repairs, maintenance and any other deviations from design parameters.

**22.300(8) Registration and reporting requirements.**

a. Duty to apply. Any person who owns or operates a source otherwise required to obtain a Title V operating permit and which would be eligible for an operating permit by rule for small sources must either register for an operating permit by rule for small sources or apply for a Title V operating permit. Any source determined not to be eligible for an operating permit by rule for small sources, and operating without a valid Title V operating permit, shall be subject to enforcement action for operation without a Title V operating permit, except as provided for in the application shield provisions contained in

rule 567—22.104(455B). For each source registering for an operating permit by rule for small sources, the owner or operator or designated representative, where applicable, shall present or mail to the Air Quality Bureau, Iowa Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324, one original and one copy of a timely and complete registration form in accordance with this rule.

(1) Timely registration. Each source registering for an operating permit by rule for small sources shall submit a registration form:

1. By August 1, 1996, if the source became subject to rule 567—22.101(455B) on or before August 1, 1995, unless otherwise required to obtain a Title V permit under rule 567—22.101(455B).

2. Within 12 months of becoming subject to rule 567—22.101(455B) (the requirement to obtain a Title V operating permit) for a new source or a source which would otherwise become subject to the Title V permit requirement after August 1, 1995.

(2) Complete registration form. To be deemed complete the registration form must provide all information required pursuant to 22.300(8) “b.”

(3) Duty to supplement or correct registration. Any registrant who fails to submit any relevant facts or who has submitted incorrect information in an operating permit by rule for small sources registration shall, upon becoming aware of such failure or incorrect submittal, promptly submit such supplementary facts or corrected information. In addition, the registrant shall provide additional information as necessary to address any requirements that become applicable to the source after the date it filed a complete registration.

(4) Certification of truth, accuracy, and completeness. Any registration form, report, or supplemental information submitted pursuant to these rules shall contain certification by a responsible official of truth, accuracy, and completeness. This certification and any other certification required under these rules shall state that, based on information and belief formed after reasonable inquiry, the statements and information in the document are true, accurate, and complete.

b. At the time of registration for an operating permit by rule for small sources each owner or operator of a stationary source shall submit to the department a standard registration form and required attachments. To register for an operating permit by rule for small sources, applicants shall complete the registration form and supply all information required by the filing instructions. The information submitted must be sufficient to evaluate the source, its registration, predicted actual emissions from the source; and to determine whether the source is subject to the exceptions listed in subrule 22.300(3). The standard registration form and attachments shall require that the following information be provided:

(1) Identifying information, including company name and address (or plant or source name if different from the company name), owner’s name and responsible official, and telephone number and names of plant site manager or contact;

(2) A description of source processes and products;

(3) The following emissions-related information shall be submitted to the department on the standard registration form:

1. The total actual emissions of each regulated air pollutant. Actual emissions shall be reported for one contiguous 12-month period within the 18 months preceding submission of the registration to the department;

2. Identification and description of each emission unit with the potential to emit a regulated air pollutant;

3. Identification and description of air pollution control equipment;

4. Limitations on source operations affecting emissions or any work practice standards, where applicable, for all regulated pollutants;

5. Fugitive emissions sources shall be included in the registration form in the same manner as stack emissions if the source is one of the source categories defined as a stationary source category in rule 567—22.100(455B).

(4) Requirements for certification. Facilities which claim to meet the requirements set forth in this rule to qualify for an operating permit by rule for small sources must submit to the department, with a complete registration form, a written statement as follows:

“I certify that all equipment at the facility with a potential to emit any regulated pollutant is included in the registration form, and submitted to the department as required in 22.300(8) “b.” I understand that the facility will be deemed to have been granted an operating permit by rule for small sources under the terms of rule 567—22.300(455B) only if all applicable requirements of rule 567—22.300(455B) are met and if the registration is not denied by the director under rule 567—22.300(11). This certification is based on information and belief formed after reasonable inquiry; the statements and information in the document are true, accurate, and complete.” The certification must be signed by one of the following individuals.

For corporations, a principal executive officer of at least the level of vice president, or a responsible official as defined at rule 567—22.100(455B).

For partnerships, a general partner.

For sole proprietorships, the proprietor.

For municipal, state, county, or other public facilities, the principal executive officer or the ranking elected official.

**22.300(9)** *Construction permits issued after registration for an operating permit by rule for small sources.* This rule shall not relieve any stationary source from complying with requirements pertaining to any otherwise applicable construction permit, or to replace a condition or term of any construction permit, or any provision of a construction permitting program. This does not preclude issuance of any construction permit with conditions or terms necessary to ensure compliance with this rule.

*a.* If the issuance of a construction permit acts to make the source no longer eligible for an operating permit by rule for small sources, the source shall, within 12 months of issuance of the construction permit, submit an application for a Title V operating permit.

*b.* If the issuance of a construction permit does not prevent the source from continuing to be eligible to operate under an operating permit by rule for small sources, the source shall, within 30 days of issuance of a construction permit, provide to the department the information as listed in 22.300(8) “b” for the new or modified source.

**22.300(10)** *Violations.*

*a.* Failure to comply with any of the applicable provisions of this rule shall constitute a violation of this rule.

*b.* A stationary source subject to this rule shall be subject to applicable federal requirements for a major source, including rules 567—22.101(455B) to 567—22.116(455B) when the conditions specified in either subparagraph (1) or (2) below, occur:

(1) Commencing on the first day following every 12-month rolling period in which the stationary source exceeds a limit specified in subrule 22.300(6), or

(2) Commencing on the first day following every 12-month rolling period in which the owner or operator cannot demonstrate that the stationary source is in compliance with the limits in subrule 22.300(6).

**22.300(11)** *Suspension, termination, and revocation of an operating permit by rule for small sources.*

*a.* Registrations may be terminated, modified, revoked, or reissued for cause. The following examples shall be considered cause for the suspension, modification, revocation, or reissuance of an operating permit by rule for small sources:

(1) The director has reasonable cause to believe that the operating permit by rule for small sources was obtained by fraud or misrepresentation.

(2) The person registering for the operating permit by rule for small sources failed to disclose a material fact required by the registration form or the rules applicable to the operating permit by rule for small sources, of which the applicant had or should have had knowledge at the time the registration form was submitted.

(3) The terms and conditions of the operating permit by rule for small sources have been or are being violated.

(4) The owner or operator of the source has failed to pay an administrative, civil or criminal penalty for violations of the operating permit by rule for small sources.

b. If the director suspends, terminates or revokes an operating permit by rule for small sources under this rule, the notice of such action shall be served on the applicant by certified mail, return receipt requested. The notice shall include a statement detailing the grounds for the action sought, and the proceeding shall in all other respects comply with the requirements of rule 561—7.16(17A,455A).

**22.300(12) Change of ownership.** The new owner shall notify the department in writing no later than 30 days after the change of ownership of equipment covered by an operating permit by rule for small sources. The notification to the department shall be mailed to Air Quality Bureau, Iowa Department of Natural Resources, 7900 Hickman Road, Suite 1, Windsor Heights, Iowa 50324, and shall include the following information:

- a. The date of ownership change; and
- b. The name, address and telephone number of the responsible official, the contact person and the owner of the equipment both before and after the change of ownership.

[ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 1913C, IAB 3/18/15, effective 4/22/15]

These rules are intended to implement Iowa Code sections 455B.133 and 455B.134.

[Filed 8/24/70; amended 5/2/72, 12/11/73, 12/17/74]

[Filed 3/1/76, Notice 11/3/75—published 3/22/76, effective 4/26/76]

[Filed 5/27/77, Notice 3/9/77—published 6/15/77, effective 1/1/78]

[Filed without Notice 10/28/77—published 11/16/77, effective 12/21/77]

[Filed 4/27/78, Notice 11/16/77—published 5/17/78, effective 6/21/78]<sup>1</sup>

[Filed emergency 10/12/78—published 11/1/78, effective 10/12/78]

[Filed 6/29/79, Notice 2/7/79—published 7/25/79, effective 8/29/79]

[Filed 4/10/80, Notice 12/26/79—published 4/30/80, effective 6/4/80]

[Filed 9/26/80, Notice 5/28/80—published 10/15/80, effective 11/19/80]

[Filed 12/12/80, Notice 10/15/80—published 1/7/81, effective 2/11/81]

[Filed 4/23/81, Notice 2/18/81—published 5/13/81, effective 6/17/81]

[Filed 9/24/82, Notice 3/17/82—published 10/13/82, effective 11/17/82]

[Filed emergency 6/3/83—published 6/22/83, effective 7/1/83]

[Filed 7/25/84, Notice 5/9/84—published 8/15/84, effective 9/19/84]

[Filed 12/20/85, Notice 7/17/85—published 1/15/86, effective 2/19/86]

[Filed 5/2/86, Notice 1/15/86—published 5/21/86, effective 6/25/86]

[Filed emergency 11/14/86—published 12/3/86, effective 12/3/86]

[Filed 2/20/87, Notice 12/3/86—published 3/11/87, effective 4/15/87]

[Filed 7/22/88, Notice 5/18/88—published 8/10/88, effective 9/14/88]

[Filed 10/28/88, Notice 7/27/88—published 11/16/88, effective 12/21/88]

[Filed 1/19/90, Notice 11/15/89—published 2/7/90, effective 3/14/90]

[Filed 9/28/90, Notice 6/13/90—published 10/17/90, effective 11/21/90]

[Filed 12/30/92, Notice 9/16/92—published 1/20/93, effective 2/24/93]

[Filed 2/25/94, Notice 10/13/93—published 3/16/94, effective 4/20/94]

[Filed 9/23/94, Notice 6/22/94—published 10/12/94, effective 11/16/94]

[Filed 10/21/94, Notice 4/13/94—published 11/9/94, effective 12/14/94]

[Filed without Notice 11/18/94—published 12/7/94, effective 1/11/95]

[Filed emergency 2/24/95—published 3/15/95, effective 2/24/95]

[Filed 5/19/95, Notices 12/21/94, 3/15/95—published 6/7/95, effective 7/12/95]<sup>◇</sup>

[Filed 8/25/95, Notice 6/7/95—published 9/13/95, effective 10/18/95]<sup>◇</sup>

[Filed emergency 10/20/95—published 11/8/95, effective 10/20/95]

[Filed emergency 11/16/95—published 12/6/95, effective 11/16/95]

[Filed 1/26/96, Notices 11/8/95, 12/6/95—published 2/14/96, effective 3/20/96]

[Filed 1/26/96, Notice 11/8/95—published 2/14/96, effective 3/20/96]<sup>◇</sup>

[Filed 4/19/96, Notice 1/17/96—published 5/8/96, effective 6/12/96]<sup>3</sup>

[Filed 5/31/96, Notice 3/13/96—published 6/19/96, effective 7/24/96]

[Filed 8/23/96, Notice 5/8/96—published 9/11/96, effective 10/16/96]

[Filed 11/1/96, Notice 8/14/96—published 11/20/96, effective 12/25/96]

- [Filed 3/20/97, Notice 10/9/96—published 4/9/97, effective 5/14/97]
- [Filed 3/20/97, Notice 11/20/96—published 4/9/97, effective 5/14/97]
- [Filed 6/27/97, Notice 3/12/97—published 7/16/97, effective 8/20/97]
- [Filed 3/19/98, Notice 1/14/98—published 4/8/98, effective 5/13/98]
- [Filed emergency 5/29/98—published 6/17/98, effective 6/29/98]
- [Filed 6/26/98, Notice 3/11/98—published 7/15/98, effective 8/19/98]
- [Filed 8/21/98, Notice 6/17/98—published 9/9/98, effective 10/14/98]<sup>◊</sup>
- [Filed 10/30/98, Notice 8/26/98—published 11/18/98, effective 12/23/98]
- [Filed 3/19/99, Notice 12/30/98—published 4/7/99, effective 5/12/99]
- [Filed 5/28/99, Notice 3/10/99—published 6/16/99, effective 7/21/99]
- [Filed 3/3/00, Notice 12/15/99—published 3/22/00, effective 4/26/00]
- [Filed 1/19/01, Notice 6/14/00—published 2/7/01, effective 3/14/01<sup>4</sup>]
- [Filed 6/21/01, Notice 3/21/01—published 7/11/01, effective 8/15/01]
- [Filed 12/19/01, Notice 10/17/01—published 1/9/02, effective 2/13/02]
- [Filed 2/28/02, Notice 12/12/01—published 3/20/02, effective 4/24/02]
- [Filed 5/24/02, Notice 10/17/01—published 6/12/02, effective 7/17/02]
- [Filed 5/24/02, Notice 3/20/02—published 6/12/02, effective 7/17/02]
- [Filed 11/21/02, Notice 6/12/02—published 12/11/02, effective 1/15/03]
- [Filed without Notice 2/28/03—published 3/19/03, effective 4/23/03]
- [Filed 5/22/03, Notice 3/19/03—published 6/11/03, effective 7/16/03]
- [Filed 8/15/03, Notice 5/14/03—published 9/3/03, effective 10/8/03]
- [Filed 8/29/03, Notice 6/11/03—published 9/17/03, effective 10/22/03]
- [Filed 11/19/03, Notice 9/17/03—published 12/10/03, effective 1/14/04]
- [Filed 10/22/04, Notice 7/21/04—published 11/10/04, effective 12/15/04]
- [Filed 2/25/05, Notice 12/8/04—published 3/16/05, effective 4/20/05]
- [Filed 5/18/05, Notice 3/16/05—published 6/8/05, effective 7/13/05]
- [Filed 8/23/05, Notice 5/11/05—published 9/14/05, effective 10/19/05]
- [Filed 2/24/06, Notice 11/9/05—published 3/15/06, effective 4/19/06]
- [Filed 5/17/06, Notice 1/18/06—published 6/7/06, effective 7/12/06]<sup>◊</sup>
- [Filed 6/28/06, Notice 4/12/06—published 7/19/06, effective 8/23/06]
- [Filed 8/25/06, Notice 6/7/06—published 9/27/06, effective 11/1/06]
- [Filed 2/8/07, Notice 12/6/06—published 2/28/07, effective 4/4/07]
- [Filed 5/3/07, Notice 1/31/07—published 5/23/07, effective 6/27/07]<sup>◊</sup>
- [Filed emergency 10/4/07 after Notice 8/1/07—published 10/24/07, effective 10/4/07]
- [Filed 1/23/08, Notice 8/29/07—published 2/13/08, effective 3/19/08]
- [Filed 4/18/08, Notice 1/2/08—published 5/7/08, effective 6/11/08]
- [Filed 8/20/08, Notice 6/4/08—published 9/10/08, effective 10/15/08]
- [Filed 12/10/08, Notice 10/8/08—published 12/31/08, effective 2/4/09]
- [Filed ARC 7565B (Notice ARC 7306B, IAB 11/5/08), IAB 2/11/09, effective 3/18/09]
- [Filed ARC 8215B (Notice ARC 7855B, IAB 6/17/09), IAB 10/7/09, effective 11/11/09]
- [Filed ARC 9224B (Notice ARC 8999B, IAB 8/11/10), IAB 11/17/10, effective 12/22/10]
- [Filed Emergency After Notice ARC 9906B (Notice ARC 9736B, IAB 9/7/11), IAB 12/14/11, effective 11/16/11]
- [Filed ARC 0330C (Notice ARC 0087C, IAB 4/18/12; Amended Notice ARC 0162C, IAB 6/13/12), IAB 9/19/12, effective 10/24/12]
- [Filed ARC 1013C (Notice ARC 0785C, IAB 6/12/13), IAB 9/18/13, effective 10/23/13]
- [Filed ARC 1227C (Notice ARC 1016C, IAB 9/18/13), IAB 12/11/13, effective 1/15/14]
- [Filed ARC 1561C (Notice ARC 1458C, IAB 5/14/14), IAB 8/6/14, effective 9/10/14]
- [Filed ARC 1913C (Notice ARC 1795C, IAB 12/24/14), IAB 3/18/15, effective 4/22/15]
- [Filed Emergency After Notice ARC 2352C (Notice ARC 2222C, IAB 10/28/15), IAB 1/6/16, effective 12/16/15]
- [Filed ARC 2949C (Notice ARC 2799C, IAB 11/9/16), IAB 2/15/17, effective 3/22/17]

[Filed ARC 3440C (Notice ARC 2895C, IAB 1/18/17; Amended Notice ARC 3251C, IAB 8/16/17),  
IAB 11/8/17, effective 12/13/17]

[Filed ARC 3679C (Notice ARC 3520C, IAB 12/20/17), IAB 3/14/18, effective 4/18/18]

<sup>0</sup> Two or more ARCs

<sup>1</sup> Effective date of 22.1(455B) [DEQ, 3.1] delayed by the Administrative Rules Review Committee 70 days from June 21, 1978. The Administrative Rules Review Committee at the August 15, 1978 meeting delayed 22.1 [DEQ, 3.1] under provisions of 67GA, SF244, §19. (See HJR 6, 1/22/79).

<sup>2</sup> Effective date of 22.100(455B), definition of "12-month rolling period"; 22.200(455B); 22.201(1)"a," "b,"; 22.201(2)"a"; 22.206(2)"c," delayed 70 days by the Administrative Rules Review Committee at its meeting held October 10, 1995; delay lifted by this Committee December 13, 1995, effective December 14, 1995.

<sup>3</sup> Effective date of 22.300 delayed 70 days by the Administrative Rules Review Committee at its meeting held June 11, 1996; delay lifted by this Committee at its meeting held June 12, 1996, effective June 12, 1996.

<sup>4</sup> Effective date of 22.1(2), unnumbered introductory paragraphs and paragraphs "g" and "i," delayed 70 days by the Administrative Rules Review Committee at its meeting held March 9, 2001.

CHAPTER 23  
EMISSION STANDARDS FOR CONTAMINANTS

[Prior to 7/1/83, DEQ Ch 4]

[Prior to 12/3/86, Water, Air and Waste Management[900]]

**567—23.1(455B) Emission standards.**

**23.1(1) *In general.*** The federal standards of performance for new stationary sources (new source performance standards) shall be applicable as specified in subrule 23.1(2). The federal standards for hazardous air pollutants (national emission standards for hazardous air pollutants) shall be applicable as specified in subrule 23.1(3). The federal standards for hazardous air pollutants for source categories (national emission standards for hazardous air pollutants for source categories) shall be applicable as specified in subrule 23.1(4). The federal emission guidelines (emission guidelines) shall be applicable as specified in subrule 23.1(5). Compliance with emission standards specified elsewhere in this chapter shall be in accordance with 567—Chapter 21.

**23.1(2) *New source performance standards.*** The federal standards of performance for new stationary sources, as defined in 40 Code of Federal Regulations Part 60 as amended or corrected through September 14, 2016, are adopted by reference, except § 60.530 through § 60.539b (Part 60, Subpart AAA), and shall apply to the following affected facilities. The corresponding 40 CFR Part 60 subpart designation is in parentheses. An earlier date for adoption by reference may be included with the subpart designation in parentheses. Reference test methods (Appendix A), performance specifications (Appendix B), determination of emission rate change (Appendix C), quality assurance procedures (Appendix F) and the general provisions (Subpart A) of 40 CFR Part 60 also apply to the affected facilities.

*a. Fossil fuel-fired steam generators.* A fossil fuel-fired steam generating unit of more than 250 million Btu heat input for which construction, reconstruction, or modification is commenced after August 17, 1971. Any facility covered under paragraph “z” is not covered under this paragraph. (Subpart D as amended through January 20, 2011)

*b. Incinerators.* An incinerator of more than 50 tons per day charging rate. (Subpart E)

*c. Portland cement plants.* Any of the following in a Portland cement plant: kiln; clinker cooler; raw mill system; finish mill system; raw mill dryer; raw material storage; clinker storage; finished product storage; conveyor transfer points; bagging and bulk loading and unloading systems. (Subpart F)

*d. Nitric acid plants.* A nitric acid production unit. Unless otherwise exempted, these standards apply to any nitric acid production unit that commences construction or modification after August 17, 1971, and on or before October 14, 2011. (Subpart G)

*e. Sulfuric acid plants.* A sulfuric acid production unit. (Subpart H)

*f. Hot mix asphalt plants.* Each hot mix asphalt facility that commenced construction or modification after June 11, 1973. For the purpose of this paragraph, a hot mix asphalt facility is comprised only of any combination of the following: dryers; systems for screening, handling, storing, and weighing hot aggregate; systems for loading, transferring, and storing mineral filler; systems for mixing hot mix asphalt; and the loading, transfer, and storage systems associated with emission control systems. (Subpart I)

*g. Petroleum refineries.* Rescinded IAB 3/18/15, effective 4/22/15.

*h. Secondary lead smelters.* Rescinded IAB 3/18/15, effective 4/22/15.

*i. Secondary brass and bronze ingot production plants.* Any of the following at a secondary brass and bronze ingot production plant; reverberatory and electric furnaces of 1000/kilograms (2205 pounds) or greater production capacity and blast (cupola) furnaces of 250 kilograms per hour (550 pounds per hour) or greater production capacity. (Subpart M)

*j. Iron and steel plants.* A basic oxygen process furnace. (Subpart N)

*k. Sewage treatment plants.* An incinerator which burns the sludge produced by municipal sewage treatment plants. (Subpart O of 40 CFR 60 and Subpart E of 40 CFR 503.)

- l. Steel plants.* Either of the following at a steel plant: electric arc furnaces and dust-handling equipment, the construction, modification, or reconstruction of which commenced after October 21, 1974, and on or before August 17, 1983. (Subpart AA)
- m. Primary copper smelters.* Rescinded IAB 3/18/15, effective 4/22/15.
- n. Primary zinc smelters.* Rescinded IAB 3/18/15, effective 4/22/15.
- o. Primary lead smelter.* Rescinded IAB 3/18/15, effective 4/22/15.
- p. Primary aluminum reduction plants.* Rescinded IAB 3/18/15, effective 4/22/15.
- q. Wet process phosphoric acid plants in the phosphate fertilizer industry.* A wet process phosphoric acid plant, which includes any combination of the following: reactors, filters, evaporators and hotwells. (Subpart T)
- r. Superphosphoric acid plants in the phosphate fertilizer industry.* A superphosphoric acid plant which includes any combination of the following: evaporators, hotwells, acid sumps, and cooling tanks. (Subpart U)
- s. Diammonium phosphate plants in the phosphate fertilizer industry.* A granular diammonium phosphate plant which includes any combination of the following: reactors, granulators, dryers, coolers, screens and mills. (Subpart V)
- t. Triple super phosphate plants in the phosphate fertilizer industry.* A triple super phosphate plant which includes any combination of the following: mixers, curing belts (dens), reactors, granulators, dryers, cookers, screens, mills and facilities which store run-of-pile triple superphosphate. (Subpart W)
- u. Granular triple superphosphate storage facilities in the phosphate fertilizer industry.* A granular triple superphosphate storage facility which includes any combination of the following: storage or curing piles, conveyors, elevators, screens and mills. (Subpart X)
- v. Coal preparation plants.* Any of the following at a coal preparation plant which processes more than 200 tons per day: thermal dryers; pneumatic coal cleaning equipment (air tables); coal processing and conveying equipment (including breakers and crushers); coal storage systems; and coal transfer and loading systems. (Subpart Y)
- w. Ferroalloy production.* Any of the following: electric submerged arc furnaces which produce silicon metal, ferrosilicon, calcium silicon, silicomanganese zirconium, ferrochrome silicon, silvery iron, high-carbon ferrochrome, charge chrome, standard ferromanganese, silicomanganese, ferromanganese silicon, or calcium carbide; and dust-handling equipment. (Subpart Z)
- x. Kraft pulp mills.* Any of the following in a kraft pulp mill: digester system; brown stock washer system; multiple effect evaporator system; black liquor oxidation system; recovery furnace; smelt dissolving tank; lime kiln; and condensate stripper system. In pulp mills where kraft pulping is combined with neutral sulfite semichemical pulping, the provisions of the standard of performance are applicable when any portion of the material charged to an affected facility is produced by the kraft pulping operation. (Subpart BB)
- y. Lime manufacturing plants.* A rotary lime kiln or a lime hydrator used in the manufacture of lime at other than a kraft pulp mill. (Subpart HH)
- z. Electric utility steam generating units.* An electric utility steam generating unit that is capable of combusting more than 250 million Btus per hour (73 megawatts) heat input of fossil fuel for which construction or modification or reconstruction is commenced after September 18, 1978, or an electric utility combined cycle gas turbine that is capable of combusting more than 250 million Btus per hour (73 megawatts) heat input. "Electric utility steam generating unit" means any steam electric generating unit that is constructed for the purpose of supplying more than one-third of its potential electric output capacity and more than 25 MW net-electrical output to any utility power distribution system for sale. Also, any steam supplied to a steam distribution system for the purpose of providing steam to a steam electric generator that would produce electrical energy for sale is considered in determining the electrical energy output capacity of the affected facility. (Subpart Da as amended through January 20, 2011)
- aa. Stationary gas turbines.* Any simple cycle gas turbine, regenerative cycle gas turbine or any gas turbine portion of a combined cycle steam/electric generating system that is not self-propelled. It may, however, be mounted on a vehicle for portability. (Subpart GG)

*bb. Petroleum storage vessels.* Unless exempted, any storage vessel for petroleum liquids for which the construction, reconstruction, or modification commenced after June 11, 1973, and prior to May 19, 1978, having a storage capacity greater than 151,412 liters (40,000 gallons). (Subpart K)

*cc. Petroleum storage vessels.* Unless exempted, any storage vessel for petroleum liquids for which the construction, reconstruction, or modification commenced after May 18, 1978, and prior to July 23, 1984, having a storage capacity greater than 151,416 liters (40,000 gallons). (Subpart Ka)

*dd. Glass manufacturing plants.* Any glass melting furnace. (Subpart CC)

*ee. Automobile and light-duty truck surface coating operations at assembly plants.* Any of the following in an automobile or light-duty truck assembly plant: prime coat operations, guide coat operations, and topcoat operations. (Subpart MM)

*ff. Ammonium sulfate manufacture.* Any of the following in the ammonium sulfate industry: ammonium sulfate dryers in the caprolactam by-product, synthetic, and coke oven by-product sectors of the industry. (Subpart PP)

*gg. Surface coating of metal furniture.* Any metal furniture surface coating operation in which organic coatings are applied. (Subpart EE)

*hh. Lead-acid battery manufacturing plants.* Any lead-acid battery manufacturing plant which uses any of the following: grid casting, paste mixing, three-process operation, lead oxide manufacturing, lead reclamation, other lead-emitting operations. (Subpart KK)

*ii. Phosphate rock plants.* Any phosphate rock plant which has a maximum plant production capacity greater than four tons per hour including the following: dryers, calciners, grinders, and ground rock handling and storage facilities, except those facilities producing or preparing phosphate rock solely for consumption in elemental phosphorus production. (Subpart NN)

*jj. Graphic arts industry.* Publication rotogravure printing. Any publication rotogravure printing press except proof presses. (Subpart QQ)

*kk. Industrial surface coating — large appliances.* Any surface coating operation in a large appliance surface coating line. (Subpart SS)

*ll. Metal coil surface coating.* Any of the following at a metal coil surface coating operation: prime coat operation, finish coat operation, and each prime and finish coat operation combined when the finish coat is applied wet-on-wet over the prime coat and both coatings are cured simultaneously. (Subpart TT)

*mm. Asphalt processing and asphalt roofing manufacturing.* Any saturator, mineral handling and storage facility at asphalt roofing plants; and any asphalt storage tank and any blowing still at asphalt processing plants, petroleum refineries, and asphalt roofing plants. (Subpart UU)

*nn. Equipment leaks of volatile organic compounds (VOC) in the synthetic organic chemicals manufacturing industry.* Standards for affected facilities in the synthetic organic chemicals manufacturing industry (SOCMI) that commenced construction, reconstruction, or modification after January 5, 1981, and on or before November 7, 2006, are set forth in Subpart VV. Standards for affected SOCMI facilities that commenced construction, reconstruction or modification after November 7, 2006, are set forth in Subpart VVa. The standards apply to pumps, compressors, pressure relief devices, sampling systems, open-ended valves or lines (OEL), valves, and flanges or other connectors which handle VOC. (Subpart VV and Subpart VVa)

*oo. Beverage can surface coating.* Any beverage can surface coating lines for two-piece steel or aluminum containers in which soft drinks or beer are sold. (Subpart WW)

*pp. Bulk gasoline terminals.* The total of all loading racks at bulk gasoline terminals which deliver liquid product into gasoline tank trucks. (Subpart XX)

*qq. Pressure sensitive tape and label surface coating operations.* Any coating line used in the tape manufacture of pressure sensitive tape and label materials. (Subpart RR)

*rr. Metallic mineral processing plants.* Any ore processing and handling equipment. (Subpart LL)

*ss. Synthetic fiber production facilities.* Any solvent-spun synthetic fiber process that produces more than 500 megagrams of fiber per year. (Subpart HHH)

*tt. Equipment leaks of VOC in petroleum refineries.* A compressor and all equipment (defined in 40 CFR, Part 60.591) within a process unit for which the construction, reconstruction, or modification commenced after January 4, 1983. (Subpart GGG)

*uu. Flexible vinyl and urethane coating and printing.* Each rotogravure printing line used to print or coat flexible vinyl or urethane products. (Subpart FFF)

*vv. Petroleum dry cleaners.* Petroleum dry-cleaning plant with a total manufacturer's rated dryer capacity equal to or greater than 38 kilograms (84 pounds): petroleum solvent dry-cleaning dryers, washers, filters, stills, and settling tanks. (Subpart JJJ)

*ww. Electric arc furnaces and argon-oxygen decarburization vessels constructed after August 17, 1983.* Steel plants that produce carbon, alloy, or specialty steels: electric arc furnaces, argon-oxygen decarburization vessels, and dust-handling systems. (Subpart AAa)

*xx. Wool fiberglass insulation manufacturing plants.* Rotary spin wool fiberglass manufacturing line. (Subpart PPP)

*yy. Iron and steel plants.* Secondary emissions from basic oxygen process steelmaking facilities for which construction, reconstruction, or modification commenced after January 20, 1983. (Subpart Na)

*zz. Equipment leaks of VOC from on-shore natural gas processing plants.* A compressor and all equipment defined in 40 CFR, Part 60.631, unless exempted, for which construction, reconstruction, or modification commenced after January 20, 1984. (Subpart KKK)

*aaa. On-shore natural gas processing: SO<sub>2</sub> emissions.* Unless exempted, each sweetening unit and each sweetening unit followed by a sulfur recovery unit for which construction, reconstruction, or modification commenced after January 20, 1984. (Subpart LLL)

*bbb. Nonmetallic mineral processing plants.* Unless exempted, each crusher, grinding mill, screening operation, bucket elevator, belt conveyor, bagging operation, storage bin, enclosed truck or rail car loading station in fixed or portable nonmetallic mineral processing plants for which construction, reconstruction, or modification commenced after August 31, 1983. (Subpart OOO)

*ccc. Industrial-commercial-institutional steam generating units.* Unless exempted, each steam generating unit for which construction, reconstruction, or modification commenced after June 19, 1984, and which has a heat input capacity of more than 100 million Btu/hour. (Subpart Db as amended through January 20, 2011)

*ddd. Volatile organic liquid storage vessels.* Unless exempted, volatile organic liquid storage vessels for which construction, reconstruction, or modification commenced after July 23, 1984. (Subpart Kb)

*eee. Rubber tire manufacturing plants.* Unless exempted, each undertread cementing operation, each sidewall cementing operation, each tread end cementing operation, each bead cementing operation, each green tire spraying operation, each Michelin-A operation, each Michelin-B operation, and each Michelin-C automatic operation that commences construction or modification after January 20, 1983. (Subpart BBB)

*fff. Industrial surface coating: surface coating of plastic parts for business machines.* Each spray booth in which plastic parts for use in the manufacture of business machines receive prime coats, color coats, texture coats, or touch-up coats for which construction, modification, or reconstruction begins after January 8, 1986. (Subpart TTT)

*ggg. VOC emissions from petroleum refinery wastewater systems.* Each individual drain system, each oil-water separator, and each aggregate facility for which construction, modification or reconstruction is commenced after May 4, 1987. (Subpart QQQ)

*hhh. Magnetic tape coating facilities.* Unless exempted, each coating operation and each piece of coating mix preparation equipment for which construction, modification, or reconstruction is commenced after January 22, 1986. (Subpart SSS)

*iii. Polymeric coating of supporting substrates.* Unless exempted, each coating operation and any on-site coating mix preparation equipment used to prepare coatings for the polymeric coating of supporting substrates for which construction, modification, or reconstruction begins after April 30, 1987. (Subpart VVV)

*jjj. VOC emissions from synthetic organic chemical manufacturing industry air oxidation unit processes.* Unless exempted, any air oxidation reactor, air oxidation reactor and recovery system or combination of two or more reactors and the common recovery system used in the production of any

of the chemicals listed in 40 CFR §60.617 for which construction, modification or reconstruction commenced after October 21, 1983. (Subpart III)

*kkk. VOC emissions from synthetic organic chemical manufacturing industry distillation operations.* Unless exempted, any distillation unit, distillation unit and recovery system or combination of two or more distillation units and the common recovery system used in the production of any of the chemicals listed in 40 CFR §60.667 for which construction, modification or reconstruction commenced after December 30, 1983. (Subpart NNN)

*lll. Small industrial-commercial-institutional steam generating units.* Each steam generating unit for which construction, modification, or reconstruction is commenced after June 9, 1989, and that has a maximum design heat input capacity of 100 million Btu per hour or less, but greater than or equal to 10 million Btu per hour. (Subpart Dc as amended through January 20, 2011)

*mmm. VOC emissions from the polymer manufacturing industry.* Each of the following process sections in the manufacture of polypropylene and polyethylene—raw materials preparation, polymerization reaction, material recovery, product finishing, and product storage; each material recovery section of polystyrene manufacturing using a continuous process; each polymerization reaction section of poly(ethylene terephthalate) manufacturing using a continuous process; each material recovery section of poly(ethylene terephthalate) manufacturing using a continuous process that uses dimethyl terephthalate; each raw material section of poly(ethylene terephthalate) manufacturing using a continuous process that uses terephthalic acid; and each group of fugitive emissions equipment within any process unit in the manufacturing of polypropylene, polyethylene, or polystyrene (including expandable polystyrene). The applicability date for construction, modification or reconstruction for polystyrene and poly(ethylene terephthalate) affected facilities and some polypropylene and polyethylene affected facilities is September 30, 1987. For the other polypropylene and polyethylene affected facilities the applicability date for these regulations is January 10, 1989. (Subpart DDD)

*nnn. Municipal waste combustors.* Unless exempted, a municipal waste combustor with a capacity greater than 225 megagrams per day of municipal solid waste for which construction is commenced after December 20, 1989, and on or before September 20, 1994, and modification or reconstruction is commenced after December 20, 1989, and on or before June 19, 1996. (Subpart Ea)

*ooo. Grain elevators.* A grain terminal elevator or any grain storage elevator except as provided under 40 CFR 60.304(b), August 31, 1993. A grain terminal elevator means any grain elevator which has a permanent storage capacity of more than 2.5 million U.S. bushels except those located at animal food manufacturers, pet food manufacturers, cereal manufacturers, breweries, and livestock feedlots. A grain storage elevator means any grain elevator located at any wheat flour mill, wet corn mill, dry corn mill (human consumption), rice mill, or soybean oil extraction plant which has a permanent grain storage capacity of 1 million bushels. Any construction, modification, or reconstruction after August 3, 1978, is subject to this paragraph. (Subpart DD)

*ppp. Mineral processing plants.* Each calciner and dryer at a mineral processing plant unless excluded for which construction, modification, or reconstruction is commenced after April 23, 1986. (Subpart UUU)

*qqq. VOC emissions from synthetic organic chemical manufacturing industry reactor processes.* Unless exempted, each affected facility that is part of a process unit that produces any of the chemicals listed in 40 CFR §60.707 as a product, coproduct, by-product, or intermediate for which construction, modification, or reconstruction commenced after June 29, 1990. Affected facility is each reactor process not discharging its vent stream into a recovery system, each combination of a reactor process and the recovery system into which its vent stream is discharged, or each combination of two or more reactor processes and the common recovery system into which their vent streams are discharged. (Subpart RRR)

*rrr. Municipal solid waste landfills, as defined by 40 CFR 60.751.* Each municipal solid waste landfill that commenced construction, reconstruction or modification or began accepting waste on or after May 30, 1991, must comply. (Subpart WWW as amended through April 10, 2000)

*sss. Municipal waste combustors.* Unless exempted, a municipal waste combustor with a combustion capacity greater than 250 tons per day of municipal solid waste for which construction,

modification or reconstruction is commenced after September 20, 1994, or for which modification or reconstruction is commenced after June 19, 1996. (Subpart Eb)

*ttt. Hospital/medical/infectious waste incinerators.* Unless exempted, a hospital/medical/infectious waste incinerator for which construction is commenced after June 20, 1996, or for which modification is commenced after March 16, 1998. (Subpart Ec)\*

\*As of November 24, 2010, the adoption by reference of Part 60 Subpart Ec is rescinded.

*uuu. New small municipal waste combustion units.* Unless exempted, this standard applies to a small municipal waste combustion unit that commenced construction after August 30, 1999, or small municipal waste combustion units that commenced reconstruction or modification after June 6, 2001. (Part 60, Subpart AAAA)

*vvv. Commercial and industrial solid waste incineration.* Unless exempted, this standard applies to units for which construction is commenced after November 30, 1999, or for which modification or reconstruction is commenced on or after June 1, 2001. (Part 60, Subpart CCCC, as amended through December 1, 2000)

*www. Other solid waste incineration (OSWI) units.* Unless exempted, this standard applies to other solid waste incineration (OSWI) units for which construction is commenced after December 9, 2004, or for which modification or reconstruction is commenced on or after June 16, 2006. (Part 60, Subpart EEEE)

*xxx.* Reserved.

*yyy. Stationary compression ignition internal combustion engines.* Unless otherwise exempted, these standards apply to each stationary compression ignition internal combustion engine whose construction, modification or reconstruction commenced after July 11, 2005. (Part 60, Subpart IIII)

*zzz. Stationary spark ignition internal combustion engines.* These standards apply to each stationary spark ignition internal combustion engine whose construction, modification or reconstruction commenced after June 12, 2006. (Part 60, Subpart JJJJ)

*aaaa. Stationary combustion turbines.* Unless otherwise exempted, these standards apply to stationary combustion turbines with a heat input at peak load equal to or greater than 10 MMBtu per hour, based on the higher heating value of the fuel, that commence construction, modification, or reconstruction after February 18, 2005. (Part 60, Subpart KKKK)

*bbbb. Nitric acid plants.* Unless otherwise exempted, these standards apply to any nitric acid production unit that commenced construction, reconstruction or modification after October 14, 2011. (Subpart Ga)

**23.1(3) Emission standards for hazardous air pollutants.** The federal standards for emissions of hazardous air pollutants, 40 Code of Federal Regulations Part 61 as amended or corrected through August 30, 2016, and 40 CFR Part 503 as adopted on August 4, 1999, are adopted by reference, except 40 CFR §61.20 to §61.26, §61.90 to §61.97, §61.100 to §61.108, §61.120 to §61.127, §61.190 to §61.193, §61.200 to §61.205, §61.220 to §61.225, and §61.250 to §61.256, and shall apply to the following affected pollutants and facilities and activities listed below. The corresponding 40 CFR Part 61 subpart designation is in parentheses. Reference test methods (Appendix B), compliance status information requirements (Appendix A), quality assurance procedures (Appendix C) and the general provisions (Subpart A) of Part 61 also apply to the affected activities or facilities.

*a. Asbestos.* Any of the following involves asbestos emissions: asbestos mills, surfacing of roadways, manufacturing operations, fabricating, insulating, waste disposal, spraying applications and demolition and renovation operations. (Subpart M). Any person subject to notification requirements under this rule shall submit fees as required in 567—Chapter 30.

*b. Beryllium.* Rescinded IAB 3/18/15, effective 4/22/15.

*c. Beryllium rocket motor firing.* Rescinded IAB 3/18/15, effective 4/22/15.

*d. Mercury.* Any of the following involving mercury emissions: mercury ore processing facilities, mercury cell chlor-alkali plants, sludge incineration plants, sludge drying plants, and a combination of sludge incineration plants and sludge drying plants. (Subpart E)

*e. Vinyl chloride.* Ethylene dichloride purification and the oxychlorination reactor in ethylene dichloride plants. Vinyl chloride formation and purification in vinyl chloride plants. Any of the

following involving polyvinyl chloride plants: reactor; stripper; mixing, weighing, and holding containers; monomer recovery system; sources following the stripper(s). Any of the following involving ethylene dichloride, vinyl chloride, and polyvinyl chloride plants: relief valve discharge; fugitive emission sources. (Subpart F)

*f. Equipment leaks of benzene (fugitive emission sources).* Any pumps, compressors, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, flanges and other connectors, product accumulator vessels, and control devices or systems which handle benzene. (Subpart J)

*g. Equipment leaks of volatile hazardous air pollutants (fugitive emission sources).* Any pumps, compressors, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, flanges and other connectors, product accumulator vessels, and control devices or systems which handle volatile hazardous air pollutants. (Subpart V)

*h. Inorganic arsenic emissions from arsenic trioxide and metallic arsenic production facilities.* Rescinded IAB 3/18/15, effective 4/22/15.

*i. Inorganic arsenic emissions from glass manufacturing plants.* Each glass melting furnace (except pot furnaces) that uses commercial arsenic as a raw material. (Subpart N)

*j. Inorganic arsenic emissions from primary copper smelters.* Rescinded IAB 3/18/15, effective 4/22/15.

*k. Benzene emissions from coke by-product recovery plants.* Each of the following sources at furnace and foundry coke by-product recovery plants: tar decanters, tar storage tanks, tar-intercepting sumps, flushing-liquor circulation tanks, light-oil sumps, light-oil condensers, light-oil decanters, wash-oil decanters, wash-oil circulation tanks, naphthalene processing, final coolers, final-cooler cooling towers, and the following equipment that is intended to operate in benzene service: pumps, valves, exhausters, pressure relief devices, sampling connection systems, open-ended valves or lines, flanges or other connectors, and control devices or systems required by 40 CFR §61.135.

The provisions of this subpart also apply to benzene storage tanks, BTX storage tanks, light-oil storage tanks, and excess ammonia-liquor storage tanks at furnace coke by-product recovery plants. (Subpart L)

*l. Benzene emissions from benzene storage vessels.* Unless exempted, each storage vessel that is storing benzene having a specific gravity within the range of specific gravities specified in ASTM D 836-84 for Industrial Grade Benzene, ASTM D 835-85 for Refined Benzene-485, ASTM D 2359-85a for Refined Benzene-535, and ASTM D 4734-87 for Refined Benzene-545. These specifications are incorporated by reference as specified in 40 CFR §61.18. (Subpart Y)

*m. Benzene emissions from benzene transfer operations.* Unless exempted, the total of all loading racks at which benzene is loaded into tank trucks, rail cars, or marine vessels at each benzene production facility and each bulk terminal. (Subpart BB)

*n. Benzene waste operations.* Unless exempted, the provisions of this subrule apply to owners and operators of chemical manufacturing plants, coke by-product recovery plants, petroleum refineries, and facilities at which waste management units are used to treat, store, or dispose of waste generated by any of these listed facilities. (Subpart FF)

**23.1(4) Emission standards for hazardous air pollutants for source categories.** The federal standards for emissions of hazardous air pollutants for source categories, 40 Code of Federal Regulations Part 63 as amended or corrected through September 14, 2016, are adopted by reference, except those provisions which cannot be delegated to the states. The corresponding 40 CFR Part 63 subpart designation is in parentheses. An earlier date for adoption by reference may be included with the subpart designation in parentheses. 40 CFR Part 63, Subpart B, incorporates the requirements of Clean Air Act Sections 112(g) and 112(j) and does not adopt standards for a specific affected facility. Test methods (Appendix A), sources defined for early reduction provisions (Appendix B), and determination of the fraction biodegraded ( $F_{bio}$ ) in the biological treatment unit (Appendix C) of Part 63 also apply to the affected activities or facilities. For the purposes of this subrule, “hazardous air pollutant” has the same meaning found in 567—22.100(455B). For the purposes of this subrule, a “major source” means any stationary source or group of stationary sources located within a contiguous area and under

common control that emits or has the potential to emit, considering controls, in the aggregate, 10 tons per year or more of any hazardous air pollutant or 25 tons per year or more of any combination of hazardous air pollutants, unless a lesser quantity is established, or in the case of radionuclides, where different criteria are employed. For the purposes of this subrule, an “area source” means any stationary source of hazardous air pollutants that is not a “major source” as defined in this subrule. Paragraph 23.1(4) “a,” general provisions (Subpart A) of Part 63, shall apply to owners or operators who are subject to subsequent subparts of 40 CFR Part 63 (except when otherwise specified in a particular subpart or in a relevant standard) as adopted by reference below.

*a. General provisions.* General provisions apply to owners or operators of affected activities or facilities except when otherwise specified in a particular subpart or in a relevant standard. (Subpart A)

*b. Requirements for control technology determinations for major sources in accordance with Clean Air Act Sections 112(g) and 112(j).* (40 CFR Part 63, Subpart B)

(1) Section 112(g) requirements. For the purposes of this subparagraph, the definitions shall be the same as the definitions found in 40 CFR 63.2 and 40 CFR 63.41 as amended through December 27, 1996. The owner or operator of a new or reconstructed major source of hazardous air pollutants must apply maximum achievable control technology (MACT) for new sources to the new or reconstructed major source. If the major source in question has been specifically regulated or exempted from regulation under a standard issued pursuant to Section 112(d), Section 112(h), or Section 112(j) of the Clean Air Act and incorporated in another subpart of 40 CFR Part 63, excluded in 40 CFR 63.40(e) and (f), or the owner or operator of such major source has received all necessary air quality permits for such construction or reconstruction project before June 29, 1998, then the major source in question is not subject to the requirements of this subparagraph. The owner or operator of an affected source shall apply for a construction permit as required in 567—paragraph 22.1(1) “b.” The construction permit application shall contain an application for a case-by-case MACT determination for the major source.

(2) Section 112(j) requirements. The owner or operator of a new or existing major source of hazardous air pollutants which includes one or more stationary sources included in a source category or subcategory for which the U.S. Environmental Protection Agency has failed to promulgate an emission standard within 18 months of the deadline established under CAA 112(d) must submit a MACT application (Parts 1 and 2) in accordance with the provisions of 40 CFR 63.52, as amended through April 5, 2002, by the CAA Section 112(j) deadline. In addition, the owner or operator of a new emission unit may submit an application for a Notice of MACT Approval before construction, as defined in 40 CFR 63.41, in accordance with the provisions of 567—paragraph 22.1(3) “a.”

*c.* Reserved.

*d. Compliance extensions for early reductions of hazardous air pollutants.* Compliance extensions for early reductions of hazardous air pollutants are available to certain owners or operators of an existing source who wish to obtain a compliance extension from a standard issued under Section 112(d) of the Act. (Subpart D)

*e.* Reserved.

*f. Emission standards for organic hazardous air pollutants from the synthetic chemical manufacturing industry.* These standards apply to chemical manufacturing process units that are part of a major source. These standards include applicability provisions, definitions and other general provisions that are applicable to Subparts F, G, and H of 40 CFR 63. (Subpart F)

*g. Emission standards for organic hazardous air pollutants from the synthetic organic chemical manufacturing industry for process vents, storage vessels, transfer operations, and wastewater.* These standards apply to all process vents, storage vessels, transfer racks, and wastewater streams within a source subject to Subpart F of 40 CFR 63. (Subpart G)

*h. Emission standards for organic hazardous air pollutants for equipment leaks.* These standards apply to emissions of designated organic hazardous air pollutants from specified processes that are located at a plant site that is a major source. Affected equipment includes: pumps, compressors, agitators, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, connectors, surge control vessels, bottoms receivers, instrumentation systems and control devices or systems required by this subpart that are intended to operate in organic hazardous air pollutant service

300 hours or more during the calendar year within a source subject to the provisions of a specific subpart in 40 CFR Part 63. In organic hazardous air pollutant or in organic HAP service means that a piece of equipment either contains or contacts a fluid (liquid or gas) that is at least 5 percent by weight of total organic HAPs as determined according to the provisions of 40 CFR Part 63.161. The provisions of 40 CFR Part 63.161 also specify how to determine that a piece of equipment is not in organic HAP service. (Subpart H)

*i. Emission standards for organic hazardous air pollutants for certain processes subject to negotiated regulation for equipment leaks.* These standards apply to emissions of designated organic hazardous air pollutants from specified processes (defined in 40 CFR 63.190) that are located at a plant site that is a major source. Subject equipment includes pumps, compressors, agitators, pressure relief devices, sampling connection systems, open-ended valves or lines, valves, connectors, and instrumentation systems at certain source categories. These standards establish the applicability of Subpart H for sources that are not classified as synthetic organic chemical manufacturing industries. (Subpart I)

*j. Emission standards for hazardous air pollutants for polyvinyl chloride and copolymers production.* Rescinded IAB 3/18/15, effective 4/22/15.

*k. Reserved.*

*l. Emission standards for coke oven batteries.* These standards apply to existing coke oven batteries, including by-product and nonrecovery coke oven batteries and to new coke oven batteries, or as defined in the subpart. (Subpart L)

*m. Perchloroethylene air emission standards for dry cleaning facilities (40 CFR Part 63, Subpart M).* These standards apply to the owner or operator of each dry cleaning facility that uses perchloroethylene (also known as perc). The specific standards applicable to dry cleaning facilities, including the compliance deadlines, are set out in the federal regulations contained in Subpart M. In general, dry cleaning facilities must meet the following requirements, which are set out in greater detail in Subpart M:

(1) New and existing major source dry cleaning facilities are required to control emissions to the level of the maximum achievable control technology (MACT).

(2) New and existing area source dry cleaning facilities are required to control emissions to the level achieved by generally available control technologies (GACT) or management practices.

(3) New area sources that are located in residential buildings and that commence operation after July 13, 2006, are prohibited from using perc.

(4) New area sources located in residential buildings that commenced operation between December 21, 2005, and July 13, 2006, must eliminate all use of perc by July 27, 2009.

(5) Existing area sources located in residential buildings must eliminate all use of perc by December 21, 2020.

(6) New area sources that are not located in residential buildings are prohibited from operating transfer machines.

(7) Existing area sources that are not located in residential buildings are prohibited from operating transfer machines after July 27, 2008.

(8) All sources must comply with the requirements in Subpart M for emissions control, equipment specifications, leak detection and repair, work practice standards, record keeping and reporting.

*n. Emission standards for chromium emissions from hard and decorative chromium electroplating and chromium anodizing tanks.* These standards limit the discharge of chromium compound air emissions from existing and new hard chromium electroplating, decorative chromium electroplating, and chromium anodizing tanks at major and area sources. (Subpart N)

*o. Emission standards for hazardous air pollutants for ethylene oxide commercial sterilization and fumigation operations.* New and existing major source ethylene oxide commercial sterilization and fumigation operations are required to control emissions to the level of the maximum achievable control technology (MACT). New and existing area source ethylene oxide commercial sterilization and fumigation operations are required to control emissions to the level achieved by generally available control technologies (GACT). Certain sources are exempt as described in 40 CFR 63.360. (Subpart O)

*p. Emission standards for primary aluminum reduction plants.* Rescinded IAB 3/18/15, effective 4/22/15.

*q. Emission standards for hazardous air pollutants for industrial process cooling towers.* These standards apply to all new and existing industrial process cooling towers that are operated with chromium-based water treatment chemicals on or after September 8, 1994, and are either major sources or are integral parts of facilities that are major sources. (Subpart Q)

*r. Emission standards for hazardous air pollutants for sources categories: gasoline distribution: (Stage 1).* These standards apply to all existing and new bulk gasoline terminals and pipeline breakout stations that are major sources of hazardous air pollutants or are located at plant sites that are major sources. Bulk gasoline terminals and pipeline breakout stations located within a contiguous area or under common control with a refinery complying with 40 CFR Subpart CC are not subject to 40 CFR Subpart R standards. (Subpart R)

*s. Emission standards for hazardous air pollutants for pulp and paper (noncombustion).* These standards apply to pulping and bleaching process sources at kraft, soda, sulfite, and stand-alone semichemical pulp mills. Affected sources include pulp mills and integrated mills (mills that manufacture pulp and paper/paperboard) that chemically pulp wood fiber (using kraft, sulfite, soda, or semichemical methods); pulp secondary fiber; pulp nonwood fiber; and mechanically pulp wood fiber. (Subpart S)

*t. Emission standards for hazardous air pollutants: halogenated solvent cleaning.* These standards require batch vapor solvent cleaning machines and in-line solvent cleaning machines to meet emission standards reflecting the application of maximum achievable control technology (MACT) for major and area sources; area source batch cold cleaning machines are required to achieve generally available control technology (GACT). The subpart regulates the emissions of the following halogenated hazardous air pollutant solvents: methylene chloride, perchloroethylene, trichloroethylene, 1,1,1-trichloroethane, carbon tetrachloride, and chloroform. (Subpart T)

*u. Emission standards for hazardous air pollutants: Group I polymers and resins.* Applicable to existing and new major sources that emit organic HAP during the manufacture of one or more elastomers including but not limited to producers of butyl rubber, halobutyl rubber, epichlorohydrin elastomers, ethylene propylene rubber, Hypalon™, neoprene, nitrile butadiene rubber, nitrile butadiene latex, polybutadiene rubber/styrene butadiene rubber by solution, polysulfide rubber, styrene butadiene rubber by emulsion, and styrene butadiene latex. MACT is required for major sources. (Subpart U)

*v. Reserved.*

*w. Emission standards for hazardous air pollutants for epoxy resins production and nonnylon polyamides production.* These standards apply to all existing, new and reconstructed manufacturers of basic liquid epoxy resins and manufacturers of wet strength resins that are located at a plant site that is a major source. (Subpart W)

*x. National emission standards for hazardous air pollutants from secondary lead smelting.* Rescinded IAB 3/18/15, effective 4/22/15.

*y. Emission standards for marine tank vessel loading operations.* This standard requires existing and new major sources to control emissions using maximum achievable control technology (MACT) to control hazardous air pollutants (HAP). (Subpart Y)

*z. Reserved.*

*aa. Emission standards for hazardous air pollutants for phosphoric acid manufacturing.* These standards apply to all new and existing major sources of phosphoric acid manufacturing. Affected processes include, but are not limited to, wet process phosphoric acid process lines, superphosphoric acid process lines, phosphate rock dryers, phosphate rock calciners, and purified phosphoric acid process lines. (Subpart AA)

*ab. Emission standards for hazardous air pollutants for phosphate fertilizers production.* These standards apply to all new and existing major sources of phosphate fertilizer production plants. Affected processes include, but are not limited to, diammonium and monoammonium phosphate process lines, granular triple superphosphate process lines, and granular triple superphosphate storage buildings. (Subpart BB)

*ac. National emission standards for hazardous air pollutants: petroleum refineries.* Rescinded IAB 3/18/15, effective 4/22/15.

*ad. Emission standards for hazardous air pollutants for off-site waste and recovery operations.* This rule applies to major sources of HAP emissions which receive certain wastes, used oil, and used solvents from off-site locations for storage, treatment, recovery, or disposal at the facility. Maximum achievable control technology (MACT) is required to reduce HAP emissions from tanks, surface impoundments, containers, oil-water separators, individual drain systems and other material conveyance systems, process vents, and equipment leaks. Regulated entities include but are not limited to businesses that operate any of the following: hazardous waste treatment, storage, and disposal facilities; Resource Conservation and Recovery Act (RCRA) exempt hazardous wastewater treatment facilities other than publicly owned treatment works; used solvent recovery plants; RCRA exempt hazardous waste recycling operations; used oil re-refineries. The regulations also apply to federal agency facilities that operate any of the waste management or recovery operations. (Subpart DD)

*ae. Emission standards for magnetic tape manufacturing operations.* These standards apply to major sources performing magnetic tape manufacturing operations. (Subpart EE)

*af. Reserved.*

*ag. National emission standards for hazardous air pollutants for source categories: aerospace manufacturing and rework facilities.* These standards apply to major sources involved in the manufacture, repair, or rework of aerospace components and assemblies, including but not limited to airplanes, helicopters, missiles, and rockets for civil, commercial, or military purposes. Hazardous air pollutants regulated under this standard include chromium, cadmium, methylene chloride, toluene, xylene, methyl ethyl ketone, ethylene glycol, and glycol ethers. (Subpart GG)

*ah. Emission standards for hazardous air pollutants for oil and natural gas production.* These standards apply to all new and existing major sources of oil and natural gas production. Affected sources include, but are not limited to, processing of liquid or gaseous hydrocarbons, such as ethane, propane, butane, pentane, natural gas, and condensate extracted from field natural gas. (Subpart HH)

*ai. Emission standards for hazardous air pollutants for shipbuilding and ship repair (surface coating) operations.* Rescinded IAB 3/18/15, effective 4/22/15.

*aj. Emission standards for hazardous air pollutants for hazardous air pollutant (HAP) emissions from wood furniture manufacturing operations.* These standards apply to each facility that is engaged, either in part or in whole, in the manufacture of wood furniture or wood furniture components and that is located at a plant site that is a major source. (Subpart JJ)

*ak. Emission standards for hazardous air pollutants for the printing and publishing industry.* Existing and new major sources are required to control hazardous air pollutants (HAP) using the maximum achievable control technology (MACT). Affected units are publication rotogravure, product and packaging rotogravure, and wide-web flexographic printing. (Subpart KK)

*al. Emission standards for hazardous air pollutants for primary aluminum reduction plants.* Rescinded IAB 3/18/15, effective 4/22/15.

*am. Emission standards for hazardous air pollutants for chemical recovery combustion sources at kraft, soda, sulfite, and stand-alone semichemical pulp mills.* (Part 63, Subpart MM)

*an. Reserved.*

*ao. Emission standards for tanks – level 1.* These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart OO)

*ap. Emission standards for containers.* These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions

(Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart PP)

*aq. Emission standards for surface impoundments.* These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart QQ)

*ar. Emission standards for individual drain systems.* These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart RR)

*as. Emission standards for closed vent systems, control devices, recovery devices and routing to a fuel gas system or a process.* These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart SS)

*at. Emission standards for equipment leaks—control level 1.* These provisions apply to the control of air emissions from equipment leaks for which another paragraph under this rule references the use of this paragraph for such emission control. These air emission standards for equipment leaks are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart TT)

*au. Emission standards for equipment leaks—control level 2 standards.* These provisions apply to the control of air emissions from equipment leaks for which another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards for equipment leaks are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart UU)

*av. Emission standards for oil-water separators and organic-water separators.* These provisions apply when another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Part 63, Subpart VV)

*aw. Emission standards for storage vessels (tanks)—control level 2.* These provisions apply to the control of air emissions from storage vessels for which another paragraph under this rule references the use of this paragraph for such air emission control. These air emission standards for storage vessels are placed here for administrative convenience and only apply to those owners and operators of facilities subject to the referencing paragraph. The provisions of paragraph 23.1(4)“a,” general provisions, (Subpart A), do not apply to this paragraph except as specified in a referencing paragraph. (Subpart WW)

*ax. Emission standards for ethylene manufacturing process units: heat exchange systems and waste operations.* This standard applies to hazardous air pollutants (HAPs) from heat exchange systems and waste streams at new and existing ethylene production units. (Part 63, Subpart XX)

*ay. Emission standards for hazardous air pollutants: generic maximum achievable control technology (Generic MACT).* These standards apply to new and existing major sources of acetal resins (AR) production, acrylic and modacrylic fiber (AMF) production, hydrogen fluoride (HF) production,

polycarbonate (PC) production, carbon black production, cyanide chemicals manufacturing, ethylene production, and Spandex production. Affected processes include, but are not limited to, producers of homopolymers and copolymers of alternating oxymethylene units, acrylic fiber, modacrylic fiber synthetics composed of acrylonitrile (AN) units, hydrogen fluoride and polycarbonate. (Subpart YY)

*az.* to *bb.* Reserved.

*bc.* *Emission standards for hazardous air pollutants for steel pickling—HCL process facilities and hydrochloric acid regeneration plants.* Rescinded IAB 3/18/15, effective 4/22/15.

*bd.* *Emission standards for hazardous air pollutants for mineral wool production.* These standards apply to all new and existing major sources of mineral wool production. Affected processes include, but are not limited to, cupolas and curing ovens. (Subpart DDD)

*be.* *Emission standards for hazardous air pollutants from hazardous waste combustors.* These standards apply to all hazardous waste combustors: hazardous waste incinerators, hazardous waste burning cement kilns, hazardous waste burning lightweight aggregate kilns, hazardous waste solid fuel boilers, hazardous waste liquid fuel boilers, and hazardous waste hydrochloric acid production furnaces, except as specified in Subpart EEE. Both area sources and major sources are subject to this subpart as of April 19, 1996, and are subject to the requirement to apply for and obtain a Title V permit. (Part 63, Subpart EEE)

*bf.* Reserved.

*bg.* *Emission standards for hazardous air pollutants for pharmaceutical manufacturing.* These standards apply to producers of finished dosage forms of drugs, for example, tablets, capsules, and solutions, that contain an active ingredient generally, but not necessarily, in association with inactive ingredients. Pharmaceuticals include components whose intended primary use is to furnish pharmacological activity or other direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease, or to affect the structure or any function of the body of humans or other animals. The regulations do not apply to research and development facilities. (Subpart GGG)

*bh.* *Emission standards for hazardous air pollutants for natural gas transmission and storage.* These standards apply to all new and existing major sources of natural gas transmission and storage. Natural gas transmission and storage facilities are those that transport or store natural gas prior to its entering the pipeline to a local distribution company. Affected sources include, but are not limited to, mains, valves, meters, boosters, regulators, storage vessels, dehydrators, compressors and delivery systems. (Subpart HHH)

*bi.* *Emission standards for hazardous air pollutants for flexible polyurethane foam production.* These standards apply to producers of slabstock, molded, and rebond flexible polyurethane foam. The regulations do not apply to processes dedicated exclusively to the fabrication (i.e., gluing or otherwise bonding foam pieces together) of flexible polyurethane foam or to research and development. (Subpart III)

*bj.* *Emission standards for hazardous air pollutants: Group IV polymers and resins.* Applicable to existing and new major sources that emit organic HAP during the manufacture of the following polymers and resins: acrylonitrile butadiene styrene resin (ABS), styrene acrylonitrile resin (SAN), methyl methacrylate acrylonitrile butadiene styrene resin (MABS), methyl methacrylate butadiene styrene resin (MBS), polystyrene resin, poly (ethylene terephthalate) resin (PET), and nitrile resin. MACT is required for major sources. (Subpart JJJ)

*bk.* Reserved.

*bl.* *Emission standards for hazardous air pollutants for Portland cement manufacturing operations.* These standards apply to all new and existing major and area sources of Portland cement manufacturing unless exempted. Cement kiln dust (CKD) storage facilities, including CKD piles and landfills, are excluded from this standard. Affected processes include, but are not limited to, all cement kilns and in-line kiln/raw mills, unless they burn hazardous waste. (Subpart LLL)

*bm.* *Emission standards for hazardous air pollutants for pesticide active ingredient production.* These standards apply to all new and existing major sources of pesticide active ingredient production that manufacture organic pesticide active ingredients (PAI), including herbicides, insecticides and fungicides. Affected processes include, but are not limited to, processing equipment,

connected piping and ducts, associated storage vessels, pumps, compressors, agitators, pressure relief devices, sampling connection systems, open-ended valves or lines, valves and connectors. Exempted sources include research and development facilities, storage vessels already subject to another 40 CFR Part 63 NESHAP, production of ethylene, storm water from segregated sewers, water from fire-fighting and deluge systems (including testing of such systems) and various spills. (Subpart MMM)

*bn. Emission standards for hazardous air pollutants for wool fiberglass manufacturing.* These standards apply to all new and existing major sources of wool fiberglass manufacturing. Affected processes include, but are not limited to, all glass-melting furnaces, rotary spin (RS) manufacturing lines that produce bonded building insulation, flame attenuation (FA) manufacturing lines producing bonded pipe insulation and new FA manufacturing lines producing bonded heavy-density products. (Subpart NNN)

*bo. Emission standards for hazardous air pollutants for amino/phenolic resins production.* These standards apply to new or existing facilities that own or operate an amino or phenolic resins production unit. (Part 63, Subpart OOO)

*bp. Emission standards for hazardous air pollutants for polyether polyols production.* These standards apply to all new and existing major sources of polyether polyols. Polyether polyols are compounds formed through polymerization of ethylene oxide, propylene oxide or other cyclic ethers with compounds having one or more reactive hydrogens to form polyethers. Affected processes include, but are not limited to, storage vessels, process vents, heat exchange systems, equipment leaks and wastewater operations. (Subpart PPP)

*bq. Emission standards for hazardous air pollutants for primary copper smelting.* Rescinded IAB 3/18/15, effective 4/22/15.

*br. Emission standards for hazardous air pollutants for secondary aluminum production.* (Part 63, Subpart RRR)

*bs.* Reserved.

*bt. Emission standards for hazardous air pollutants for primary lead smelting.* Rescinded IAB 3/18/15, effective 4/22/15.

*bu. Emission standards for hazardous air pollutants for petroleum refineries: catalytic cracking units, catalytic reforming units, and sulfur recovery units.* Rescinded IAB 2/15/17, effective 3/22/17.

*bv. Emission standards for hazardous air pollutants publicly owned treatment works (POTW).* (Part 63, Subpart VVV)

*bw.* Reserved.

*bx. Emission standards for hazardous air pollutants for ferroalloys production: ferromanganese and silicomanganese.* Rescinded IAB 3/14/18, effective 4/18/18.

*by.* and *bz.* Reserved.

*ca. Emission standards for hazardous air pollutants: municipal solid waste landfills.* This standard applies to existing and new municipal solid waste (MSW) landfills. (Part 63, Subpart AAAA)

*cb.* No change.

*cc. Emission standards for hazardous air pollutants for the manufacturing of nutritional yeast.* (Part 63, Subpart CCCC)

*cd. Emission standards for hazardous air pollutants for plywood and composite wood products (formerly plywood and particle board manufacturing).* These standards apply to new and existing major sources with equipment used to manufacture plywood and composite wood products. This equipment includes dryers, refiners, blenders, formers, presses, board coolers, and other process units associated with the manufacturing process. This also includes coating operations, on-site storage and wastewater treatment. However, only certain process units (defined in the federal rule) are subject to control or work practice requirements. (Part 63, Subpart DDDD)

*ce. Emission standards for hazardous air pollutants for organic liquids distribution (non-gasoline).* These standards apply to new and existing major source organic liquids distribution (non-gasoline) operations, which are carried out at storage terminals, refineries, crude oil pipeline stations, and various manufacturing facilities. (Part 63, Subpart EEEE)

*cf. Emission standards for hazardous air pollutants for miscellaneous organic chemical manufacturing (MON).* These standards establish emission limits and work practice standards for new and existing major sources with miscellaneous organic chemical manufacturing process units, wastewater treatment and conveyance systems, transfer operations, and associated ancillary equipment. (Part 63, Subpart FFFF)

*cg. Emission standards for hazardous air pollutants for solvent extraction for vegetable oil production.* (Part 63, Subpart GGGG)

*ch. Emission standards for hazardous air pollutants for wet-formed fiberglass mat production.* This standard applies to wet-formed fiberglass mat production plants that are major sources of hazardous air pollutants. These plants may be stand-alone facilities or located with asphalt roofing and processing facilities. (Part 63, Subpart HHHH)

*ci. Emission standards for hazardous air pollutants for surface coating of automobiles and light-duty trucks.* These standards apply to new, reconstructed, or existing affected sources, as defined in the standard, that are located at a facility which applies topcoat to new automobile or new light-duty truck bodies or body parts for new automobiles or new light-duty trucks and that is a major source, is located at a major source, or is part of a major source of emissions of hazardous air pollutants. Additional applicability criteria and exemptions from these standards may apply. (Part 63, Subpart IIII)

*cj. Emission standards for hazardous air pollutants: paper and other web coating.* This standard applies to a facility that is engaged in the coating of paper, plastic film, metallic foil, and other web surfaces located at a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart JJJJ)

*ck. Emission standards for hazardous air pollutants for surface coating of metal cans.* These standards apply to a metal can surface coating operation that uses at least 5,700 liters (1,500 gallons (gal)) of coatings per year and is a major source, is located at a major source, or is part of a major source of hazardous air pollutant emissions. Coating operations located at an area source are not subject to this rule. Additional applicability criteria and exemptions from these standards may apply. (Part 63, Subpart KKKK)

*cl. Reserved.*

*cm. Emission standards for hazardous air pollutants for surface coating of miscellaneous metal parts and products.* These standards apply to miscellaneous metal parts and products surface coating facilities that are a major source, are located at a major source, or are part of a major source of hazardous air pollutant emissions. A miscellaneous metal parts and products surface coating facility that is located at an area source is not subject to this standard. Certain sources are exempt as described in the standard. (Part 63, Subpart MMMM)

*cn. Emission standards for hazardous air pollutants: surface coating of large appliances.* This standard applies to a facility that applies coatings to large appliance parts or products, and is a major source, is located at a major source, or is part of a major source of emissions of hazardous air pollutants (HAPs). The large appliances source category includes facilities that apply coatings to large appliance parts or products. Large appliances include “white goods” such as ovens, refrigerators, freezers, dishwashers, laundry equipment, trash compactors, water heaters, comfort furnaces, electric heat pumps and most HVAC equipment intended for any application. (Part 63, Subpart NNNN)

*co. Emission standards for hazardous air pollutants for printing, coating, and dyeing of fabrics and other textiles.* These standards apply to new and existing facilities with fabric or other textile coating, printing, slashing, dyeing, or finishing operations, or group of such operations, that are a major source of hazardous air pollutants or are part of a facility that is a major source of hazardous air pollutants. Coating, printing, slashing, dyeing, or finishing operations located at an area source are not subject to this standard. Several exclusions from this source category are listed in the standard. (Part 63, Subpart OOOO)

*cp. Emission standards for surface coating of plastic parts and products.* These standards apply to new and existing major sources with equipment used to coat plastic parts and products. The surface coating application process includes drying/curing operations, mixing or thinning operations, and cleaning operations. Coating materials include, but are not limited to, paints, stains, sealers, topcoats, basecoats, primers, inks, and adhesives. (Part 63, Subpart PPPP)

*cq. Emission standards for hazardous air pollutants for surface coating of wood building products.* These standards establish emission limitations, operating limits, and work practice requirements for wood building products surface coating facilities that use at least 1,100 gallons of coatings per year and are a major source, are located at a major source, or are part of a major source of hazardous air pollutant emissions. Wood building products surface coating facilities located at an area source are not subject to this standard. Several exclusions from this source category are listed in the standard. (Part 63, Subpart QQQQ)

*cr. Emission standards for hazardous air pollutants: surface coating of metal furniture.* This standard applies to a metal furniture surface coating facility that is a major source, is located at a major source, or is part of a major source of HAP emissions. A metal furniture surface coating facility is one that applies coatings to metal furniture or components of metal furniture. Metal furniture means furniture or components that are constructed either entirely or partially from metal. (Part 63, Subpart RRRR)

*cs. Emission standards for hazardous air pollutants: surface coating of metal coil.* This standard requires that all new and existing “major” air toxics sources in the metal coil coating industry meet specific emission limits. Metal coil coating is the process of applying a coating (usually protective or decorative) to one or both sides of a continuous strip of sheet metal. Industries using coated metal include: transportation, building products, appliances, can manufacturing, and packaging. Other products using coated metal coil include measuring tapes, ventilation systems for walls and roofs, lighting fixtures, office filing cabinets, cookware, and sign stock material. (Part 63, Subpart SSSS)

*ct. Emission standards for hazardous air pollutants for leather finishing operations.* This standard applies to a new or existing leather finishing operation that is a major source of hazardous air pollutants (HAPs) emissions or that is located at, or is part of, a major source of HAP emissions. In general, a leather finishing operation is a single process or group of processes used to adjust and improve the physical and aesthetic characteristics of the leather surface through multistage application of a coating comprised of dyes, pigments, film-forming materials, and performance modifiers dissolved or suspended in liquid carriers. (Part 63, Subpart TTTT)

*cu. Emission standards for hazardous air pollutants for cellulose products manufacturing.* This standard applies to a new or existing cellulose products manufacturing operation that is located at a major source of HAP emissions. Cellulose products manufacturing includes both the miscellaneous viscose processes source category and the cellulose ethers production source category. (Part 63, Subpart UUUU)

*cv. Emission standards for hazardous air pollutants for boat manufacturing.* (Part 63, Subpart VVVV)

*cw. Emission standards for hazardous air pollutants: reinforced plastic composites production.* This standard applies to a new or an existing reinforced plastic composites production facility that is located at a major source of HAP emissions. (Part 63, Subpart WWWW)

*cx. Emission standards for hazardous air pollutants: rubber tire manufacturing.* This standard applies to a rubber tire manufacturing facility that is located at, or is a part of, a major source of hazardous air pollutant (HAP) emissions. Rubber tire manufacturing includes the production of rubber tires and/or the production of components integral to rubber tires, the production of tire cord, and the application of puncture sealant. (Part 63, Subpart XXXX)

*cy. Emission standards for hazardous air pollutants for stationary combustion turbines.* These standards apply to stationary combustion turbines which are located at a major source of hazardous air pollutant emissions. Several subcategories have been defined within the stationary combustion turbine source category. Each subcategory has distinct requirements as specified in the standards. These standards do not apply to stationary combustion turbines located at an area source of hazardous air pollutant emissions. (Part 63, Subpart YYYY)

*cz. Emission standards for stationary reciprocating internal combustion engines.* These standards apply to new and existing major sources and to new and existing area sources with stationary reciprocating internal combustion engines (RICE). For purposes of these standards, stationary RICE

means any reciprocating internal combustion engine which uses reciprocating motion to convert heat energy into mechanical work and which is not mobile. (Part 63, Subpart ZZZZ)

*da. Emission standards for hazardous air pollutants for lime manufacturing plants.* These standards regulate hazardous air pollutant emissions from new and existing lime manufacturing plants that are major sources, are colocated with major sources, or are part of major sources. Additional applicability criteria and exemptions from these standards may apply. (Part 63, Subpart AAAAA)

*db. Emission standards for hazardous air pollutants: semiconductor manufacturing.* These standards apply to new and existing major sources with semiconductor manufacturing. (Part 63, Subpart BBBBB)

*dc. Emission standards for hazardous air pollutants for coke ovens: pushing, quenching, and battery stacks.* This standard applies to a new or existing coke oven battery at a plant that is a major source of HAP emissions. (Part 63, Subpart CCCCC)

*dd. Emission standards for industrial, commercial and institutional boilers and process heaters.* These standards apply to new and existing major sources with industrial, commercial or institutional boilers and process heaters. (Part 63, Subpart DDDDD)\*

\*As of April 15, 2009, the adoption by reference of Part 63, Subpart DDDDD, is rescinded. On July 30, 2007, the United States Court of Appeals for the District of Columbia Circuit issued its mandate vacating 40 CFR Part 63, Subpart DDDDD, in its entirety, and requiring EPA to repromulgate final standards for industrial, commercial or institutional boilers and process heaters at new and existing major sources.

*de. Emission standards for hazardous air pollutants for iron and steel foundaries.* These standards apply to each new or existing iron and steel foundary that is a major source of hazardous air pollutant emissions. A new affected source is an iron and steel foundary for which construction or reconstruction began after December 23, 2002. An existing affected source is an iron and steel foundary for which construction or reconstruction began on or before December 23, 2002. (Part 63, Subpart EEEEE)

*df. Emission standards for hazardous air pollutants for integrated iron and steel manufacturing.* These standards apply to affected sources at an integrated iron and steel manufacturing facility that is, or is part of, a major source of hazardous air pollutant emissions. The affected sources are each new or existing sinter plant, blast furnace, and basic oxygen process furnace (BOPF) shop at an integrated iron and steel manufacturing facility that is, or is part of, a major source of hazardous air pollutant emissions. (Part 63, Subpart FFFFF)

*dg. Emission standards for hazardous air pollutants: site remediation.* These standards apply to new and existing major sources with certain types of site remediation activity on the source's property or on a contiguous property. These standards control hazardous air pollutant (HAP) emissions at major sources where remediation technologies and practices are used at the site to clean up contaminated environmental media (e.g., soil, groundwater, or surface water) or certain stored or disposed materials that pose a reasonable potential threat to contaminate environmental media.

Some site remediations already regulated by rules established under the Comprehensive Environmental Response and Compensation Liability Act (CERCLA) or the Resource Conservation and Recovery Act (RCRA) are not subject to these standards, as specified in Subpart GGGGG. There are also exemptions for short-term remediation and for certain leaking underground storage tanks, as specified in Subpart GGGGG. (Part 63, Subpart GGGGG)

*dh. Emission standards for hazardous air pollutants for miscellaneous coating manufacturing.* These standards establish emission limits and work practice requirements for new and existing miscellaneous coating manufacturing operations, including, but not limited to, process vessels, storage tanks, wastewater, transfer operations, equipment leaks, and heat exchange systems. (Part 63, Subpart HHHHH)

*di. Emission standards for mercury emissions from mercury cell chlor-alkali plants.* These standards apply to the chlorine production source category. This source category contains the mercury cell chlor-alkali plant subcategory and includes all plants engaged in the manufacture of chlorine and caustic in mercury cells. These standards define two affected sources: mercury cell chlor-alkali production facilities and mercury recovery facilities. (Part 63, Subpart IIIII)

*dj. Emission standards for hazardous air pollutants for brick and structural clay products manufacturing.* Rescinded IAB 2/15/17, effective 3/22/17.

*dk. Emission standards for hazardous air pollutants for clay ceramics manufacturing.* Rescinded IAB 2/15/17, effective 3/22/17.

*dl. Emission standards for hazardous air pollutants: asphalt processing and asphalt roofing manufacturing.* This standard applies to an existing or new asphalt processing or asphalt roofing manufacturing facility that is a major source of hazardous air pollutants (HAPs) emissions, or is located at, or is part of a major source of HAP emissions. (Part 63, Subpart LLLLL)

*dm. Emission standards for hazardous air pollutants: flexible polyurethane foam fabrication operations.* This standard applies to a new or existing source at a flexible polyurethane foam fabrication facility. The standard defines two affected sources (units or collections of units to which a given standard or limit applies) corresponding to the two subcategories, loop slitter adhesive use or flame lamination. (Part 63, Subpart MMMMM)

*dn. Emission standards for hazardous air pollutants: hydrochloric acid production.* This standard applies to a new or existing HCl production facility that produces a liquid HCl product at a concentration of 30 weight percent or greater during its normal operations and is located at, or is part of, a major source of HAP. This does not include HCl production facilities that only occasionally produce liquid HCl product at a concentration of 30 weight percent or greater. (Part 63, Subpart NNNNN)

*do.* Reserved.

*dp. Emission standards for hazardous air pollutants: engine test cells/stands.* This standard applies to an engine test cell/stand that is located at a major source of HAP emissions. An engine test cell/stand is any apparatus used for testing uninstalled stationary or uninstalled mobile engines. (Part 63, Subpart PPPPP)

*dq. Emission standards for hazardous air pollutants for friction materials manufacturing facilities.* This standard applies to a new or existing friction materials manufacturing facility that is (or is part of) a major source of hazardous air pollutants (HAPs) emissions. Friction materials manufacturing facilities produce friction materials for use in brake and clutch assemblies. (Part 63, Subpart QQQQQ)

*dr. Emission standards for hazardous air pollutants: taconite iron ore processing.* Rescinded IAB 3/18/15, effective 4/22/15.

*ds. Emission standards for hazardous air pollutants for refractory products manufacturing.* This standard applies to a new or existing refractory products manufacturing facility that is, is located at, or is part of, a major source of hazardous air pollutant (HAP) emissions. (Part 63, Subpart SSSSS)

*dt. Emission standards for hazardous air pollutants: primary magnesium refining.* Rescinded IAB 3/18/15, effective 4/22/15.

*du.* Reserved.

*dv.* Reserved.

*dw. Emission standards for hazardous air pollutants for hospital ethylene oxide sterilizer area sources.* This standard applies to a hospital that is an area source for hazardous air pollutant emissions and that owns or operates a new or existing ethylene oxide sterilization facility. (Part 63, Subpart WWWW)

*dx.* Reserved.

*dy. Emission standards for hazardous air pollutants for electric arc furnace steelmaking area sources.* This standard applies to new or existing electric arc furnace (EAF) steelmaking facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart YYYYY)

*dz. Emission standards for hazardous air pollutants for iron and steel foundry area sources.* This standard applies to new or existing iron and steel foundries that are area sources for hazardous air pollutant emissions. (Part 63, Subpart ZZZZZ)

*ea.* Reserved.

*eb. Emission standards for hazardous air pollutants for gasoline distribution area sources: bulk terminals, bulk plants and pipeline facilities.* This standard applies to new and existing bulk gasoline terminals, pipeline breakout stations, pipeline pumping stations and bulk gasoline plants that are area sources for hazardous air pollutant emissions. (Part 63, Subpart BBBBB)

*ec. Emission standards for hazardous air pollutants for area sources: gasoline dispensing facilities.* This standard applies to new and existing gasoline dispensing facilities (GDF) that are area sources for hazardous air pollutant emissions. The affected equipment includes each gasoline cargo tank during delivery of product to GDF and also includes each storage tank. The equipment used for refueling of motor vehicles is not covered under these standards. (Part 63, Subpart CCCCCC)

*ed.* Reserved.

*ee.* Reserved.

*ef.* Reserved.

*eg.* Reserved.

*eh. Emission standards for hazardous air pollutants for area sources: paint stripping and miscellaneous surface coating operations.* This standard applies to new or existing area sources of hazardous air pollutant emissions that engage in any of the following activities: (1) paint stripping operations that use methylene chloride (MeCl)-containing paint stripping formulations; (2) spray application of coatings to motor vehicles or mobile equipment; or (3) spray application of coatings to plastic or metal substrate with coatings that contain compounds of chromium (Cr), lead (Pb), manganese (Mn), nickel (Ni) or cadmium (Cd). (Part 63, Subpart HHHHHH)

*ei.* Reserved.

*ej. Emission standards for hazardous air pollutants for area sources: industrial, commercial, and institutional boilers.* This standard applies to new and existing industrial, commercial and institutional boilers that are area sources for hazardous air pollutant emissions. (Part 63, Subpart JJJJJJ)

*ek.* Reserved.

*el. Emission standards for hazardous air pollutants for acrylic and modacrylic fibers production area sources.* This standard applies to acrylic and modacrylic fibers production plants that are area sources for hazardous air pollutant emissions. (Part 63, Subpart LLLLLL)

*em. Emission standards for hazardous air pollutants for carbon black production area sources.* This standard applies to carbon black production plants that are area sources for hazardous air pollutants. (Part 63, Subpart MMMMMM)

*en. Emission standards for hazardous air pollutants for chemical manufacturing of chromium compounds area sources.* This standard applies to plants that produce chromium compounds and are area sources for hazardous air pollutants. (Part 63, Subpart NNNNNN)

*eo. Emission standards for hazardous air pollutants for flexible polyurethane foam production and fabrication area sources.* This standard applies to plants that produce flexible polyurethane foam or rebond foam, and plants that fabricate polyurethane foam, that are area sources for hazardous air pollutants. This standard applies to both new and existing area sources. An affected source is existing if construction or reconstruction commenced on or before April 4, 2007. An affected source is new if construction or reconstruction commenced after April 4, 2007. (Part 63, Subpart OOOOOO)

*ep. Emission standards for hazardous air pollutants for lead acid battery manufacturing area sources.* This standard applies to lead acid battery manufacturing plants that are area sources for hazardous air pollutants. Affected sources include all grid casting facilities, paste mixing facilities, three-process operation facilities, lead oxide manufacturing facilities, lead reclamation facilities, and any other lead-emitting operation that is associated with a lead acid battery manufacturing plant. This standard applies to both new and existing area sources. An affected source is existing if construction or reconstruction commenced on or before April 4, 2007. An affected source is new if construction or reconstruction commenced after April 4, 2007. (Part 63, Subpart PPPPPP)

*eq. Emission standards for hazardous air pollutants for wood preserving area sources.* This standard applies to wood preserving operations that are area sources for hazardous air pollutants. This standard applies to both new and existing area sources. An affected source is existing if construction or reconstruction commenced on or before April 4, 2007. An affected source is new if construction or reconstruction commenced after April 4, 2007. (Part 63, Subpart QQQQQQ)

*er. Emission standards for hazardous air pollutants for clay ceramics manufacturing area sources.* This standard applies to any new or existing clay ceramics manufacturing facility with an atomized glaze spray booth or kiln that fires glazed ceramic ware, that processes more than 50 tons

per year of wet clay, and that is an area source for hazardous air pollutant emissions. (Part 63, Subpart RRRRRR)

*es. Emission standards for hazardous air pollutants for glass manufacturing area sources.* This standard applies to any new or existing glass manufacturing facility that is an area source for hazardous air pollutant emissions and meets the following criteria: (1) manufactures flat glass, glass containers or pressed and blown glass by melting a mixture of raw materials to produce molten glass and form the molten glass into sheets, containers or other shapes; and (2) uses one or more continuous furnaces to produce glass at a rate of at least 50 tons per year and that contains compounds of one or more “glass manufacturing metal HAP,” as defined in 40 CFR 63.11459, as raw materials in a glass manufacturing batch formulation. (Part 63, Subpart SSSSSS)

*et. Emissions standards for hazardous air pollutants for secondary nonferrous metals processing area sources.* This standard applies to any new or existing secondary nonferrous metals processing facility that is an area source for hazardous air pollutant emissions. This standard applies to all crushing and screening operations at a secondary zinc processing facility and to all furnace melting operations located at any secondary nonferrous metals processing facility. (Part 63, Subpart TTTTTT)

*eu.* Reserved.

*ev. Emission standards for hazardous air pollutants for area sources: chemical manufacturing.* This standard applies to chemical manufacturing at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart VVVVVV)

*ew. Emission standards for hazardous air pollutants for area sources: plating and polishing.* This standard applies to plating and polishing activities at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart WWWWWW)

*ex. Emission standards for hazardous air pollutants for area sources: metal fabrication and finishing.* This standard applies to new and existing facilities in which the primary activity or activities at the facility are metal fabrication and finishing and that are area sources for hazardous air pollutant emissions. (Part 63, Subpart XXXXXX)

*ey.* Reserved.

*ez. Emission standards for hazardous air pollutants for area sources: aluminum, copper, and other nonferrous foundries.* This standard applies to aluminum, copper, and other nonferrous foundries at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart ZZZZZZ)

*fa.* and *fb.* Reserved.

*fc. Emission standards for hazardous air pollutants for area sources: paint and allied products manufacturing.* This standard applies to paint and allied products manufacturing at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart CCCCCC)

*fd. Emission standards for hazardous air pollutants for area sources: prepared feeds manufacturing.* This standard applies to prepared feeds manufacturing that produces animal feed products (not including feed for cats or dogs) and uses chromium or manganese compounds at new and existing facilities that are area sources for hazardous air pollutant emissions. (Part 63, Subpart DDDDDDD)

**23.1(5) Emission guidelines.** The emission guidelines and compliance times for existing sources, as defined in 40 Code of Federal Regulations Part 60 as amended through June 9, 2006, shall apply to the following affected facilities. The corresponding 40 CFR Part 60 subpart designation is in parentheses. An earlier date for adoption by reference may be included with the subpart designation in parentheses. The control of the designated pollutants will be in accordance with federal standards established in Sections 111 and 129 of the Act and 40 CFR Part 60, Subpart B (Adoption and Submittal of State Plans for Designated Facilities), and the applicable subpart(s) for the existing source. Reference test methods (Appendix A), performance specifications (Appendix B), determination of emission rate change (Appendix C), quality assurance procedures (Appendix F) and the general provisions (Subpart A) of 40 CFR Part 60 also apply to the affected facilities.

*a. Emission guidelines for municipal solid waste landfills (Subpart Cc).* Emission guidelines and compliance times for the control of certain designated pollutants from designated municipal solid waste

landfills shall be in accordance with federal standards established in Subparts Cc (Emission Guidelines and Compliance Times for Municipal Solid Waste Landfills) and WWW (Standards of Performance for Municipal Solid Waste Landfills) of 40 CFR Part 60 as amended through April 10, 2000.

(1) Definitions. For the purpose of 23.1(5)“a,” the definitions have the same meaning given to them in the Act and 40 CFR Part 60, Subparts A (General Provisions), B, and WWW, if not defined in this subparagraph.

“*Municipal solid waste landfill*” or “*MSW landfill*” means an entire disposal facility in a contiguous geographical space where household waste is placed in or on land. An MSW landfill may also receive other types of RCRA Subtitle D wastes such as commercial solid waste, nonhazardous sludge, and industrial solid waste. Portions of an MSW landfill may be separated by access roads. An MSW landfill may be publicly or privately owned. An MSW landfill may be a new MSW landfill, an existing MSW landfill or a lateral expansion.

(2) Designated facilities.

1. The designated facility to which the emission guidelines apply is each existing MSW landfill for which construction, reconstruction or modification was commenced before May 30, 1991.

2. Physical or operational changes made to an existing MSW landfill solely to comply with an emission guideline are not considered a modification or reconstruction and would not subject an existing MSW landfill to the requirements of 40 CFR Part 60, Subpart WWW (40 CFR 60.750).

3. For MSW landfills subject to rule 567—22.101(455B) only because of applicability to subparagraph 23.1(5)“a”(2), the following apply for obtaining and maintaining a Title V operating permit under 567—22.104(455B):

The owner or operator of an MSW landfill with a design capacity less than 2.5 million megagrams or 2.5 million cubic meters is not required to obtain an operating permit for the landfill.

The owner or operator of an MSW landfill with a design capacity greater than or equal to 2.5 million megagrams and 2.5 million cubic meters on or before June 22, 1998, becomes subject to the requirements of 567—subrule 22.105(1) on September 20, 1998. This requires the landfill to submit a Title V permit application to the Air Quality Bureau, Department of Natural Resources, no later than September 20, 1999.

The owner or operator of a closed MSW landfill does not have to maintain an operating permit for the landfill if either of the following conditions are met: the landfill was never subject to the requirement for a control system under subparagraph 23.1(5)“a”(3); or the owner or operator meets the conditions for control system removal specified in 40 CFR § 60.752(b)(2)(v).

(3) Emission guidelines for municipal solid waste landfill emissions.

1. MSW landfill emissions at each MSW landfill meeting the conditions below shall be controlled. A design capacity report must be submitted to the director by November 18, 1997.

The landfill has accepted waste at any time since November 8, 1987, or has additional design capacity available for future waste deposition.

The landfill has a design capacity greater than or equal to 2.5 million megagrams and 2.5 million cubic meters. The landfill may calculate design capacity in either megagrams or cubic meters for comparison with the exemption values. Any density conversions shall be documented and submitted with the report. All calculations used to determine the maximum design capacity must be included in the design capacity report.

The landfill has a nonmethane organic compound (NMOC) emission rate of 50 megagrams per year or more. If the MSW landfill’s design capacity exceeds the established thresholds in 23.1(5)“a”(3)“1,” the NMOC emission rate calculations must be provided with the design capacity report.

2. The planning and installation of a collection and control system shall meet the conditions provided in 40 CFR 60.752(b)(2) at each MSW landfill meeting the conditions in 23.1(5)“a”(3)“1.”

3. MSW landfill emissions collected through the use of control devices must meet the following requirements, except as provided in 40 CFR 60.24 after approval by the Director and U.S. Environmental Protection Agency.

An open flare designed and operated in accordance with the parameters established in 40 CFR 60.18; a control system designed and operated to reduce NMOC by 98 weight percent; or an enclosed combustor

designed and operated to reduce the outlet NMOC concentration to 20 parts per million as hexane by volume, dry basis at 3 percent oxygen, or less.

(4) Test methods and procedures. The following must be used:

1. The calculation of the landfill NMOC emission rate listed in 40 CFR 60.754, as applicable, to determine whether the landfill meets the condition in 23.1(5)“a”(3)“3”;
2. The operational standards in 40 CFR 60.753;
3. The compliance provisions in 40 CFR 60.755; and
4. The monitoring provisions in 40 CFR 60.756.

(5) Reporting and record-keeping requirements. The record-keeping and reporting provisions listed in 40 CFR 60.757 and 60.758, as applicable, except as provided under 40 CFR 60.24 after approval by the Director and U.S. Environmental Protection Agency, shall be used.

(6) Compliance times.

1. Except as provided for under 23.1(5)“a”(6)“2,” planning, awarding of contracts, and installation of MSW landfill air emission collection and control equipment capable of meeting the emission guidelines established under 23.1(5)“a”(3) shall be accomplished within 30 months after the date the initial NMOC emission rate report shows NMOC emissions greater than or equal to 50 megagrams per year.

2. For each existing MSW landfill meeting the conditions in 23.1(5)“a”(3)“1” whose NMOC emission rate is less than 50 megagrams per year on August 20, 1997, installation of collection and control systems capable of meeting emission guidelines in 23.1(5)“a”(3) shall be accomplished within 30 months of the date when the condition in 23.1(5)“a”(3)“1” is met (i.e., the date of the first annual nonmethane organic compounds emission rate which equals or exceeds 50 megagrams per year).

*b. Emission guidelines for hospital/medical/infectious waste incinerators (Subpart Ce).* This paragraph contains emission guidelines and compliance times for the control of certain designated pollutants from hospital/medical/infectious waste incinerator(s) (HMIWI) in accordance with Subparts Ce and Ec (Standards of Performance for Hospital/Medical/Infectious Waste Incinerators) of 40 CFR Part 60.\*

\*As of November 24, 2010, the emission guidelines for hospital/medical/infectious waste incinerators (Subpart Ce) are rescinded.

*c. Emission guidelines and compliance schedules for existing commercial and industrial solid waste incineration units that commenced construction on or before November 30, 1999.* Emission guidelines and compliance schedules for the control of designated pollutants from affected commercial and industrial solid waste incinerators that commenced construction on or before November 30, 1999, shall be in accordance with requirements established in Subpart III of 40 CFR Part 62 and 40 CFR §62.3916 as adopted through August 24, 2004.

*d. Emission guidelines for mercury for coal-fired electric utility steam generating units.* Rescinded IAB 10/7/09, effective 11/11/09.

**23.1(6) Calculation of emission limitations based upon stack height.** This rule sets limits for the maximum stack height credit to be used in ambient air quality modeling for the purpose of setting an emission limitation and calculating the air quality impact of a source. The rule does not limit the actual physical stack height for any source.

For the purpose of this subrule, definitions of “stack,” “a stack in existence,” “dispersion technique,” “nearby” and “excessive concentration” as set forth in 40 CFR §§ 51.100(ff) through (hh), (jj) and (kk) as amended through June 14, 1996, are adopted by reference.

*a. “Good engineering practice (GEP) stack height” means the greater of:*

- (1) Sixty-five meters, measured from the ground level elevation at the base of the stack; or
- (2) For stacks in existence on January 12, 1979, and for which the owner and operator had obtained all applicable permits or approvals required under 567—Chapter 22 and 40 CFR § 52.21 as amended through June 13, 2007,

$$H_g = 2.5H$$

provided the owner or operator produces evidence that this equation was actually relied on in establishing an emission limitation;

For all other stacks,

$$H_g = H + 1.5L$$

where:

$H_g$  = good engineering practice stack height, measured from the ground level elevation at the base of the stack,

$H$  = height of nearby structure(s) measured from the ground level elevation at the base of the stack,

$L$  = lesser dimension, height or projected width, of nearby structure(s), provided that the department may require the use of a field study or fluid model to verify GEP stack height for the source; or

(3) The height demonstrated by a fluid model or a field study approved by the department, which ensures that the emissions from a stack do not result in excessive concentrations of any air pollutant as a result of atmospheric downwash, wakes, or eddy effects created by the source itself, nearby structures or nearby terrain features. Public notification of the availability of such study and opportunity for public hearing are required prior to approval by the department.

*b.* The degree of emission limitation required for control of any air contaminant under this chapter shall not be affected in any manner by:

(1) The consideration of that portion of a stack which exceeds GEP stack height; or

(2) Varying the rate of emission of a pollutant according to atmospheric conditions or ambient concentrations of that pollutant; or

(3) Increasing final exhaust gas plume rise by manipulating source process parameters, exhaust gas parameters, stack parameters, or combined exhaust gases from several existing stacks into one stack; or other selective handling of exhaust gas streams so as to increase gas plume rise.

This rule is intended to implement Iowa Code section 455B.133.

[ARC 7565B, IAB 2/11/09, effective 3/18/09; ARC 7623B, IAB 3/11/09, effective 4/15/09; ARC 8216B, IAB 10/7/09, effective 11/11/09; ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 9154B, IAB 10/20/10, effective 11/24/10 (See Delay note at end of chapter) (See Rescission note at end of chapter); ARC 0329C, IAB 9/19/12, effective 10/24/12; ARC 1014C, IAB 9/18/13, effective 10/23/13; ARC 1561C, IAB 8/6/14, effective 9/10/14; ARC 1913C, IAB 3/18/15, effective 4/22/15; ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

### **567—23.2(455B) Open burning.**

**23.2(1) Prohibition.** No person shall allow, cause or permit open burning of combustible materials, except as provided in 23.2(2) and 23.2(3).

**23.2(2) Variances from rules.** Any person wishing to conduct open burning of materials not exempted in 23.2(3) may make application for a variance as specified in 567—subrule 21.2(1). In addition to requiring the information specified under 567—subrule 21.2(1), the director may require any person applying for a variance from the open burning rules to submit adequate documentation to allow the director to assess whether granting the variance will hinder attainment or maintenance of a National Ambient Air Quality Standard (NAAQS).

**23.2(3) Exemptions.** The open burning exemptions specified in this subrule shall not be construed as exemptions from any other applicable environmental regulations. In particular, the exemptions contained in this subrule do not absolve any person from compliance with the rules for solid waste disposal, including ash disposal, and solid waste permitting contained in 567—Chapters 100 through 130 or the rules for storm water runoff and storm water permitting contained in 567—Chapters 60 and 64. The following shall be permitted unless prohibited by local ordinances or regulations.

*a. Disaster rubbish.* The open burning of rubbish, including landscape waste, for the duration of the community disaster period in cases where an officially declared emergency condition exists. Burning of any structures or demolished structures shall be conducted in accordance with 40 CFR Section 61.145 as amended through January 16, 1991, which is the “Standard for Demolition and Renovation” of the asbestos National Emission Standard for Hazardous Air Pollutants.

*b. Trees and tree trimmings.* The open burning of trees and tree trimmings not originated on the premises provided that the burning site is operated by a local governmental entity, the burning site is fenced and access is controlled, burning is conducted on a regularly scheduled basis and is supervised at all times, burning is conducted only when weather conditions are favorable with respect to surrounding property, and the burning site is limited to areas at least one-quarter mile from any inhabited building

unless a written waiver in the form of an affidavit is submitted by the owner of the building to the department and to the local governmental entity prior to the first instance of open burning at the site which occurs after November 13, 1996. The written waiver shall become effective only upon recording in the office of the recorder of deeds of the county in which the inhabited building is located. However, when the open burning of trees and tree trimmings causes air pollution as defined in Iowa Code section 455B.131(3), the department may take appropriate action to secure relocation of the burning operation. Rubber tires shall not be used to ignite trees and tree trimmings.

This exemption shall not apply within the area classified as the PM10 (inhalable) particulate Group II area of Mason City. This Group II area is described as follows: the area in Cerro Gordo County, Iowa, in Lincoln Township including Sections 13, 24 and 25; in Lime Creek Township including Sections 18, 19, 20, 21, 27, 28, 29, 30, 31, 32, 33, 34 and 35; in Mason Township the W ½ of Section 1, Sections 2, 3, 4, 5, 8, 9, the N ½ of Section 11, the NW ¼ of Section 12, the N ½ of Section 16, the N ½ of Section 17 and the portions of Sections 10 and 15 north and west of the line from U.S. Highway 18 south on Kentucky Avenue to 9th Street SE; thence west on 9th Street SE to the Minneapolis and St. Louis railroad tracks; thence south on Minneapolis and St. Louis railroad tracks to 19th Street SE; thence west on 19th Street SE to the section line between Sections 15 and 16.

*c. Flare stacks.* The open burning or flaring of waste gases, providing such open burning or flaring is conducted in compliance with 23.3(2) “d” and 23.3(3) “e.”

*d. Landscape waste.* The disposal by open burning of landscape waste originating on the premises. However, the burning of landscape waste produced in clearing, grubbing and construction operations shall be limited to areas located at least one-fourth mile from any building inhabited by other than the landowner or tenant conducting the open burning. Rubber tires shall not be used to ignite landscape waste.

*e. Recreational fires.* Open fires for cooking, heating, recreation and ceremonies, provided they comply with 23.3(2) “d.” Burning rubber tires is prohibited from this activity.

*f. Residential waste.* Backyard burning of residential waste at dwellings of four-family units or less. The adoption of more restrictive ordinances or regulations of a governing body of the political subdivision, relating to control of backyard burning, shall not be precluded by these rules.

*g. Training fires.* For purposes of subrule 23.2(3), a “training fire” is a fire set for the purposes of conducting bona fide training of public or industrial employees in firefighting methods. For purposes of this paragraph, “bona fide training” means training that is conducted according to the National Fire Protection Association 1403 Standard of Live Fire Training Evolutions (2002 Edition) or a comparable training fire standard. A training fire may be conducted, provided that all of the following conditions are met:

- (1) A training fire on a building is conducted with the building structurally intact.
- (2) The training fire does not include the controlled burn of a demolished building.
- (3) If the training fire is to be conducted on a building, written notification is provided to the department on DNR Form 542-8010, Notification of an Iowa Training Fire-Demolition or a Controlled Burn of a Demolished Building, and is postmarked or delivered to the director at least ten working days before such action commences.

- (4) Notification shall be made in accordance with 40 CFR Section 61.145, “Standard for Demolition and Renovation” of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991.

- (5) All asbestos-containing materials shall be removed prior to the training fire.

- (6) Asphalt roofing may be burned in the training fire only if notification to the director contains testing results indicating that none of the layers of asphalt roofing contain asbestos. During each calendar year, each fire department may conduct no more than two training fires on buildings where asphalt roofing has not been removed, provided that for each of those training fires the asphalt roofing material present has been tested to ensure that it does not contain asbestos. Each fire department’s limit on the burning of asphalt roofing shall include both training fires and the controlled burning of a demolished building, as specified in 23.2(3) “j.”

- (7) Rubber tires shall not be burned during a training fire.

*h. Paper or plastic pesticide containers and seed corn bags.* The disposal by open burning of paper or plastic pesticide containers (except those formerly containing organic forms of beryllium, selenium, mercury, lead, cadmium or arsenic) and seed corn bags resulting from farming activities occurring on the premises. Such open burning shall be limited to areas located at least one-fourth mile from any building inhabited by other than the landowner or tenant conducting the open burning, livestock area, wildlife area, or water source. The amount of paper or plastic pesticide containers and seed corn bags that can be disposed of by open burning shall not exceed one day's accumulation or 50 pounds, whichever is less. However, when the burning of paper or plastic pesticide containers or seed corn bags causes a nuisance, the director may take action to secure relocation of the burning operation. Since the concentration levels of pesticide combustion products near the fire may be hazardous, the person conducting the open burning should take precautions to avoid inhalation of the pesticide combustion products.

*i. Agricultural structures.* The open burning of agricultural structures, provided that the open burning occurs on the premises and, for agricultural structures located within a city or town, at least one-fourth mile from any building inhabited by a person other than the landowner, a tenant, or an employee of the landowner or tenant conducting the open burning unless a written waiver in the form of an affidavit is submitted by the owner of the building to the department prior to the open burning; all chemicals and asphalt roofing are removed; burning is conducted only when weather conditions are favorable with respect to surrounding property; and permission from the local fire chief is secured in advance of the burning. Rubber tires shall not be used to ignite agricultural structures. The asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991, requires the burning of agricultural structures to be conducted in accordance with 40 CFR Section 61.145, "Standard for Demolition and Renovation."

For the purposes of this subrule, "agricultural structures" means barns, machine sheds, storage cribs, animal confinement buildings, and homes located on the premises and used in conjunction with crop production, livestock or poultry raising and feeding operations. "Agricultural structures," for asbestos NESHAP purposes, includes all of the above, with the exception of a single residential structure on the premises having four or fewer dwelling units, which has been used only for residential purposes.

*j. Controlled burning of a demolished building.* A city, as "city" is defined in Iowa Code section 362.2(4), with approval of its council, as "council" is defined in Iowa Code section 362.2(8), may conduct a controlled burn of a demolished building. A city is the only party that may conduct such a burn and is responsible for ensuring that all of the following conditions are met:

(1) *Prohibition.* The controlled burning of a demolished building is prohibited within the city limits of Cedar Rapids, Marion, Hiawatha, Council Bluffs, Carter Lake, Des Moines, West Des Moines, Clive, Windsor Heights, Urbandale, Pleasant Hill, Buffalo, Davenport, Mason City or any other area where area-specific state implementation plans require the control of particulate matter.

(2) *Notification requirements.* For each building proposed to be burned, the city fire department or a city official, on behalf of the city, shall submit to the department a completed notification postmarked at least 10 working days prior to commencing demolition and at least 30 days before the proposed controlled burn commences. Documentation of city council approval shall be submitted with the notification. Information required to be provided shall include: the exact location of the burn site; the approximate distance to the nearest neighboring residence or business; the method used by the city to notify nearby residents of the proposed burn; an explanation of why alternative methods of demolition debris management are not being used; and information required by 40 CFR Section 61.145, "Standard for Demolition and Renovation" of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991. Notification shall be provided on DNR Form 542-8010, Notification of an Iowa Training Fire-Demolition or a Controlled Burn of a Demolished Building. For burns conducted outside the city limits, the city shall send to the chairperson of the applicable county board a copy of the completed DNR notification form 542-8010 and documentation of city council approval. Notification to the county board shall be postmarked, faxed or sent by electronic mail at least 30 days before the proposed controlled burn commences.

(3) *Asbestos removal requirements.* All asbestos-containing materials shall be removed before the building to be burned is demolished. The department may require proof that any applicable inspection,

notification, removal and demolition occurred, or will occur, in accordance with 40 CFR Section 61.145, “Standard for Demolition and Renovation” of the asbestos National Emission Standard for Hazardous Air Pollutants (NESHAP), as amended through January 16, 1991.

(4) *Requirements for asphalt roofing.* During each calendar year, each city shall conduct no more than two controlled burns of a demolished building in which asphalt roofing has not been removed, provided that for each controlled burn of a demolished building the asphalt roofing material present has been tested to ensure that it does not contain asbestos. Each city’s limit on the burning of asphalt roofing shall include both the controlled burning of a demolished building and training fires, as specified in paragraph 23.2(3)“g.”

(5) *Building size limit.* For each proposed controlled burn located within the city limits, more than one demolished building may be included in the burn, provided that the sum total of all building material to be burned at a designated site does not exceed 1700 square feet in size. For a controlled burn site located outside the city limits, the sum total of all building material to be burned, per day, may not exceed 1700 square feet in size. For purposes of this subparagraph, “square feet” includes both finished and unfinished basements and excludes unfinished attics, carports, attached garages, and porches that are not protected from weather.

(6) *Time of day requirements.* The controlled burning of a demolished building may be conducted only between the hours of 6 a.m. and 6 p.m. and only when weather conditions are favorable with respect to surrounding property. The city shall adequately schedule and sufficiently control the burn to ensure that burning is completed by 6 p.m.

(7) *Prohibited materials.* Rubber tires, chemicals, furniture, carpeting, household appliances, vinyl products (such as flooring or siding), trade waste, garbage, rubbish, landscape waste, residential waste, and other nonstructural materials shall not be burned.

(8) *Limits on the number and location of burns.* For burns conducted within the city limits, each city may undertake no more than one controlled burn of demolished building material in every 0.6-mile-radius circle during each calendar year. For burn sites established outside the city limits, each city shall undertake no more than one controlled burn of demolished building material per day. A burn site outside the city limits must be located at least 0.6 of a mile from any building inhabited by a person, as “person” is defined in Iowa Code section 362.2(17).

(9) *Requirements for burn access and supervision.* The city shall control access to all demolished building burn sites. Representatives of the city who are city employees or who are hired by the city shall supervise the burning of demolished building material at all times.

(10) *Record-keeping requirements.* The city shall retain at least one copy of all notifications and supplementary information required to be sent to the department under subparagraph (2). Additionally, the city shall maintain a map of the exact location of each burn site, and supporting documentation showing the date of each demolished building burn and the square feet of building material burned on each date. All maps, notifications and associated records shall be maintained by the city clerk, as “clerk” is defined in Iowa Code section 362.2(7), for a period of at least three years and shall be made available for inspection by the department upon request.

(11) *Variance from this paragraph.* In accordance with 567—subrules 21.2(1) and 23.2(2), a city may apply for a variance from the specific conditions for controlled burning of a demolished building and may request that the director conduct a review of the ambient air impacts of the request. The director shall approve or deny the request in accordance with 567—subrule 21.2(4).

(12) *Compliance with other applicable environmental regulations.* Compliance with the exemption requirements in this paragraph shall not absolve a city of the responsibility to comply with any other applicable environmental regulations. In particular, a city conducting a controlled burn of a demolished building shall comply with all applicable solid waste disposal, including ash disposal, and solid waste permitting rules contained in 567—Chapters 100 through 130, as well as all applicable storm water discharge and storm water permitting rules contained in 567—Chapters 60 and 64.

**23.2(4) Unavailability of exemptions in certain areas.** Notwithstanding 23.2(2) and 23.2(3)“b,” “d,” “f,” and “i,” no person shall allow, cause or permit the open burning of trees or tree trimmings, residential or landscape waste or agricultural structures in the cities of: Cedar Rapids, Marion,

Hiawatha, Council Bluffs, Carter Lake, Des Moines, West Des Moines, Clive, Windsor Heights, Urbandale, and Pleasant Hill.

This rule is intended to implement Iowa Code section 455B.133.

**567—23.3(455B) Specific contaminants.**

**23.3(1) General.** The emission standards contained in this rule shall apply to each source operation unless a performance standard for the process is specified in subrule 23.1(2), in which case the performance standard shall apply.

**23.3(2) Particulate matter.** No person shall cause or allow the emission of particulate matter from any source in excess of the emission standards specified in this chapter, except as provided in 567—Chapter 24.

*a. General emission rate.*

(1) For sources constructed, modified or reconstructed on or after July 21, 1999, the emission of particulate matter from any process shall not exceed an emission standard of 0.1 grain per dry standard cubic foot (dscf) of exhaust gas, except as provided in 567—21.2(455B), 23.1(455B), 23.4(455B), and 567—Chapter 24.

(2) For sources constructed, modified or reconstructed prior to July 21, 1999, the emission of particulate matter from any process shall not exceed the amount determined from Table I, or amount specified in a permit if based on an emission standard of 0.1 grain per standard cubic foot of exhaust gas, or established from standards provided in 23.1(455B) and 23.4(455B).

TABLE I  
ALLOWABLE RATE OF EMISSION BASED ON PROCESS WEIGHT RATE\*

| Process Weight Rate |         | Emission Rate | Process Weight Rate |          | Emission Rate |
|---------------------|---------|---------------|---------------------|----------|---------------|
| Lb/Hr               | Tons/Hr | Lb/Hr         | Lb/Hr               | Tons/Hr  | Lb/Hr         |
| 100                 | 0.05    | 0.55          | 16,000              | 8.00     | 16.5          |
| 200                 | 0.10    | 0.88          | 18,000              | 9.00     | 17.9          |
| 400                 | 0.20    | 1.40          | 20,000              | 10.00    | 19.2          |
| 600                 | 0.30    | 1.83          | 30,000              | 15.00    | 25.2          |
| 800                 | 0.40    | 2.22          | 40,000              | 20.00    | 30.5          |
| 1,000               | 0.50    | 2.58          | 50,000              | 25.00    | 35.4          |
| 1,500               | 0.75    | 3.38          | 60,000              | 30.00    | 40.0          |
| 2,000               | 1.00    | 4.10          | 70,000              | 35.00    | 41.3          |
| 2,500               | 1.25    | 4.76          | 80,000              | 40.00    | 42.5          |
| 3,000               | 1.50    | 5.38          | 90,000              | 45.00    | 43.6          |
| 3,500               | 1.75    | 5.96          | 100,000             | 50.00    | 44.6          |
| 4,000               | 2.00    | 6.52          | 120,000             | 60.00    | 46.3          |
| 5,000               | 2.50    | 7.58          | 140,000             | 70.00    | 47.8          |
| 6,000               | 3.00    | 8.56          | 160,000             | 80.00    | 49.0          |
| 7,000               | 3.50    | 9.49          | 200,000             | 100.00   | 51.2          |
| 8,000               | 4.00    | 10.4          | 1,000,000           | 500.00   | 69.0          |
| 9,000               | 4.50    | 11.2          | 2,000,000           | 1,000.00 | 77.6          |
| 10,000              | 5.00    | 12.0          | 6,000,000           | 3,000.00 | 92.7          |
| 12,000              | 6.00    | 13.6          |                     |          |               |

\*Interpolation of the data in this table for process weight rates up to 60,000 lb/hr shall be accomplished by the use of the equation

$$E=4.10 P^{0.67},$$

and interpolation and extrapolation of the data for process weight rates in excess of 60,000 lb/hr shall be accomplished by use of the equation

$$E=55.0 P^{0.11}-40,$$

where E = rate of emission in lb/hr, and

P = process weight in tons/hr

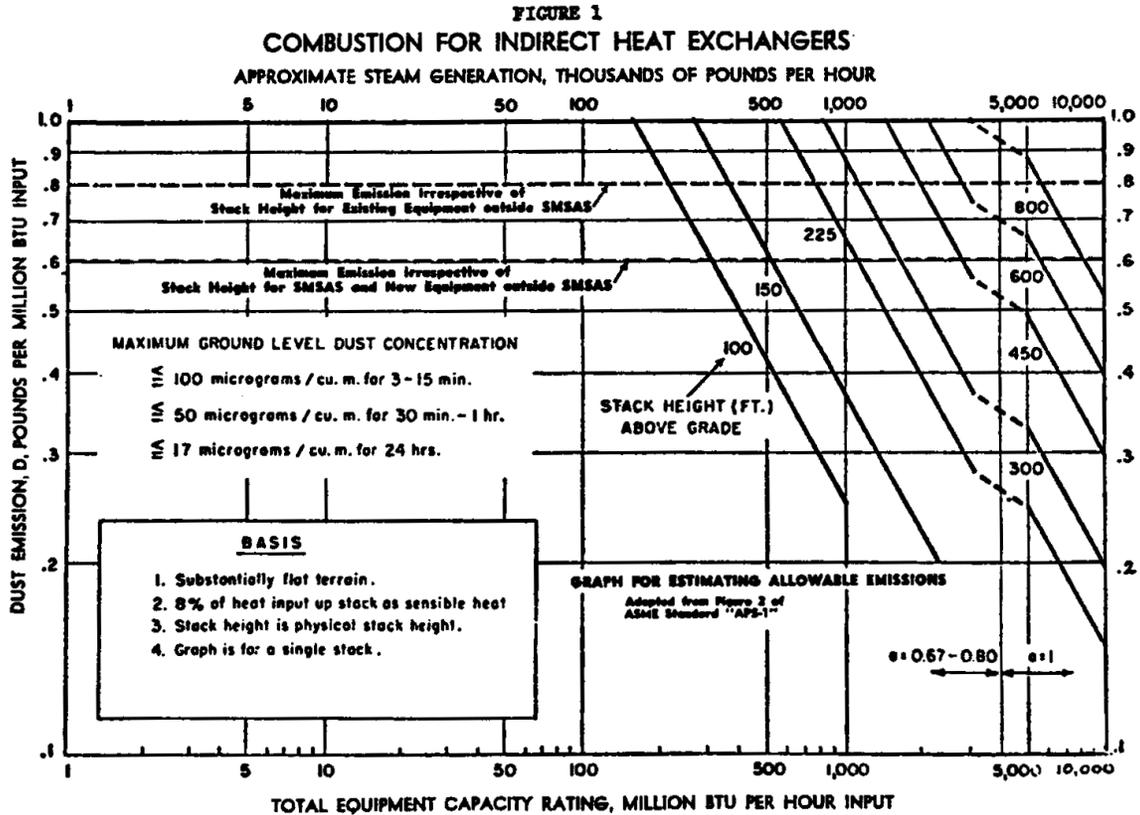
*b. Combustion for indirect heating.* Emissions of particulate matter from the combustion of fuel for indirect heating or for power generation shall be limited by the ASME Standard APS-1, Second Edition, November, 1968, "Recommended Guide for the Control of Dust Emission—Combustion for Indirect Heat Exchangers." For the purpose of this paragraph, the allowable emissions shall be calculated from equation (15) in that standard, with  $C_{max}^2=50$  micrograms per cubic meter. Allowable emissions from a single stack may be estimated from Figure 1. The maximum ground level dust concentrations designated are above the background level. For plants with 4,000 million Btu/hour input or more, the "a" factor shall be 1.0. In plants with less than 4,000 million Btu/hour input, appropriate "a" factors, less than 1.0, shall be applied. Pertinent correction factors, as specified in the standard, shall be applied for installations with multiple stacks. However, for fuel-burning units in operation on January 13, 1976, the maximum allowable emissions calculated under APS-1 for the facility's equipment configuration on January 13, 1976, shall not be increased even if the changes in the equipment or stack configuration would otherwise allow a recalculation and a higher maximum allowable emission under APS-1.

(1) Outside any standard metropolitan statistical area, the maximum allowable emissions from each stack, irrespective of stack height, shall be 0.8 pounds of particulates per million Btu input.

(2) Inside any standard metropolitan statistical area, the maximum allowable emission from each stack, irrespective of stack height, shall be 0.6 pounds of particulates per million Btu input.

(3) For a new fossil fuel-fired steam generating unit of more than 250 million Btu per hour heat input, 23.1(2) "a" shall apply. For a new unit of between 150 million and 250 million (inclusive) Btu per hour heat input, the maximum allowable emissions from such new unit shall be 0.2 pounds of particulates per million Btu of heat input. For a new unit of less than 150 million Btu per hour heat input, the maximum allowable emissions from such new unit shall be 0.6 pounds of particulates per million Btu of heat input.

(4) Measurements of emissions from a particulate source will be made in accordance with the provisions of 567—Chapter 25.



(5) For fuel-burning sources in operation prior to July 29, 1977, which are not subject to 23.1(2) and which significantly impact a primary or secondary particulate standard nonattainment area, the emission limitations specified in this subparagraph apply. A significant impact shall be equal to or exceeding 5 micrograms of particulate matter per cubic meter of air (24-hour average) or 1 microgram of particulate matter per cubic meter of air (annual average) determined by an EPA approved single source dispersion model using allowable emission rates and five-year worst case meteorological conditions. In the case where two or more boilers discharge into a common stack, the applicable stack emission limitation shall be based upon the heat input of the largest operating boiler. The plantwide allowable emission limitation shall be the weighted average of the allowable emission limitations for each stack or the applicable APS-1 plantwide standard as determined under paragraph 23.3(2) "b," whichever is more stringent.

The maximum allowable emission rate for a single stack with a total heat input capacity less than 250 million Btu per hour shall be 0.60 pound of particulate matter per million Btu heat input; the maximum allowable emission rate for a single stack with a total heat input capacity greater than or equal to 250 million Btu per hour and less than 500 million Btu per hour shall be 0.40 pound of particulate matter per million Btu heat input; the maximum allowable emission rate for a single stack with a total heat input capacity greater than or equal to 500 million Btu per hour shall be 0.30 pound of particulate matter per million Btu heat input; except that the maximum allowable emission rate for the stack serving Unit #1 of Iowa Public Service at Port Neal shall be 0.50 pound of particulate matter per million Btu heat input.

All sources regulated under this subparagraph shall demonstrate compliance by October 1, 1981; however, a source is considered to be in compliance with this subparagraph if by October 1, 1981, it is on a compliance schedule to be completed as expeditiously as possible, but no later than December 31, 1982.

*c. Fugitive dust.*

(1) Attainment and unclassified areas. A person shall take reasonable precautions to prevent particulate matter from becoming airborne in quantities sufficient to cause a nuisance as defined in Iowa Code section 657.1 when the person allows, causes or permits any materials to be handled, transported

or stored or a building, its appurtenances or a construction haul road to be used, constructed, altered, repaired or demolished, with the exception of farming operations or dust generated by ordinary travel on unpaved roads. Ordinary travel includes routine traffic and road maintenance activities such as scarifying, compacting, transporting road maintenance surfacing material, and scraping of the unpaved public road surface. All persons, with the above exceptions, shall take reasonable precautions to prevent the discharge of visible emissions of fugitive dusts beyond the lot line of the property on which the emissions originate. The public highway authority shall be responsible for taking corrective action in those cases where said authority has received complaints of or has actual knowledge of dust conditions which require abatement pursuant to this subrule. Reasonable precautions may include, but not be limited to, the following procedures.

1. Use, where practical, of water or chemicals for control of dusts in the demolition of existing buildings or structures, construction operations, the grading of roads or the clearing of land.
2. Application of suitable materials, such as but not limited to asphalt, oil, water or chemicals on unpaved roads, material stockpiles, race tracks and other surfaces which can give rise to airborne dusts.
3. Installation and use of containment or control equipment, to enclose or otherwise limit the emissions resulting from the handling and transfer of dusty materials, such as but not limited to grain, fertilizer or limestone.
4. Covering, at all times when in motion, open-bodied vehicles transporting materials likely to give rise to airborne dusts.
5. Prompt removal of earth or other material from paved streets or to which earth or other material has been transported by trucking or earth-moving equipment, erosion by water or other means.
6. Reducing the speed of vehicles traveling over on-property surfaces as necessary to minimize the generation of airborne dusts.

(2) *Nonattainment areas.* Subparagraph (1) notwithstanding, no person shall allow, cause or permit any visible emission of fugitive dust in a nonattainment area for particulate matter to go beyond the lot line of the property on which a traditional source is located without taking reasonable precautions to prevent emission. Traditional source means a source category for which a particulate emission standard has been established in 23.1(2), 23.3(2) "a," 23.3(2) "b" or 23.4(455B) and includes a quarry operation, haul road or parking lot associated with a traditional source. This paragraph does not modify the emission standard stated in 23.1(2), 23.3(2) "a," 23.3(2) "b" or 23.4(455B), but rather establishes a separate requirement for fugitive dust from such sources. For guidance on the types of controls which may constitute reasonable precautions, see "Identification of Techniques for the Control of Industrial Fugitive Dust Emissions," [available from the department] adopted by the commission on May 19, 1981.

(3) *Reclassified areas.* Reasonable precautions implemented pursuant to the nonattainment area provisions of subparagraph (2) shall remain in effect if the nonattainment area is redesignated to either attainment or unclassified after March 6, 1980.

*d. Visible emissions.* No person shall allow, cause or permit the emission of visible air contaminants into the atmosphere from any equipment, internal combustion engine, premise fire, open fire or stack, equal to or in excess of 40 percent opacity or that level specified in a construction permit, except as provided below and in 567—Chapter 24.

(1) *Residential heating equipment.* Residential heating equipment serving dwellings of four family units or less is exempt.

(2) *Gasoline-powered vehicles.* No person shall allow, cause or permit the emission of visible air contaminants from gasoline-powered motor vehicles for longer than five consecutive seconds.

(3) *Diesel-powered vehicles.* No person shall allow, cause or permit the emission of visible air contaminants from diesel-powered motor vehicles in excess of 40 percent opacity, for longer than five consecutive seconds.

(4) *Diesel-powered locomotives.* No person shall allow, cause or permit the emission of visible air contaminants from diesel-powered locomotives in excess of 40 percent opacity, except for a maximum period of 40 consecutive seconds during acceleration under load, or for a period of four consecutive minutes when a locomotive is loaded after a period of idling.

(5) *Startup and testing.* Initial start and warmup of a cold engine, the testing of an engine for trouble, diagnosis or repair, or engine research and development activities, is exempt.

(6) *Uncombined water.* The provisions of this paragraph shall apply to any emission which would be in violation of these provisions except for the presence of uncombined water, such as condensed water vapor.

**23.3(3) Sulfur compounds.** The provisions of this subrule shall apply to any installation from which sulfur compounds are emitted into the atmosphere.

*a. Sulfur dioxide from use of solid fuels.*

(1) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere from an existing solid fuel-burning unit, (i.e., a unit which was in operation or for which components had been purchased, or which was under construction prior to September 23, 1970), in an amount greater than 6 pounds, replicated maximum three-hour average, per million Btu of heat input if such unit is located within the following counties: Black Hawk, Clinton, Des Moines, Dubuque, Jackson, Lee, Linn, Lousia, Muscatine and Scott.

(2) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere from an existing solid fuel-burning unit, (i.e., a unit which was in operation or for which components had been purchased, or which was under construction prior to September 23, 1970), in an amount greater than 5 pounds, replicated maximum three-hour average, per million Btu of heat input if such unit is located within the remaining 89 counties of the state not listed in subparagraph 23.3(3)“a”(1).

(3) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere from any new solid fuel-burning unit (i.e., a unit which was not in operation or for which components had not been purchased, or which was not under construction prior to September 23, 1970) which has a capacity of 250 million Btu or less per hour heat input, in an amount greater than 6 pounds, replicated maximum three-hour average, per million Btu of heat input.

(4) Subparagraphs (1) through (3) notwithstanding, a fossil fuel-fired steam generator to which 23.1(2)“a,” 23.1(2)“z” or 23.1(2)“ccc” applies shall comply with 23.1(2)“a,” 23.1(2)“z” or 23.1(2)“ccc,” respectively.

*b. Sulfur dioxide from use of liquid fuels.*

(1) No person shall allow, cause, or permit the combustion of number 1 or number 2 fuel oil exceeding a sulfur content of 0.5 percent by weight.

(2) No person shall allow, cause, or permit the emission of sulfur dioxide into the atmosphere in an amount greater than 2.5 pounds of sulfur dioxide, replicated maximum three-hour average, per million Btu of heat input from a liquid fuel-burning unit.

(3) Notwithstanding this paragraph, a fossil fuel-fired steam generator to which 23.1(2)“a,” 23.1(2)“z” or 23.1(2)“ccc” applies shall comply with 23.1(2)“a,” 23.1(2)“z” or 23.1(2)“ccc.”

*c. Sulfur dioxide from sulfuric acid manufacture.* After January 1, 1975, no person shall allow, cause or permit the emission of sulfur dioxide from an existing sulfuric acid manufacturing plant in excess of 30 pounds of sulfur dioxide, maximum three-hour average, per ton of product calculated as 100 percent sulfuric acid.

*d. Acid mist from sulfuric acid manufacture.* After January 1, 1974, no person shall allow, cause or permit the emission of acid mist calculated as sulfuric acid from an existing sulfuric acid manufacturing plant in excess of 0.5 pounds, maximum three-hour average, per ton of product calculated as 100 percent sulfuric acid.

*e. Other processes capable of emitting sulfur dioxide.* After January 1, 1974, no person shall allow, cause or permit the emission of sulfur dioxide from any process, other than sulfuric acid manufacture, in excess of 500 parts per million, based on volume. This paragraph shall not apply to devices which have been installed for air pollution abatement purposes where it is demonstrated by the owner of the source that the ambient air quality standards are not being exceeded.

This rule is intended to implement Iowa Code section 455B.133.

[ARC 2949C, IAB 2/15/17, effective 3/22/17]

**567—23.4(455B) Specific processes.**

**23.4(1) General.** The provisions of this rule shall not apply to those facilities for which performance standards are specified in 23.1(2). The emission standards specified in this rule shall apply and those specified in 23.3(2) “a” and 23.3(2) “b” shall not apply to each process of the types listed in the following subrules, except as provided below.

EXCEPTION: Whenever the director determines that a process complying with the emission standard prescribed in this section is causing or will cause air pollution in a specific area of the state, the specific emission standard may be suspended and compliance with the provisions of 23.3(455B) may be required in such instance.

**23.4(2) Asphalt batching plants.** No person shall cause, allow or permit the operation of an asphalt batching plant in a manner such that the particulate matter discharged to the atmosphere exceeds 0.15 grain per standard cubic foot of exhaust gas.

**23.4(3) Cement kilns.** Cement kilns shall be equipped with air pollution control devices to reduce the particulate matter in the gas discharged to the atmosphere to no more than 0.3 percent of the particulate matter entering the air pollution control device. Regardless of the degree of efficiency of the air pollution control device, particulate matter discharged from such kilns shall not exceed 0.1 grain per standard cubic foot of exhaust gas.

**23.4(4) Cupolas for metallurgical melting.** The emissions of particulate matter from all new foundry cupolas, and from all existing foundry cupolas with a process weight rate in excess of 20,000 pounds per hour, shall not exceed the amount specified in paragraph 23.3(2) “a,” except as provided in 567—Chapter 24.

The emissions of particulate matter from all existing foundry cupolas with a process weight rate less than or equal to 20,000 pounds per hour shall not exceed the amount determined from Table II of these rules, except as provided in 567—Chapter 24.

TABLE II  
ALLOWABLE EMISSIONS FROM  
EXISTING SMALL FOUNDRY CUPOLAS

| Process weight rate<br>(lb/hr) | Allowable emission<br>(lb/hr) |
|--------------------------------|-------------------------------|
| 1,000                          | 3.05                          |
| 2,000                          | 4.70                          |
| 3,000                          | 6.35                          |
| 4,000                          | 8.00                          |
| 5,000                          | 9.58                          |
| 6,000                          | 11.30                         |
| 7,000                          | 12.90                         |
| 8,000                          | 14.30                         |
| 9,000                          | 15.50                         |
| 10,000                         | 16.65                         |
| 12,000                         | 18.70                         |
| 16,000                         | 21.60                         |
| 18,000                         | 23.40                         |
| 20,000                         | 25.10                         |

**23.4(5) Electric furnaces for metallurgical melting.** The emissions of particulate matter to the atmosphere from electric furnaces used for metallurgical melting shall not exceed 0.1 grain per standard cubic foot of exhaust gas.

**23.4(6) Sand handling and surface finishing operations in metal processing.** This subrule shall apply to any new foundry or metal processing operation not properly termed a combustion, melting, baking or pouring operation. For purposes of this subrule, a new process is any process which has not started operation, or the construction of which has not been commenced, or the components of which have not been ordered or contracts for the construction of which have not been let on August 1, 1977. No person shall allow, cause or permit the operation of any equipment designed for sand shakeout, mulling, molding, cleaning, preparation, reclamation or rejuvenation or any equipment for abrasive cleaning, shot blasting, grinding, cutting, sawing or buffing in such a manner that particulate matter discharged from any stack exceeds 0.05 grains per dry standard cubic foot of exhaust gas, regardless of the types and number of operations that discharge from the stack.

**23.4(7) Grain handling and processing plants.** The owner or operator of equipment at a permanent installation for the handling or processing of grain, grain products and grain by-products shall not cause, allow or permit the particulate matter discharged to the atmosphere to exceed 0.1 grain per dry standard cubic foot of exhaust gas, except as follows:

*a.* The particulate matter discharged to the atmosphere from a grain bin vent at a country grain elevator, as “country grain elevator” is defined in 567—subrule 22.10(1), shall not exceed 1.0 grain per dry standard cubic foot of exhaust gas.

*b.* The particulate matter discharged to the atmosphere from a grain bin vent that was constructed, modified or reconstructed before March 31, 2008, at a country grain terminal elevator, as “country grain terminal elevator” is defined in 567—subrule 22.10(1), or at a grain terminal elevator, as “grain terminal elevator” is defined in 567—subrule 22.10(1), shall not exceed 1.0 grain per dry standard cubic foot of exhaust gas.

*c.* The particulate matter discharged to the atmosphere from a grain bin vent that is constructed or reconstructed on or after March 31, 2008, at a country grain terminal elevator, as “country grain terminal elevator” is defined in 567—subrule 22.10(1), or at a grain terminal elevator, as “grain terminal elevator” is defined in 567—subrule 22.10(1), shall not exceed 0.1 grain per dry standard cubic foot of exhaust gas.

**23.4(8) Lime kilns.** No person shall cause, allow or permit the operation of a kiln for the processing of limestone such that the particulate matter in the gas discharged to the atmosphere exceeds 0.1 grain per standard cubic foot of exhaust gas.

**23.4(9) Meat smokehouses.** No person shall cause, allow or permit the operation of a meat smokehouse or a group of meat smokehouses, which consume more than ten pounds of wood, sawdust or other material per hour such that the particulate matter discharged to the atmosphere exceeds 0.2 grain per standard cubic foot of exhaust gas.

**23.4(10) Phosphate processing plants.**

*a.* Phosphoric acid manufacture. No person shall allow, cause or permit the operation of equipment for the manufacture of phosphoric acid that was in existence on October 22, 1974, in a manner that produces more than 0.04 pound of fluoride per ton of phosphorous pentoxide or equivalent input.

*b.* Diammonium phosphate manufacture. No person shall allow, cause or permit the operation of equipment for the manufacture of diammonium phosphate that was in existence on October 22, 1974, in a manner that produces more than 0.15 pound of fluoride per ton of phosphorous pentoxide or equivalent input.

*c.* Nitrophosphate manufacture. No person shall allow, cause or permit the operation of equipment for the manufacture of nitrophosphate in a manner that produces more than 0.06 pound of fluoride per ton of phosphorus pentoxide or equivalent input.

*d.* No person shall allow, cause or permit the operation of equipment for the processing of phosphate ore, rock or other phosphatic material (other than equipment used for the manufacture of phosphoric acid, diammonium phosphate or nitrophosphate) in a manner that the unit emissions of fluoride exceed 0.4 pound of fluoride per ton of phosphorous pentoxide or its equivalent input.

*e.* Notwithstanding “*a*” through “*d*,” no person shall allow, cause or permit the operation of equipment for the processing of phosphorous ore, rock or other phosphatic material including, but not limited to, phosphoric acid, in a manner that emissions of fluorides exceed 100 pounds per day.

*f.* “Fluoride” means elemental fluorine and all fluoride compounds as measured by reference methods specified in Appendix A to 40 CFR Part 60 as amended through March 12, 1996.

*g.* Calculation. The allowable total emission of fluoride shall be calculated by multiplying the unit emission specified above by the expressed design production capacity of the process equipment.

**23.4(11) Portland cement concrete batching plants.** No person shall cause, allow or permit the operation of a Portland cement concrete batching plant such that the particulate matter discharged to the atmosphere exceeds 0.1 grain per standard cubic foot of exhaust gas.

**23.4(12) Incinerators.** A person shall not cause, allow or permit the operation of an incinerator unless provided with appropriate control of emissions of particulate matter and visible air contaminants.

*a. Particulate matter.* A person shall not cause, allow or permit the operation of an incinerator with a rated refuse burning capacity of 1000 or more pounds per hour in a manner such that the particulate matter discharged to the atmosphere exceeds 0.2 grain per standard cubic foot of exhaust gas adjusted to 12 percent carbon dioxide.

A person shall not cause, allow or permit the operation of an incinerator with a rated refuse burning capacity of less than 1000 pounds per hour in a manner such that the particulate matter discharged to the atmosphere exceeds 0.35 grain per standard cubic foot of exhaust gas adjusted to 12 percent carbon dioxide.

*b. Visible emissions.* A person shall not allow, cause or permit the operation of an incinerator in a manner such that it produces visible air contaminants in excess of 40 percent opacity; except that visible air contaminants in excess of 40 percent opacity but less than or equal to 60 percent opacity may be emitted for periods aggregating not more than 3 minutes in any 60-minute period during an operation breakdown or during the cleaning of air pollution control equipment.

**23.4(13) Painting and surface-coating operations.** No person shall allow, cause or permit painting and surface-coating operations in a manner such that particulate matter in the gas discharge exceeds 0.01 grain per standard cubic foot of exhaust gas.

This rule is intended to implement Iowa Code section 455B.133.

#### **567—23.5(455B) Anaerobic lagoons.**

**23.5(1)** Applications for construction permits for animal feeding operations using anaerobic lagoons shall meet the requirements of rules 567—65.9(455B) and 65.15(455B) to 65.17(455B).

**23.5(2)** Criteria for approval of industrial anaerobic lagoons.

*a.* Lagoons designed to treat 100,000 gpd or less.

(1) The sulfate content of the water supply shall not exceed 250 mg/l. However, this paragraph does not apply to an expansion of an industrial anaerobic lagoon facility which was constructed prior to February 22, 1979.

(2) The design loading rate for the total lagoon volume shall not be less than 10 pounds nor more than 20 pounds of biochemical oxygen demand (five day) per thousand cubic feet per day.

*b.* Lagoons designed to treat more than 100,000 gpd.

(1) The sulfate content of the water supply shall not exceed 100 mg/l. However, this paragraph does not apply to an expansion of an industrial anaerobic lagoon facility which was constructed prior to February 22, 1979.

(2) The design loading rate for the total lagoon volume shall not be less than 10 pounds nor more than 20 pounds of biochemical oxygen demand (five day) per thousand cubic feet per day.

This rule is intended to implement Iowa Code section 455B.133.

**567—23.6(455B) Alternative emission limits (the “bubble concept”).** Emission limits for individual emission points included in 23.3(455B) (except 23.3(2)“*d*,” 23.3(2)“*b*”(3), and 23.3(3)“*a*”(3)) and 23.4(455B) (except 23.4(12)“*b*” and 23.4(6)) may be replaced by alternative emission limits. The alternative emission limits must be consistent with 567—22.7(455B) and 567—subrule 25.1(12).

Under this rule, less stringent control limits where costs of emission control are high may be allowed in exchange for more stringent control limits where costs of control are less expensive.

Rules 23.3(455B) to 23.6(455B) are intended to implement Iowa Code section 455B.133.

[Filed 8/24/70; amended 5/2/72, 12/11/73, 12/17/74]

[Filed 3/1/76, Notice 11/3/75—published 3/22/76, effective 4/26/76]

[Filed 5/28/76, Notice 12/15/75, 1/12/76, 1/26/76, 2/23/76—published 6/14/76, effective 7/19/76]

[Filed 11/24/76, Notice 8/9/76—published 12/15/76, effective 1/19/77]

[Filed 12/22/76, Notice 8/9/76—published 1/12/77, effective 2/16/77]

[Filed 2/25/77, Notice 8/9/76—published 3/23/77, effective 4/27/77]<sup>1</sup>

[Filed 5/27/77, Notice 8/9/76, 12/29/76—published 6/15/77, effective 7/20/77]

[Filed 5/27/77, Notice 1/12/76, 3/9/77—published 6/15/77, effective 1/1/78 and 1/1/79]

[Filed without Notice 10/28/77—published 11/16/77, effective 12/21/77]

[Filed 4/27/78, Notice 11/16/77—published 5/17/78, effective 6/21/78]

[Filed 3/16/79, Notice 10/18/78—published 4/4/79, effective 5/9/79]

[Filed 4/12/79, Notice 9/6/78—published 5/2/79, effective 6/6/79]

[Filed 6/29/79, Notice 2/7/79—published 7/25/79, effective 8/29/79]

[Filed without Notice 6/29/79—published 7/25/79, effective 8/29/79]

[Filed 10/26/79, Notices 5/2/79, 8/8/79—published 11/14/79, effective 12/19/79]

[Filed 4/10/80, Notices 12/26/79, 1/23/80—published 4/30/80, effective 6/4/80]

[Filed 7/31/80, Notice 12/26/79—published 8/20/80, effective 9/24/80]

[Filed 9/26/80, Notice 5/28/80—published 10/15/80, effective 11/19/80]

[Filed 12/12/80, Notice 10/15/80—published 1/7/81, effective 2/11/81]

[Filed 4/23/81, Notice 2/4/81—published 5/13/81, effective 6/17/81]

[Filed 5/21/81, Notice 3/18/81—published 6/10/81, effective 7/15/81]

[Filed 7/31/81, Notices 12/10/80, 5/13/81—published 8/19/81, effective 9/23/81]

[Filed emergency 9/11/81—published 9/30/81, effective 9/23/81]

[Filed 9/11/81, Notice 7/8/81—published 9/30/81, effective 11/4/81]

[Filed emergency 6/18/82—published 7/7/82, effective 7/1/82]

[Filed 9/24/82, Notice 6/23/82—published 10/13/82, effective 11/17/82]

[Filed emergency 6/3/83—published 6/22/83, effective 7/1/83]

[Filed 7/28/83, Notice 2/16/83—published 8/17/83, effective 9/21/83]<sup>2</sup>

[Filed 11/30/83, Notice 9/14/83—published 12/21/83, effective 1/25/84]

[Filed 8/24/84, Notice 5/9/84—published 9/12/84, effective 10/18/84]

[Filed 9/20/84, Notice 7/18/84—published 10/10/84, effective 11/14/84]

[Filed 11/27/85, Notice 7/31/85—published 12/18/85, effective 1/22/86]

[Filed 5/2/86, Notice 1/15/86—published 5/21/86, effective 6/25/86]

[Filed emergency 11/14/86—published 12/3/86, effective 12/3/86]

[Filed 8/21/87, Notice 6/17/87—published 9/9/87, effective 10/14/87]

[Filed 1/22/88, Notice 11/18/87—published 2/10/88, effective 3/16/88]

[Filed 3/30/89, Notice 1/11/89—published 4/19/89, effective 5/24/89]

[Filed 5/24/90, Notice 3/21/90—published 6/13/90, effective 7/18/90]

[Filed 7/19/90, Notice 4/18/90—published 8/8/90, effective 9/12/90]

[Filed 3/29/91, Notice 1/9/91—published 4/17/91, effective 5/22/91]

[Filed 12/30/92, Notice 9/16/92—published 1/20/93, effective 2/24/93]

[Filed 11/19/93, Notice 9/15/93—published 12/8/93, effective 1/12/94]

[Filed 2/25/94, Notice 10/13/93—published 3/16/94, effective 4/20/94]

[Filed 7/29/94, Notice 3/16/94—published 8/17/94, effective 9/21/94]

[Filed 9/23/94, Notice 6/22/94—published 10/12/94, effective 11/16/94]

[Filed without Notice 2/24/95—published 3/15/95, effective 4/19/95]

[Filed 5/19/95, Notice 3/15/95—published 6/7/95, effective 7/12/95]

[Filed 8/25/95, Notice 6/7/95—published 9/13/95, effective 10/18/95]

[Filed 4/19/96, Notice 1/17/96—published 5/8/96, effective 6/12/96]

- [Filed 9/20/96, Notice 6/19/96—published 10/9/96, effective 11/13/96]  
 [Filed 3/20/97, Notice 11/20/96—published 4/9/97, effective 5/14/97]  
 [Filed 6/27/97, Notice 3/12/97—published 7/16/97, effective 8/20/97]  
 [Filed 3/19/98, Notice 1/14/98—published 4/8/98, effective 5/13/98]  
 [Filed emergency 5/29/98—published 6/17/98, effective 6/29/98]  
 [Filed 8/21/98, Notice 6/17/98—published 9/9/98, effective 10/14/98]<sup>◇</sup>  
 [Filed 10/30/98, Notice 8/26/98—published 11/18/98, effective 12/23/98]  
 [Filed 3/19/99, Notice 12/30/98—published 4/7/99, effective 5/12/99]  
 [Filed 5/28/99, Notice 3/10/99—published 6/16/99, effective 7/21/99]  
 [Filed 3/3/00, Notice 12/15/99—published 3/22/00, effective 4/26/00]  
 [Filed 1/19/01, Notice 6/14/00—published 2/7/01, effective 3/14/01]  
 [Filed 2/28/02, Notice 12/12/01—published 3/20/02, effective 4/24/02]  
 [Filed 8/29/03, Notice 6/11/03—published 9/17/03, effective 10/22/03]  
 [Filed 11/19/03, Notice 7/9/03—published 12/10/03, effective 1/14/04]  
 [Filed 2/26/04, Notice 12/10/03—published 3/17/04, effective 4/21/04]  
 [Filed 10/22/04, Notice 7/21/04—published 11/10/04, effective 12/15/04]  
 [Filed 2/25/05, Notice 12/8/04—published 3/16/05, effective 4/20/05]  
 [Filed 5/18/05, Notice 3/16/05—published 6/8/05, effective 7/13/05]  
 [Filed 8/23/05, Notices 5/11/05, 7/6/05—published 9/14/05, effective 10/19/05]  
 [Filed 10/21/05, Notice 8/17/05—published 11/9/05, effective 12/14/05]  
 [Filed 5/17/06, Notice 1/18/06—published 6/7/06, effective 7/12/06]  
 [Filed 6/28/06, Notice 4/12/06—published 7/19/06, effective 8/23/06]  
 [Filed 2/8/07, Notice 12/6/06—published 2/28/07, effective 4/4/07]  
 [Filed 1/23/08, Notice 8/29/07—published 2/13/08, effective 3/19/08]  
 [Filed 4/18/08, Notice 1/2/08—published 5/7/08, effective 6/11/08]  
 [Filed 8/20/08, Notice 6/4/08—published 9/10/08, effective 10/15/08]  
 [Filed ARC 7565B (Notice ARC 7306B, IAB 11/5/08), IAB 2/11/09, effective 3/18/09]  
 [Filed ARC 7623B (Notice ARC 7395B, IAB 12/3/08), IAB 3/11/09, effective 4/15/09]  
 [Filed ARC 8216B (Notice ARC 7622B, IAB 3/11/09; Amended Notice ARC 7738B, IAB 5/6/09),  
 IAB 10/7/09, effective 11/11/09]  
 [Filed ARC 8215B (Notice ARC 7855B, IAB 6/17/09), IAB 10/7/09, effective 11/11/09]  
 [Filed ARC 9154B (Notice ARC 8845B, IAB 6/16/10), IAB 10/20/10, effective 11/24/10]<sup>3,4</sup>  
 [Editorial change: IAC Supplement 12/1/10]  
 [Editorial change: IAC Supplement 4/20/11]  
 [Filed ARC 0329C (Notice ARC 0165C, IAB 6/13/12), IAB 9/19/12, effective 10/24/12]  
 [Filed ARC 1014C (Notice ARC 0740C, IAB 5/15/13), IAB 9/18/13, effective 10/23/13]  
 [Filed ARC 1561C (Notice ARC 1458C, IAB 5/14/14), IAB 8/6/14, effective 9/10/14]  
 [Filed ARC 1913C (Notice ARC 1795C, IAB 12/24/14), IAB 3/18/15, effective 4/22/15]  
 [Filed Emergency After Notice ARC 2352C (Notice ARC 2222C, IAB 10/28/15), IAB 1/6/16, effective  
 12/16/15]  
 [Filed ARC 2949C (Notice ARC 2799C, IAB 11/9/16), IAB 2/15/17, effective 3/22/17]  
 [Filed ARC 3679C (Notice ARC 3520C, IAB 12/20/17), IAB 3/14/18, effective 4/18/18]

<sup>◇</sup> Two or more ARCs

<sup>1</sup> Objection, see filed rule [DEQ, 4.2(4)] published IAC Supp. 1/22/77, 3/9/77.

<sup>2</sup> Effective date of 23.2(4) delayed 70 days by the Administrative Rules Review Committee on 9/14/83.

<sup>3</sup> 11/24/10 effective date of 23.1(4), introductory paragraph, and 23.1(4) “*ev*” and “*fa*” to “*fd*” delayed 70 days by the Administrative Rules Review Committee at its meeting held November 9, 2010.

<sup>4</sup> Amendment to 23.1(4), introductory paragraph, (ARC 9154B, Item 4) rescinded by Executive Order Number 72 on 4/4/11. Amendment removed and prior language restored IAC Supplement 4/20/11.

CHAPTER 25  
MEASUREMENT OF EMISSIONS

[Prior to 7/1/83, DEQ Ch 7]

[Prior to 12/3/86, Water, Air and Waste Management[900]]

**567—25.1(455B) Testing and sampling of new and existing equipment.**

**25.1(1)** *Continuous monitoring of opacity from coal-fired steam generating units.* The owner or operator of any coal-fired or coal-gas-fired steam generating unit with a rated capacity of greater than 250 million Btus per hour heat input shall install, calibrate, maintain, and operate continuous monitoring equipment to monitor opacity. If an exhaust services more than one steam generating unit as defined in the preceding sentence, the owner has the option of installing opacity monitoring equipment on each unit or on the common stack. Such monitoring equipment shall conform to performance specifications specified in 25.1(9) and shall be operational within 18 months of the date these rules become effective. The director may require the owner or operator of any coal-fired or coal-gas-fired steam generating unit to install, calibrate, maintain and operate continuous monitoring equipment to monitor opacity whenever the compliance status, history of operations, ambient air quality in the vicinity surrounding the generator or the type of control equipment utilized would warrant such monitoring.

**25.1(2)** and **25.1(3)** Reserved.

**25.1(4)** *Continuous monitoring of sulfur dioxide from sulfuric acid plants.* The owner or operator of any sulfuric acid plant of greater than 300 tons per day production capacity, the production being expressed as 100 percent acid, shall install, calibrate, maintain and operate continuous monitoring equipment to monitor sulfur dioxide emissions. Said monitoring equipment shall conform to the minimum performance specifications specified in 25.1(9) and shall be operational within 18 months of the date these rules become effective.

**25.1(5)** *Maintenance of records of continuous monitors.* The owner or operator of any facility which is required to install, calibrate, maintain and operate continuous monitoring equipment shall maintain, for a minimum of two years, a file of all information pertinent to each monitoring system present at the facility. Such information must include but is not limited to all emissions data (raw data, adjusted data, and any or all adjusted factors used to convert emissions from units of measurement to units of the applicable standard), performance evaluations, calibrations and zero checks, and records of all malfunctions of monitoring equipment or source and repair procedures performed.

**25.1(6)** *Reporting of continuous monitoring information.* The owner or operator of any facility required to install a continuous monitoring system or systems shall provide quarterly reports to the director, no later than 30 calendar days following the end of the calendar quarter, on forms provided by the director. This provision shall not excuse compliance with more stringent applicable reporting requirements. All periods of recorded emissions in excess of the applicable standards, the results of all calibrations and zero checks and performance evaluations occurring during the reporting period, and any periods of monitoring equipment malfunctions or source upsets and any apparent reasons for these malfunctions and upsets shall be included in the report.

**25.1(7)** *Tests by owner.* The owner of new or existing equipment or the owner's authorized agent shall conduct emission tests to determine compliance with applicable rules in accordance with these requirements.

*a. General.* The owner of new or existing equipment or the owner's authorized agent shall notify the department in writing not less than 30 days before a required test or before a performance evaluation of a continuous emission monitor to determine compliance with applicable requirements of 567—Chapter 23 or a permit condition. Such notice shall include the time, the place, the name of the person who will conduct the tests and other information as required by the department. If the owner or operator does not provide timely notice to the department, the department shall not consider the test results or performance evaluation results to be a valid demonstration of compliance with applicable rules or permit conditions. Upon written request, the department may allow a notification period of less than 30 days. At the department's request, a pretest meeting shall be held not later than 15 days before the owner or operator conducts the compliance demonstration. A testing protocol shall be

submitted to the department no later than 15 days before the owner or operator conducts the compliance demonstration. A representative of the department shall be permitted to witness the tests. Results of the tests shall be submitted in writing to the director in the form of a comprehensive report within six weeks of the completion of the testing.

*b. New equipment.* Unless otherwise specified by the department, all new equipment shall be tested by the owner or the owner's authorized agent to determine compliance with applicable emission limits. Tests conducted to demonstrate compliance with the requirements of the rules or a permit shall be conducted within 60 days of achieving maximum production but no later than 180 days of startup, unless a shorter time frame is specified in the permit.

*c. Existing equipment.* The director may require the owner or the owner's authorized agent to conduct an emission test on any equipment if the director has reason to believe that the equipment does not comply with applicable requirements. Grounds for requiring such a demonstration of compliance include a modification of control or process equipment, age of equipment, or observation of opacities or other parameters outside the range of those indicative of properly maintained and operated equipment. Testing may be required as necessary to determine actual emissions from a source where that source is believed to have a significant impact on the public health or ambient air quality of an area. The director shall provide the owner or agent not less than 30 days to perform the compliance demonstration and shall provide written notice of the requirement.

**25.1(8) Tests by department.** Representatives of the department may conduct separate and additional air contaminant emission tests and continuous monitor performance tests of an installation on behalf of the state and at the expense of the state. Sampling holes, safe scaffolding and pertinent allied facilities, but not instruments or sensing devices, as needed, shall be requested in writing by the director and shall be provided by and at the expense of the owner of the installation at such points as specified in the request. The owner shall provide a suitable power source to the point or points of testing so that sampling instruments can be operated as required. Analytical results shall be furnished to the owner.

**25.1(9) Methods and procedures.** Stack sampling and associated analytical methods used to evaluate compliance with emission limitations of 567—Chapter 23 or a permit condition are as follows:

*a. Performance test (stack test).* A stack test shall be conducted according to EPA reference methods as specified in 40 CFR 51, Appendix M (as amended through August 30, 2016); 40 CFR 60, Appendix A (as amended through August 30, 2016); 40 CFR 61, Appendix B (as amended through August 30, 2016); and 40 CFR 63, Appendix A (as amended through August 30, 2016). The owner of the equipment or the owner's authorized agent may use an alternative methodology if the methodology is approved by the department in writing before testing. Each test shall consist of at least three separate test runs. Unless otherwise specified by the department, compliance shall be assessed on the basis of the arithmetic mean of the emissions measured in the three test runs.

*b. Continuous monitoring systems.* Minimum performance specifications and quality assurance procedures for performance evaluations of continuous monitoring systems are as specified in 40 CFR 60, Appendix B (as amended through August 30, 2016); 40 CFR 60, Appendix F (as amended through August 30, 2016); 40 CFR 75, Appendix A (as amended through August 30, 2016); 40 CFR 75, Appendix B (as amended through August 30, 2016); and 40 CFR 75, Appendix F (as amended through August 30, 2016). The owner of the equipment or the owner's authorized agent may use an alternative methodology for continuous monitoring systems if the methodology is approved by the department in writing before the minimum performance specification and quality assurance procedure is conducted.

*c. Permit and compliance demonstration requirements.* After October 24, 2012, all stack sampling and associated analytical methods used to evaluate compliance with emission limitations of 567—Chapter 23 or required in a permit issued by the department pursuant to 567—Chapter 22 or 33 shall be conducted using the methodology referenced in this rule. If stack sampling was required for a compliance demonstration pursuant to 567—Chapter 23 or for a performance test required in a permit issued by the department pursuant to 567—Chapter 22 or 33 before October 24, 2012, and the demonstration or test was not required to be completed before October 24, 2012, then the methodology referenced in this subrule applies retroactively.

**25.1(10) Exemptions from continuous monitoring requirements.** The owner or operator of any source is exempt if it can be demonstrated that any of the conditions set forth in this subrule are met with the provision that periodic recertification of the existence of these conditions can be requested.

*a.* An affected source is subject to a new source performance standard promulgated in 40 CFR Part 60 as amended through September 28, 2007.

*b.* An affected steam generator had an annual capacity factor for calendar year 1974, as reported to the Federal Power Commission, of less than 30 percent or the projected use of the unit indicates the annual capacity factor will not be increased above 30 percent in the future.

*c.* An affected steam generator is scheduled to be retired from service within five years of the date these rules become effective.

*d.* Rescinded IAB 1/20/93, effective 2/24/93.

*e.* The director may provide a temporary exemption from the monitoring and reporting requirements during any period of monitoring system malfunction, provided that the source owner or operator shows, to the satisfaction of the director, that the malfunction was unavoidable and is being repaired as expeditiously as practical.

**25.1(11) Extensions.** The owner or operator of any source may request an extension of time provided for installation of the required monitor by demonstrating to the director that good faith efforts have been made to obtain and install the monitor in the prescribed time.

**25.1(12) Continuous monitoring of sulfur dioxide from emission points involved in an alternative emission control program.** The owner or operator of any facility applying for an alternative emission control program under 567—subrule 22.7(1) that involves the trade-off of sulfur dioxide emissions shall install, calibrate, maintain and operate continuous sulfur dioxide monitoring equipment consistent with EPA reference methods (40 CFR Part 60, Appendix B, as amended through September 28, 2007). The equipment shall be operational within three months of EPA approval of an alternative emission control program.

[ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 0330C, IAB 9/19/12, effective 10/24/12; ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—25.2(455B) Continuous emission monitoring under the acid rain program.** The continuous emission monitoring requirements for affected units under the acid rain program as provided in 40 CFR Part 75, including Appendices A, B, F and K as amended through August 30, 2016, are adopted by reference.

[ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—25.3(455B) Mercury emissions testing and monitoring.** Any stationary, coal-fired boiler or stationary, coal-fired combustion turbine serving, at any time since the later of November 15, 1990, or the start-up of the unit's combustion chamber, a generator with a nameplate capacity of more than 25 megawatt electrical (MWe) producing electricity for sale is an affected source under the provisions of this rule.

The provisions of this rule expire on April 22, 2015, except for any affected facility that receives an extension to comply with the emission standards for hazardous air pollutants: coal- and oil-fired electric utility steam generating units (EGUs) (40 CFR Part 63, Subpart UUUUU, commonly known as mercury air toxics standards (MATS)). Any facility receiving an extension of the MATS compliance date shall continue to comply with the provisions of this rule until the date the facility is required to comply with MATS or, alternatively, is no longer subject to the MATS compliance requirements. However, facilities complying with the requirements of this rule as specified in subrule 25.3(3), continuous emissions monitoring systems (CEMS), may submit a written request to the department to discontinue concurrent, annual stack tests. The department will evaluate and grant requests on a case-by-case basis, based upon previous stack test results and how recent the last stack test occurred or other extenuating circumstances, such as those that may cause testing conditions to be unrepresentative of normal operations or cause tests to be unsafe to perform. If the department grants a request, the facility will be required to continue operating CEMS and conduct relative accuracy test audits (RATAs), as specified in subrule 25.3(3),

until the facility is required to comply with MATS or, alternatively, is no longer subject to MATS compliance requirements.

**25.3(1) *Testing frequency and methods.*** The owner or operator of an affected source shall complete one stack test for mercury in each calendar quarter for four consecutive calendar quarters. Testing shall commence no later than the third calendar quarter in 2010 (July 1 – September 30). At such time as four consecutive quarterly stack tests are completed and the test results are approved in writing by the department, the owner or operator of an affected source shall complete one stack test for mercury in each subsequent calendar year. Stack testing to fulfill the requirements of this subrule shall meet the following conditions:

*a.* Stack testing shall be conducted according to U.S. EPA Method 29 or according to ASTM Method D6784-02 (Ontario Hydro Method) and shall quantify both vapor phase and particulate bound mercury. Each stack test shall consist of a minimum of three runs at the normal operating load while combusting coal, and the minimum time per run shall be two hours.

*b.* The owner or operator or the owner's authorized agent shall notify the department in writing not less than 30 days before each stack test. The notice shall include the time, the place, the name of the person who will conduct the test and other information as required by the department. Upon written request, the department may allow a notification period of less than 30 days. At the department's request, a pretest meeting shall be held no later than 15 days before the scheduled test date. A testing protocol shall be submitted to the department no later than 15 days before the scheduled test date. A representative of the department shall be permitted to witness the tests. Within six weeks of the completion of the testing, the results of the tests shall be submitted in writing to the department in the form of a comprehensive test report.

**25.3(2) *Low mass emitter (LME).*** In lieu of complying with the requirements of 25.3(1), the owner or operator of an affected source may submit a written request to the department to be classified as a low mass emitter (LME) for mercury. To be eligible for LME classification by the department, the owner or operator shall meet the following conditions:

*a.* The owner or operator shall complete at least one stack test prior to July 1, 2010, according to U.S. EPA Method 29 or according to ASTM Method D6784-02 (Ontario Hydro Method) and shall quantify both vapor phase and particulate bound mercury. Each stack test shall consist of a minimum of three runs at the normal operating load while combusting coal, and the minimum time per run shall be two hours.

*b.* The owner or operator or the owner's authorized agent shall notify the department in writing not less than 30 days before each stack test. The notice shall include the time, the place, the name of the person who will conduct the test and other information as required by the department. Upon written request, the department may allow a notification period of less than 30 days. At the department's request, a pretest meeting shall be held no later than 15 days before the scheduled test date. A testing protocol shall be submitted to the department no later than 15 days before the scheduled test date. A representative of the department shall be permitted to witness the tests. Within six weeks of the completion of the testing, the results of the tests shall be submitted in writing to the department in the form of a comprehensive test report.

*c.* Using the highest mercury concentration measured from any of the stack test runs, the owner or operator shall submit documentation to the department sufficient to demonstrate that the potential annual mercury emissions from the affected source are less than or equal to 29 pounds (464 ounces) per year.

*d.* Upon written notification of LME classification by the department, the owner or operator of an affected source shall be exempt from the requirements of 25.3(1).

*e.* If at any time the potential annual mercury emissions from the affected source exceed 29 pounds per year, it shall be the responsibility of the owner or operator of the affected source to notify the department in writing within 30 days.

**25.3(3) *Continuous emission monitoring systems (CEMS).*** In lieu of complying with the requirements of 25.3(1), the owner or operator of an affected source may submit a request to the department to record mercury emissions data using a continuous emission monitoring system (CEMS).

To be eligible for department approval to use CEMS, the owner or operator shall meet the following conditions:

*a.* The owner or operator shall complete at least one stack test concurrently with operating and recording data from the CEMS prior to September 30, 2010, and thereafter on an annual basis, to demonstrate that the CEMS are providing accurate emissions data, as follows:

(1) The stack test conducted concurrently with the CEMS shall be conducted according to U.S. EPA Method 29 or according to ASTM Method D6784-02 (Ontario Hydro Method) and shall quantify both vapor phase and particulate bound mercury. Each stack test shall consist of a minimum of three runs at the normal operating load while combusting coal, and the minimum time per run shall be two hours.

(2) While conducting the concurrent stack test, the owner and operator shall perform a relative accuracy test audit (RATA) and other CEMS certification procedures according to an approved EPA performance protocol. If an approved EPA performance protocol is not available, the owner or operator may submit an alternative CEMS certification protocol in writing to the department for approval. Department approval must be received before the owner or operator conducts the CEMS certification.

*b.* The owner or operator or the owner's authorized agent shall notify the department in writing not less than 30 days before each stack test conducted concurrently with CEMS. The notice shall include the time, the place, the name of the person who will conduct the test and other information as required by the department. Upon written request, the department may allow a notification period of less than 30 days. At the department's request, a pretest meeting shall be held no later than 15 days before the scheduled test date. Protocols for the stack testing and for the concurrent CEMS operation and data collection shall be submitted to the department no later than 15 days before the scheduled test date. A representative of the department shall be permitted to witness the tests. Results of the tests and CEMS certification shall be submitted in writing to the department in the form of a comprehensive test and CEMS certification report within six weeks of the completion of the testing.

*c.* The owner or operator of an affected source shall comply with the provisions of 25.3(1) until such time as the department approves use of CEMS.

*d.* Upon receiving department approval for CEMS use, the owner or operator of an affected source shall operate and record CEMS data, including calibrating each individual CEMS for zero and span on a daily basis, and shall provide all CEMS data to the department upon written request. CEMS certification shall be completed on an annual basis according to the procedures specified in paragraph 25.3(3) "a."

**25.3(4)** *EPA-required stack testing for mercury.* If the owner or operator of an affected source is required by EPA to complete stack testing for mercury, the owner or operator may submit a written request to the department that the EPA-required stack test be allowed to fulfill all or part of the testing requirements specified in 25.3(1). The department shall consider each such request on a case-by-case basis.

**25.3(5)** *Affected sources subject to Section 112(g).* The owner or operator of an affected source subject to the requirements of Clean Air Act Section 112(g) shall comply with the requirements contained in permits issued by the department under 567—Chapters 22 and 33.

[ARC 8216B, IAB 10/7/09, effective 11/11/09; ARC 1913C, IAB 3/18/15, effective 4/22/15]

These rules are intended to implement Iowa Code section 455B.133.

[Filed 8/24/70; amended 12/11/73, 12/17/74]

[Filed 5/27/77, Notices 8/9/76, 12/29/76—published 6/15/77, effective 7/20/77]

[Filed 9/26/80, Notice 5/28/80—published 10/15/80, effective 11/19/80]

[Filed emergency 6/3/83—published 6/22/83, effective 7/1/83]

[Filed emergency 11/14/86—published 12/3/86, effective 12/3/86]

[Filed 12/30/92, Notice 9/16/92—published 1/20/93, effective 2/24/93]

[Filed 2/25/94, Notice 10/13/93—published 3/16/94, effective 4/20/94]

[Filed 5/19/95, Notice 3/15/95—published 6/7/95, effective 7/12/95]

[Filed 3/19/98, Notice 1/14/98—published 4/8/98, effective 5/13/98]

[Filed 10/30/98, Notice 8/26/98—published 11/18/98, effective 12/23/98]

[Filed 5/28/99, Notice 3/10/99—published 6/16/99, effective 7/21/99]

[Filed 1/19/01, Notice 6/14/00—published 2/7/01, effective 3/14/01]

- [Filed 2/28/02, Notice 12/12/01—published 3/20/02, effective 4/24/02]
- [Filed 8/29/03, Notice 6/11/03—published 9/17/03, effective 10/22/03]
- [Filed 10/22/04, Notice 7/21/04—published 11/10/04, effective 12/15/04]
- [Filed 5/18/05, Notice 3/16/05—published 6/8/05, effective 7/13/05]
- [Filed 5/17/06, Notice 1/18/06—published 6/7/06, effective 7/12/06]
- [Filed 2/8/07, Notice 12/6/06—published 2/28/07, effective 4/4/07]
- [Filed 4/18/08, Notice 1/2/08—published 5/7/08, effective 6/11/08]
- [Filed 8/20/08, Notice 6/4/08—published 9/10/08, effective 10/15/08]
- [Filed ARC 8216B (Notice ARC 7622B, IAB 3/11/09; Amended Notice ARC 7738B, IAB 5/6/09),  
IAB 10/7/09, effective 11/11/09]
- [Filed ARC 8215B (Notice ARC 7855B, IAB 6/17/09), IAB 10/7/09, effective 11/11/09]
- [Filed ARC 0330C (Notice ARC 0087C, IAB 4/18/12; Amended Notice ARC 0162C, IAB 6/13/12),  
IAB 9/19/12, effective 10/24/12]
- [Filed ARC 1913C (Notice ARC 1795C, IAB 12/24/14), IAB 3/18/15, effective 4/22/15]
- [Filed ARC 2949C (Notice ARC 2799C, IAB 11/9/16), IAB 2/15/17, effective 3/22/17]
- [Filed ARC 3679C (Notice ARC 3520C, IAB 12/20/17), IAB 3/14/18, effective 4/18/18]

CHAPTER 30  
FEES

**567—30.1(455B) Purpose.** This chapter sets forth requirements to pay fees for specified activities. Rule 567—30.1(455B) adds definitions for this chapter, a duty to correct errors, and an exemption to fee requirements for administrative amendments. Rule 567—30.2(455B) sets forth the requirements for applicants to submit fees for specified activities associated with new source review in 567—Chapter 22, 567—Chapter 31 and 567—Chapter 33. Rule 567—30.3(455B) contains requirements for the submission of demolition and renovation notification fees for the asbestos emission standard for hazardous air pollutants listed in 567—paragraph 23.1(3)“a.” Rule 567—30.4(455B) sets forth the requirements for applicants to submit fees for specified activities associated with the Title V program found in 567—Chapter 22. Rule 567—30.5(455B) sets forth the requirement to convene fee advisory groups. Rule 567—30.6(455B) details the process by which fee levels shall be established, lists the types of fees and the dollar caps on the fee types that the commission may set, and establishes the mechanism for notification of the fee schedule. Rule 567—30.7(455B) details how fee revenues may be expended and specifies the calculated estimate of maximum fee revenues.

The department shall not initiate review and processing of an application submittal from a minor source until all required fees have been paid to the department. Fees are nonrefundable, except as provided in subrule 30.1(4).

**30.1(1) Definitions.** For purposes of this chapter, the following definitions shall apply:

“*Application submittal*” means one or more applications required under rule 567—22.1(455B) and submitted at the same time or required to be submitted under rule 567—22.4(455B), rule 567—22.5(455B), 567—Chapter 31 or 567—Chapter 33.

“*Major source*” means a “major source” as defined in rule 567—22.100(455B).

“*Minor source*” means any stationary source not included in the definition of “major source” as defined in rule 567—22.100(455B).

“*Regulated air pollutant*” means “regulated air pollutant or contaminant (for fee calculation)” as defined in rule 567—22.100(455B).

**30.1(2) Duty to correct errors.** If an owner or operator, or the department, finds an error in a fee assessed or collected under this chapter, the owner or operator shall submit to the department revised forms making the necessary corrections to the fee and shall submit the correct fee. Corrected forms shall be submitted as soon as possible after the error is discovered or upon notification by the department. If the error correction results in a determination by the department that a fee was overpaid or that a duplicate fee was submitted, the department will return the overpaid balance of the fee to the applicant.

**30.1(3) Exemption to fee requirements for administrative amendments.** A fee shall not be required for any of the following:

- a. Corrections of typographical errors;
- b. Corrections of word processing errors;
- c. Changes in the name, address, or telephone number of any person identified in a permit, or similar minor administrative changes at the source;
- d. Changes in ownership or operational control of a source where the department determines that no other change in the permit is necessary, provided that a written agreement that contains a specific date for transfer of permit responsibility, coverage, and liability between the current permittee and the new permittee has been submitted to the department.

**30.1(4) Refund of application fee minus administrative cost for permit applications at minor sources.** The department may refund the application fee minus administrative costs if the owner or operator requests to withdraw the application prior to commencement of the technical review of the application.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.2(455B) Fees associated with new source review applications.** Beginning on January 15, 2016, each owner or operator required to provide an application submittal, including air quality

modeling as applicable; registration; permit by rule; and template under 567—subrule 22.1(1), rule 567—22.4(455B), rule 567—22.5(455B), rule 567—22.8(455B), rule 567—22.10(455B), 567—Chapter 31 or 567—Chapter 33, shall pay fees as specified in the fee schedule approved by the commission and posted on the department’s website. Fees shall be submitted with forms supplied by the department.

**30.2(1) *Payment of regulatory applicability determination fee.*** Beginning on January 15, 2016, each owner or operator requesting a regulatory applicability determination, as specified in 567—paragraph 22.1(3) “a,” shall pay fees as specified in the fee schedule approved by the commission and posted on the department’s website. Fees shall be submitted with forms provided by the department.

**30.2(2) Reserved.**

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.3(455B) Fees associated with asbestos demolition or renovation notification.**

**30.3(1) *Payment of fees established.*** Beginning on January 15, 2016, the owner or operator of a site subject to the national emission standard for hazardous air pollutants (NESHAP) for asbestos notifications, adopted by reference in 567—paragraph 23.1(3) “a,” shall submit a fee with each required original or each annual notification for each demolition or renovation, including abatement. Fees shall be paid as specified in the fee schedule approved by the commission and posted on the department’s website. Fees shall be submitted with the notification forms provided by the department.

**30.3(2) *Fee not required.*** A fee shall not be required for the following:

- a. Notifications when the total amount of asbestos to be removed or disturbed is less than 260 linear feet, less than 160 square feet, and less than 35 cubic feet of facility components and is below the reporting thresholds as defined in 40 CFR 61.145 as amended on January 16, 1991;
- b. Notifications of training fires as required in 567—paragraph 23.2(3) “g”;
- c. Controlled burning of demolished buildings as required in 567—paragraph 23.2(3) “j”;
- d. Revised, canceled, and courtesy notifications. A revision to a previously submitted courtesy notification due to applicability of the notification requirements in 567—paragraph 23.1(3) “a” is considered an original notification and is subject to the fee requirements of subrule 30.3(1).

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.4(455B) Fees associated with Title V operating permits.**

**30.4(1) *Payment of Title V application fee.*** Beginning on January 15, 2016, each owner or operator required to apply for a Title V permit, or a renewal of a Title V permit, shall pay fees as specified in the fee schedule approved by the commission and posted on the department’s website. Fees shall be submitted with forms supplied by the department.

**30.4(2) *Payment of Title V annual emissions fee.***

a. *Fee required.* Any person required to obtain a Title V permit shall pay an annual fee based on the first 4,000 tons of each regulated air pollutant, beginning on November 15, 1994. Beginning on July 1, 1996, Title V operating permit fees shall be paid on or before July 1 of each year. The Title V emissions fee shall be based on actual emissions required to be included in the Title V operating permit application and the annual emissions statement for the previous calendar year. The commission shall not set the fee higher than \$70 per ton without adopting the change pursuant to formal rule making.

b. *Fee and documentation due dates.* The fee shall be submitted annually by July 1 with forms specified by the department.

c. *Phase I acid rain sources.* No fee shall be required to be paid for emissions which occurred during the years 1993 through 1999, inclusive, with respect to any Phase I acid rain affected unit under 42 U.S.C. 7651c.

d. *Operation in Iowa.* The fee for a portable emissions unit or stationary source which operates both in Iowa and out of state shall be calculated only for emissions from the source while it is operating in Iowa.

e. *Title V exempted stationary sources.* No fee shall be required for emissions until the year in which sources exempted under 567—subrules 22.102(1) and 22.102(2) are required to apply for a Title

V permit. Fees shall be paid for the emission year preceding the year in which the application is due and thereafter.

*f. Insignificant activities.* No fee shall be required for insignificant activities as defined in rule 567—22.103(455B).

[ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—30.5(455B) Fee advisory groups.** Prior to each March commission meeting, the director shall convene fee advisory groups for the purposes of reviewing a draft budget and providing recommendations to the department regarding establishing or adjusting fees. Any stakeholder may attend meetings of the advisory groups. The meetings will be open to the public. The date of each meeting shall be posted on the department's website 14 days prior to the meeting date.

**30.5(1) New source review for major sources fee advisory group.** The director shall convene annually a fee advisory group to review the draft budget and major source fees required by rule 567—30.2(455B) and listed in rule 567—30.6(455B). Participants in the advisory group may provide recommendations to the department regarding fees necessary to cover all direct and indirect costs to administer the major source permit program.

**30.5(2) New source review for minor sources fee advisory group.** The director shall convene annually a fee advisory group which shall not include major sources as defined in subrule 30.1(1). The fee advisory group will review the draft budget and minor source application fees required in rule 567—30.2(455B) and listed in rule 567—30.6(455B). Participants in the fee advisory group shall include, but may not be limited to, any minor sources and their representatives. The advisory group may provide recommendations to the department regarding fees necessary to cover all direct and indirect costs to administer the minor source permit program.

**30.5(3) Asbestos fee advisory group.** The director shall convene annually an asbestos NESHAP fee advisory group to review the draft budget and asbestos notification fee required by rule 567—30.3(455B) and listed in rule 567—30.6(455B). Participants in the advisory group may provide recommendations to the department regarding fees necessary to cover all direct and indirect costs to administer the asbestos NESHAP program.

**30.5(4) Title V fee advisory group.** The director shall convene annually a fee advisory group to review the draft budget and Title V emissions and application fees required by rule 567—30.4(455B) and listed in rule 567—30.6(455B). Participants in the advisory group may provide recommendations to the department regarding fees necessary to cover all direct and indirect costs to administer the Title V operating permit program.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.6(455B) Process to establish or adjust fees and notification of fee rates.**

**30.6(1) Setting the fees.** Beginning on January 15, 2016, fees shall be paid as specified in the fee schedule approved by the commission and posted on the department's website. Following the setting of the fee schedule effective January 15, 2016, the department shall submit the proposed budget and fees for major and minor source construction permit programs, the Title V operating permit program, and the asbestos NESHAP program for the following fiscal year to the commission no later than the March commission meeting of each year, at which time the proposal will be available for public comment until such time as the commission acts on the proposal or until the May commission meeting, whichever occurs first. The department's calculated estimate for each fee shall not produce total revenues in excess of limits specified in Iowa Code sections 455B.133B and 455B.133C during any fiscal year. If an established fee amount must be adjusted, the commission shall set the fees no later than the May commission meeting of each year.

Fees established prior to January 15, 2016, shall become effective on January 15, 2016. In subsequent years, adjusted or established fees shall become effective on July 1. A fee not adjusted by the commission shall remain in effect as previously established until the fee is adjusted by the commission.

**30.6(2) Fee types and dollar caps on fee types.** The commission may set fees for the fee types and activities specified in this subrule and shall not set a fee in the fee schedule higher than the levels specified in this subrule without adopting the change pursuant to formal rule making:

- a. New source review applications from major sources, which may include:
  - (1) Review of each application for a construction permit: \$115 per hour;
  - (2) Review of each application for a prevention of significant deterioration permit: \$115 per hour;
  - (3) Review of each plantwide applicability limit request, renewal, or reopening: \$115 per hour;
  - (4) Review of each regulatory applicability determination: \$115 per hour; and
  - (5) Air quality modeling review: \$90 per hour, which may include:
    - 1. Reviewing air quality modeling for construction permit application submittal; prevention of significant deterioration application submittal; and nonattainment new source review project application submittal; and
    - 2. Conducting air quality modeling for construction permit application submittal.
- b. New source review applications from minor sources, which may include:
  - (1) Each application for a construction permit: \$385;
  - (2) Each application for a registration permit: \$100;
  - (3) Each application for a permit by rule: \$100; and
  - (4) Each application for a permit template: \$100.
- c. Asbestos notifications: \$100.
- d. Review of each initial or renewal Title V operating permit application: \$100 per hour.
- e. Title V annual emissions: \$70 per ton.

**30.6(3) Notification of fee schedule.** Following the initial setting of any fee by the commission, the department shall make available to the public a fee schedule at least 30 days prior to its effective date. If any established fee amount is adjusted, the department shall make available to the public a revised fee schedule at least 30 days prior to its effective date. The fee schedule shall be posted on the department's website.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

**567—30.7(455B) Fee revenue.** Each fee program is established to provide revenue for and is limited in use to specific activities.

**30.7(1) New source review application fees from major sources.** In accordance with Iowa Code section 455B.133C(5), new source review fee revenues may be used to fund the direct and indirect costs related to reviewing and acting on applications for new source review permits, including permit revisions submitted by major sources as defined under new source review programs pursuant to the federal Act, and as provided under 567—Chapter 22, 567—Chapter 31, and 567—Chapter 33, as follows:

- a. Reviewing and acting on any application for a new source review permit, including the determination of all applicable requirements and dispersion modeling as part of the processing of a permit or permit revision or an applicability determination;
- b. General administrative costs of administering new source review programs, including supporting and tracking of any application for a new source review permit and related data entry; and
- c. Developing and implementing an expedited new source review permit application process, and additional fees associated with this process.

The calculated estimate of total revenues from new source review application fees from major sources shall not exceed \$1,500,000 during any state fiscal year.

**30.7(2) New source review application fees from minor sources.** In accordance with Iowa Code section 455B.133C(6), minor new source review fee revenues may be used to fund the direct and indirect costs for reviewing and acting on applications submitted by minor air contaminant sources for construction permits and providing for registrations, permits by rule, or template permits in lieu of obtaining construction permits, under minor source new source review programs pursuant to the federal Clean Air Act Amendments of 1990, including as provided under 567—Chapter 22. The calculated estimate of total revenues from new source review application fees from minor sources shall not exceed \$250,000 during any state fiscal year.

**30.7(3) Title V emissions.** In accordance with Iowa Code section 455B.133B(5), Title V emissions fee revenues may be used to fund the direct and indirect costs related to:

*a.* General administrative costs of administering the operating permit program, including the supporting and tracking of operating permit applications, compliance certification, and related data entry.

*b.* Costs of implementing and enforcing the terms of an operating permit, not including any court costs or other costs associated with an enforcement action, including adequate resources to determine which sources are subject to the program.

*c.* Costs of emissions and ambient site-specific monitors.

*d.* Costs of Title V source-specific modeling, analyses or demonstrations.

*e.* Costs of preparing inventories and tracking emissions.

*f.* Costs of providing direct support to sources under the small business stationary source technical and environmental compliance assistance program as provided in Iowa Code section 455B.133A.

*g.* Costs associated with implementing and administering regulatory activities, including programs, as provided for in division II of Iowa Code chapter 455B, other than costs covered by any of the following: operating permit application fees, new source review application fees, or notification fees, pursuant to Iowa Code section 455B.133B(5)“d”(2).

The calculated estimate of total revenues from emissions fees shall not exceed \$8,250,000 during any state fiscal year.

**30.7(4) Title V applications.** In accordance with Iowa Code section 455B.133B(6), Title V application fee revenues may be used to fund the direct and indirect costs related to reviewing and acting on applications for operating permits submitted by major sources as defined in rule 567—22.100(455B) and sources subject to rule 567—22.101(455B), as follows:

*a.* Costs of reviewing and acting on any application for an operating permit or operating permit revision.

*b.* General administrative costs of administering the operating permit program, including the supporting and tracking of operating permit applications and related data entry.

The calculated estimate of total revenues from Title V application fees shall not exceed \$1,250,000 during any state fiscal year.

**30.7(5) Asbestos notification.** Pursuant to Iowa Code section 455B.133C(7), asbestos notification fee revenues may be used to fund the direct and indirect costs related to implementing and administering the asbestos national emission standard for hazardous air pollutants program pursuant to 567—Chapter 23. The calculated estimate of total revenues from asbestos notification fees shall not exceed \$450,000 during any state fiscal year.

[ARC 2352C, IAB 1/6/16, effective 12/16/15]

These rules are intended to implement Iowa Code sections 455B.133, 455B.133B and 455B.133C.  
[Filed Emergency After Notice ARC 2352C (Notice ARC 2222C, IAB 10/28/15), IAB 1/6/16, effective 12/16/15]

[Filed ARC 3679C (Notice ARC 3520C, IAB 12/20/17), IAB 3/14/18, effective 4/18/18]



CHAPTER 33  
SPECIAL REGULATIONS AND CONSTRUCTION PERMIT REQUIREMENTS  
FOR MAJOR STATIONARY SOURCES—PREVENTION OF SIGNIFICANT  
DETERIORATION (PSD) OF AIR QUALITY

**567—33.1(455B) Purpose.** This chapter implements the major New Source Review (NSR) program contained in Part C of Title I of the federal Clean Air Act as amended on November 15, 1990, and as promulgated under 40 CFR 51.166 and 52.21 as amended through October 18, 2016. This is a preconstruction review and permitting program applicable to new or modified major stationary sources of air pollutants regulated under Part C of the Clean Air Act as amended on November 15, 1990. In areas that do not meet the national ambient air quality standards (NAAQS), the nonattainment major program applies. The requirements for the nonattainment major NSR program are set forth in 567—22.5(455B), 567—22.6(455B), 567—31.20(455), and 567—31.3(455B). In areas that meet the NAAQS, the PSD program applies. Collectively, the nonattainment major and PSD programs are referred to as the major NSR program. An owner or operator required to apply for a construction permit under 567—Chapter 33 shall submit fees as required in 567—Chapter 30.

Rule 567—33.2(455B) is reserved.

Rule 567—33.3(455B) sets forth the definitions, standards and permitting requirements that are specific to the PSD program.

Rules 567—33.4(455B) through 567—33.8(455B) are reserved.

Rule 567—33.9(455B) includes the conditions under which a source subject to PSD may obtain a plantwide applicability limitation (PAL) on emissions. An owner or operator requesting a PAL under 567—33.9(455B) shall submit fees as required in 567—Chapter 30.

In addition to the requirements in this chapter, stationary sources may also be subject to the permitting requirements in 567—Chapter 22, including requirements for Title V operating permits.

[ARC 9906B, IAB 12/14/11, effective 11/16/11; ARC 1227C, IAB 12/11/13, effective 1/15/14; ARC 2352C, IAB 1/6/16, effective 12/16/15; ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—33.2(455B)** Reserved.

**567—33.3(455B) Special construction permit requirements for major stationary sources in areas designated attainment or unclassified (PSD).**

**33.3(1) Definitions.** Definitions included in this subrule apply to the provisions set forth in this rule (PSD program requirements). For purposes of this rule, the definitions herein shall apply, rather than the definitions contained in 40 CFR 52.21 and 51.166, except for the PAL program definitions referenced in rule 567—33.9(455B). For purposes of this rule, the following terms shall have the meanings indicated in this subrule:

“*Act*” means the Clean Air Act, 42 U.S.C. Sections 7401, et seq., as amended through November 15, 1990.

“*Actual emissions*” means:

1. The actual rate of emissions of a regulated NSR pollutant from an emissions unit, as determined in accordance with paragraphs “2” through “4,” except that this definition shall not apply for calculating whether a significant emissions increase has occurred, or for establishing a PAL under rule 567—33.9(455B). Instead, the requirements specified under the definitions for “projected actual emissions” and “baseline actual emissions” shall apply for those purposes.

2. In general, actual emissions as of a particular date shall equal the average rate, in tons per year, at which the unit actually emitted the pollutant during a consecutive 24-month period which precedes the particular date and which is representative of normal source operation. The department shall allow the use of a different time period upon a determination that it is more representative of normal source operation. Actual emissions shall be calculated using the unit’s actual operating hours, production rates, and types of materials processed, stored, or combusted during the selected time period.

3. The department may presume that source-specific allowable emissions for the unit are equivalent to the actual emissions of the unit.

4. For any emissions unit that has not begun normal operations on the particular date, actual emissions shall equal the potential to emit of the unit on that date.

“*Administrator*” means the administrator for the United States Environmental Protection Agency (EPA) or designee.

“*Allowable emissions*” means the emissions rate of a stationary source calculated using the maximum rated capacity of the source (unless the source is subject to federally enforceable limits or enforceable permit conditions which restrict the operating rate, or hours of operation, or both) and the most stringent of the following:

1. The applicable standards as set forth in 567—subrules 23.1(2) through 23.1(5) (new source performance standards, emissions standards for hazardous air pollutants, and federal emissions guidelines) or an applicable federal standard not adopted by the state, as set forth in 40 CFR Parts 60, 61 and 63;

2. The applicable state implementation plan (SIP) emissions limitation, including those with a future compliance date; or

3. The emissions rate specified as an enforceable permit condition, including those with a future compliance date.

“*Baseline actual emissions,*” for the purposes of this chapter, means the rate of emissions, in tons per year, of a regulated NSR pollutant, as “regulated NSR pollutant” is defined in this subrule, and as determined in accordance with paragraphs “1” through “4.”

1. For any existing electric utility steam generating unit, “baseline actual emissions” means the average rate, in tons per year, at which the unit actually emitted the pollutant during any consecutive 24-month period selected by the owner or operator within the five-year period immediately preceding the date on which the owner or operator begins actual construction of the project. The department shall allow the use of a different time period upon a determination that it is more representative of normal source operation.

(a) The average rate shall include fugitive emissions to the extent quantifiable and emissions associated with startups, shutdowns, and malfunctions.

(b) The average rate shall be adjusted downward to exclude any noncompliant emissions that occurred while the source was operating above an emissions limitation that was legally enforceable during the consecutive 24-month period.

(c) For a regulated NSR pollutant, when a project involves multiple emissions units, only one consecutive 24-month period must be used to determine the baseline actual emissions for the emissions units being changed. A different consecutive 24-month period may be used for each regulated NSR pollutant.

(d) The average rate shall not be based on any consecutive 24-month period for which there is inadequate information for determining annual emissions, in tons per year, and for adjusting this amount if required by paragraph “1”(b) of this definition.

2. For an existing emissions unit, other than an electric utility steam generating unit, “baseline actual emissions” means the average rate, in tons per year, at which the emissions unit actually emitted the pollutant during any consecutive 24-month period selected by the owner or operator within the ten-year period immediately preceding either the date on which the owner or operator begins actual construction of the project, or the date on which a complete permit application is received by the department for a permit required either under this chapter or under a SIP approved by the Administrator, whichever is earlier, except that the ten-year period shall not include any period earlier than November 15, 1990.

(a) The average rate shall include fugitive emissions to the extent quantifiable and emissions associated with startups, shutdowns, and malfunctions.

(b) The average rate shall be adjusted downward to exclude any noncompliant emissions that occurred while the source was operating above an emissions limitation that was legally enforceable during the consecutive 24-month period.

(c) The average rate shall be adjusted downward to exclude any emissions that would have exceeded an emissions limitation with which the major stationary source must currently comply, had such major stationary source been required to comply with such limitations during the consecutive

24-month period. However, if an emissions limitation is part of a maximum achievable control technology standard that the Administrator proposed or promulgated under 40 CFR Part 63, the baseline actual emissions need only be adjusted if the state has taken credit for such emissions reductions in an attainment demonstration or maintenance plan consistent with the requirements of 40 CFR 51.165(a)(3)(ii)(G) as amended through November 29, 2005.

(d) For a regulated NSR pollutant, when a project involves multiple emissions units, only one consecutive 24-month period must be used to determine the baseline actual emissions for the emissions units being changed. A different consecutive 24-month period may be used for each regulated NSR pollutant.

(e) The average rate shall not be based on any consecutive 24-month period for which there is inadequate information for determining annual emissions, in tons per year, and for adjusting this amount if required by paragraphs “2”(b) and “2”(c) of this definition.

3. For a new emissions unit, the baseline actual emissions for purposes of determining the emissions increase that will result from the initial construction and operation of such unit shall equal zero; and thereafter, for all other purposes, shall equal the unit’s potential to emit.

4. For a PAL for a stationary source, the baseline actual emissions shall be calculated for existing electric utility steam generating units in accordance with the procedures contained in paragraph “1”; for other existing emissions units in accordance with the procedures contained in paragraph “2”; and for a new emissions unit in accordance with the procedures contained in paragraph “3.”

*“Baseline area”* means:

1. Any intrastate area (and every part thereof) designated as attainment or unclassifiable under Section 107(d)(1)(A)(ii) or (iii) of the Act in which the major source or major modification establishing the minor source baseline date would construct or would have an air quality impact for the pollutant for which the baseline date is established, as follows: equal to or greater than 1  $\mu\text{g}/\text{m}^3$  (annual average) for sulfur dioxide ( $\text{SO}_2$ ), nitrogen dioxide ( $\text{NO}_2$ ) or  $\text{PM}_{10}$ ; or equal to or greater than 0.3  $\mu\text{g}/\text{m}^3$  (annual average) for  $\text{PM}_{2.5}$ .

2. Area redesignations under Section 107(d)(1)(A)(ii) or (iii) of the Act cannot intersect or be smaller than the area of impact of any major stationary source or major modification which establishes a minor source baseline date or is subject to regulations specified in this rule, in 40 CFR 52.21 (PSD requirements), or in department rules approved by EPA under 40 CFR Part 51, Subpart I, and would be constructed in the same state as the state proposing the redesignation.

3. Any baseline area established originally for the total suspended particulate increments shall remain in effect and shall apply for purposes of determining the amount of available  $\text{PM}_{10}$  increments, except that such baseline area shall not remain in effect if the permitting authority rescinds the corresponding minor source baseline date in accordance with the definition of “baseline date” specified in this subrule.

*“Baseline concentration”* means:

1. The ambient concentration level that exists in the baseline area at the time of the applicable minor source baseline date. A baseline concentration is determined for each pollutant for which a minor source baseline date is established and shall include:

(a) The actual emissions representative of sources in existence on the applicable minor source baseline date, except as provided in paragraph “2” of this definition;

(b) The allowable emissions of major stationary sources that commenced construction before the major source baseline date, but were not in operation by the applicable minor source baseline date.

2. The following will not be included in the baseline concentration and will affect the applicable maximum allowable increase(s):

(a) Actual emissions from any major stationary source on which construction commenced after the major source baseline date; and

(b) Actual emissions increases and decreases at any stationary source occurring after the minor source baseline date.

*“Baseline date”* means:

1. Either “major source baseline date” or “minor source baseline date” as follows:

(a) The “major source baseline date” means, in the case of PM<sub>10</sub> and sulfur dioxide, January 6, 1975; in the case of nitrogen dioxide, February 8, 1988; and in the case of PM<sub>2.5</sub>, October 20, 2010.

(b) The “minor source baseline date” means the earliest date after the trigger date on which a major stationary source or a major modification subject to 40 CFR 52.21 as amended through October 20, 2010, or subject to this rule (PSD program requirements), or subject to a department rule approved by EPA under 40 CFR Part 51, Subpart I, submits a complete application under the relevant regulations. The trigger date for PM<sub>10</sub> and sulfur dioxide is August 7, 1977. For nitrogen dioxide, the trigger date is February 8, 1988. For PM<sub>2.5</sub>, the trigger date is October 20, 2011.

2. The “baseline date” is established for each pollutant for which increments or other equivalent measures have been established if:

(a) The area in which the proposed source or modification would construct is designated as attainment or unclassifiable under Section 107(d)(1)(A)(ii) or (iii) of the Act for the pollutant on the date of its complete application under 40 CFR 52.21 as amended through October 20, 2010, or under regulations specified in this rule (PSD program requirements); and

(b) In the case of a major stationary source, the pollutant would be emitted in significant amounts, or in the case of a major modification, there would be a significant net emissions increase of the pollutant.

Any minor source baseline date established originally for the total suspended particulate increments shall remain in effect and shall apply for purposes of determining the amount of available PM<sub>10</sub> increments, except that the reviewing authority may rescind any such minor source baseline date where it can be shown, to the satisfaction of the reviewing authority, that the emissions increase from the major stationary source, or the net emissions increase from the major modification, responsible for triggering that date did not result in a significant amount of PM<sub>10</sub> emissions.

“*Begin actual construction*” means, in general, initiation of physical on-site construction activities on an emissions unit which are of a permanent nature. Such activities include, but are not limited to, installation of building supports and foundations, laying of underground pipework, and construction of permanent storage structures. With respect to a change in method of operation, this term refers to those on-site activities, other than preparatory activities, which mark the initiation of the change.

“*Best available control technology*” or “*BACT*” means an emissions limitation, including a visible emissions standard, based on the maximum degree of reduction for each regulated NSR pollutant which would be emitted from any proposed major stationary source or major modification which the reviewing authority, on a case-by-case basis, taking into account energy, environmental, and economic impacts and other costs, determines is achievable for such source or modification through application of production processes or available methods, systems, and techniques, including fuel cleaning or treatment or innovative fuel combination techniques for control of such pollutant. In no event shall application of best available control technology result in emissions of any pollutant which would exceed the emissions allowed by any applicable standard under 567—subrules 23.1(2) through 23.1(5) (standards for new stationary sources, federal standards for hazardous air pollutants, and federal emissions guidelines), or federal regulations as set forth in 40 CFR Parts 60, 61 and 63 but not yet adopted by the state. If the department determines that technological or economic limitations on the application of measurement methodology to a particular emissions unit would make the imposition of an emissions standard infeasible, a design, equipment, work practice, operational standard or combination thereof may be prescribed instead to satisfy the requirement for the application of best available control technology. Such standard shall, to the degree possible, set forth the emissions reduction achievable by implementation of such design, equipment, work practice or operation and shall provide for compliance by means which achieve equivalent results.

“*Building, structure, facility, or installation*” means all of the pollutant-emitting activities which belong to the same industrial grouping, are located on one or more contiguous or adjacent properties, and are under the control of the same person (or persons under common control) except the activities of any vessel. Pollutant-emitting activities shall be considered as part of the same industrial grouping if they belong to the same major group (i.e., which have the same two-digit code) as described in the Standard Industrial Classification Manual, 1972, as amended by the 1977 Supplement (U.S. Government Printing Office stock numbers 4101-0066 and 003-005-00176-0, respectively).

“CFR” means the Code of Federal Regulations, with standard references in this chapter by title and part, so that “40 CFR 51” or “40 CFR Part 51” means “Title 40 Code of Federal Regulations, Part 51.”

“Clean coal technology” means any technology, including technologies applied at the precombustion, combustion, or postcombustion stage, at a new or existing facility which will achieve significant reductions in air emissions of sulfur dioxide or oxides of nitrogen associated with the utilization of coal in the generation of electricity, or process steam which was not in widespread use as of November 15, 1990.

“Clean coal technology demonstration project” means a project using funds appropriated under the heading “Department of Energy—Clean Coal Technology,” up to a total amount of \$2,500,000,000 for commercial demonstration of clean coal technology, or similar projects funded through appropriations for the Environmental Protection Agency. The federal contribution for a qualifying project shall be at least 20 percent of the total cost of the demonstration project.

“Commence,” as applied to construction of a major stationary source or major modification, means that the owner or operator has all necessary preconstruction approvals or permits and either has:

1. Begun, or caused to begin, a continuous program of actual on-site construction of the source, to be completed within a reasonable time; or

2. Entered into binding agreements or contractual obligations, which cannot be canceled or modified without substantial loss to the owner or operator, to undertake a program of actual construction of the source to be completed within a reasonable time.

“Complete” means, in reference to an application for a permit, that the application contains all the information necessary for processing the application. Designating an application complete for purposes of permit processing does not preclude the department from requesting or accepting any additional information.

“Construction” means any physical change or change in the method of operation, including fabrication, erection, installation, demolition, or modification of an emissions unit, that would result in a change in emissions.

“Continuous emissions monitoring system” or “CEMS” means all of the equipment that may be required to meet the data acquisition and availability requirements of this chapter, to sample, to condition (if applicable), to analyze, and to provide a record of emissions on a continuous basis.

“Continuous emissions rate monitoring system” or “CERMS” means the total equipment required for the determination and recording of the pollutant mass emissions rate (in terms of mass per unit of time).

“Continuous parameter monitoring system” or “CPMS” means all of the equipment necessary to meet the data acquisition and availability requirements of this chapter, to monitor the process device operational parameters and the control device operational parameters (e.g., control device secondary voltages and electric currents) and other information (e.g., gas flow rate, O<sub>2</sub> or CO<sub>2</sub> concentrations), and to record the average operational parameter value(s) on a continuous basis.

“Electric utility steam generating unit” means any steam electric generating unit that is constructed for the purpose of supplying more than one-third of its potential electric output capacity and more than 25 MW electrical output to any utility power distribution system for sale. Any steam supplied to a steam distribution system for the purpose of providing steam to a steam-electric generator that would produce electrical energy for sale is also considered in determining the electrical energy output capacity of the affected facility.

“Emissions unit” means any part of a stationary source that emits or would have the potential to emit any regulated NSR pollutant and includes an electric utility steam generating unit. For purposes of this chapter, there are two types of emissions units:

1. A new emissions unit is any emissions unit that is (or will be) newly constructed and that has existed for less than two years from the date such emissions unit first operated.

2. An existing emissions unit is any emissions unit that does not meet the requirements in “1” above. A replacement unit is an existing emissions unit.

“Enforceable permit condition,” for the purpose of this chapter, means any of the following limitations and conditions: requirements developed pursuant to new source performance standards,

prevention of significant deterioration standards, emissions standards for hazardous air pollutants, requirements within the SIP, and any permit requirements established pursuant to this chapter, any permit requirements established pursuant to 40 CFR 52.21 or Part 51, Subpart I, as amended through October 20, 2010, or under construction or Title V operating permit rules.

*“Federal land manager”* means, with respect to any lands in the United States, the secretary of the department with authority over such lands.

*“Federally enforceable”* means all limitations and conditions which are enforceable by the Administrator and the department, including those federal requirements not yet adopted by the state, developed pursuant to 40 CFR Parts 60, 61 and 63; requirements within 567—subrules 23.1(2) through 23.1(5); requirements within the SIP; any permit requirements established pursuant to 40 CFR 52.21 or under regulations approved pursuant to 40 CFR Part 51, Subpart I, as amended through October 20, 2010, including operating permits issued under an EPA-approved program, that are incorporated into the SIP and expressly require adherence to any permit issued under such program.

*“Fugitive emissions”* means those emissions which could not reasonably pass through a stack, chimney, vent, or other functionally equivalent opening.

*“High terrain”* means any area having an elevation 900 feet or more above the base of the stack of a source.

*“Indian governing body”* means the governing body of any tribe, band, or group of Indians subject to the jurisdiction of the United States and recognized by the United States as possessing power of self-government.

*“Indian reservation”* means any federally recognized reservation established by treaty, agreement, executive order, or Act of Congress.

*“Innovative control technology”* means any system of air pollution control that has not been adequately demonstrated in practice, but would have a substantial likelihood of achieving greater continuous emissions reduction than any control system in current practice or of achieving at least comparable reductions at lower cost in terms of energy, economics, or non-air quality environmental impacts.

*“Lowest achievable emissions rate”* or *“LAER”* means, for any source, the more stringent rate of emissions based on the following:

1. The most stringent emissions limitation which is contained in the SIP for such class or category of stationary source, unless the owner or operator of the proposed stationary source demonstrates that such limitations are not achievable; or

2. The most stringent emissions limitation which is achieved in practice by such class or category of stationary sources. This limitation, when applied to a modification, means the lowest achievable emissions rate for the new or modified emissions units within a stationary source. In no event shall the application of the term permit a proposed new or modified stationary source to emit any pollutant in excess of the amount allowable under an applicable new source standard of performance.

*“Low terrain”* means any area other than high terrain.

*“Major modification”* means any physical change in or change in the method of operation of a major stationary source that would result in a significant emissions increase of a regulated NSR pollutant and a significant net emissions increase of that pollutant from the major stationary source.

1. Any significant emissions increase from any emissions units or net emissions increase at a major stationary source that is significant for volatile organic compounds or NO<sub>x</sub> shall be considered significant for ozone.

2. A physical change or change in the method of operation shall not include:

- (a) Routine maintenance, repair and replacement
- (b) Use of an alternative fuel or raw material by reason of any order under Section 2(a) and (b) of the Energy Supply and Environmental Coordination Act of 1974 or by reason of a natural gas curtailment plan pursuant to the Federal Power Act;
- (c) Use of an alternative fuel by reason of an order or rule under Section 125 of the Act;
- (d) Use of an alternative fuel at a steam generating unit to the extent that the fuel is generated from municipal solid waste;

(e) Use of an alternative fuel or raw material by a stationary source that the source was capable of accommodating before January 6, 1975, unless such change would be prohibited under any federally enforceable permit condition, or that the source is approved to use under any federally enforceable permit condition;

(f) An increase in the hours of operation or in the production rate, unless such change would be prohibited under any federally enforceable permit condition which was established after January 6, 1975;

(g) Any change in ownership at a stationary source;

(h) Reserved.

(i) The installation, operation, cessation, or removal of a temporary clean coal technology demonstration project, provided that the project complies with the requirements within the SIP; and other requirements necessary to attain and maintain the national ambient air quality standards during the project and after the project is terminated;

(j) The installation or operation of a permanent clean coal technology demonstration project that constitutes repowering, provided that the project does not result in an increase in the potential to emit of any regulated pollutant emitted by the unit. This exemption shall apply on a pollutant-by-pollutant basis;

(k) The reactivation of a very clean coal-fired electric utility steam generating unit.

3. This definition shall not apply with respect to a particular regulated NSR pollutant when the major stationary source is complying with the requirements under rule 567—33.9(455B) for a PAL for that pollutant. Instead, the definition under rule 567—33.9(455B) shall apply.

*“Major source baseline date”* is defined under the definition of “baseline date.”

*“Major stationary source”* means:

(1) (a) Any one of the following stationary sources of air pollutants which emits, or has the potential to emit, 100 tons per year or more of any regulated NSR pollutant:

- Fossil fuel-fired steam electric plants of more than 250 million British thermal units per hour heat input;

- Coal cleaning plants (with thermal dryers);

- Kraft pulp mills;

- Portland cement plants;

- Primary zinc smelters;

- Iron and steel mill plants;

- Primary aluminum ore reduction plants;

- Primary copper smelters;

- Municipal incinerators capable of charging more than 250 tons of refuse per day;

- Hydrofluoric, sulfuric, and nitric acid plants;

- Petroleum refineries;

- Lime plants;

- Phosphate rock processing plants;

- Coke oven batteries;

- Sulfur recovery plants;

- Carbon black plants (furnace process);

- Primary lead smelters;

- Fuel conversion plants;

- Sintering plants;

- Secondary metal production plants;

- Chemical process plants (which does not include ethanol production facilities that produce ethanol by natural fermentation included in NAICS code 325193 or 312140);

- Fossil-fuel boilers (or combinations thereof) totaling more than 250 million British thermal units per hour heat input;

- Petroleum storage and transfer units with a total storage capacity exceeding 300,000 barrels;

- Taconite ore processing plants;

- Glass fiber processing plants; and

- Charcoal production plants.

(b) Notwithstanding the stationary source size specified in paragraph “1”(a), any stationary source which emits, or has the potential to emit, 250 tons per year or more of a regulated NSR pollutant; or

(c) Any physical change that would occur at a stationary source not otherwise qualifying under this definition as a major stationary source if the change would constitute a major stationary source by itself.

(2) A major source that is major for volatile organic compounds or NO<sub>x</sub> shall be considered major for ozone.

(3) The fugitive emissions of a stationary source shall not be included in determining for any of the purposes of this rule whether it is a major stationary source, unless the source belongs to one of the categories of stationary sources listed in paragraph “1”(a) of this definition or to any other stationary source category which, as of August 7, 1980, is being regulated under Section 111 or 112 of the Act.

“*Minor source baseline date*” is defined under the definition of “baseline date.”

“*Necessary preconstruction approvals or permits*” means those permits or approvals required under federal air quality control laws and regulations and those air quality control laws and regulations which are part of the SIP.

“*Net emissions increase*” means, with respect to any regulated NSR pollutant emitted by a major stationary source, the amount by which the following exceeds zero:

- The increase in emissions from a particular physical change or change in the method of operation at a stationary source as calculated according to the applicability requirements under subrule 33.3(2); and

- Any other increases and decreases in actual emissions at the major stationary source that are contemporaneous with the particular change and are otherwise creditable. Baseline actual emissions for calculating increases and decreases under this definition of “net emissions increase” shall be determined as provided for under the definition of “baseline actual emissions,” except that paragraphs “1”(c) and “2”(d) of the definition of “baseline actual emissions,” which describe provisions for multiple emissions units, shall not apply.

1. An increase or decrease in actual emissions is contemporaneous with the increase from the particular change only if the increase or decrease in actual emissions occurs between the date five years before construction on the particular change commences and the date that the increase from the particular change occurs.

2. An increase or decrease in actual emissions is creditable only if:

- (a) The increase or decrease in actual emissions occurs within the contemporaneous time period, as noted in paragraph “1” of this definition; and

- (b) The department has not relied on the increase or decrease in actual emissions in issuing a permit for the source under this rule, which permit is in effect when the increase in actual emissions from the particular change occurs.

3. An increase or decrease in actual emissions of sulfur dioxide, particulate matter, or nitrogen oxides that occurs before the applicable minor source baseline date is creditable only if the increase or decrease in actual emissions is required to be considered in calculating the amount of maximum allowable increases remaining available.

4. An increase in actual emissions is creditable only to the extent that the new level of actual emissions exceeds the old level.

5. A decrease in actual emissions is creditable only to the extent that:

- (a) The old level of actual emissions or the old level of allowable emissions, whichever is lower, exceeds the new level of actual emissions;

- (b) The decrease in actual emissions is enforceable as a practical matter at and after the time that actual construction on the particular change begins; and

- (c) The decrease in actual emissions has approximately the same qualitative significance for public health and welfare as that attributed to the increase from the particular change.

6. An increase that results from a physical change at a source occurs when the emissions unit on which construction occurred becomes operational and begins to emit a particular pollutant. Any replacement unit that requires shakedown becomes operational only after a reasonable shakedown period, not to exceed 180 days.

7. The definition of “actual emissions,” paragraph “2,” shall not apply for determining creditable increases and decreases.

“*Nonattainment area*” means an area so designated by the Administrator, acting pursuant to Section 107 of the Act.

“*Permitting authority*” means the Iowa department of natural resources or the director thereof.

“*Pollution prevention*” means any activity that, through process changes, product reformulation or redesign, or substitution of less polluting raw materials, eliminates or reduces the release of air pollutants (including fugitive emissions) and other pollutants to the environment prior to recycling, treatment, or disposal. “Pollution prevention” does not mean recycling (other than certain “in-process recycling” practices), energy recovery, treatment, or disposal.

“*Potential to emit*” means the maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the source to emit a pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design if the limitation or the effect it would have on emissions is federally enforceable. Secondary emissions do not count in determining the potential to emit of a stationary source.

“*Predictive emissions monitoring system*” or “*PEMS*” means all of the equipment necessary to monitor the process device operational parameters and the control device operational parameters (e.g., control device secondary voltages and electric currents) and other information (e.g., gas flow rate, O<sub>2</sub> or CO<sub>2</sub> concentrations), and calculate and record the mass emissions rate (e.g., lb/hr) on a continuous basis.

“*Prevention of significant deterioration (PSD) program*” means a major source preconstruction permit program that has been approved by the Administrator and incorporated into the SIP or means the program in 40 CFR 52.21. Any permit issued under such a program is a major NSR permit.

“*Project*” means a physical change in, or change in method of operation of, an existing major stationary source.

“*Projected actual emissions,*” for the purposes of this chapter, means the maximum annual rate, in tons per year, at which an existing emissions unit is projected to emit a regulated NSR pollutant in any one of the five years (12-month period) beginning on the first day of the month following the date when the unit resumes regular operation after the project, or in any one of the ten years following that date, if the project involves increasing the emissions unit’s design capacity or its potential to emit that regulated NSR pollutant, and full utilization of the unit would result in a significant emissions increase, or a significant net emissions increase at the major stationary source. For purposes of this definition, “regular” shall be determined by the department on a case-by-case basis.

In determining the projected actual emissions before beginning actual construction, the owner or operator of the major stationary source:

1. Shall consider all relevant information including, but not limited to, historical operational data, the company’s own representations, the company’s expected business activity and the company’s highest projections of business activity, the company’s filings with the state or federal regulatory authorities, and compliance plans under the approved plan; and

2. Shall include fugitive emissions to the extent quantifiable and emissions associated with startups, shutdowns, and malfunctions; and

3. Shall exclude, in calculating any increase in emissions that results from the particular project, that portion of the unit’s emissions following the project that an existing unit could have accommodated during the consecutive 24-month period used to establish the baseline actual emissions and that are also unrelated to the particular project, including any increased utilization due to product demand growth; and

4. In lieu of using the method set out in paragraphs “1” through “3,” may elect to use the emissions unit’s potential to emit, in tons per year.

“*Reactivation of a very clean coal-fired electric utility steam generating unit*” means any physical change or change in the method of operation associated with the commencement of commercial operations by a coal-fired utility unit after a period of discontinued operation in which the unit:

1. Has not been in operation for the two-year period prior to the enactment of the Act, and the emissions from such unit continue to be carried in the permitting authority's emissions inventory at the time of the enactment;

2. Was equipped prior to shutdown with a continuous system of emissions control that achieves a removal efficiency for sulfur dioxide of no less than 85 percent and a removal efficiency for particulates of no less than 98 percent;

3. Is equipped with low-NO<sub>x</sub> burners prior to the time of commencement of operations following reactivation; and

4. Is otherwise in compliance with the requirements of the Act.

*"Regulated NSR pollutant"* means the following:

1. Any pollutant for which a national ambient air quality standard has been promulgated and any constituents or precursors for such pollutants identified by the Administrator:

(a) Volatile organic compounds and nitrogen oxides are precursors to ozone in all attainment and unclassifiable areas;

(b) Sulfur dioxide is a precursor to PM<sub>2.5</sub> in all attainment and unclassifiable areas;

(c) Nitrogen oxides are presumed to be precursors to PM<sub>2.5</sub> in all attainment and unclassifiable areas, unless the department demonstrates to EPA's satisfaction or EPA demonstrates that emissions of nitrogen oxides from sources in a specific area are not a significant contributor to the area's ambient PM<sub>2.5</sub> concentrations;

(d) Volatile organic compounds are presumed not to be precursors to PM<sub>2.5</sub> in any attainment and unclassifiable areas, unless the department demonstrates to EPA's satisfaction or EPA demonstrates that emissions of volatile organic compounds from sources in a specific area are a significant contributor to that area's ambient PM<sub>2.5</sub> concentrations;

2. Any pollutant that is subject to any standard promulgated under Section 111 of the Act;

3. Any Class I or Class II substance subject to a standard promulgated under or established by Title VI of the Act; or

4. Any pollutant that otherwise is subject to regulation under the Act as defined in 33.3(1), definition of "subject to regulation."

5. Notwithstanding paragraphs "1" through "4," the definition of "regulated NSR pollutant" shall not include any or all hazardous air pollutants that are either listed in Section 112 of the Act or added to the list pursuant to Section 112(b)(2) of the Act and that have not been delisted pursuant to Section 112(b)(3) of the Act, unless the listed hazardous air pollutant is also regulated as a constituent or precursor of a general pollutant listed under Section 108 of the Act.

6. Particulate matter (PM) emissions, PM<sub>2.5</sub> emissions and PM<sub>10</sub> emissions shall include gaseous emissions from a source or activity which condense to form particulate matter at ambient temperatures.

*"Replacement unit"* means an emissions unit for which all the criteria listed in paragraphs "1" through "4" of this definition are met. No creditable emissions reductions shall be generated from shutting down the existing emissions unit that is replaced.

1. The emissions unit is a reconstructed unit within the meaning of 40 CFR 60.15(b)(1) as amended through December 16, 1975, or the emissions unit completely takes the place of an existing emissions unit.

2. The emissions unit is identical to or functionally equivalent to the replaced emissions unit.

3. The replacement does not change the basic design parameter(s) of the process unit.

4. The replaced emissions unit is permanently removed from the major stationary source, otherwise permanently disabled, or permanently barred from operation by a permit that is enforceable as a practical matter. If the replaced emissions unit is brought back into operation, it shall constitute a new emissions unit.

*"Repowering"* means:

1. Replacement of an existing coal-fired boiler with one of the following clean coal technologies: atmospheric or pressurized fluidized bed combustion; integrated gasification combined cycle; magnetohydrodynamics; direct and indirect coal-fired turbines; integrated gasification fuel cells; or, as determined by the Administrator in consultation with the Secretary of Energy, a derivative of one

or more of these technologies; and any other technology capable of controlling multiple combustion emissions simultaneously with improved boiler or generation efficiency and with significantly greater waste reduction relative to the performance of technology in widespread commercial use as of November 15, 1990.

2. Repowering shall also include any oil or gas-fired unit which has been awarded clean coal technology demonstration funding as of January 1, 1991, by the Department of Energy.

3. The department shall give expedited consideration to permit applications for any source that satisfies the requirements of this definition and is granted an extension under Section 409 of the Act.

“*Reviewing authority*” means the department, or the Administrator in the case of EPA-implemented permit programs under 40 CFR 52.21.

“*Secondary emissions*” means emissions which occur as a result of the construction or operation of a major stationary source or major modification, but do not come from the major stationary source or major modification itself. For the purposes of this chapter, “secondary emissions” must be specific, well-defined, and quantifiable, and must impact the same general areas as the stationary source modification which causes the secondary emissions. “Secondary emissions” includes emissions from any offsite support facility which would not be constructed or increase its emissions except as a result of the construction or operation of the major stationary source or major modification. “Secondary emissions” does not include any emissions which come directly from a mobile source, such as emissions from the tailpipe of a motor vehicle, from a train, or from a vessel.

“*Significant*” means:

1. In reference to a net emissions increase or the potential of a source to emit any of the following pollutants, a rate of emissions that would equal or exceed any of the following rates:

Pollutant and Emissions Rate

- Carbon monoxide: 100 tons per year (tpy)
- Nitrogen oxides: 40 tpy
- Sulfur dioxide: 40 tpy
- Particulate matter: 25 tpy of particulate matter emissions
- PM<sub>10</sub>: 15 tpy
- PM<sub>2.5</sub>: 10 tpy of direct PM<sub>2.5</sub> emissions; 40 tpy of sulfur dioxide emissions; 40 tpy of nitrogen oxide emissions (unless the department demonstrates to EPA’s satisfaction that emissions of nitrogen oxides from sources in a specific area are not a significant contributor to the area’s ambient PM<sub>2.5</sub> concentrations)
  - Ozone: 40 tpy of volatile organic compounds or NO<sub>x</sub>
  - Lead: 0.6 tpy
  - Fluorides: 3 tpy
  - Sulfuric acid mist: 7 tpy
  - Hydrogen sulfide (H<sub>2</sub>S): 10 tpy
  - Total reduced sulfur (including H<sub>2</sub>S): 10 tpy
  - Reduced sulfur compounds (including H<sub>2</sub>S): 10 tpy
  - Municipal waste combustor organics (measured as total tetra- through octa-chlorinated dibenzo-p-dioxins and dibenzofurans):  $3.2 \times 10^{-6}$  megagrams per year ( $3.5 \times 10^{-6}$  tons per year)
  - Municipal waste combustor metals (measured as particulate matter): 14 megagrams per year (15 tons per year)
  - Municipal waste combustor acid gases (measured as sulfur dioxide and hydrogen chloride): 36 megagrams per year (40 tons per year)
  - Municipal solid waste landfill emissions (measured as nonmethane organic compounds): 45 megagrams per year (50 tons per year)

2. “Significant” means, for purposes of this rule and in reference to a net emissions increase or the potential of a source to emit a regulated NSR pollutant not listed in paragraph “1,” any emissions rate.

3. Notwithstanding paragraph “1,” “significant,” for purposes of this rule, means any emissions rate or any net emissions increase associated with a major stationary source or major modification, which

would construct within ten kilometers of a Class I area and have an impact on such area equal to or greater than 1 µg/m<sup>3</sup> (24-hour average).

“*Significant emissions increase*” means, for a regulated NSR pollutant, an increase in emissions that is significant for that pollutant.

“*State implementation plan*” or “*SIP*” means the plan adopted by the state of Iowa and approved by the Administrator which provides for implementation, maintenance, and enforcement of such primary and secondary ambient air quality standards as they are adopted by the Administrator, pursuant to the Act.

“*Stationary source*” means any building, structure, facility, or installation which emits or may emit a regulated NSR pollutant.

“*Subject to regulation*” means, for any air pollutant, that the pollutant is subject to either a provision in the Clean Air Act, or a nationally applicable regulation codified by the Administrator in 40 CFR Subchapter C (Air Programs) that requires actual control of the quantity of emissions of that pollutant, and that such a control requirement has taken effect and is operative to control, limit or restrict the quantity of emissions of that pollutant released from the regulated activity, except that:

1. Greenhouse gases (GHGs), the air pollutant defined in 40 CFR §86.1818-12(a) (as amended through September 15, 2011) as the aggregate group of six greenhouse gases that includes carbon dioxide, nitrous oxide, methane, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride, shall not be subject to regulation except as provided in paragraph “4,” and shall not be subject to regulation if the stationary source maintains its total sourcewide emissions below the GHG PAL level, meets the requirements in rule 567—33.9(455B), and complies with the PAL permit containing the GHG PAL.

2. For purposes of paragraphs “3” and “4,” the term “tpy CO<sub>2</sub> equivalent emissions (CO<sub>2</sub>e)” shall represent an amount of GHGs emitted and shall be computed as follows:

(a) Multiply the mass amount of emissions (tpy) for each of the six greenhouse gases in the pollutant GHGs by the associated global warming potential of the gas published at 40 CFR Part 98, Subpart A, Table A-1, “Global Warming Potentials,” (as amended through December 24, 2014). For purposes of this definition, prior to July 21, 2014, the mass of the greenhouse gas carbon dioxide shall not include carbon dioxide emissions resulting from the combustion or decomposition of non-fossilized and biodegradable organic material originating from plants, animals, or micro-organisms (including products, by-products, residues and waste from agriculture, forestry and related industries as well as the non-fossilized and biodegradable organic fractions of industrial and municipal wastes, including gases and liquids recovered from the decomposition of non-fossilized and biodegradable organic material).

(b) Sum the resultant value from paragraph (a) for each gas to compute a tpy CO<sub>2</sub>e.

3. The term “emissions increase,” as used in this paragraph and in paragraph “4,” shall mean that both a significant emissions increase (as calculated using the procedures specified in 33.3(2) “c” through 33.3(2) “h”) and a significant net emissions increase (as specified in 33.3(1), in the definitions of “net emissions increase” and “significant”) occur. For the pollutant GHGs, an emissions increase shall be based on tpy CO<sub>2</sub>e and shall be calculated assuming the pollutant GHGs are a regulated NSR pollutant, and “significant” is defined as 75,000 tpy CO<sub>2</sub>e rather than calculated by applying the value specified in 33.3(1), in paragraph “2” of the definition of “significant.”

4. Beginning January 2, 2011, the pollutant GHGs are subject to regulation if:

(a) The stationary source is a new major stationary source for a regulated NSR pollutant that is not a GHG, and also will emit or will have the potential to emit 75,000 tpy CO<sub>2</sub>e or more, or

(b) The stationary source is an existing major stationary source for a regulated NSR pollutant that is not a GHG, and also will have an emissions increase of a regulated NSR pollutant and an emissions increase of 75,000 tpy CO<sub>2</sub>e or more.

“*Temporary clean coal technology demonstration project*” means a clean coal technology demonstration project that is operated for a period of five years or less and that complies with the SIP and other requirements necessary to attain and maintain the national ambient air quality standards during the project and after the project is terminated.

“*Title V permit*” means an operating permit under Title V of the Act.

“Volatile organic compounds” or “VOC” means any compound included in the definition of “volatile organic compounds” found at 40 CFR 51.100(s) as amended through August 1, 2016.

**33.3(2) Applicability.** The requirements of this rule (PSD program requirements) apply to the construction of any new “major stationary source” as defined in subrule 33.3(1) or any project at an existing major stationary source in an area designated as attainment or unclassifiable under Section 107(d)(1)(A)(ii) or (iii) of the Act. In addition to the provisions set forth in rules 567—33.3(455B) through 567—33.9(455B), the provisions of 40 CFR Part 51, Appendix W (Guideline on Air Quality Models) as amended through November 9, 2005, are adopted by reference.

*a.* The requirements of subrules 33.3(10) through 33.3(18) apply to the construction of any new major stationary source or the major modification of any existing major stationary source, except as this rule (PSD program requirements) otherwise provides.

*b.* No new major stationary source or major modification to which the requirements of subrule 33.3(10) through paragraph 33.3(18) “*e*” apply shall begin actual construction without a permit that states that the major stationary source or major modification will meet those requirements.

*c.* Except as otherwise provided in paragraphs 33.3(2) “*i*” and “*j*,” and consistent with the definition of “major modification” contained in subrule 33.3(1), a project is a major modification for a “regulated NSR pollutant” if it causes two types of emissions increases: a “significant emissions increase”; and a “net emissions increase” which is “significant.” The project is not a major modification if it does not cause a significant emissions increase. If the project causes a significant emissions increase, then the project is a major modification only if it also results in a significant net emissions increase.

*d.* The procedure for calculating (before beginning actual construction) whether a significant emissions increase (i.e., the first step of the process) will occur depends upon the type of emissions units being modified, according to paragraphs “*e*” through “*h*” of this subrule. The procedure for calculating (before beginning actual construction) whether a significant net emissions increase will occur at the major stationary source (i.e., the second step of the process) is contained in the definition of “net emissions increase.” Regardless of any such preconstruction projections, a major modification results if the project causes a significant emissions increase and a significant net emissions increase.

*e.* Actual-to-projected-actual applicability test for projects that only involve existing emissions units. A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the difference between the “projected actual emissions” and the “baseline actual emissions” for each existing emissions unit equals or exceeds the significant amount for that pollutant.

*f.* Actual-to-potential test for projects that involve only construction of a new emissions unit(s). A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the difference between the “potential to emit” from each new emissions unit following completion of the project and the “baseline actual emissions” for a new emissions unit before the project equals or exceeds the significant amount for that pollutant.

*g.* Reserved.

*h.* Hybrid test for projects that involve multiple types of emissions units. A significant emissions increase of a regulated NSR pollutant is projected to occur if the sum of the emissions increases for each emissions unit, using the method specified in paragraphs “*e*” through “*g*” of this subrule, as applicable with respect to each emissions unit, for each type of emissions unit equals or exceeds the significant amount for that pollutant.

*i.* For any major stationary source with a PAL for a regulated NSR pollutant, the major stationary source shall comply with rule requirements under 567—33.9(455B).

*j.* Reserved.

**33.3(3) Ambient air increments.** The provisions for ambient air increments as specified in 40 CFR 52.21(c) as amended through October 20, 2010, are adopted by reference.

**33.3(4) Ambient air ceilings.** The provisions for ambient air ceilings as specified in 40 CFR 52.21(d) as amended through November 29, 2005, are adopted by reference.

**33.3(5) Restrictions on area classifications.** The provisions for restrictions on area classifications as specified in 40 CFR 52.21(e) as amended through November 29, 2005, are adopted by reference.

**33.3(6) Exclusions from increment consumption.** The provisions by which the SIP may provide for exclusions from increment consumption as specified in 40 CFR 51.166(f) as amended through November 29, 2005, are adopted by reference. The following phrases contained in 40 CFR 51.166(f) are not adopted by reference: “the plan may provide that,” “the plan provides that,” and “it shall also provide that.” Additionally, the term “the plan” shall mean “SIP.”

**33.3(7) Redesignation.** The provisions for redesignation as specified in 40 CFR 52.21(g) as amended through November 29, 2005, are adopted by reference.

**33.3(8) Stack heights.** The provisions for stack heights as specified in 40 CFR 52.21(h) as amended through November 29, 2005, are adopted by reference.

**33.3(9) Exemptions.** The provisions for allowing exemptions from certain requirements for PSD-subject sources as specified in 40 CFR 52.21(i) as amended through March 6, 2015, are adopted by reference.

**33.3(10) Control technology review.** The provisions for control technology review as specified in 40 CFR 52.21(j) as amended through November 29, 2005, are adopted by reference.

**33.3(11) Source impact analysis.** The provisions for a source impact analysis as specified in 40 CFR 52.21(k) as amended through December 9, 2013, are adopted by reference.

**33.3(12) Air quality models.** The provisions for air quality models as specified in 40 CFR 52.21(l) as amended through November 29, 2005, are adopted by reference.

**33.3(13) Air quality analysis.** The provisions for an air quality analysis as specified in 40 CFR 52.21(m) as amended through November 29, 2005, are adopted by reference.

**33.3(14) Source information.** The provisions for providing source information as specified in 40 CFR 52.21(n) as amended through November 29, 2005, are adopted by reference.

**33.3(15) Additional impact analyses.** The provisions for an additional impact analysis as specified in 40 CFR 52.21(o) as amended through November 29, 2005, are adopted by reference.

**33.3(16) Sources impacting federal Class I areas—additional requirements.** The provisions for sources impacting federal Class I areas as specified in 40 CFR 51.166(p) as amended through October 20, 2010, are adopted by reference. The following phrases contained in 40 CFR 51.166(p) are not adopted by reference: “the plan may provide that,” “the plan shall provide that,” “the plan shall provide” and “mechanism whereby.”

**33.3(17) Public participation.**

*a.* The department shall notify all applicants within 30 days as to the completeness of the application or any deficiency in the application or information submitted. In the event of such a deficiency, the date of receipt of the application shall be the date on which the department received all required information.

*b.* Within one year after receipt of a complete application, the department shall:

(1) Make a preliminary determination whether construction should be approved, approved with conditions, or disapproved.

(2) Make available in at least one location in each region in which the proposed source would be constructed a copy of all materials the applicant submitted, a copy of the preliminary determination, and a copy or summary of other materials, if any, considered in making the preliminary determination.

(3) Notify the public, by posting on a publicly available website identified by the department, of the application, of the preliminary determination, of the degree of increment consumption that is expected from the source or modification, and of the opportunity for comment at a public hearing as well as written public comment. The electronic notice shall be available for the duration of the public comment period and shall include the notice of public comment, the draft permit(s), information on how to access the administrative record for the draft permit(s) and how to request or attend a public hearing on the draft permit(s). The department may use other means if necessary to ensure adequate notice to the affected public. At least 30 days shall be provided for public comment and for notification of any public hearing.

(4) Send a copy of the notice of public comment to the applicant, to the Administrator and to officials and agencies having cognizance over the location where the proposed construction would occur as follows: any other state or local air pollution control agencies; the chief executives of the city and county where the source would be located; any comprehensive regional land use planning agency; and

any state, federal land manager, or Indian governing body whose lands may be affected by emissions from the source or modification.

(5) Provide opportunity for a public hearing for interested persons to appear and submit written or oral comments on the air quality impact of the source, alternatives to the proposed source or modification, the control technology required, and other appropriate considerations. At least 30 days' notice shall be provided for any public hearing.

(6) Consider all written comments submitted within a time specified in the notice of public comment and all comments received at any public hearing(s) in making a final decision on the approvability of the application. The department shall make all comments available for public inspection at the same locations where the department made available preconstruction information relating to the proposed source or modification.

(7) Make a final determination whether construction should be approved, approved with conditions, or disapproved.

(8) Notify the applicant in writing of the final determination and make such notification available for public inspection at the same locations where the department made available preconstruction information and public comments relating to the proposed source or modification.

c. Reopening of the public comment period.

(1) If comments submitted during the public comment period raise substantial new issues concerning the permit, the department may, at its discretion, take one or more of the following actions:

1. Prepare a new draft permit, appropriately modified;
2. Prepare a revised fact sheet;
3. Prepare a revised fact sheet and reopen the public comment period; or
4. Reopen or extend the public comment period to provide interested persons an opportunity to comment on the comments submitted.

(2) The public notice provided by the department pursuant to this rule shall define the scope of the reopening. Department review of any comments filed during a reopened comment period shall be limited to comments pertaining to the substantial new issues causing the reopening.

**33.3(18) Source obligation.**

a. Approval to construct shall not relieve any owner or operator of the responsibility to comply fully with applicable provisions of the plan and any other requirements under local, state or federal law.

b. At such time that a particular source or modification becomes a major stationary source or major modification solely by virtue of a relaxation in any enforceable limitation which was established after August 7, 1980, on the capacity of the source or modification otherwise to emit a pollutant, such as a restriction on hours of operation, the requirements of subrules 33.3(10) through 33.3(19) shall apply to the source or modification as though construction had not yet commenced on the source or modification.

c. Any owner or operator who constructs or operates a source or modification not in accordance with the application pursuant to the provisions in rule 567—33.3(455B) or with the terms of any approval to construct, or any owner or operator of a source or modification subject to the provisions in rule 567—33.3(455B) who commences construction after April 15, 1987 (the effective date of Iowa's PSD program), without applying for and receiving department approval, shall be subject to appropriate enforcement action.

d. Approval to construct shall become invalid if construction is not commenced within 18 months after receipt of such approval, if construction is discontinued for a period of 18 months or more, or if construction is not completed within a reasonable time. The department may extend the 18-month period upon a satisfactory showing that an extension is justified. These provisions do not apply to the time between construction of the approved phases of a phased construction project; each phase must commence construction within 18 months of the projected and approved commencement date.

e. Reserved.

f. Except as otherwise provided in subparagraph (8), the following specific provisions shall apply with respect to any regulated NSR pollutant emitted from projects at existing emissions units at a major stationary source, other than projects at a source with a PAL, in circumstances where there is a "reasonable possibility," within the meaning of subparagraph (8), that a project that is not part of

a major modification may result in a significant emissions increase of such pollutant, and the owner or operator elects to use the method for calculating projected actual emissions as specified in subrule 33.3(1), paragraphs “1” through “3” of the definition of “projected actual emissions.”

(1) Before beginning actual construction of the project, the owner or operator shall document and maintain a record of the following information:

1. A description of the project;
2. Identification of the emissions unit(s) whose emissions of a regulated NSR pollutant could be affected by the project; and
3. A description of the applicability test used to determine that the project is not a major modification for any regulated NSR pollutant, including the baseline actual emissions, the projected actual emissions, the amount of emissions excluded under paragraph “3” of the definition of “projected actual emissions” in subrule 33.3(1), an explanation describing why such amount was excluded, and any netting calculations, if applicable.

(2) No less than 30 days before beginning actual construction, the owner or operator shall meet with the department to discuss the owner’s or operator’s determination of projected actual emissions for the project and shall provide to the department a copy of the information specified in paragraph “f.” The owner or operator is not required to obtain a determination from the department regarding the project’s projected actual emissions prior to beginning actual construction.

(3) If the emissions unit is an existing electric utility steam generating unit, before beginning actual construction, the owner or operator shall provide a copy of the information set out in subparagraph (1) to the department. The requirements in subparagraphs (1), (2) and (3) shall not be construed to require the owner or operator of such a unit to obtain any determination from the department before beginning actual construction.

(4) The owner or operator shall:

1. Monitor the emissions of any regulated NSR pollutant that could increase as a result of the project and that is emitted by any emissions unit identified in subparagraph (1);

2. Calculate the annual emissions, in tons per year on a calendar-year basis, for a period of five years following resumption of regular operations and maintain a record of regular operations after the change, or for a period of ten years following resumption of regular operations after the change if the project increases the design capacity or potential to emit of that regulated NSR pollutant at such emissions unit (for purposes of this requirement, “regular” shall be determined by the department on a case-by-case basis); and

3. Maintain a written record containing the information required in this subparagraph.

(5) The written record containing the information required in subparagraph (4) shall be retained by the owner or operator for a period of ten years after the project is completed.

(6) If the unit is an existing electric utility steam generating unit, the owner or operator shall submit a report to the department within 60 days after the end of each year during which records must be generated under subparagraph (4) setting out the unit’s annual emissions during the calendar year that preceded submission of the report.

(7) If the unit is an existing unit other than an electric utility steam generating unit, the owner or operator shall submit a report to the department if the annual emissions, in tons per year, from the project identified in subparagraph (1), exceed the baseline actual emissions, as documented and maintained pursuant to subparagraph (4), by an amount that is “significant” as defined in subrule 33.3(1) for that regulated NSR pollutant, and if such emissions differ from the preconstruction projection as documented and maintained pursuant to subparagraph (4). Such report shall be submitted to the department within 60 days after the end of such year. The report shall contain the following:

1. The name, address and telephone number of the major stationary source;
2. The annual emissions as calculated pursuant to subparagraph (4); and
3. Any other information that the owner or operator wishes to include in the report (e.g., an explanation as to why the emissions differ from the preconstruction projection).

(8) A “reasonable possibility” under this paragraph (paragraph 33.3(18) “f”) occurs when the owner or operator calculates the project to result in either:

1. A projected actual emissions increase of at least 50 percent of the amount that is a “significant emissions increase,” as defined under subrule 33.3(1) (without reference to the amount that is a significant net emissions increase), for the regulated NSR pollutant; or

2. A projected actual emissions increase that, when added to the amount of emissions excluded under subrule 33.3(1), paragraph “3” of the definition of “projected actual emissions,” equals at least 50 percent of the amount that is a “significant emissions increase,” as defined under subrule 33.3(1) (without reference to the amount that is a significant net emissions increase), for the regulated NSR pollutant. For a project for which a reasonable possibility occurs only within the meaning of this numbered paragraph, and not also within the meaning of numbered paragraph “1” of this subparagraph (subparagraph (8)), then the provisions of subparagraphs (3) through (7) do not apply to the project.

g. The owner or operator of the source shall make the information required to be documented and maintained pursuant to paragraph “f” available for review upon request for inspection by the department or the general public pursuant to the requirements for Title V operating permits contained in 567—subrule 22.107(6).

**33.3(19) Innovative control technology.** The provisions for innovative control technology as specified in 40 CFR 51.166(s) as amended through November 29, 2005, are adopted by reference. The following phrases contained in 40 CFR 51.166(s) are not adopted by reference: “the plan may provide that” and “the plan shall provide that.”

**33.3(20) Conditions for permit issuance.** Except as explained below, a permit may not be issued to any new “major stationary source” or “major modification” as defined in subrule 33.3(1) that would locate in any area designated as attainment or unclassifiable for any national ambient air quality standard pursuant to Section 107 of the Act, when the source or modification would cause or contribute to a violation of any national ambient air quality standard. A major stationary source or major modification will be considered to cause or contribute to a violation of a national ambient air quality standard when such source or modification would, at a minimum, exceed the following significance levels at any locality that does not or would not meet the applicable national standard:

| Pollutant         | Averaging Time                         |   |  |  |                                       |
|-------------------|--|---|--|--|---------------------------------------|
|                   | Annual<br>( $\mu\text{g}/\text{m}^3$ ) | 24 hrs.<br>( $\mu\text{g}/\text{m}^3$ ) | 8 hrs.<br>( $\mu\text{g}/\text{m}^3$ ) | 3 hrs.<br>( $\mu\text{g}/\text{m}^3$ ) | 1 hr.<br>( $\mu\text{g}/\text{m}^3$ ) |
| SO <sub>2</sub>   | 1.0                                    | 5                                       | _____                                  | 25                                     | _____                                 |
| PM <sub>10</sub>  | 1.0                                    | 5                                       | _____                                  | _____                                  | _____                                 |
| PM <sub>2.5</sub> | 0.3                                    | 1.2                                     | _____                                  | _____                                  | _____                                 |
| NO <sub>2</sub>   | 1.0                                    | _____                                   | _____                                  | _____                                  | _____                                 |
| CO                | _____                                  | _____                                   | 500                                    | _____                                  | 2000                                  |

A permit may be granted to a major stationary source or major modification as identified above if the major stationary source or major modification reduces the impact of its emissions upon air quality by obtaining sufficient emissions reductions to compensate for its adverse ambient air impact where the major stationary source or major modification would otherwise contribute to a violation of any national ambient air quality standard. This subrule shall not apply to a major stationary source or major modification with respect to a particular pollutant if the owner or operator demonstrates that the source is located in an area designated under Section 107 of the Act as nonattainment for that pollutant.

**33.3(21) Administrative amendments.**

a. Upon request for an administrative amendment, the department may take final action on any such request and may incorporate the requested changes without providing notice to the public or to affected states, provided that the department designates any such permit revisions as having been made pursuant to subrule 33.3(21).

b. An administrative amendment is a permit revision that does any of the following:

- (1) Corrects typographical errors;
- (2) Corrects word processing errors;

(3) Identifies a change in name, address or telephone number of any person identified in the permit or provides a similar minor administrative change at the source; or

(4) Allows for a change in ownership or operational control of a source where the department determines that no other change in the permit is necessary, provided that a written agreement that contains a specific date for transfer of permit responsibility, coverage, and liability between the current permittee and the new permittee has been submitted to the department.

**33.3(22) Permit rescission.** Any permit issued under 40 CFR 52.21 or this chapter or any permit issued under rule 567—22.4(455B) shall remain in effect unless and until it is rescinded. The department will consider requests for rescission that meet the conditions specified under paragraphs “a” and “b” of this subrule. If the department rescinds a permit or a condition in a permit issued under 40 CFR 52.21, this chapter, or rule 567—22.4(455B), the public shall be given adequate notice of the proposed rescission. Posting of an announcement of rescission on a publicly available website identified by the department 60 days prior to the proposed date for rescission shall be considered adequate notice.

a. The department may rescind a permit or a portion of a permit upon request from an owner or operator of a stationary source who holds a permit for a source or modification that was issued:

(1) Under 40 CFR 52.21 as in effect on July 30, 1987, or earlier, provided the application also meets the provisions in paragraph 33.3(22) “b”;

(2) Under this chapter between July 1, 2011, and July 6, 2015, to a source that was classified as a major stationary source under subrule 33.3(1) solely on the basis of potential emissions of greenhouse gases; or

(3) Under this chapter between July 1, 2011, and July 6, 2015, for a modification that was classified as a major modification under subrule 33.3(1) solely on the basis of an increase in emissions of greenhouse gases.

b. If the application for rescission meets the provisions in paragraph “a” of this subrule, the department may rescind a permit if the owner or operator shows that the PSD provisions under 40 CFR 52.21 or this chapter would not apply to the source or modification.

[ARC 8215B, IAB 10/7/09, effective 11/11/09; ARC 9224B, IAB 11/17/10, effective 12/22/10; ARC 9906B, IAB 12/14/11, effective 11/16/11; ARC 0260C, IAB 8/8/12, effective 9/12/12; ARC 0783C, IAB 6/12/13, effective 7/17/13; ARC 1913C, IAB 3/18/15, effective 4/22/15; ARC 2949C, IAB 2/15/17, effective 3/22/17; ARC 3679C, IAB 3/14/18, effective 4/18/18]

**567—33.4 to 33.8** Reserved.

**567—33.9(455B) Plantwide applicability limitations (PALs).** This rule provides an existing major source the option of establishing a plantwide applicability limitation (PAL) on emissions, provided the conditions in this rule are met. The provisions for a PAL as set forth in 40 CFR 52.21(aa) as amended through July 12, 2012, are adopted by reference, except that the term “Administrator” shall mean “the department of natural resources.”

[ARC 0783C, IAB 6/12/13, effective 7/17/13]

**567—33.10(455B) Exceptions to adoption by reference.** All references to Clean Units and Pollution Control Projects set forth in 40 CFR Sections 52.21 and 51.166 are not adopted by reference.

These rules are intended to implement Iowa Code chapter 455B.

[Filed 8/25/06, Notice 6/7/06—published 9/27/06, effective 11/1/06]

[Filed 2/8/07, Notice 12/6/06—published 2/28/07, effective 4/4/07]

[Filed emergency 10/4/07 after Notice 8/1/07—published 10/24/07, effective 10/4/07]

[Filed 4/18/08, Notice 1/2/08—published 5/7/08, effective 6/11/08]

[Filed 8/20/08, Notice 6/4/08—published 9/10/08, effective 10/15/08]

[Filed ARC 8215B (Notice ARC 7855B, IAB 6/17/09), IAB 10/7/09, effective 11/11/09]

[Filed ARC 9224B (Notice ARC 8999B, IAB 8/11/10), IAB 11/17/10, effective 12/22/10]

[Filed Emergency After Notice ARC 9906B (Notice ARC 9736B, IAB 9/7/11), IAB 12/14/11, effective 11/16/11]

[Filed ARC 0260C (Notice ARC 0097C, IAB 4/18/12), IAB 8/8/12, effective 9/12/12]

[Filed ARC 0783C (Notice ARC 0648C, IAB 3/20/13), IAB 6/12/13, effective 7/17/13]

[Filed ARC 1227C (Notice ARC 1016C, IAB 9/18/13), IAB 12/11/13, effective 1/15/14]

[Filed ARC 1913C (Notice ARC 1795C, IAB 12/24/14), IAB 3/18/15, effective 4/22/15]

[Filed Emergency After Notice ARC 2352C (Notice ARC 2222C, IAB 10/28/15), IAB 1/6/16, effective 12/16/15]

[Filed ARC 2949C (Notice ARC 2799C, IAB 11/9/16), IAB 2/15/17, effective 3/22/17]

[Filed ARC 3679C (Notice ARC 3520C, IAB 12/20/17), IAB 3/14/18, effective 4/18/18]



CHAPTER 34  
PROVISIONS FOR AIR QUALITY EMISSIONS TRADING PROGRAMS

**567—34.1(455B) Purpose.** This chapter implements the provisions for certain federal air emissions trading programs to control emissions of specific pollutants.

**567—34.2 to 34.199** Reserved.

**567—34.200(455B) Provisions for air emissions trading and other requirements for the Clean Air Interstate Rule (CAIR).** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.201(455B) CAIR NO<sub>x</sub> annual trading program general provisions.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.202(455B) CAIR designated representative for CAIR NO<sub>x</sub> sources.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.203(455B) Permits.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.204** Reserved.

**567—34.205(455B) CAIR NO<sub>x</sub> allowance allocations.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.206(455B) CAIR NO<sub>x</sub> allowance tracking system.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.207(455B) CAIR NO<sub>x</sub> allowance transfers.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.208(455B) Monitoring and reporting.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.209(455B) CAIR NO<sub>x</sub> opt-in units.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.210(455B) CAIR SO<sub>2</sub> trading program.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.211 to 34.219** Reserved.

**567—34.220(455B) CAIR NO<sub>x</sub> ozone season trading program.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.221(455B) CAIR NO<sub>x</sub> ozone season trading program general provisions.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.222(455B) CAIR designated representative for CAIR NO<sub>x</sub> ozone season sources.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.223(455B) CAIR NO<sub>x</sub> ozone season permits.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.224** Reserved.

**567—34.225(455B) CAIR NO<sub>x</sub> ozone season allowance allocations.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.226(455B) CAIR NO<sub>x</sub> ozone season allowance tracking system.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.227(455B) CAIR NO<sub>x</sub> ozone season allowance transfers.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.228(455B) CAIR NO<sub>x</sub> ozone season monitoring and reporting.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.229(455B) CAIR NO<sub>x</sub> ozone season opt-in units.** Rescinded **ARC 3679C**, IAB 3/14/18, effective 4/18/18.

**567—34.230 to 34.299** Reserved.

**567—34.300(455B) Provisions for air emissions trading and other requirements for the Clean Air Mercury Rule (CAMR).** Rescinded IAB 10/7/09, effective 11/11/09.

\*As of November 11, 2009, the requirements for the Clean Air Mercury Rule (CAMR) are rescinded and the adoption by reference of federal regulations associated with CAMR is also rescinded. On March 14, 2008, the United States Court of Appeals for the District of Columbia Circuit issued its mandate to vacate the federal CAMR regulations in their entirety. [ARC 8216B, IAB 10/7/09, effective 11/11/09]

**567—34.301(455B) Mercury (Hg) budget trading program general provisions.** Rescinded IAB 10/7/09, effective 11/11/09.

\*As of November 11, 2009, the requirements for the Clean Air Mercury Rule (CAMR) are rescinded and the adoption by reference of federal regulations associated with CAMR is also rescinded. On March 14, 2008, the United States Court of Appeals for the District of Columbia Circuit issued its mandate to vacate the federal CAMR regulations in their entirety. [ARC 8216B, IAB 10/7/09, effective 11/11/09]

**567—34.302(455B) Hg designated representative for Hg budget sources.** Rescinded IAB 10/7/09, effective 11/11/09.

\*As of November 11, 2009, the requirements for the Clean Air Mercury Rule (CAMR) are rescinded and the adoption by reference of federal regulations associated with CAMR is also rescinded. On March 14, 2008, the United States Court of Appeals for the District of Columbia Circuit issued its mandate to vacate the federal CAMR regulations in their entirety. [ARC 8216B, IAB 10/7/09, effective 11/11/09]

**567—34.303(455B) General Hg budget trading program permit requirements.** Rescinded IAB 10/7/09, effective 11/11/09.

\*As of November 11, 2009, the requirements for the Clean Air Mercury Rule (CAMR) are rescinded and the adoption by reference of federal regulations associated with CAMR is also rescinded. On March 14, 2008, the United States Court of Appeals for the District of Columbia Circuit issued its mandate to vacate the federal CAMR regulations in their entirety. [ARC 8216B, IAB 10/7/09, effective 11/11/09]

**567—34.304(455B) Hg allowance allocations.** Rescinded IAB 10/7/09, effective 11/11/09.

\*As of November 11, 2009, the requirements for the Clean Air Mercury Rule (CAMR) are rescinded and the adoption by reference of federal regulations associated with CAMR is also rescinded. On March 14, 2008, the United States Court of Appeals for the District of Columbia Circuit issued its mandate to vacate the federal CAMR regulations in their entirety. [ARC 8216B, IAB 10/7/09, effective 11/11/09]

**567—34.305(455B) Hg allowance tracking system.** Rescinded IAB 10/7/09, effective 11/11/09.

\*As of November 11, 2009, the requirements for the Clean Air Mercury Rule (CAMR) are rescinded and the adoption by reference of federal regulations associated with CAMR is also rescinded. On March 14, 2008, the United States Court of Appeals for the District of Columbia Circuit issued its mandate to vacate the federal CAMR regulations in their entirety.  
[ARC 8216B, IAB 10/7/09, effective 11/11/09]

**567—34.306(455B) Hg allowance transfers.** Rescinded IAB 10/7/09, effective 11/11/09.

\*As of November 11, 2009, the requirements for the Clean Air Mercury Rule (CAMR) are rescinded and the adoption by reference of federal regulations associated with CAMR is also rescinded. On March 14, 2008, the United States Court of Appeals for the District of Columbia Circuit issued its mandate to vacate the federal CAMR regulations in their entirety.  
[ARC 8216B, IAB 10/7/09, effective 11/11/09]

**567—34.307(455B) Monitoring and reporting.** Rescinded IAB 10/7/09, effective 11/11/09.

\*As of November 11, 2009, the requirements for the Clean Air Mercury Rule (CAMR) are rescinded and the adoption by reference of federal regulations associated with CAMR is also rescinded. On March 14, 2008, the United States Court of Appeals for the District of Columbia Circuit issued its mandate to vacate the federal CAMR regulations in their entirety.  
[ARC 8216B, IAB 10/7/09, effective 11/11/09]

**567—34.308(455B) Performance specifications.** Rescinded IAB 10/7/09, effective 11/11/09.

\*As of November 11, 2009, the requirements for the Clean Air Mercury Rule (CAMR) are rescinded and the adoption by reference of federal regulations associated with CAMR is also rescinded. On March 14, 2008, the United States Court of Appeals for the District of Columbia Circuit issued its mandate to vacate the federal CAMR regulations in their entirety.  
[ARC 8216B, IAB 10/7/09, effective 11/11/09]

These rules are intended to implement Iowa Code section 455B.133.

[Filed 5/17/06, Notice 1/18/06—published 6/7/06, effective 7/12/06]<sup>◇</sup>

[Filed 2/8/07, Notice 12/6/06—published 2/28/07, effective 4/4/07]

[Filed 10/4/07, Notice 8/1/07—published 10/24/07, effective 11/28/07]

[Filed ARC 8216B (Notice ARC 7622B, IAB 3/11/09; Amended Notice ARC 7738B, IAB 5/6/09),  
IAB 10/7/09, effective 11/11/09]

[Filed ARC 3679C (Notice ARC 3520C, IAB 12/20/17), IAB 3/14/18, effective 4/18/18]

<sup>◇</sup> Two or more ARCs



## **TRANSPORTATION DEPARTMENT[761]**

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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CHAPTER 425  
MOTOR VEHICLE AND TRAVEL TRAILER DEALERS,  
MANUFACTURERS, DISTRIBUTORS AND WHOLESALERS  
[Prior to 7/17/96, see 761—Chapters 420 and 422]

**761—425.1(322) Introduction.**

**425.1(1)** This chapter applies to the licensing of motor vehicle and travel trailer dealers, manufacturers, distributors and wholesalers. Also included in this chapter are the criteria for the issuance and use of dealer plates.

**425.1(2)** The office of vehicle and motor carrier services administers this chapter. The mailing address is: Office of Vehicle and Motor Carrier Services, Iowa Department of Transportation, P.O. Box 9278, Des Moines, Iowa 50306-9278.

*a.* Applications required by the chapter shall be submitted to the office of vehicle and motor carrier services.

*b.* Information about dealer plates and the licensing of motor vehicles and travel trailer dealers, manufacturers, distributors and wholesalers is available from the office of vehicle and motor carrier services or on the department's website at [www.iowadot.gov](http://www.iowadot.gov).

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3687C, IAB 3/14/18, effective 4/18/18]

**761—425.2** Reserved.

**761—425.3(322) Definitions.** The following definitions, in addition to those found in Iowa Code sections 322.2 and 322C.2, apply to this chapter of rules:

*“Certificate of title”* means a document issued by the appropriate official which contains a statement of the owner's title, the name and address of the owner, a description of the vehicle, a statement of all security interests, and additional information required under the laws or rules of the jurisdiction in which the document was issued, and which is recognized as a matter of law as a document evidencing ownership of the vehicle described. The terms “title certificate,” “title only” and “title” shall be synonymous with the term “certificate of title.”

*“Consumer use”* means use of a motor vehicle or travel trailer for business or pleasure, not for sale at retail, by a person who has obtained a certificate of title and has registered the vehicle under Iowa Code chapter 321.

*“Dealer,”* unless otherwise specified, means a person who is licensed to engage in this state in the business of selling motor vehicles or travel trailers at retail under Iowa Code chapter 322 or 322C.

*“Engage in this state in the business”* or similar wording means doing any of the following acts for the purpose of selling motor vehicles or travel trailers at retail: to acquire, sell, exchange, hold, offer, display, broker, accept on consignment or conduct a retail auction, advertise as being engaged in any of those acts, or to act as an agent for the purpose of doing any of those acts. A person selling at retail more than six motor vehicles or six travel trailers during a 12-month period may be presumed to be engaged in the business. See rule 761—425.20(322) for provisions regarding fleet sales and retail auction sales.

*“Manufacturer's certificate of origin”* means a certification signed by the manufacturer, distributor or importer that the vehicle described has been transferred to the person or dealer named, and that the transfer is the first transfer of the vehicle in ordinary trade and commerce. The terms “manufacturer's statement,” “importer's statement or certificate,” “MSO” and “MCO” shall be synonymous with the term “manufacturer's certificate of origin.” See rule 761—400.1(321) for more information.

*“Principal place of business”* means a building actually occupied where the public and the department may contact the owner or operator during regular business hours. In lieu of a building, a travel trailer dealer may use a manufactured or mobile home as an office if taxes are current or a travel trailer as an office if registration fees are current. The principal place of business must be located in this state.

*“Registered dealer”* means a dealer licensed under Iowa Code chapter 322 or 322C who possesses a current dealer certificate under Iowa Code section 321.59.

“*Regular business hours*” means to be consistently open to the public on a weekly basis at hours reported to the office of vehicle services. Except as provided in Iowa Code section 322.36, regular business hours for a motor vehicle or travel trailer dealer shall include a minimum of 32 posted hours between 7 a.m. and 9 p.m., Monday through Friday.

“*Salesperson*” means a person employed by a motor vehicle or travel trailer dealer for the purpose of buying or selling vehicles.

“*Vehicle*,” unless otherwise specified, means a motor vehicle or travel trailer.

“*Wholesaler*” means a person who sells new vehicles to dealers and not at retail.

This rule is intended to implement Iowa Code chapters 322 and 322C.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0136C, IAB 5/30/12, effective 7/4/12; ARC 0778C, IAB 6/12/13, effective 7/17/13; ARC 3687C, IAB 3/14/18, effective 4/18/18]

**761—425.4 to 425.9** Reserved.

**761—425.10(322) Application for dealer’s license.**

**425.10(1) Application form.** To apply for a license as a motor vehicle or travel trailer dealer, the applicant shall complete an application on a form prescribed by the department.

**425.10(2) Surety bond.**

a. The applicant shall obtain a surety bond in the following amounts and file the original with the office of vehicle and motor carrier services:

(1) For a motor vehicle dealer’s license, \$75,000.

(2) For a travel trailer dealer’s license, \$25,000. However, an applicant for a travel trailer dealer’s license is not required to file a bond if the person is licensed as a motor vehicle dealer under the same name and at the same principal place of business.

b. The surety bond shall provide for notice to the office of vehicle and motor carrier services at least 30 days before cancellation.

c. The office of vehicle and motor carrier services shall notify the bonding company of any conviction of the dealer for a violation of laws related to the operations of the dealership.

d. If the bond is canceled, the office of vehicle and motor carrier services shall notify the dealer by first-class mail that the dealer’s license shall be revoked on the same date that the bond is canceled unless the bond is reinstated or a new bond is filed.

e. If an applicant whose dealer’s license was revoked pursuant to paragraph “d” establishes that the applicant obtained a reinstated or new bond meeting the requirements of subrule 425.10(2) that was effective on or before the date of cancellation, but due to mistake or inadvertence failed to file the original bond with the office of vehicle and motor carrier services, the applicant may file the original of the reinstated or new bond. Upon filing, the department will rescind the revocation of the dealer’s license.

**425.10(3) Franchise.**

a. An applicant who intends to sell new motor vehicles or travel trailers shall submit to the office of vehicle and motor carrier services a copy of a signed franchise agreement with the manufacturer or distributor of each make the applicant intends to sell.

b. If a signed franchise agreement is not available at the time of application, the department may accept written evidence of a franchise which includes all of the following:

(1) The name and address of the applicant and the manufacturer or distributor.

(2) The make of motor vehicle or travel trailer that the applicant is authorized to sell.

(3) The applicant’s area of responsibility as stipulated in the franchise and certified on a form prescribed by the department.

(4) The signature of the manufacturer or distributor.

**425.10(4) Corporate applicants.** If the applicant is a corporation, the applicant shall certify on the application that the corporation complies with all applicable state requirements for incorporation.

**425.10(5) Principal place of business.** The applicant shall maintain a principal place of business, which must be staffed during regular business hours. See rules 761—425.12(322) and 761—425.14(322) for further requirements.

**425.10(6) Zoning.** The applicant shall provide to the office of vehicle and motor carrier services written evidence, issued by the office responsible for the enforcement of zoning ordinances in the city or county where the applicant's business is located, which states that the applicant's principal place of business and any extensions comply with all applicable zoning provisions or are a legal nonconforming use.

**425.10(7) Separate licenses required.**

*a.* A separate license is required for each city or township in which an applicant for a motor vehicle dealer's license maintains a place of business.

*b.* A separate license is required for each county in which an applicant for a travel trailer dealer's license maintains a place of business.

**425.10(8) Financial liability.** The applicant for a motor vehicle dealer's license shall certify on the application that the applicant has the required financial liability coverage in the limits as set forth in Iowa Code subsection 322.4(1). It is the applicant's responsibility to ensure the required financial liability coverage is continuous with no lapse in coverage as long as the applicant maintains a valid dealer's license.

**425.10(9) Ownership information.**

*a.* If the owner of the business is an individual, the application shall include the legal name, bona fide address, and telephone number of the individual. If the owner is a partnership, the application shall include the legal name, bona fide address, and telephone number of two partners. If the owner is a corporation, the application shall include the legal name, bona fide address, and telephone number of two corporate officers. In all cases, the telephone number must be a number where the individual, partner, or corporate officer can be reached during normal business hours.

*b.* The application shall include the federal employer identification number of the business. However, if the business is owned by an individual who is not required to have a federal employer identification number, the application shall include the individual's social security number, Iowa nonoperator's identification number or Iowa driver's license number.

**425.10(10) Reserved.**

**425.10(11) Verification of compliance.** The department shall verify the applicant's compliance with all statutory and regulatory dealer licensing requirements.

This rule is intended to implement Iowa Code sections 322.1 to 322.15 and 322C.1 to 322C.6.  
[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3687C, IAB 3/14/18, effective 4/18/18]

**761—425.11** Reserved.

**761—425.12(322) Motor vehicle dealer's place of business.**

**425.12(1) Verification of compliance.** Before a motor vehicle dealer's license is issued, a representative of the department may physically inspect an applicant's principal place of business to verify compliance with this rule.

**425.12(2) Telephone service and office area.** A motor vehicle dealer's principal place of business shall include telephone service and an adequate office area, separate from other facilities, for keeping business records, manufacturers' certificates of origin, certificates of title or other evidence of ownership for all motor vehicles offered for sale. Telephone service must be a land line and not cellular phone service. Evidence of ownership may include a copy of an original document if the original document is held by a lienholder.

**425.12(3) Facility for displaying motor vehicles.** A motor vehicle dealer's principal place of business shall include a suitable space reserved for display purposes where motor vehicles may be viewed by prospective buyers. The facility shall be:

*a.* Within a building. EXCEPTION: For used motor vehicle dealers and for dealers selling new trucks or motor homes exclusively, the display facility may be an outdoor area with an all-weather surface. An all-weather surface does not include grass or exposed soil.

*b.* Of a minimum size.

(1) For display of motorcycles, motorized bicycles and autocycles, the minimum size of the display facility is 10 feet by 15 feet.

(2) For display of other motor vehicles, the minimum size of the display facility is 18 feet by 30 feet.

**425.12(4) Facility for reconditioning and repairing motor vehicles.** A motor vehicle dealer's principal place of business shall include a facility for reconditioning and repairing motor vehicles. The facility shall be an area that:

- a. Is equipped to repair and recondition one or more motor vehicles of a type sold by the dealer.
- b. Is within a building.
- c. Has adequate access.
- d. Is separated from the display and office areas by solid, floor-to-ceiling walls and solid, full-length doors.
- e. Is of a minimum size.

(1) The minimum size facility for motorcycles, motorized bicycles and autocycles is an unobstructed rectangular area measuring 10 feet by 15 feet.

(2) The minimum size facility for other types of motor vehicles is an unobstructed rectangular area measuring 14 feet by 24 feet.

**425.12(5) Motor vehicle dealer who is also a recycler.** If a motor vehicle dealer also does business as a recycler, there shall be separate parking for motor vehicles being offered for sale at retail from motor vehicles that are salvage.

This rule is intended to implement Iowa Code sections 322.1 to 322.15.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 0778C, IAB 6/12/13, effective 7/17/13; ARC 2985C, IAB 3/15/17, effective 4/19/17]

**761—425.13** Reserved.

**761—425.14(322) Travel trailer dealer's place of business.**

**425.14(1) Telephone service and office area.** A travel trailer dealer's principal place of business shall include telephone service and an adequate office area, separate from other facilities, for keeping business records, manufacturers' certificates of origin, certificates of title or other evidence of ownership for all travel trailers offered for sale. Telephone service must be a land line and not cellular phone service. Evidence of ownership may include a copy of an original document if the original document is held by a lienholder.

**425.14(2) Facility for displaying travel trailers.** A travel trailer dealer's principal place of business shall include a space of sufficient size to permit the display of one or more travel trailers. The display facility may be an indoor area or an outdoor area with an all-weather surface. An all-weather surface does not include grass or exposed soil. If an outdoor display facility is maintained, it may be used only to display, recondition or repair travel trailers or to park vehicles.

**425.14(3) Facility for repairing and reconditioning travel trailers.** A travel trailer dealer's principal place of business shall include a facility for reconditioning and repairing travel trailers. The facility:

- a. Shall be equipped and of sufficient size to repair and recondition one or more travel trailers of a type sold by the dealer.
- b. Shall have adequate access.
- c. May be an indoor area or an outdoor area with an all-weather surface. An all-weather surface does not include grass or exposed soil.
- d. May occupy the same area as the display facility.

**425.14(4) Travel trailer dealer also licensed as a motor vehicle dealer.** If a travel trailer dealer is also licensed as a motor vehicle dealer under the same name and at the same principal place of business, separate facilities for displaying, repairing and reconditioning travel trailers are not required.

This rule is intended to implement Iowa Code sections 322C.1 to 322C.6.

**761—425.15** and **425.16** Reserved.

**761—425.17(322) Extension lot license.** Extension lots of motor vehicle and travel trailer dealers must be licensed. Application to license an extension lot shall be made on a form prescribed by the department.

**425.17(1)** For a motor vehicle dealer, an extension lot is a car lot for the sale of motor vehicles that is located within the same city or township as, but is not adjacent to, the motor vehicle dealer's principal place of business.

**425.17(2)** For a travel trailer dealer, an extension lot is a travel trailer lot for the sale of travel trailers that is located within the same county as, but is not adjacent to, the travel trailer dealer's principal place of business.

**425.17(3)** An extension lot must be owned or leased by the dealer.

**425.17(4)** Parcels of property are adjacent if the parcels are owned or leased by the dealer and the parcels are either adjoining or are separated only by an alley, street or highway that is not a fully controlled access facility.

This rule is intended to implement Iowa Code sections 322.1 to 322.15 and 322C.1 to 322C.6.

**761—425.18(322) Supplemental statement of changes.** A motor vehicle dealer shall file a written statement with the office of vehicle and motor carrier services at least ten days before any change of name, location, hours, or method or plan of doing business. A license is not valid until the changes listed in the statement have been approved by the office of vehicle and motor carrier services.

This rule is intended to implement Iowa Code sections 322.1 to 322.15.

[ARC 3687C, IAB 3/14/18, effective 4/18/18]

**761—425.19** Reserved.

**761—425.20(322) Fleet vehicle sales and retail auction sales.**

**425.20(1) Fleet sales.** Any person who has acquired vehicles for consumer use in a business shall obtain the appropriate dealer's license when more than six vehicles are offered for sale at retail in a 12-month period.

**425.20(2) Retail auction sales.** Any person who sells at public auction more than six vehicles in a 12-month period shall obtain the appropriate dealer's license. All certificates of title for the vehicles offered for sale at public auction shall be duly assigned to the dealer.

**425.20(3) Place of business.** A dealer's license issued under this rule does not require a place of business.

**425.20(4) Exceptions.**

*a.* The state of Iowa, counties, cities and other governmental subdivisions are not required to obtain a dealer's license to sell their vehicles at retail.

*b.* This rule does not apply to a vehicle owner, or to an auctioneer representing the owner, selling vehicles at a retail auction if the vehicles were acquired by the owner for consumer use, the vehicles are incidental to the auction, and only one owner's vehicles are sold.

This rule is intended to implement Iowa Code sections 322.1 to 322.15 and 322C.1 to 322C.6.

**761—425.21 to 425.23** Reserved.

**761—425.24(322) Miscellaneous requirements.**

**425.24(1)** The department shall not issue a license under Iowa Code chapter 322 or 322C to any other person at a principal place of business of a person currently licensed under Iowa Code chapter 322 or 322C.

**425.24(2)** A motor vehicle or travel trailer dealer shall not represent or advertise the dealership under any name or style other than the name which appears on the dealer's license.

**425.24(3)** Other business activities are allowed at a place of business of a dealer, but those activities shall not include the sale of firearms, dangerous weapons as defined in Iowa Code section 702.7, or alcoholic beverages as defined in Iowa Code subsection 123.3(4).

This rule is intended to implement Iowa Code sections 322.1 to 322.15 and 322C.1 to 322C.6.

[ARC 9048B, IAB 9/8/10, effective 10/13/10]

761—425.25 Reserved.

**761—425.26(322) State fair, fairs, shows and exhibitions.**

**425.26(1) Definitions.** As used in this rule:

“Community” means an area of responsibility as defined in Iowa Code section 322A.1.

“Display” means having new motor vehicles or new travel trailers available for public viewing at fairs, vehicle shows or vehicle exhibitions. The dealer may also post, display or provide product information through literature or other descriptive media. However, the product information shall not include prices, except for the manufacturer’s sticker price. “Display” does not mean offering new vehicles for sale or negotiating sales of new vehicles.

“Fair” means a county fair or a scheduled gathering for a predetermined period of time at a specific location for the exhibition, display or sale of various wares, products, equipment, produce or livestock, but not solely new vehicles, and sponsored by a person other than a single dealer.

“Offer” new vehicles “for sale,” “negotiate sales” of new vehicles, or similar wording, means doing any of the following at the state fair or a fair, vehicle show or vehicle exhibition: posting prices in addition to the manufacturer’s sticker price, discussing prices or trade-ins, arranging for payments or financing, and initiating contracts.

“State fair” means the fair as discussed in Iowa Code chapter 173.

“Vehicle exhibition” means a scheduled event conducted at a specific location where various types, makes or models of new vehicles are displayed either at the same time or consecutively in time, and sponsored by a person other than a single dealer.

“Vehicle show” means a scheduled event conducted for a predetermined period of time at a specific location for the purpose of displaying at the same time various types, makes or models of new vehicles, which may be in conjunction with other events or displays, and sponsored by a person other than a single dealer.

**425.26(2) Permits for dealers of new motor vehicles.**

a. A “display only” fair, vehicle show or vehicle exhibition permit allows a motor vehicle dealer to display new motor vehicles at a specified fair, vehicle show or vehicle exhibition in any Iowa county. The permit is valid on Sundays.

b. A “full” fair, state fair, vehicle show or vehicle exhibition permit allows a motor vehicle dealer to display and offer new motor vehicles for sale and negotiate sales of new motor vehicles at the state fair, or a specified fair, vehicle show or vehicle exhibition that is held within the motor vehicle dealer’s community. EXCEPTION: A motor vehicle dealer who is licensed to sell motor homes may be issued a permit to offer for sale Class “A” and Class “C” motor homes at a specified fair, vehicle show or vehicle exhibition in any Iowa county. A “full” fair, show or exhibition permit is not valid on Sundays.

c. The following restrictions are applicable to both types of permits:

(1) Permits will be issued to motor vehicle dealers only for the state fair, fairs, vehicle shows or vehicle exhibitions where more than one motor vehicle dealer may participate.

(2) A permit is limited to the line makes for which the motor vehicle dealer is licensed in Iowa.

**425.26(3) Reserved.**

**425.26(4) Permits for dealers of new travel trailers.** A fair, vehicle show or vehicle exhibition permit allows a travel trailer dealer to display and offer new travel trailers for sale and negotiate sales of new travel trailers at a specified fair, vehicle show, or vehicle exhibition in any Iowa county.

a. The permit is valid on Sundays.

b. The permit is limited to the line makes for which the travel trailer dealer is licensed in Iowa.

c. A travel trailer dealer who does not have a permit may display vehicles at fairs, vehicle shows and vehicle exhibitions.

**425.26(5) Permit application.** A motor vehicle or travel trailer dealer shall apply for a permit on an application form prescribed by the department. The application shall include the dealer’s name, address and license number and the following information about the event: name, location, sponsor(s) and duration, including the opening and closing dates.

**425.26(6) *Display of permit.*** The motor vehicle or travel trailer dealer shall display the permit in close proximity to the vehicles being exhibited.

This rule is intended to implement Iowa Code sections 322.5(2) and 322C.3(9).  
[ARC 3687C, IAB 3/14/18, effective 4/18/18]

**761—425.27 and 425.28** Reserved.

**761—425.29(322) Classic car permit.** A classic car permit allows a motor vehicle dealer to display and sell classic cars at a specified county fair, vehicle show or vehicle exhibition that is held in the same county as the motor vehicle dealer's principal place of business. "Classic car" is defined in Iowa Code subsection 322.5(3).

**425.29(1)** The permit period is the duration of the event, not to exceed five days. The permit is valid on Sundays. Only one permit may be issued to each motor vehicle dealer for an event. No more than three permits may be issued to a motor vehicle dealer in any one calendar year.

**425.29(2)** Application for a classic car permit shall be made on a form prescribed by the department. The application shall include the dealer's name, address and license number and the following information about the county fair, vehicle show or vehicle exhibition: name, location, sponsor(s) and duration, including the opening and closing dates.

**425.29(3)** The motor vehicle dealer shall display the permit in a prominent place at the location of the county fair, vehicle show or vehicle exhibition.

This rule is intended to implement Iowa Code subsection 322.5(3).

**761—425.30(322) Motor truck display permit.** Application for a permit under Iowa Code subsection 322.5(4) shall be made on a form prescribed by the department. The application shall include information or documentation showing that the nonresident motor vehicle dealer is eligible for issuance of a permit and that the event meets the statutory conditions for permit issuance.

This rule is intended to implement Iowa Code subsection 322.5(4).

**761—425.31(322) Firefighting and rescue show permit.**

**425.31(1)** Application for a firefighting and rescue show permit shall be made on a form prescribed by the department. The application shall include the name, address and license number of the applicant, the type of vehicles being displayed, and the following information about the vehicle show or vehicle exhibition: name, location, sponsor(s), and duration, including the opening and closing dates.

**425.31(2)** The permit is not valid on Sundays. Only one permit shall be issued to each licensee for an event.

**425.31(3)** The permit holder shall display the permit in a prominent place at the location of the vehicle show or vehicle exhibition.

This rule is intended to implement Iowa Code section 322.5(5).  
[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3687C, IAB 3/14/18, effective 4/18/18]

**761—425.32 to 425.39** Reserved.

**761—425.40(322) Salespersons of dealers.**

**425.40(1)** Every motor vehicle and travel trailer dealer shall:

*a.* Keep a current written record of all salespersons acting in its behalf. The record shall be open to inspection by any peace officer or any employee of the department.

*b.* Maintain a current record of authorized persons allowed to sign all documents required under Iowa Code chapter 321 for vehicle sales.

**425.40(2)** No person shall either directly or indirectly claim to represent a dealer unless the person is listed as a salesperson by that dealer.

This rule is intended to implement Iowa Code sections 322.3, 322.13, and 322C.4.

**761—425.41 to 425.49** Reserved.

**761—425.50(322) Manufacturers, distributors, and wholesalers.** This rule applies to the licensing of manufacturers, distributors, and wholesalers of new motor vehicles and travel trailers.

**425.50(1) Application for license.** To apply for a license, the applicant shall complete an application form prescribed by the department. A list of the applicant's franchised dealers in Iowa and a sample copy of a completed manufacturer's certificate of origin that is issued by the firm shall accompany the application. A distributor or wholesaler shall also provide a copy of written authorization from the manufacturer to act as its distributor or wholesaler.

**425.50(2) Licensing requirements.**

*a.* New motor homes delivered to Iowa dealers must contain the systems and meet the standards specified in Iowa Code section 321.1(36C) "d."

*b.* A licensee shall ensure that any new retail outlet is properly licensed as a dealer before any vehicles are delivered to the outlet.

*c.* A licensee shall notify the office of vehicle and motor carrier services in writing at least ten days prior to any:

(1) Change in name, location or method of doing business, as shown on the license.

(2) Issuance of a franchise to a dealer in this state to sell new vehicles at retail.

(3) Change in the trade name of a travel trailer manufactured for delivery in this state.

*d.* A licensee shall notify the office of vehicle and motor carrier services in writing at least ten days before any new make of vehicle is offered for sale at retail in this state.

This rule is intended to implement Iowa Code sections 322.27 to 322.30 and 322C.7 to 322C.9.  
[ARC 3687C, IAB 3/14/18, effective 4/18/18]

**761—425.51(322) Factory or distributor representatives.** Rescinded IAB 11/3/99, effective 12/8/99.

**761—425.52(322) Used vehicle wholesalers.** Rescinded IAB 11/7/07, effective 12/12/07.

**761—425.53(322) Wholesaler's financial liability coverage.** A new motor vehicle wholesaler shall certify on the license application that it has the required financial liability coverage in the limits set forth in Iowa Code section 322.27A. It is the wholesaler's responsibility to ensure that the required financial liability coverage is continuous with no lapse in coverage as long as the wholesaler maintains a valid wholesaler's license.

This rule is intended to implement Iowa Code section 322.27A.

**761—425.54 to 425.59** Reserved.

**761—425.60(322) Right of inspection.**

**425.60(1)** Peace officers have the authority to inspect vehicles or component parts of vehicles, business records, and manufacturers' certificates of origin, certificates of title and other evidence of ownership for all vehicles offered for sale.

**425.60(2)** The department has the right at any time to verify compliance of a person licensed under Iowa Code chapter 322 or 322C or issued a certificate under Iowa Code section 321.59 with all statutory and regulatory requirements.

This rule is intended to implement Iowa Code sections 321.62, 321.95, 322.13, and 322C.1.

**761—425.61** Reserved.

**761—425.62(322) Denial, suspension or revocation.**

**425.62(1)** The department may deny an application or suspend or revoke a certificate or license if the applicant, certificate holder or licensee fails to comply with the applicable provisions of this chapter of rules, Iowa Code sections 321.57 to 321.63 or Iowa Code chapter 322 or 322C.

**425.62(2)** The department may deny a dealer's application for the state fair or a fair, vehicle show or vehicle exhibition permit for a period not to exceed six months if the dealer fails to comply with the applicable provisions of rule 761—425.26(322) or Iowa Code section 322.5(2) or 322C.3(9).

**425.62(3)** The department may deny a motor vehicle dealer's application for a demonstration permit for a period not to exceed six months if the dealer fails to comply with rule 761—425.72(321).

**425.62(4)** The department shall send notice by certified mail to a person whose certificate, license or permit is to be revoked, suspended, canceled or denied. The notice shall be mailed to the person's mailing address as shown on departmental records or, if the person is currently licensed, to the principal place of business, and shall become effective 20 days from the date mailed. A person who is aggrieved by a decision of the department and who is entitled to a hearing may contest the decision in accordance with 761—Chapter 13. The request shall be submitted in writing to the director of the office of vehicle and motor carrier services at the address in subrule 425.1(2). The request shall be deemed timely submitted if it is delivered or postmarked on or before the effective date specified in the notice of revocation, suspension, cancellation or denial.

This rule is intended to implement Iowa Code chapter 17A and sections 321.57 to 321.63, 322.6, 322.9, 322.31, and 322C.6.

[ARC 9048B, IAB 9/8/10, effective 10/13/10; ARC 3687C, IAB 3/14/18, effective 4/18/18]

**761—425.63 to 425.69** Reserved.

**761—425.70(321) Dealer plates.**

**425.70(1) Definition.** The definitions of “dealer” and “vehicle” in Iowa Code section 321.1 apply to this rule.

**425.70(2) Persons who may be issued dealer plates.** Dealer plates as provided in Iowa Code sections 321.57 to 321.63 may be issued to:

- a. Licensed motor vehicle dealers.
- b. Licensed travel trailer dealers.
- c. A person engaged in the business of buying, selling or exchanging trailer-type vehicles subject to registration under Iowa Code chapter 321, other than travel trailers, and who has an established place of business for such purpose in this state.
- d. Insurers selling vehicles of a type subject to registration under Iowa Code chapter 321 solely for the purpose of disposing of vehicles acquired as a result of a damage settlement or recovered stolen vehicles acquired as a result of a loss settlement. The plates shall display the words “limited use.”
- e. Persons selling vehicles of a type subject to registration under Iowa Code chapter 321 solely for the purpose of disposing of vehicles acquired or repossessed by them in exercise of powers or rights granted by lien or title-retention instruments or contracts given as security for loans or purchase money obligations, and who are not required to be licensed dealers. The plates shall display the words “limited use.”
- f. Persons engaged in the business of selling special equipment body units which have been or will be installed on motor vehicle chassis not owned by them, solely for the purpose of delivering, testing or demonstrating the special equipment body and the motor vehicle. The plates shall display the words “limited use.”
- g. A licensed manufacturer of ambulances, rescue vehicles or fire vehicles, solely for the purpose of transporting, demonstrating, showing or exhibiting the vehicles. The plates shall display the words “limited use.”
- h. A licensed wholesaler who is also licensed as a motor vehicle dealer as specified in paragraph 425.70(3)“e.”

**425.70(3) Use of dealer plates.**

a. Dealer plates shall not be displayed on vehicles that are rented or loaned. However, a dealer plate may be displayed on a motor vehicle, other than a truck or truck tractor, loaned to a customer of a licensed motor vehicle dealer while the customer's motor vehicle is being serviced or repaired by the dealer.

b. Saddle-mounted vehicles being transported shall display dealer plates.

c. Dealer plates may be displayed on a trailer carrying a load, provided the motor vehicle towing the trailer is properly registered under Iowa Code section 321.109, 321.120, or 321.122, or is displaying a

dealer plate described in paragraph 425.70(3) “e,” or a demonstration permit has been issued as described in rule 761—425.72(321).

*d.* Dealer plates may be used by a dealer licensed as a wholesaler for a new motor vehicle model when operating a new motor vehicle of that model if the motor vehicle is owned by the wholesaler and is operated solely for the purpose of demonstration, show or exhibition.

*e.* A dealer plate issued under Iowa Code section 321.60 for the purpose of hauling a load or towing a trailer shall be marked “HAUL & TOW.” Dealer “HAUL & TOW” plates may only be displayed on vehicles in the dealer’s inventory that are continuously offered for sale at retail.

This rule is intended to implement Iowa Code sections 321.57 to 321.63.  
[ARC 3687C, IAB 3/14/18, effective 4/18/18]

**761—425.71** Reserved.

**761—425.72(321) Demonstration permits.**

**425.72(1)** Demonstration permits may be issued by motor vehicle dealers to permit the use of dealer plates for the purpose of demonstrating the load capabilities of motor trucks and truck tractors. A demonstration permit must be issued on a form prescribed by the department.

**425.72(2)** The dealer shall complete the permit. The information to be filled out includes, but is not limited to, the following:

*a.* Date of issuance by the dealer, date of expiration, and the specific dates for which the permit is valid. The expiration date shall be five days or less from the date of issuance.

*b.* Dealer’s name, address and license number.

*c.* Name(s) of the prospective buyer(s) and all prospective drivers.

*d.* Route of the demonstration trip. The points of origin and destination shall be the dealership. The permit is not valid for a route outside Iowa.

*e.* The make, year and vehicle identification number of the motor vehicle being demonstrated.

**425.72(3)** The permit shall at all times be carried in the motor vehicle to which it refers and shall be shown to any peace officer upon request.

**425.72(4)** Only one demonstration permit per motor vehicle shall be issued for a prospective buyer.

**425.72(5)** The demonstration permit is valid only for a movement that does not exceed the legal length, width, height and weight restrictions. The permit is not valid for an overdimensional or overweight movement.

**425.72(6)** A dealer plate issued under Iowa Code section 321.60 for the purpose of hauling a load or towing a trailer may be used in lieu of a demonstration permit.

This rule is intended to implement Iowa Code sections 321.57 to 321.63.  
[ARC 3687C, IAB 3/14/18, effective 4/18/18]

[761—Chapter 420 appeared as Ch 10, Department of Public Safety, 1973 IDR]

[Filed 7/1/75]

[Filed 10/28/77, Notice 8/24/77—published 11/16/77, effective 12/21/77]

[Filed 11/22/77, Notice 10/5/77—published 12/14/77, effective 1/18/78]

[Filed 5/9/78, Notice 3/22/78—published 5/31/78, effective 7/5/78]

[Filed 10/10/78, Notice 8/23/78—published 11/1/78, effective 12/6/78]

[Filed 8/23/79, Notice 7/11/79—published 9/19/79, effective 10/24/79]

[Filed 2/14/80, Notice 12/26/79—published 3/5/80, effective 4/9/80]

[Filed 9/9/81, Notice 7/22/81—published 9/30/81, effective 11/4/81]

[Filed 1/28/82, Notice 12/9/81—published 2/17/82, effective 3/24/82]

[Filed 1/21/83, Notice 12/8/82—published 2/16/83, effective 3/23/83]

[Filed emergency 2/17/83—published 3/16/83, effective 3/23/83]

[Filed 9/4/85, Notice 7/17/85—published 9/25/85, effective 10/30/85]

[Filed emergency 10/23/86—published 11/19/86, effective 10/24/86]

[Filed 1/6/87, Notice 11/19/86—published 1/28/87, effective 3/4/87]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 11/3/88, Notice 9/21/88—published 11/30/88, effective 1/4/89]<sup>o</sup>

[Filed emergency 11/30/89—published 12/27/89, effective 12/1/89]  
[Filed 12/5/90, Notice 10/17/90—published 12/26/90, effective 1/30/91]  
[Filed 1/15/92, Notice 12/11/91—published 2/5/92, effective 3/11/92]  
[Filed 1/14/93, Notice 11/25/92—published 2/3/93, effective 3/10/93]  
[Filed 12/16/93, Notice 11/10/93—published 1/5/94, effective 2/9/94]  
[Filed 6/19/96, Notice 1/17/96—published 7/17/96, effective 8/21/96]  
[Filed 3/5/97, Notice 1/29/97—published 3/26/97, effective 4/30/97]  
[Filed 12/17/97, Notice 11/5/97—published 1/14/98, effective 2/18/98]  
[Filed 10/14/99, Notice 9/8/99—published 11/3/99, effective 12/8/99]  
[Filed 7/20/00, Notice 6/14/00—published 8/9/00, effective 9/13/00]  
[Filed 6/19/02, Notice 4/17/02—published 7/10/02, effective 8/14/02]  
[Filed 11/2/05, Notice 9/14/05—published 11/23/05, effective 12/28/05]  
[Filed 10/11/07, Notice 8/15/07—published 11/7/07, effective 12/12/07]  
[Filed ARC 9048B (Notice ARC 8869B, IAB 6/30/10), IAB 9/8/10, effective 10/13/10]  
[Filed ARC 0136C (Notice ARC 0068C, IAB 4/4/12), IAB 5/30/12, effective 7/4/12]  
[Filed ARC 0778C (Notice ARC 0658C, IAB 4/3/13), IAB 6/12/13, effective 7/17/13]  
[Filed ARC 2985C (Notice ARC 2908C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]  
[Filed ARC 3687C (Notice ARC 3513C, IAB 12/20/17), IAB 3/14/18, effective 4/18/18]

◊ Two or more ARCs



CHAPTER 540  
TRANSPORTATION NETWORK COMPANIES

**761—540.1(321N) Purpose and applicability.** This chapter implements the permitting and regulation requirements of Iowa Code chapter 321N, and applies to transportation network companies and transportation network company drivers.

[ARC 2987C, IAB 3/15/17, effective 4/19/17]

**761—540.2(321N) Definitions.** The definitions in Iowa Code section 321N.1 are hereby made part of and fully incorporated in this chapter.

[ARC 2987C, IAB 3/15/17, effective 4/19/17]

**761—540.3(321N) General information.**

**540.3(1) Information and location.** Applications, forms, electronic or otherwise, and information regarding transportation network company permits are available by mail from the Office of Vehicle and Motor Carrier Services, Iowa Department of Transportation, P.O. Box 10382, Des Moines, Iowa 50306-0382; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)237-3268; by e-mail at [omcs@iowadot.us](mailto:omcs@iowadot.us); by facsimile at (515)237-3225; or on the department's Web site at [www.iowadot.gov](http://www.iowadot.gov).

**540.3(2) Complaints.** Complaints against transportation network companies pertaining to the provisions of Iowa Code chapter 321N and this chapter that are within the regulation and jurisdiction of the department shall be submitted in writing to the office of vehicle and motor carrier services.

[ARC 2987C, IAB 3/15/17, effective 4/19/17]

**761—540.4(321N) Application for transportation network company permit and supporting documents.**

**540.4(1) Application.** An application for a transportation network company permit shall be made to the office of vehicle and motor carrier services on a form designated by the department, electronic or otherwise, and prescribed for that purpose. The form shall require all of the following:

- a. The transportation network company's full legal name and tax identification number.
- b. The address of the transportation network company's principal place of business.
- c. If incorporated or otherwise organized, the transportation network company's state of incorporation or organization.
- d. The name, address, telephone number and e-mail address of the person submitting the application on behalf of the transportation network company.
- e. A statement confirming the transportation network company's agreement to comply with all applicable requirements of Iowa Code chapter 321N and this chapter, signed by the transportation network company's authorized representative.
- f. The name and address of the transportation network company's agent for service of process in the state of Iowa.
- g. The name by which the transportation network company will do business in the state of Iowa, if different from the transportation network company's full legal name.
- h. A description of the transportation network company's digital network and the means or manner by which it may be accessed by the transportation network company's drivers and riders. This paragraph is not intended to and shall not be construed as requiring the disclosure of information proprietary to the transportation network company.
- i. The name, address, telephone number and e-mail address of the person through whom the department may coordinate examination of the transportation network company's records as required by Iowa Code section 321N.2(5).

**540.4(2) Application fee.** An application for a transportation network company permit shall be accompanied by the fee required by Iowa Code section 321N.2. The fee shall be made payable to the Iowa Department of Transportation by cash, check, money order, or other means acceptable to, and offered by, the department.

**540.4(3) Supporting documents.** An application for a transportation network company permit shall be accompanied by the following:

*a.* Proof of compliance with the financial responsibility requirements of Iowa Code section 321N.4. Proof of compliance shall be submitted by providing a valid certificate of coverage from an insurer governed by Iowa Code chapter 515, or by a surplus lines insurer governed by Iowa Code chapter 515I. The certificate of coverage shall demonstrate coverage in the amounts and circumstances required by Iowa Code section 321N.4, and shall certify that if insurance maintained by a transportation network company driver under Iowa Code chapter 321N lapses or does not provide coverage in the amounts or types required by Iowa Code section 321N.4, subsection 2 or 3, the insurance certified in the certificate of coverage shall provide coverage in the amounts and types required by Iowa Code section 321N.4, subsection 2 or 3, beginning with the first dollar of the claim, and the insurer providing such coverage shall defend the claim. The certificate of coverage shall also certify that the coverage therein is not dependent on the insurer of a transportation network company driver's personal vehicle first denying a claim, and does not require the insurer of a personal automobile insurance policy to first deny a claim to trigger coverage and defense under the coverage certified.

*b.* Proof that the transportation network company has established a zero tolerance policy for the use of drugs and alcohol as provided in Iowa Code section 321N.3(5). The transportation network company shall provide a written copy of the applicable policy and an explanation of the manner or means by which the policy is made known to transportation network company drivers and the manner or means by which the policy is enforced.

*c.* Proof that the transportation network company has adopted and is enforcing nondiscrimination and accessibility policies. As used herein, "nondiscrimination policy" means a policy that prohibits discrimination against transportation network company riders on the basis of race, age, disability, religion, color, sex, or national origin. "Accessibility policy" means a policy that prohibits discrimination against and assures equal opportunity and access to transportation network company riders who are persons with disabilities under the Americans with Disabilities Act of 1990 (ADA) as amended by the ADA Amendments Act of 2008 (P.L. 110-325) codified at 42 U.S.C. 12101 et. seq. The transportation network company shall provide a written copy of the applicable policy and an explanation of the manner or means by which the policy is made known to transportation network company drivers and the manner or means by which the policy is enforced.

*d.* Proof that the transportation network company has established record retention guidelines that comply with the requirements of Iowa Code section 321N.2(2). The transportation network company shall provide a written copy of the applicable policy and an explanation of the manner or means by which the policy is made known to the designated records retention officer or responsible staff and the manner or means by which the policy is enforced.

*e.* Proof that the transportation network company has established a means for informing persons seeking approval to serve as transportation network company drivers of their notification obligations under Iowa Code section 321N.3(2). The transportation network company shall provide a copy of the disclosure form used by the transportation network company to inform such persons of the notification obligations under Iowa Code section 321N.3(2) and an explanation of the manner or means by which the disclosure form is made known to and signed by such persons.

*f.* Proof that the transportation network company has established a means for making the automobile insurance disclosures required by Iowa Code section 321N.5 to persons serving as transportation network company drivers. The transportation network company shall provide a copy of the written disclosure used by the transportation network company and an explanation of the manner or means by which the written disclosure is made known to transportation network company drivers.

*g.* Proof that the transportation network company has established a means for making the driver and vehicle disclosures required by Iowa Code section 321N.7 to transportation network company riders. The transportation network company shall provide an explanation of the manner or means by which the disclosure is made known to transportation network company riders.

*h.* Proof that the transportation network company has established a means for transmitting an electronic receipt to transportation network company riders as required by Iowa Code section 321N.8.

The transportation network company shall include a sample, representative receipt and an explanation of the manner or means by which the receipt is delivered and the time frame within which the receipt is delivered.

*i.* If incorporated or organized, a copy of the transportation network company's certificate of good standing from the transportation network company's state of incorporation or organization.

*j.* Other such documents as requested by the department.  
[ARC 2987C, IAB 3/15/17, effective 4/19/17; ARC 3688C, IAB 3/14/18, effective 4/18/18]

**761—540.5(321N) Issuance of permit.** A transportation network company shall not operate or conduct business in the state of Iowa without a valid permit issued under this chapter. Upon submission of a completed application package as set forth in rule 761—540.4(321N), the department shall process the package and shall inform the transportation network company of the package's status no later than 30 days after the department receives the package. Application package statuses for the purpose of this rule are as follows: "in process," "granted," and "denied." If the department informs a transportation network company that the application is "in process," then the department shall also inform the transportation network company of the reason for the status. If the department determines that the transportation network company is in compliance with the provisions of Iowa Code chapter 321N and this chapter, the department shall issue a permit to the transportation network company. A permit, when issued, shall be valid for one year. The department may deny issuance of the permit if the department determines, and evidence demonstrates, that the transportation network company is not in compliance or is not able to comply with the provisions of Iowa Code chapter 321N or this chapter.

[ARC 2987C, IAB 3/15/17, effective 4/19/17]

**761—540.6(321N) Amendment to transportation network company permit.** If during the period the permit is valid any information required and presented in the application under paragraph 540.4(1) "a," "b," "c," "f," "g" or "i" changes, the transportation network company shall notify the office of vehicle and motor carrier services of the change in writing, within 30 days after the change. Notification shall include the permit number and a recitation of the information that has changed and that should be updated in the department's records. Submission of amended information is not a request for a new permit or for permit approval and shall not extend the period the permit is valid. Upon determination that the information submitted is complete and correct, the department shall update its records and issue an amended permit, if the department determines it is necessary.

[ARC 2987C, IAB 3/15/17, effective 4/19/17]

**761—540.7(321N) Suspension.** If the department determines that the transportation network company has violated Iowa Code chapter 321N or this chapter and the violation is more than an isolated event and remains uncorrected, the department shall issue to the transportation network company a written notice of the violation. The written notice shall specify the violation and shall advise the transportation network company that failure to remedy the violation and to comply with the applicable requirements within 30 days shall result in the issuance of a written notice of suspension of the permit and the privilege to operate or conduct business as a transportation network company in the state of Iowa. If the transportation network company fails to remedy the violation within 30 days, the department shall issue to the transportation network company a written notice of suspension of the permit and the privilege to operate or conduct business as a transportation network company in the state of Iowa, which shall be effective 30 days after service of the written notice of suspension. Once effective, the suspension shall remain in effect until the transportation network company demonstrates to the department that it is in compliance with the applicable requirements or the permit is revoked or expires, whichever occurs first.

[ARC 2987C, IAB 3/15/17, effective 4/19/17]

**761—540.8(321N) Revocation.** If the department determines that the transportation network company is in continued noncompliance with Iowa Code chapter 321N or this chapter, the department shall revoke the transportation network company's permit and the privilege to operate or conduct business as a transportation network company in the state of Iowa. Notice of revocation shall be in writing, shall

specify the continued noncompliance, and shall be effective 30 days after service of the written notice of revocation. The period of revocation shall be for at least 90 days, and shall continue thereafter until the following criteria are satisfied: (1) The transportation network company submits a new application, application fee, and supporting documents under rule 761—540.4(321N), and (2) the department determines a new permit should be issued, pursuant to rule 761—540.5(321N). As used in this rule, “continued noncompliance” means a violation of Iowa Code chapter 321N or this chapter for which a notice of suspension has become effective and has remained in effect for a period of at least 180 days. [ARC 2987C, IAB 3/15/17, effective 4/19/17]

#### **761—540.9(321N) Appeal.**

**540.9(1)** A transportation network company whose permit has been suspended, revoked, or denied may request an informal settlement or a contested case proceeding as provided in 761—Chapter 13 to contest said action.

**540.9(2)** The request shall be submitted in writing, to the director of the office of vehicle and motor carrier services, at the address indicated in subrule 540.3(1), and may be submitted electronically by facsimile, e-mail or other means prescribed by the department. To be timely, the request must be submitted within 20 days of service of the notice of suspension, revocation, or denial. Failure to contest denial of a permit application does not preclude the transportation network company from submitting a new application for a permit at any time after the denial.

**540.9(3)** When the department receives a properly submitted, timely request for an informal settlement or contested case proceeding or an appeal of a presiding officer’s proposed decision regarding a suspension or revocation, the department shall stay the suspension or revocation pending resolution of the informal resolution, contested case, or appeal.

[ARC 2987C, IAB 3/15/17, effective 4/19/17]

#### **761—540.10(321N) Renewal.**

**540.10(1)** A transportation network company that has been issued and holds a valid permit may renew the permit by submitting, at minimum, the following: (1) the application, (2) the application fee and (3) the supporting documents as set forth in rule 761—540.4(321N). The application for renewal must be submitted no more than 60 days before the expiration date of the existing permit and no fewer than 30 days before the expiration date of the existing permit.

**540.10(2)** Pursuant to Iowa Code section 17A.18(2), when a transportation network company has made a timely and sufficient application for the renewal of a valid permit, the existing permit does not expire until the application has been finally determined by the department, and, in case the application is denied or the terms of the new permit are limited, until the last day for seeking judicial review of the department’s order or a later date fixed by order of the department or the reviewing court.

**540.10(3)** If the application for renewal is submitted fewer than 30 days before the expiration date of the existing permit, then the application shall be considered a new application and Iowa Code section 17A.18(2) shall not apply. If a transportation network company does not file a renewal application pursuant to this rule, then the original application shall expire on the expiration date set forth on the original permit.

**540.10(4)** If a transportation network company initiates an appeal, informal settlement, or contested case proceeding pursuant to rule 761—540.9(321N) and the original application expires pursuant to the expiration date of the application, then the transportation network company shall be required to submit a renewal application pursuant to subrule 540.10(1) if the transportation network company intends to hold a valid permit under this chapter once the appeal, informal settlement, or contested case proceeding has been finally determined.

[ARC 2987C, IAB 3/15/17, effective 4/19/17]

These rules are intended to implement Iowa Code chapter 321N.

[Filed ARC 2987C (Notice ARC 2907C, IAB 1/18/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3688C (Notice ARC 3572C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

CHAPTER 607  
COMMERCIAL DRIVER LICENSING

**761—607.1(321) Scope.** This chapter applies to licensing persons for the operation of commercial motor vehicles. Unless otherwise stated, the provisions of this chapter are in addition to other motor vehicle licensing rules.

This rule is intended to implement Iowa Code chapter 321.

**761—607.2(17A) Information.**

**607.2(1) Information and location.** Applications, forms and information about the commercial driver's license (CDL) are available at any driver's license examination station. Assistance is also available by mail from Driver and Identification Services, Iowa Department of Transportation, P.O. Box 9204, Des Moines, Iowa 50306-9204; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)244-8725; by facsimile at (515)239-1837; or on the department's website at [www.iowadot.gov](http://www.iowadot.gov).

**607.2(2) Manual.** A copy of a study manual for the commercial driver's license tests is available upon request at any driver's license examination station and on the department's Web site.

This rule is intended to implement Iowa Code section 17A.3.

[ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18]

**761—607.3(321) Definitions.** The definitions in Iowa Code section 321.1 apply to this chapter of rules. In addition, the following definitions are adopted:

*"Air brake system"* means a system that uses air as a medium for transmitting pressure or force from the driver's control to the service brake. "Air brake system" shall include any braking system operating fully or partially on the air brake principle.

*"Air over hydraulic brakes"* means any braking system operating partially on the air brake and partially on the hydraulic brake principle.

*"Automatic transmission"* means any transmission other than a manual transmission.

*"CDLIS"* means "commercial driver's license information system" as defined in Iowa Code section 321.1.

*"Commercial driver's license downgrade"* or *"CDL downgrade"* means either:

1. The driver changes the driver's self-certification of type of driving from non-expected interstate to expected interstate, non-expected intrastate, or expected intrastate driving, or
2. The department removed the CDL privilege from the driver's license.

*"Commercial motor vehicle"* or *"CMV"* as defined in Iowa Code section 321.1 does not include a motor vehicle designed as off-road equipment rather than as a motor truck, such as a forklift, motor grader, scraper, tractor, trencher or similar industrial-type equipment. "Commercial motor vehicle" also does not include self-propelled implements of husbandry described in Iowa Code subsection 321.1(32).

*"Controlled substance"* as used in Iowa Code section 321.208 means a substance defined in Iowa Code section 124.101.

*"Hazardous materials"* means any material that has been designated as hazardous under 49 U.S.C. Section 5103 and is required to be placarded under 49 CFR Part 172, Subpart F, or any quantity of a material listed as a select agent or toxin in 42 CFR Part 73.

*"Manual transmission"* means a transmission utilizing a driver-operated clutch that is activated by a pedal or lever and a gear-shift mechanism operated either by hand or by foot. All other transmissions, whether semi-automatic or automatic, will be considered automatic.

*"Medical examiner"* means a person who is licensed, certified or registered, in accordance with applicable state laws and regulations, to perform physical examinations. The term includes but is not limited to doctors of medicine, doctors of osteopathy, physician assistants, advanced registered nurse practitioners, and doctors of chiropractic.

*"Medical examiner's certificate"* means a certificate completed and signed by a medical examiner under the provisions of 49 CFR Section 391.43.

“*Medical variance*” means a driver has received one of the following from the Federal Motor Carrier Safety Administration that allows the driver to be issued a medical certificate:

1. An exemption letter permitting operation of a commercial motor vehicle pursuant to 49 CFR Part 381, Subpart C, or 49 CFR Section 391.62, or 49 CFR Section 391.64.
2. A skill performance evaluation certificate permitting operation of a commercial motor vehicle pursuant to 49 CFR Section 391.49.

“*Passenger vehicle*” means either of the following:

1. A motor vehicle designed to transport 16 or more persons including the operator.
2. A motor vehicle of a size and design to transport 16 or more persons including the operator which is redesigned or modified to transport fewer than 16 persons with disabilities. The size of a redesigned or modified vehicle shall be any such vehicle with a gross vehicle weight rating of 10,001 or more pounds.

“*School bus*” means a commercial motor vehicle used to transport pre-primary, primary, or secondary school students from home to school, from school to home, or to and from school-sponsored events. “School bus” does not include a bus used as a common carrier.

“*Self-certification*” means a written certification of which category of type of driving an applicant for a commercial driver’s license engages in or intends to engage in, from the following categories:

1. Non-excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, is both subject to and meets the qualification requirements under 49 CFR Part 391, and is required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
2. Excepted interstate. The person certifies that the person operates or expects to operate in interstate commerce, but engages exclusively in transportation or operations excepted under 49 CFR Section 390.3(f), 391.2, 391.68 or 398.3 from all or parts of the qualification requirements of 49 CFR Part 391, and is therefore not required to obtain a medical examiner’s certificate by 49 CFR Section 391.45.
3. Non-excepted intrastate. The person certifies that the person operates only in intrastate commerce and is subject to state driver qualification requirements.
4. Excepted intrastate. The person certifies that the person operates only in intrastate commerce, but engages exclusively in transportation or operations excepted from all or parts of the state driver qualification requirements as set forth in Iowa Code section 321.449.

“*State,*” as used in this chapter and in “another state” in Iowa Code subsection 321.174(2), “former state of residence” in Iowa Code subsection 321.188(5), or “any state” in Iowa Code subsection 321.208(1), means one of the United States or the District of Columbia unless the context means the state of Iowa.

This rule is intended to implement Iowa Code sections 321.1, 321.174, 321.188, 321.191, 321.193, 321.207 and 321.208.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.4 and 607.5** Reserved.

**761—607.6(321) Exemptions.**

**607.6(1) *Persons exempt.*** A person listed in Iowa Code section 321.176A is exempt from commercial driver licensing requirements.

**607.6(2) *Exempt until April 1, 1992.*** Rescinded IAB 6/23/93, effective 7/28/93.

This rule is intended to implement Iowa Code sections 321.1 and 321.176A.

**761—607.7(321) Records.** The operating record of a person who has been issued a commercial driver’s license or a commercial learner’s permit or a person who has been disqualified from operating a commercial motor vehicle shall be maintained as provided in the department’s “Record Management Manual” adopted in 761—Chapter 4.

This rule is intended to implement Iowa Code sections 22.11, 321.12 and 321.199.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.8** and **607.9** Reserved.

**761—607.10(321) Adoption of federal regulations.**

**607.10(1) Code of Federal Regulations.** The department's administration of commercial driver's licenses shall be in compliance with the state procedures set forth in 49 CFR Section 383.73, and this chapter shall be construed to that effect. The department adopts the following portions of the Code of Federal Regulations which are referenced throughout this chapter of rules:

- a. 49 CFR Section 391.11 as adopted in 761—Chapter 520.
- b. 49 CFR Section 392.5 as adopted in 761—Chapter 520.
- c. The following portions of 49 CFR Part 383 (October 1, 2016):
  - (1) Section 383.51, Disqualification of drivers.
  - (2) Subpart E—Testing and Licensing Procedures.
  - (3) Subpart G—Required Knowledge and Skills.
  - (4) Subpart H—Tests.

**607.10(2) Copies of regulations.** Copies of the federal regulations may be reviewed at the state law library or through the Internet at <http://www.fmcsa.dot.gov>.

This rule is intended to implement Iowa Code sections 321.187, 321.188, 321.207, 321.208 and 321.208A.

[ARC 7902B, IAB 7/1/09, effective 8/5/09; ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 2986C, IAB 3/15/17, effective 4/19/17]

**761—607.11** to **607.14** Reserved.

**761—607.15(321) Application.** An applicant for a commercial driver's license shall comply with the requirements of Iowa Code sections 321.180(2)“e,” 321.182 and 321.188, and 761—Chapter 601, and must provide the proofs of citizenship or lawful permanent residence and state of domicile required by 49 CFR Section 383.71. If the applicant is domiciled in a foreign jurisdiction and applying for a nondomiciled commercial driver's license, the applicant must provide a document required by 49 CFR Section 383.71(f).

This rule is intended to implement Iowa Code sections 321.180, 321.182 and 321.188.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.16(321) Commercial driver's license (CDL).**

**607.16(1) Classes.** The department may issue a commercial driver's license only as a Class A, B or C driver's license. The license class identifies the types of vehicles that may be operated. A commercial driver's license may have endorsements which authorize additional vehicle operations or restrictions which limit vehicle operations.

**607.16(2) Validity.**

a. A Class A commercial driver's license allows a person to operate a combination of commercial motor vehicles as specified in Iowa Code paragraph 321.189(1)“a.” With the required endorsements and subject to the applicable restrictions, a Class A commercial driver's license is valid to operate any vehicle.

b. A Class B commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)“b.” With the required endorsements and subject to the applicable restrictions, a Class B commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A commercial driver's license.

c. A Class C commercial driver's license allows a person to operate a commercial motor vehicle as specified in Iowa Code paragraph 321.189(1)“c.” With the required endorsements and subject to the applicable restrictions, a Class C commercial driver's license is valid to operate any vehicle except a truck-tractor semitrailer combination as a chauffeur (Class D) or a vehicle requiring a Class A or Class B commercial driver's license.

*d.* A commercial driver's license is valid for operating a motorcycle as a commercial motor vehicle only if the license has a motorcycle endorsement and a hazardous material endorsement. A commercial driver's license is valid for operating a motorcycle as a noncommercial motor vehicle only if the license has a motorcycle endorsement.

*e.* A commercial driver's license valid for eight years shall be issued to a qualified applicant who is at least 18 years of age but not yet 72 years of age. However, the expiration date of the license issued shall not exceed the licensee's 74th birthday.

*f.* A commercial driver's license valid for two years shall be issued to a qualified applicant 72 years of age or older. A two-year license may also be issued, at the discretion of the department, to an applicant whose license is restricted due to vision or other physical disabilities.

*g.* A commercial driver's license is valid for 60 days after the expiration date.

*h.* A person with a commercial driver's license valid for the vehicle operated is not required to obtain a Class D driver's license to operate the vehicle as a chauffeur.

**607.16(3) Requirements.**

*a.* The minimum age to obtain a commercial driver's license is 18 years.

*b.* The applicant shall meet the requirements set forth in rule 761—607.15(321).

**607.16(4) Transition from five-year to eight-year licenses.** During the period January 1, 2014, to December 31, 2018, the department shall issue qualified applicants otherwise eligible for an eight-year license a five-year, six-year, seven-year, or eight-year license, subject to all applicable limitations for age and ability. The applicable period shall be randomly assigned to the applicant by the department's computerized issuance system based on a distribution formula intended to spread renewal volumes as equally as practical over the eight-year period beginning January 1, 2019, and ending December 31, 2026.

This rule is intended to implement Iowa Code sections 321.177, 321.182, 321.188, 321.189, and 321.196 and 2013 Iowa Acts, chapter 104, section 2.

[ARC 1714C, IAB 11/12/14, effective 12/17/14; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.17(321) Endorsements.** All endorsements except the hazardous material endorsement continue to be valid without retesting or additional fees when renewing or upgrading a license. The endorsements that authorize additional commercial motor vehicle operations with a commercial driver's license are:

**607.17(1) Hazardous material.** A hazardous material endorsement (H) is required to transport hazardous materials. Upon license renewal, retesting and fee payment are required. Retesting and fee payment are also required when an applicant upgrades an Iowa license or transfers a commercial driver's license from another state unless the applicant provides evidence of passing the endorsement test within the preceding 24 months. A farmer or a person working for a farmer is not subject to the hazardous material endorsement while operating either a pickup or a special truck within 150 air miles of the farmer's farm to transport supplies to or from the farm.

**607.17(2) Passenger vehicle.** A passenger vehicle endorsement (P) is required to operate a passenger vehicle as defined in rule 761—607.3(321).

**607.17(3) Tank vehicle.** A tank vehicle endorsement (N) is required to operate a tank vehicle as defined in Iowa Code section 321.1. A vehicle transporting a tank, regardless of the tank's capacity, which does not otherwise meet the definition of a commercial motor vehicle in Iowa Code section 321.1 is not a tank vehicle.

**607.17(4) Double/triple trailer.** A double/triple trailer endorsement (T) is required to operate a commercial motor vehicle with two or more towed trailers when the combination of vehicles meets the criteria for a Class A commercial motor vehicle. Operation of a triple trailer combination vehicle is not permitted in Iowa.

**607.17(5) Hazardous material and tank.** A combined endorsement (X) authorizes both hazardous material and tank vehicle operations.

**607.17(6) School bus.** After September 30, 2005, a school bus endorsement (S) is required to operate a school bus as defined in rule 761—607.3(321). An applicant for a school bus endorsement must also qualify for a passenger vehicle endorsement.

**607.17(7) Exceptions for towing operations.**

*a.* A driver who tows a vehicle in an emergency “first move” from the site of a vehicle malfunction or accident on a highway to the nearest appropriate repair facility is not required to have the endorsement(s) applicable to the towed vehicle. In any subsequent move, a driver who tows a vehicle from one repair or disposal facility to another is required to have the endorsement(s) applicable to the towed vehicle with one exception: A tow truck driver is not required to have a passenger endorsement to tow a passenger vehicle.

*b.* The double/triple trailer endorsement is not required to operate a commercial motor vehicle with two or more towed vehicles that are not trailers.

This rule is intended to implement Iowa Code sections 321.1, 321.176A and 321.189.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.18(321) Restrictions.** The restrictions that may limit commercial motor vehicle operation with a commercial driver’s license are listed in 761—subrule 605.5(3) and are explained below:

**607.18(1) Air brake.** The air brake restriction (L, no air brake equipped CMV) applies to a licensee who either fails the air brake component of the knowledge test or performs the skills test in a vehicle not equipped with air brakes and prohibits the operation of a commercial motor vehicle equipped with an air brake system until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

**607.18(2) Full air brake.** The full air brake restriction (Z, no full air brake equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with air over hydraulic brakes and prohibits the operation of a commercial motor vehicle equipped with any braking system operating fully on the air brake principle until the licensee passes the required air brake tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

**607.18(3) Manual transmission.** The manual transmission restriction (E, no manual transmission equipped CMV) applies to a licensee who performs the skills test in a vehicle equipped with automatic transmission and prohibits the operation of a commercial motor vehicle equipped with a manual transmission until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

**607.18(4) Tractor-trailer.** The tractor-trailer restriction (O, no tractor trailer CMV) applies to a licensee who performs the skills test in a combination vehicle for a Class A commercial driver’s license with the power unit and towed unit connected with a pintle hook or other non-fifth wheel connection and prohibits operation of a tractor-trailer combination connected by a fifth wheel that requires a Class A commercial driver’s license until the licensee passes the required tests and pays the fee for upgrading the license. Retesting and fee payment are not required when the license is renewed.

**607.18(5) Class A passenger vehicle.** The Class A passenger vehicle restriction (M, no Class A passenger vehicle) applies to a licensee who applies for a passenger endorsement and performs the skills test in a passenger vehicle that requires a Class B commercial driver’s license and prohibits operation of a passenger vehicle that requires a Class A commercial driver’s license.

**607.18(6) Class A and B passenger vehicle.** The Class A and B passenger vehicle restriction (N, no Class A and B passenger vehicle) applies to a licensee who applies for a passenger endorsement and performs the skills test in a passenger vehicle that requires a Class C commercial driver’s license and prohibits operation of a passenger vehicle that requires a Class A or Class B commercial driver’s license.

**607.18(7) Intrastate only.** The intrastate only restriction (K, intrastate only) applies to a licensee who self-certifies to non-expected intrastate or expected intrastate driving and prohibits the operation of a commercial motor vehicle in interstate commerce.

**607.18(8) Medical variance.** The medical variance restriction (V, medical variance) applies to a licensee when the department is notified pursuant to 49 CFR Section 383.73(o)(3) that the driver has

been issued a medical variance and indicates there is information about a medical variance on the CDLIS driver record.

This rule is intended to implement Iowa Code sections 321.189 and 321.191.  
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.19** Reserved.

**761—607.20(321) Commercial learner's permit.**

**607.20(1) Validity.**

*a.* A commercial learner's permit allows the permit holder to operate a commercial motor vehicle when accompanied as required by Iowa Code section 321.180(2)“*d.*”

*b.* A commercial learner's permit is valid for one year without retaking the general and endorsement knowledge tests required by Iowa Code section 321.188.

*c.* A commercial learner's permit is invalid after the expiration date of the underlying commercial or noncommercial driver's license issued to the permit holder or the expiration date of the permit whichever occurs first.

*d.* The issuance of a commercial learner's permit is a precondition to the initial issuance of a commercial driver's license. The issuance of a commercial learner's permit is also a precondition to the upgrade of a commercial driver's license if the upgrade requires a skills test. The holder of a commercial learner's permit is not eligible to take a required driving skills test for the first 14 days after the permit holder is issued the permit. The 14-day period includes the day the commercial learner's permit was issued.

EXAMPLE: The commercial learner's permit is issued on September 1. The earliest date the permit holder would be eligible to take the skills test is September 15.

*e.* A commercial learner's permit is not valid for the operation of a vehicle transporting hazardous materials.

**607.20(2) Requirements.**

*a.* An applicant for a commercial learner's permit must hold a valid Class A, B, C, or D driver's license issued in this state that is not an instruction permit, a special instruction permit, a motorized bicycle license or a temporary restricted license; must be at least 18 years of age; and must meet the requirements to obtain a valid commercial driver's license, including the requirements set forth in Iowa Code section 321.188. However, the applicant does not have to complete the driving skills tests required for a commercial driver's license to obtain a commercial learner's permit.

*b.* The applicant must successfully pass a general knowledge test that meets the federal standards contained in 49 CFR Part 383, Subparts F, G and H, for the commercial motor vehicle the applicant operates or expects to operate, including any endorsement for which the applicant applies.

**607.20(3) Endorsements.** A commercial learner's permit may include the following endorsements. All other endorsements are prohibited on a commercial learner's permit.

*a.* An applicant for a passenger endorsement (P) must take and pass the passenger endorsement knowledge test. A commercial learner's permit holder with a passenger endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2)“*d.*”

*b.* An applicant for a school bus endorsement (S) must take and pass the school bus endorsement knowledge test. A commercial learner's permit holder with a school bus endorsement is prohibited from operating a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2)“*d.*”

*c.* An applicant for a tank vehicle endorsement (N) must take and pass the tank vehicle endorsement knowledge test. A commercial learner's permit holder with a tank vehicle endorsement may only operate an empty tank vehicle and is prohibited from operating any tank vehicle that previously contained hazardous materials that has not been purged of any residue.

**607.20(4) Restrictions.** A commercial learner's permit may include the air brake (L), medical variance (V), Class A passenger vehicle (M), Class A and B passenger vehicle (N) and intrastate only (K) restrictions described in rule 761—607.18(321). In addition, a commercial learner's permit may include the following restrictions that are specific to the commercial learner's permit:

*a. Passenger.* The passenger restriction (P, no passengers in CMV bus) applies to a permit holder who has a commercial learner's permit with a passenger or school bus endorsement and prohibits the operation of a commercial motor vehicle carrying passengers, other than federal/state auditors and inspectors, test examiners, other trainees, and the commercial driver's license holder accompanying the permit holder required by Iowa Code section 321.180(2) "d."

*b. Cargo.* The cargo restriction (X, no cargo in CMV tank vehicle) applies to a permit holder who has a commercial learner's permit with a tank vehicle endorsement and prohibits the operation of any tank vehicle containing cargo or any tank vehicle that previously contained hazardous materials that has not been purged of any residue.

This rule is intended to implement Iowa Code sections 321.180, 321.186 and 321.188.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18]

**761—607.21 to 607.24** Reserved.

**761—607.25(321) Examination for a commercial driver's license.** In addition to the requirements of 761—Chapter 604, an applicant for a commercial driver's license shall pass the knowledge and skills tests as required in 49 CFR Part 383, Subparts G and H.

This rule is intended to implement Iowa Code section 321.186.

**761—607.26(321) Vision screening.** An applicant for a commercial driver's license or commercial learner's permit must pass a vision screening test administered by the department. The vision standards are given in 761—604.11(321).

This rule is intended to implement Iowa Code sections 321.186 and 321.186A.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16]

**761—607.27(321) Knowledge tests.**

**607.27(1) General knowledge test.** The general knowledge test for a commercial driver's license is a written test of topics such as vehicle inspection, operation, safety and control in accordance with 49 CFR Section 383.111.

**607.27(2) Additional tests.** In addition to the general knowledge test for a commercial driver's license, an additional knowledge test is required for each of the following:

- a.* Class A license for combination vehicle operation as required in 49 CFR Section 383.111.
- b.* Hazardous material endorsement as required in 49 CFR Section 383.121. The knowledge test for a hazardous material endorsement shall not be administered orally or in a language other than English.
- c.* Passenger vehicle endorsement as required in 49 CFR Section 383.117.
- d.* Tank vehicle endorsement as required in 49 CFR Section 383.119.
- e.* Double/triple trailer endorsement as required in 49 CFR Section 383.115.
- f.* School bus endorsement as required in 49 CFR Section 383.123. The applicant must also qualify for a passenger vehicle endorsement.
- g.* Removal of the air brake restriction as required in 49 CFR Section 383.111.

**607.27(3) Test methods.** All knowledge tests shall be administered in compliance with 49 CFR Section 383.133(b). All tests other than the hazardous material endorsement test may be administered in written form, verbally, or in automated format and can be administered in a foreign language, provided no interpreter is used in administering the test. A verbal test shall be offered only at specified locations. Information about the locations is available at any driver's license examination station.

**607.27(4) Waiver.** A waiver of any knowledge test is permitted only as provided in Iowa Code subsection 321.188(5). The burden of proof of having passed the hazardous material endorsement test within the preceding 24 months rests with the applicant.

**607.27(5) Requirement.** An applicant must pass the applicable knowledge test(s) before taking the skills test. Passing scores for a knowledge test shall meet the standards contained in 49 CFR Section 383.135(a).

This rule is intended to implement Iowa Code sections 321.186 and 321.188.  
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.28(321) Skills test.**

**607.28(1) Content.** The skills test for a commercial driver’s license is a three-part test as required in 49 CFR Part 383, Subparts E, G and H.

**607.28(2) Test methods.** All skills tests shall be administered in compliance with 49 CFR Section 383.133(c). Interpreters are prohibited during the administration of skills tests. Applicants must be able to understand and respond to verbal commands and instructions in English by a skills test examiner. Neither the applicant nor the examiner may communicate in a language other than English during the skills test.

**607.28(3) Order.** The skills test must be administered and successfully completed in the following order: pre-trip inspection, basic vehicle control skills, on-road skills. If an applicant fails one segment of the skills test, the applicant cannot continue to the next segment of the test, and scores for the passed segments of the test are only valid during initial issuance of the commercial learner’s permit.

**607.28(4) Vehicle.** The applicant shall provide a representative vehicle for the skills test. “Representative vehicle” means a commercial motor vehicle that meets the statutory description for the class of license applied for.

*a.* To obtain a passenger vehicle endorsement applicable to a specific vehicle class, the applicant must take the skills test in a passenger vehicle, as defined in rule 761—607.3(321), satisfying the requirements of that class, as required in 49 CFR Section 383.117.

*b.* To obtain a school bus endorsement, the applicant must qualify for a passenger vehicle endorsement and take the skills test in a school bus, as defined in rule 761—607.3(321), in the same vehicle class as the applicant will drive, as required in 49 CFR Section 383.123. Up to and including September 30, 2005, the skills test for a school bus endorsement is waived for an applicant meeting the requirements of 49 CFR Section 383.123(b).

*c.* To remove an air brake or full air brake restriction, the applicant must take the skills test in a vehicle equipped with an air brake system, as defined in rule 761—607.3(321) and as required in 49 CFR Section 383.113.

*d.* To remove a manual transmission restriction, the applicant must take the skills test in a vehicle equipped with a manual transmission, as defined in rule 761—607.3(321).

**607.28(5) Skills test scoring.** Passing scores for a skills test shall meet the standards contained in 49 CFR Section 383.135(b).

**607.28(6) Military waiver.** The department may waive the requirement that an applicant pass a required skills test for an applicant who is on active duty in the military service or who has separated from such service in the past year, provided the applicant meets the requirements of Iowa Code subsection 321.188(6).

**607.28(7) Locations.** The skills test for a commercial driver’s license shall be given only at specified locations where adequate testing facilities are available. An applicant may contact any driver’s license examination station for the location of the nearest skills testing station. A skills test by appointment shall be offered only at specified regional test sites.

This rule is intended to implement Iowa Code sections 321.186 and 321.188.  
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18]

**761—607.29(321) Waiver of skills test.** Rescinded IAB 6/23/93, effective 7/28/93.

**761—607.30(321) Third-party testing.**

**607.30(1) Purpose and definitions.** The skills test required by rule 761—607.28(321) may be administered by third-party testers and third-party skills test examiners approved and certified by the

department. For the purpose of administering third-party skills testing and this rule, the following definitions shall apply:

*“Community college”* means an Iowa community college established under Iowa Code chapter 260C.

*“Iowa-based motor carrier”* means a motor carrier or its subsidiary that has its principal place of business in the state of Iowa and operates a permanent commercial driver training facility in the state of Iowa.

*“Motor carrier”* means the same as defined in 49 CFR Section 390.5.

*“Permanent commercial driver training facility”* means a facility dedicated to a program of commercial driving instruction that is offered to employees or potential employees of the motor carrier as incident to the motor carrier’s commercial operations, that requires at least 40 hours of instruction, and that includes fixed and permanent structures and facilities for the off-road portions of commercial driving instruction, including classroom, pretrip inspection, and basic vehicle control skills. A permanent commercial driver training facility must include a fixed and paved or otherwise hard-surfaced area for basic vehicle control skills testing that is permanently marked and capable of inspection and measurement by the department.

*“Skills test”* means the skills test required by rule 761—607.28(321).

*“Subsidiary”* means a company that is partly or wholly owned by a motor carrier that holds a controlling interest in the subsidiary company.

*“Third-party skills test examiner”* means the same as defined in 49 CFR Section 383.5.

*“Third-party tester”* means the same as defined in 49 CFR Section 383.5.

**607.30(2) Certification of third-party testers.**

a. The department may certify as a third-party tester a community college or Iowa-based motor carrier to administer skills tests. A community college or Iowa-based motor carrier that seeks certification as a third-party tester shall contact the department’s office of driver services and schedule a review of the proposed testing program, which shall include the proposed testing courses and facilities, information sufficient to identify all proposed third-party skills test examiners, and any other information necessary to demonstrate compliance with 49 CFR Section 383.75.

b. No community college or Iowa-based motor carrier shall be certified to conduct third-party testing unless and until the community college or Iowa-based motor carrier enters an agreement with the department that meets the requirements of 49 CFR Section 383.75 and demonstrates sufficient ability to conduct skills tests in a manner that consistently meets the requirements of 49 CFR Section 383.75.

c. The department shall issue a certified third-party tester a certificate of authority that identifies the classes and types of vehicles for which skills tests may be administered. The certificate shall be valid for the duration of the agreement executed pursuant to paragraph 607.30(2) “b,” unless revoked by the department for engaging in fraudulent activities related to conducting skills tests or failing to comply with the requirements, qualifications, and standards of this chapter, the agreement, or 49 CFR Section 383.75.

**607.30(3) Certification of third-party skills test examiners.**

a. A certified third-party tester shall not employ or otherwise use as a third-party skills test examiner a person who has not been approved and certified by the department to administer skills tests. Each certified third-party tester shall submit for approval the names of all proposed third-party skills test examiners on a form provided by the department. The department shall not approve as a third-party skills test examiner a person who does not meet the requirements, qualifications and standards of 49 CFR Sections 383.75 and 384.228, including but not limited to all required training and examination and a nationwide criminal background check. The criteria for passing the nationwide criminal background check shall include no felony convictions within the last ten years and no convictions involving fraudulent activities.

b. The department shall issue a certificate of authority for each person certified as a third-party skills test examiner that identifies the certified third-party tester for which the person will administer skills tests and the classes and types of vehicles for which the person may administer skills tests. The certificate shall be valid for a period of four years from the date of issuance of the certificate.

c. The department shall revoke the certificate if the person holding the certificate does not administer skills tests to at least ten different applicants per calendar year; does not successfully complete the refresher training required by 49 CFR Section 384.228 every four years; is involved in fraudulent activities related to conducting skills tests; or otherwise fails to comply with and meet the requirements, qualifications and standards of this chapter or 49 CFR Sections 383.75 and 384.228.

d. A third-party skills test examiner who is also a skills instructor shall not administer a skills test to an applicant who received skills training from that third-party skills test examiner.

**607.30(4) Bond.** As a condition of certification, an Iowa-based motor carrier must maintain a bond in the amount of \$50,000 to pay for the retesting of drivers in the event that the third-party tester or one or more of its third-party skills test examiners are involved in fraudulent activities related to conducting skills tests of applicants for a commercial driver's license.

**607.30(5) Limitation applicable to Iowa-based motor carriers.** An Iowa-based motor carrier certified as a third-party tester may only administer the skills test to persons who are enrolled in the Iowa-based motor carrier's commercial driving instruction program and shall not administer skills tests to persons who are not enrolled in that program.

**607.30(6) Training and refresher training for third-party skills test examiners.** All training and refresher training required under this rule shall be provided by the department, in form and content that meet the recommendations of the American Association of Motor Vehicle Administrators' International Third-Party Examiner/Tester Certification Program.

This rule is intended to implement Iowa Code section 321.187.  
[ARC 2530C, IAB 5/11/16, effective 6/15/16]

#### **761—607.31(321) Test results.**

**607.31(1) Period of validity.** Passing knowledge and skills test results shall remain valid for a period of one year.

**607.31(2) Retesting.** Subject to rule 761—607.28(321), an applicant shall be required to repeat only the knowledge test(s) or part(s) of the skills test that the applicant failed. An applicant who fails a test shall not be permitted to repeat that test the same day.

**607.31(3) Skills test results from other states.** As required by 49 CFR Section 383.79, the department shall accept the valid results of a skills test administered to an applicant who is domiciled in the state of Iowa and that was administered by another state, in accordance with 49 CFR Part 383, Subparts F, G and H, in fulfillment of the applicant's testing requirements under 49 CFR Section 383.71 and the state's test administration requirements under 49 CFR Section 383.73. The results must be transmitted directly from the testing state to the department as required by 49 CFR Section 383.79.

**607.31(4) Skills test results from certified third-party testers.** A third-party skills tester certified under rule 761—607.30(321) shall transmit the skills test results of tests administered by the third-party tester through secure electronic means determined by the department. The department may retest any person who has passed a skills test administered by a certified third-party tester if it appears to the department that the skills test administered by the third-party tester was administered fraudulently or improperly, and as needed to meet the third-party skills test examiner oversight requirements of 49 CFR Section 383.75(a)(5).

This rule is intended to implement Iowa Code sections 321.180, 321.186, 321.187 and 321.188.  
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16; ARC 3689C, IAB 3/14/18, effective 4/18/18]

**761—607.32 to 607.34** Reserved.

**761—607.35(321) Issuance of commercial driver's license and commercial learner's permit.** A commercial driver's license or commercial learner's permit issued by the department shall include the information and markings required by Iowa Code section 321.189(2) "b."

This rule is intended to implement Iowa Code section 321.189.  
[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.36(321) Conversion to commercial driver's license.** Rescinded IAB 6/23/93, effective 7/28/93.

**761—607.37(321) Commercial driver's license renewal.** The department shall administer commercial driver's license renewals as required by 49 CFR Section 383.73.

**607.37(1) Licensee requirements.** To renew a commercial driver's license, the licensee shall apply at a driver's license examination station and complete the following requirements:

*a.* The licensee shall make a written self-certification of type of driving as required by rule 761—607.50(321) and provide a current medical examiner's certificate if required.

*b.* If the licensee has and wishes to retain a hazardous material endorsement, the licensee shall pass the test required in 49 CFR Section 383.121 and comply with the Transportation Security Administration security threat assessment standards specified in 49 CFR Sections 383.71(b)(8) and 383.141 for such endorsement. A lawful permanent resident of the United States must also provide the licensee's U.S. Citizenship and Immigration Services alien registration number.

*c.* The licensee shall provide proof of citizenship or lawful permanent residency and state of domicile as required by rule 761—607.15(321) and 49 CFR 383.73(d)(7). Proof of citizenship or lawful permanent residency is not required if the licensee provided such proof at initial issuance or a previous renewal or upgrade of the license and the department has a notation on the licensee's record confirming that the required proof of legal citizenship or legal presence check was made and the date on which it was made.

*d.* If the licensee is domiciled in a foreign jurisdiction and renewing a non-domiciled commercial driver's license, the licensee must provide a document required by 49 CFR 383.71(f) at each renewal.

**607.37(2) Early renewal.** A valid commercial driver's license may be renewed 90 days before the expiration date. If this is impractical, the department for good cause may renew a license earlier, not to exceed 364 days prior to the expiration date. The department may allow renewal earlier than 364 days prior to the expiration date for active military personnel being deployed due to actual or potential military conflict.

This rule is intended to implement Iowa Code sections 321.186, 321.188 and 321.196.  
[ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.38(321) Transfers from another state.** Upon initial application for an Iowa license, an Iowa resident who has a valid commercial driver's license from a former state of residence is not required to retest except as specified in Iowa Code subsection 321.188(5) but is required to pay the applicable endorsement and restriction removal fees.

This rule is intended to implement Iowa Code sections 321.188 and 321.191.

**761—607.39(321) Disqualification.**

**607.39(1) Date.** A disqualifying act, action or offense under Iowa Code section 321.208, that occurred before July 1, 1990, shall not be grounds for disqualification from operating a commercial motor vehicle.

**607.39(2) Notice.** A 30-day advance notice of disqualification shall be served by the department in accordance with rule 761—615.37(321). Pursuant to Iowa Code subsection 321.208(12), a peace officer on behalf of the department may serve the notice of disqualification immediately.

**607.39(3) Hearing and appeal process.** A person who has received a notice of disqualification may contest the disqualification in accordance with 761—615.38(17A,321).

**607.39(4) Reduction of lifetime disqualification.** Reserved.

This rule is intended to implement Iowa Code chapter 17A and section 321.208.  
[ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.40(321) Sanctions.** When a person's motor vehicle license is denied, canceled, suspended, revoked or barred, the person is also disqualified from operating a commercial motor vehicle.

This rule is intended to implement Iowa Code section 321.208.

**761—607.41 to 607.44** Reserved.

**761—607.45(321) Reinstatement.** To reinstate a commercial driver's license after completion of a period of disqualification, a person shall appear at a driver's license examination station. The person must also meet the vision standards for licensing, pass the applicable knowledge test(s) and the skills test, and pay the required reinstatement fee and the fees for a new license.

This rule is intended to implement Iowa Code sections 321.191 and 321.208.

**761—607.46 to 607.48** Reserved.

**761—607.49(321) Restricted commercial driver's license.**

**607.49(1) Scope.** This rule pertains to the issuance of restricted commercial driver's licenses to suppliers or employees of suppliers of agricultural inputs. Issuance is permitted by 49 CFR 383.3(f). A restricted commercial driver's license shall meet all requirements of a regular commercial driver's license, as set out in Iowa Code chapter 321 and this chapter of rules, except as specified in this rule.

**607.49(2) Agricultural inputs.** The term "agricultural inputs" means suppliers or applicators of agricultural chemicals, fertilizer, seed or animal feeds.

**607.49(3) Validity.**

a. A restricted commercial driver's license allows the licensee to drive a commercial motor vehicle for agricultural input purposes. The license is valid to:

(1) Operate Group B and Group C commercial motor vehicles including tank vehicles and vehicles equipped with air brakes, except passenger vehicles.

(2) Transport the hazardous materials listed in paragraph 607.49(3) "b."

(3) Operate only during the current, validated seasonal period.

(4) Operate between the employer's place of business and the farm currently being served, not to exceed 150 miles.

b. A restricted commercial driver's license is not valid for transporting hazardous materials requiring placarding, except as follows:

(1) Liquid fertilizers such as anhydrous ammonia may be transported in vehicles or implements of husbandry with total capacities of 3,000 gallons or less.

(2) Solid fertilizers such as ammonium nitrate may be transported provided they are not mixed with any organic substance.

(3) A hazardous material endorsement is not needed to transport the products listed in the preceding subparagraphs.

c. When not driving for agricultural input purposes, the license is valid for operating a noncommercial motor vehicle that may be legally operated under the noncommercial license held by the licensee.

**607.49(4) Requirements.**

a. The applicant must have two years of previous driving experience. This means that the applicant must have held a license that permits unaccompanied driving for at least two years. This does not include a motorized bicycle license, a minor's school license or a minor's restricted license.

b. The applicant must have a good driving record for the most recent two-year period, as defined in subrule 607.49(5).

c. An applicant who currently holds a commercial driver's license or a commercial learner's permit is not eligible for issuance of a restricted commercial driver's license.

**607.49(5) Good driving record.** A "good driving record" means a driving record showing:

a. No multiple licenses.

b. No driver's license suspensions, revocations, disqualifications, denials, bars, or cancellations of any kind.

c. No convictions in any type of motor vehicle for:

(1) Driving under the influence of alcohol or drugs.

(2) Leaving the scene of an accident.

- (3) Committing any felony involving a motor vehicle.
- (4) Speeding 15 miles per hour or more over the posted speed limit.
- (5) Reckless driving, drag racing, or eluding or attempting to elude a law enforcement officer.
- (6) Improper or erratic lane changes.
- (7) Following too closely.
- (8) A moving violation that contributed to a motor vehicle accident.
- (9) A violation deemed serious under rule 761—615.17(321).
- d. No record of contributive accidents, as defined in rule 761—615.1(321).

**607.49(6) Issuance.**

a. The knowledge and skills tests described in rules 761—607.27(321) and 761—607.28(321) are waived.

b. A restricted commercial driver's license shall be coded with restriction "W" on the face of the driver's license, with the restriction explained in text on the back of the driver's license. In addition, the license shall be issued with a restriction stating the license's period of validity.

c. The expiration date for a restricted commercial driver's license that is converted to this license from another Iowa license shall carry the same expiration date as the previous license.

d. A restricted commercial driver's license may be renewed for the period of time specified in Iowa Code section 321.196. The licensee's good driving record shall be confirmed at the time of renewal.

e. The fee for a restricted commercial driver's license shall be as specified in Iowa Code section 321.191.

f. On or before December 31, 2016, there are two periods of validity for commercial motor vehicle operation: March 15 through June 30, and October 4 through December 14. Validity shall not exceed 180 days in any 12-month period. Any period of validity authorized previously by another state's license shall be considered a part of the 180-day maximum period of validity.

g. On or after January 1, 2017, a licensee may have up to three individual periods of validity for a restricted commercial driver's license, provided the cumulative period of validity for all individual periods does not exceed 180 days in any calendar year. An individual period of validity may be 60, 90, or 180 consecutive days, at the election of the licensee. A licensee may add 30 days to an individual period of validity by applying for an extension, subject to the 180-day cumulative maximum period of validity. A request for extension must be made no later than the date of expiration of the individual period of validity for which an extension is requested; a request for extension made after that date shall be treated as a request for a new individual period of validity. An extension shall be calculated from the date of expiration of the individual period of validity for which an extension is requested. Any period of validity authorized previously by another state's license shall be considered a part of the 180-day cumulative maximum period of validity.

h. A restricted commercial driver's license must be validated for commercial motor vehicle operation for each individual period of validity. This means that the applicant/licensee must have the person's good driving record confirmed at each application for an individual period of validity. Upon confirmation, the department shall issue a replacement license with a restriction validating the license for that individual period of validity, provided the person is otherwise eligible for the license. The fee for a replacement license shall be as specified in Iowa Code section 321.195.

i. The same process must be repeated for each individual period of validity within a calendar year.

This rule is intended to implement Iowa Code section 321.176B.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

**761—607.50(321) Self-certification of type of driving and submission of medical examiner's certificate.**

**607.50(1) Applicants for commercial learner's permit or new, transferred, renewed or upgraded CDL.**

a. A person shall provide to the department a self-certification of type of driving if the person is applying for:

- (1) A commercial learner's permit,

- (2) An initial commercial driver's license,
- (3) A transfer of a commercial driver's license from a prior state of domicile to the state of Iowa,
- (4) Renewal of a commercial driver's license, or
- (5) A license upgrade for a commercial driver's license or an endorsement authorizing the operation of a commercial motor vehicle not covered by the current commercial driver's license.

*b.* The self-certification shall be on a form or in a format, which may be electronic, as provided by the department.

**607.50(2)** *Submission of medical examiner's certificate by persons certifying to non-excepted interstate driving.* Every person who self-certifies to non-excepted interstate driving must give the department a copy of the person's current medical examiner's certificate. A person who fails to provide a required medical examiner's certificate shall not be allowed to proceed with an initial issuance, transfer, renewal, or upgrade of a license until the person gives the department a medical examiner's certificate that complies with the requirements of this subrule, or changes the person's self-certification of type of driving to a type other than non-excepted interstate driving. For persons submitting a current medical examiner's certificate, the department shall post a medical certification status of "certified" on the person's CDLIS driver's record. A person who self-certifies to a type of driving other than non-excepted interstate shall have no medical certification status on the CDLIS driver's record.

**607.50(3)** *Maintaining certified status.* To maintain a medical certification status of "certified," a person who self-certifies to non-excepted interstate driving must give the department a copy of each subsequently issued medical examiner's certificate valid for the person. The copy must be given to the department at least ten days before the previous medical examiner's certificate expires.

**607.50(4)** *CDL downgrade.* If the medical examiner's certificate or medical variance for a person self-certifying to non-excepted interstate driving expires or if the Federal Motor Carrier Safety Administration notifies the department that the person's medical variance was removed or rescinded, the department shall post a medical certification status of "not certified" to the person's CDLIS driver's record and shall initiate a downgrade of the person's commercial driver's license or commercial learner's permit. The medical examiner's certificate of a person who fails to maintain a medical certification status of "certified" as required by subrule 607.50(3) shall be deemed to be expired on the date of expiration of the last medical examiner's certificate filed for the person as shown by the person's CDLIS driver's record. The downgrade will be initiated and completed as follows:

*a.* The department shall give the person written notice that the person's medical certification status is "not certified" and that the commercial motor vehicle privileges will be removed from the person's commercial driver's license or commercial learner's permit 60 days after the date the medical examiner's certificate or medical variance expired or the medical variance was removed or rescinded unless the person submits to the department a current medical certificate or medical variance or self-certifies to a type of driving other than non-excepted interstate.

*b.* If the person submits a current medical examiner's certificate or medical variance before the end of the 60-day period, the department shall post a medical certification status of "certified" on the person's CDLIS driver's record and shall terminate the downgrade of the person's commercial driver's license or commercial learner's permit.

*c.* If the person self-certifies to a type of driving other than non-excepted interstate before the end of the 60-day period, the department shall not remove the commercial motor vehicle privileges from the person's commercial driver's license or commercial learner's permit, and the person will have no medical certification status on the person's CDLIS driver's record.

*d.* If the person fails to take the action in either paragraph 607.50(4) "b" or "c" before the end of the 60-day period, the department shall remove the commercial motor vehicle privileges from the person's commercial driver's license or commercial learner's permit and shall leave the person's medical certification status as "not certified" on the person's CDLIS driver's record.

**607.50(5)** *Establishment or reestablishment of "certified" status.* A person who has no medical certification status or whose medical certification status has been posted as "not certified" on the person's CDLIS driver's record may establish or reestablish the status as "certified" by submitting a current medical examiner's certificate or medical variance to the department. A person who has failed

to self-certify to a type of driving or has self-certified to a type of driving other than non-excepted interstate must also make a self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of “certified” on the person’s CDLIS driver’s record.

**607.50(6) Reestablishment of the CDL privilege.** A person whose commercial motor vehicle privileges have been removed from the person’s commercial driver’s license or commercial learner’s permit under the provisions of paragraph 607.50(4) “d” may reestablish the commercial motor vehicle privileges by either of the following methods:

*a.* Submitting a current medical examiner’s certificate or medical variance to the department. A person who has failed to self-certify to a type of driving must also make an initial self-certification of type of driving to non-excepted interstate driving. The department shall then post a medical certification status of “certified” on the person’s CDLIS driver’s record and reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit.

*b.* Self-certifying to a type of driving other than non-excepted interstate. The department shall then reestablish the commercial motor vehicle privileges, provided that the person otherwise remains eligible for a commercial driver’s license or commercial learner’s permit; the person will have no medical certification status on the driver’s CDLIS driver’s record.

**607.50(7) Change of type of driving.** A person may change the person’s self-certification of type of driving at any time. As required by subrule 607.50(2), a person certifying to non-excepted interstate driving must give the department a copy of the person’s current medical examiner’s certificate prepared by a medical examiner.

**607.50(8) Record keeping.** The department shall comply with the medical record-keeping requirements set forth in 49 CFR Section 383.73.

This rule is intended to implement Iowa Code sections 321.182, 321.188 and 321.207.

[ARC 9954B, IAB 1/11/12, effective 1/30/12; ARC 0031C, IAB 3/7/12, effective 4/11/12; ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

#### **761—607.51(321) Determination of gross vehicle weight rating.**

**607.51(1) Actual weight prohibited.** In determining whether the vehicle is a representative vehicle for the skills test and the group of commercial driver’s license for which the applicant is applying, the vehicle’s gross weight rating or gross combination weight rating must be used, not the vehicle’s actual gross weight or gross combination weight. For purposes of this rule, “gross weight rating” and “gross combination weight rating” mean as defined in 49 CFR Section 383.5.

**607.51(2) Vehicle without legible manufacturer’s certification label.** To complete a skills test using a vehicle that has no legible manufacturer’s certification label, whether a power unit or towed vehicle, the applicant must provide documentation of the vehicle’s gross vehicle weight rating, such as a manufacturer’s certificate of origin, a title, or the vehicle identification number information for the vehicle. In the absence of such documentation, the vehicle may not be used, either alone or in combination.

This rule is intended to implement Iowa Code section 321.1.

[ARC 2071C, IAB 8/5/15, effective 7/14/15; ARC 2337C, IAB 1/6/16, effective 2/10/16; ARC 2530C, IAB 5/11/16, effective 6/15/16]

[Filed emergency 10/24/90—published 11/14/90, effective 10/24/90]

[Filed emergency 1/10/91—published 2/6/91, effective 1/10/91]

[Filed 5/9/91, Notices 11/14/90, 2/20/91—published 5/29/91, effective 7/3/91]

[Filed 5/27/93, Notice 3/17/93—published 6/23/93, effective 7/28/93]

[Filed 1/11/95, Notice 11/23/94—published 2/1/95, effective 3/8/95]

[Filed 11/1/95, Notice 9/27/95—published 11/22/95, effective 12/27/95]

[Filed 10/30/96, Notice 9/25/96—published 11/20/96, effective 12/25/96]

[Filed 6/19/02, Notice 4/17/02—published 7/10/02, effective 8/14/02]

[Filed emergency 3/21/03—published 4/16/03, effective 3/21/03]

[Filed emergency 6/15/05 after Notice 5/11/05—published 7/6/05, effective 7/1/05]

[Filed 10/11/06, Notice 8/30/06—published 11/8/06, effective 12/13/06]

[Filed 12/12/07, Notice 11/7/07—published 1/2/08, effective 2/6/08]

[Filed ARC 7902B (Notice ARC 7721B, IAB 4/22/09), IAB 7/1/09, effective 8/5/09]

[Filed Emergency ARC 9954B, IAB 1/11/12, effective 1/30/12]

[Filed ARC 0031C (Notice ARC 9955B, IAB 1/11/12), IAB 3/7/12, effective 4/11/12]

[Filed ARC 1714C (Notice ARC 1601C, IAB 9/3/14), IAB 11/12/14, effective 12/17/14]

[Filed Emergency ARC 2071C, IAB 8/5/15, effective 7/14/15]

[Filed ARC 2337C (Notice ARC 2070C, IAB 8/5/15), IAB 1/6/16, effective 2/10/16]

[Filed ARC 2530C (Notice ARC 2451C, IAB 3/16/16), IAB 5/11/16, effective 6/15/16]

[Filed ARC 2986C (Notice ARC 2878C, IAB 1/4/17), IAB 3/15/17, effective 4/19/17]

[Filed ARC 3689C (Notice ARC 3532C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

CHAPTER 910  
COORDINATION OF PUBLIC TRANSIT SERVICES

[Prior to 6/3/87, Transportation Department [820]—(09,A)Ch 2]

**761—910.1(324A) Definitions.** For purposes of this chapter, the following definitions shall apply in addition to the definitions in Iowa Code section 324A.1:

“*Council*” means the statewide transportation coordination advisory council formed in rule 910.3(324A).

“*Department*” means the state department of transportation. The department’s office of public transit administers Iowa Code chapter 324A.

“*Emergency transportation*” means transportation provided when life, health or safety is in danger, such as ambulance or law enforcement transportation.

“*Incidental transportation*” means the provision of transit rides when existing public transportation services cannot meet demand. Allowable charter service and meal deliveries are examples of incidental transportation.

“*Provider*” means any recipient of direct or indirect, state, federal or local funds, including a public transit system, that provides or contracts for public transit services.

“*Public school transportation*” means passenger transportation provided by or for a legally organized Iowa public school district for school district purposes.

“*Public transit service*” means any publicly funded passenger transportation for the general public or for specific client groups not including exclusive public school transportation, emergency transportation or incidental transportation or transportation provided by the state department of human services or state department of corrections on the grounds of the following institutions:

- State training school, Eldora;
- Cherokee mental health institute;
- Independence mental health institute;
- Glenwood state hospital-school;
- Woodward state hospital-school;
- Iowa veterans home, Marshalltown;
- Iowa state penitentiary, Fort Madison;
- Anamosa state penitentiary, Anamosa;
- Iowa correctional institution for women, Mitchellville;
- Mount Pleasant correctional facility, Mount Pleasant;
- Newton correctional facility, Newton;
- Iowa medical and classification center, Coralville;
- North central correctional facility, Rockwell City;
- Fort Dodge correctional facility, Fort Dodge;
- Clarinda correctional facility, Clarinda.

This rule is intended to implement Iowa Code section 324A.1.

[ARC 3690C, IAB 3/14/18, effective 4/18/18]

**761—910.2(17A) Information and location.** Forms or information about the coordination of public transit services are available from the Office of Public Transit, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)233-7870 or on the department’s website at [www.iowadot.gov](http://www.iowadot.gov).

This rule is intended to implement Iowa Code section 17A.3.

[Editorial change: IAC Supplement 2/23/11; ARC 3690C, IAB 3/14/18, effective 4/18/18]

**761—910.3(324A) Statewide transportation coordination advisory council.**

**910.3(1) Purpose.** An advisory council shall be formed by the department to assist with implementation of the compliance reviews required by statute. The council shall assist in the review of information concerning the transportation operations of providers and advise the department as to

whether the provider should be found to be in compliance with the transportation coordination mandate of Iowa Code chapter 324A.

**910.3(2) *Advisory council.***

*a. Membership.* Membership in the council shall at minimum include one representative from the department of human services, one from the department on aging and one from the department. Other state agencies as well as federal agencies and statewide private agencies funding local transportation services may also be granted membership.

*b. Chairperson.* The director of transportation or the director's representative shall serve as chairperson of the council.

*c. Staff.* Staff support for council activities shall be provided by the department.

*d. Meetings.* Meetings shall be held at least once each quarter and may be held more frequently if necessary to enable the council to expeditiously discharge its duties.

**910.3(3) *Duties.*** The council shall:

*a.* Review and make recommendations to the member agencies concerning guidelines and criteria for the review process operated by the council.

*b.* Provide the department with written recommendations for findings of compliance or noncompliance with the transportation coordination mandate of Iowa Code chapter 324A for individual providers based upon review of each provider's request for certification.

*c.* Upon request of a member agency, review all transportation components of funding applications or plans submitted by a recipient of the member agency.

*d.* Advise and make recommendations to the department concerning public transportation policy.

This rule is intended to implement Iowa Code sections 324A.4 and 324A.5.

[Editorial change: IAC Supplement 2/23/11; **ARC 3690C**, IAB 3/14/18, effective 4/18/18]

**761—910.4(324A) Certification process.**

**910.4(1) *Requirement for certification.*** All providers are required to request a certification of compliance with the transportation coordination mandate of Iowa Code chapter 324A by submitting the certification application form in the Appendix to this rule plus a copy of a certificate of insurance or documentation of self-insurance. <sup>1</sup>Agencies that provide a mixture of public transit service and other service shall request certification based on that part of their overall operation which is public transit service.

**910.4(2) *Form distribution.***

*a. Recipients of state or state-administered funds.* Each state agency in its own funding application or contract process shall require each recipient of funding to submit a request for certification of compliance.

*b. Recipients of other funds.* The department shall contact local governments and federal agencies to determine whether they are funding any providers that are not funded through the state. The department shall send to any providers identified in this way, or by other means, an explanation of the certification requirement and a copy of the certification request form in the Appendix.

**910.4(3) *Submission of request forms.***

*a.* Recipients of state funds shall submit both the certification application and the certificate of insurance forms annually to the funding agency.

*b.* Recipients of funds from multiple sources may submit a single request form to all state funding sources if it covers all agency transportation functions.

*c.* Providers not receiving any funds from state agencies shall return their completed forms within 20 working days of receipt.

*d.* Agencies or organizations that receive a form from the department and believe that none of their services fit the definition of public transit services shall respond to the department within 20 working days of receipt, stating this belief and providing a brief description of any passenger transportation service they do provide and why it should not be considered public transit service.

**910.4(4) *Incomplete or unreturned request forms.***

*a.* Forms submitted to a state funding agency as part of a funding application shall be reviewed for completeness by that agency within 10 working days.

*b.* Forms submitted directly to the department by its recipients or by providers not receiving state or state-administered funds shall be reviewed for completeness by the office of public transit within 10 working days.

*c.* The reviewing agency shall inform the provider in writing of any information deficiencies and allow 10 working days from receipt for submittal of missing information.

*d.* Each state agency shall report to the council each case in which a provider has failed upon notification to supply the required information within the required time frame.

*e.* All completed request forms submitted to state funding agencies shall be forwarded to the council staff within five working days after verifying completeness.

**910.4(5) Processing requests.**

*a.* The council staff shall evaluate completed requests based on the compliance standards found in rule 910.5(324A) and make a recommendation for a finding of compliance or noncompliance to the council within 20 working days of receiving the completed request form.

*b.* Ten working days prior to the council's scheduled monthly meeting, the council staff shall distribute to each council member and to the respective providers a meeting agenda and copies of all compliance finding recommendations completed since the previous agenda mailing.

*c.* At their monthly meeting the council shall consider the compliance finding recommendations of the staff and may accept the staff recommendations as their recommendations to the director of transportation, change the recommendations and provide a statement of reasons, or defer action pending further review.

*d.* Upon consideration of the council recommendations, the department shall make a final finding of compliance or noncompliance and notify the provider and the state funding agency, if applicable, in writing of the department's decision within five working days after the council meeting.

This rule is intended to implement Iowa Code section 324A.4.

[ARC 3690C, IAB 3/14/18, effective 4/18/18]

<sup>1</sup> See Appendix at end of Chapter 910.

**761—910.5(324A) Standards for compliance.** A provider shall be found compliant if the provider meets both of the following standards:

**910.5(1)** All vehicles used for the public transit services it provides or contracts for are insured for \$1 million per accident for all hazards or the provider maintains a self-insurance fund adequate to provide equivalent protection.

**910.5(2)** The provider:

*a.* Purchases all services from a designated public transit system, or  
*b.* Operates all services open to the public under contract with and under control of a designated transit system, or

*c.* Purchases all services from a private-for-profit operator of public transit services, or

*d.* Operates its own services which:

(1) The designated public transit system is currently unable to provide, or

(2) When considered as a whole using fully allocated costs, prove to be more economical than the purchase of equivalent services from the designated public transit system.

*e.* Uses a combination of services in paragraphs "*a.*," "*b.*," "*c.*," and "*d.*"

This rule is intended to implement Iowa Code section 324A.4.

[ARC 3690C, IAB 3/14/18, effective 4/18/18]

**761—910.6(324A) Noncompliance.** A provider shall be found noncompliant if:

**910.6(1)** The provider has not submitted required data upon expiration of either the original submittal deadline or the additional ten-day grace period after written notification of deficiencies in an original submittal.

**910.6(2)** The provider's request for certification has been processed and the provider did not qualify for a finding of compliance.

This rule is intended to implement Iowa Code section 324A.4.

**761—910.7(324A) Noncompliant sanctions.** A provider that is denied certification and continues the noncompliant activities for more than 30 days shall be subject to the penalties and sanctions specified in Iowa Code subsection 324A.5(3).

**910.7(1)** If the department of human services purchases services from the noncompliant provider, the office of public transit shall notify the department of human services of the noncompliant finding.

**910.7(2)** If the noncompliant provider is a recipient of public funds from other than the department of human services, the department shall notify the proper authority as required in Iowa Code section 324A.5.

This rule is intended to implement Iowa Code sections 324A.4 and 324A.5.  
[ARC 3690C, IAB 3/14/18, effective 4/18/18]

**761—910.8(324A) Revocation.**

**910.8(1)** If certification is revoked, the department shall send a written notice of revocation to the provider.

**910.8(2)** The affected public transit system, the provider and the department shall meet within 10 days after the date of the revocation notice to determine an acceptable amendment of the transportation services. The amendments which are agreed upon shall become effective within 60 days. The contract between the provider and the affected public transit system shall be amended, if necessary, to agree with the service changes.

**910.8(3)** If the transportation services are not amended in a timely manner, the department shall initiate actions as required in Iowa Code section 324A.5(2).

This rule is intended to implement Iowa Code section 324A.5.  
[ARC 3690C, IAB 3/14/18, effective 4/18/18]

Appendix to rule 761—910.4(324A)

Date \_\_\_\_\_

FY \_\_\_\_\_

**CERTIFICATION APPLICATION**

State/Federal Administering Agency \_\_\_\_\_

**I. GENERAL INFORMATION:**

Agency Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone:(\_\_\_\_\_) \_\_\_\_\_

Service Area (counties): \_\_\_\_\_

Types of Clients: \_\_\_\_\_

Types of Services: \_\_\_\_\_

Does agency provide transportation services? Yes \_\_\_\_\_ No \_\_\_\_\_

Does agency use public funds for transportation? Yes \_\_\_\_\_ No \_\_\_\_\_

**II. TRANSPORTATION ACTIVITIES:**

Population groups served: Elderly \_\_\_\_\_ Youth Economically Deprived \_\_\_\_\_ Public \_\_\_\_\_

Persons with physical disabilities \_\_\_\_\_ Persons with mental disabilities \_\_\_\_\_ Other \_\_\_\_\_

Describe others: \_\_\_\_\_

Services Accessed: Medical \_\_\_\_\_ Day Care \_\_\_\_\_ Shopping \_\_\_\_\_ Nutrition \_\_\_\_\_ Employment \_\_\_\_\_

Recreation \_\_\_\_\_ Education/training \_\_\_\_\_ Other social services \_\_\_\_\_

What percent of your transportation service (in terms of miles driven) is operated during the following time periods?

\_\_\_\_\_ % weekdays + \_\_\_\_\_ % evenings + \_\_\_\_\_ % weekends = 100%

Is any part of agency's transportation purchased from an urban or regional transit system?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please indicate system: \_\_\_\_\_



**V. PURCHASE OF SERVICE (Contracts and Vendor Agreements):**

Total \$ \_\_\_\_\_

|                               | Average Monthly Ridership | Average Monthly Vehicle Miles | Projected Annual Expenditures |
|-------------------------------|---------------------------|-------------------------------|-------------------------------|
| Taxi                          |                           |                               | \$                            |
| Intracity bus                 |                           |                               | \$                            |
| Regional/Urban Transit System |                           |                               | \$                            |
| Other - specify               |                           |                               | \$                            |
| Total                         | _____                     | _____                         | \$                            |

**VI. OPERATION OF OWN TRANSPORTATION SERVICE:**

Total \$ \_\_\_\_\_

| STAFF                    | Number | % of Time | Projected Annual Expenditures |
|--------------------------|--------|-----------|-------------------------------|
| Administrative           |        |           | \$                            |
| Drivers                  |        |           | \$                            |
| Maintenance              |        |           | \$                            |
| Professional             |        |           | \$                            |
| Escorts                  |        |           | \$                            |
| Volunteers reimbursement |        | \$ /mile  | \$                            |
| Other - specify          |        |           | \$                            |
| Subtotal                 | _____  | _____     | \$                            |

| VEHICLE OPERATING COSTS              | Projected Annual Expenditures |
|--------------------------------------|-------------------------------|
| Fuel and oil                         | \$                            |
| Maintenance and repair               | \$                            |
| Insurance                            | \$                            |
| Licenses and fees                    | \$                            |
| Staff mileage reimbursement \$ /mile | \$                            |
| Indirect cost or overhead            | \$                            |
| Other - specify                      | \$                            |
| Subtotal                             | \$                            |

**PURCHASE OR LEASE OF VEHICLES AND SPECIAL EQUIPMENT**

| Vehicle Type | No. to be Leased | No. to be Purchased | No. for Replacement | No. for Expansion | Special Equipment | Projected Annual Cost |
|--------------|------------------|---------------------|---------------------|-------------------|-------------------|-----------------------|
|              |                  |                     |                     |                   |                   | \$                    |
|              |                  |                     |                     |                   |                   | \$                    |
|              |                  |                     |                     |                   |                   | \$                    |
| Subtotal     | _____            | _____               | _____               | _____             | _____             | \$                    |

**Note: The total funding in Section IV must equal the total expenditures in Section V plus Section VI.**

[Filed 3/8/85, Notice 1/16/85—published 3/27/85, effective 5/1/85]

[Filed 2/20/86, Notice 1/1/86—published 3/12/86, effective 4/16/86]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 11/3/88, Notice 9/21/88—published 11/30/88, effective 1/4/89]

[Filed 1/15/92, Notice 12/11/91—published 2/5/92, effective 3/11/92]

[Filed emergency 7/1/92—published 7/22/92, effective 7/27/92]

[Filed 11/20/92, Notice 10/14/92—published 12/9/92, effective 1/13/93]

[Filed 9/8/94, Notice 7/20/94—published 9/28/94, effective 11/2/94]

[Editorial change: IAC Supplement 2/23/11]

[Filed ARC 3690C (Notice ARC 3533C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]



CHAPTER 911  
SCHOOL TRANSPORTATION SERVICES PROVIDED  
BY REGIONAL TRANSIT SYSTEMS

**761—911.1(321) Purpose and information.**

**911.1(1) Purpose.** This chapter establishes standards for school transportation services provided by Iowa's regional transit systems under contract with local schools.

**911.1(2) Information.** Information and forms may be obtained from the Office of Public Transit, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)233-7870; or the department's website at [www.iowadot.gov](http://www.iowadot.gov).

[ARC 3691C, IAB 3/14/18, effective 4/18/18]

**761—911.2(321,324A) Definitions.** For the purpose of these rules, the following definitions apply:

“*Automobile*” means the same as defined in Iowa Code section 321.1.

“*Bus*” means a motor vehicle, excluding a trailer, designed to carry ten or more persons.

“*Contract*” means a written agreement between a public or nonpublic school or other group and a regional transit system which defines the terms and conditions under which school transportation service is to be provided. It shall not include the relationship between a regional transit system and an individual fare-paying passenger in either fixed route or demand response service.

“*Multipurpose vehicle*” means the same as defined in Iowa Code section 321.1.

“*Public transit system*” means the same as defined in Iowa Code section 324A.1.

“*Regional transit system*” means the same as defined in Iowa Code section 324A.1.

“*School bus*” means a bus that complies with all federal motor vehicle safety standards applicable to a school bus.

“*School transportation service*” means transit service provided under contract to a public or nonpublic school or other group, including day care centers, to transport students to or from schools or school-sponsored activities.

“*Student*” means a person attending a public or nonpublic school, grades prekindergarten through high school, including a Head Start participant.

“*Vehicle*” means an automobile, multipurpose vehicle, bus or school bus as defined in this rule.

[ARC 3691C, IAB 3/14/18, effective 4/18/18]

**761—911.3(321) Services to students as part of the general public.** All services provided by regional transit systems must be open to the public. This chapter shall not be construed to restrict the use of these services by any individual fare-paying passenger, in either fixed route or demand response service.

**761—911.4(321) Contracts for nonexclusive school transportation.** As common carriers in urban transportation service, regional transit systems may contract with schools, day care providers, after-school program providers, or others to provide nonexclusive school transportation service that meets the requirements of this chapter. Exclusive service contracts are prohibited.

**761—911.5(321) Adoption of federal regulations.**

**911.5(1) Code of Federal Regulations.** The department of transportation adopts the following portions of the October 1, 2017, Code of Federal Regulations, which are referenced throughout this chapter:

a. 49 CFR Part 38, Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation Vehicles.

b. 49 CFR Part 571, Federal Motor Vehicle Safety Standards.

c. 49 CFR Part 655, Prevention of Alcohol Misuse and Prohibited Drug Use in Transit Operations.

**911.5(2) Obtaining copies of regulations.** Copies of these regulations are available from the state law library or online through the U.S. Government Publishing Office at [www.ecfr.gov](http://www.ecfr.gov).

[ARC 3691C, IAB 3/14/18, effective 4/18/18]

**761—911.6(321) Driver standards.** The following standards apply to regional transit system drivers assigned to provide school transportation service:

**911.6(1) *FTA drug and alcohol testing.*** Each driver is subject to the following testing for drug and alcohol usage as detailed by the Federal Transit Administration in 49 CFR Part 655, including:

- a. Preemployment testing.
- b. Reasonable suspicion testing.
- c. Postaccident testing.
- d. Random testing.
- e. Return to duty testing.
- f. Follow-up testing.

**911.6(2) *Training.*** Each new driver must, before or within the first six months of assignment and at least every 24 months thereafter, complete a course of instruction approved by the department of education, in accordance with Iowa Code section 321.376.

**911.6(3) *Driving record check.*** The regional transit system must review the driving record of each driver prior to employment and on an annual basis.

**911.6(4) *Criminal record check.*** The regional transit system must conduct a criminal records review of each driver prior to employment and on an annual basis. This review verifies that the driver has no history of child abuse or other criminal activity.

**911.6(5) *Driver licensing.*** Each driver must be licensed appropriately for the size and type of vehicle used as provided in Iowa Code section 321.189. A Class A, B or C commercial driver's license with passenger endorsement may be required. A driver may operate the vehicle for purposes of training if the driver has the appropriate commercial learner's permit as defined in 761—Chapter 607, and the restrictions in rule 761—607.20(321) shall apply. If a commercial driver's license is not required, a Class D (chauffeur) license with passenger endorsement is required.

**911.6(6) *Authorization to operate a school bus.*** Each driver who transports students must have an authorization to operate a school bus issued by the department of education in accordance with Iowa Code section 321.376.

**911.6(7) *Physical fitness.*** Each driver who transports students must undergo a physical examination by a certified medical examiner who is listed on the National Registry of Certified Medical Examiners in accordance with Iowa Code section 321.375(1)“d” and with department of education rule 281—43.15(285) or 281—43.17(285). Annually, the driver must submit the signed medical examiner's certificate to the driver's employer.

[ARC 3691C, IAB 3/14/18, effective 4/18/18]

**761—911.7(321) Vehicle standards.** The following standards apply to regional transit system vehicles assigned to provide school transportation service:

**911.7(1) *Vehicle construction.***

a. Each vehicle must be constructed in compliance with the federal motor vehicle safety standards for that type of vehicle as set forth in 49 CFR Part 571. The capacity rating of automobiles and multipurpose vehicles shall not be modified or altered in any way except by the original manufacturer.

b. Each bus in use must also comply with the following federal motor vehicle safety standards:

(1) Standard No. 217, Bus Emergency Exits and Window Retention and Release. Buses utilized for school transportation shall incorporate a rear emergency exit door in meeting this standard.

(2) Standard No. 220, School Bus Rollover Protection.

(3) Standard No. 221, School Bus Body Joint Strength.

(4) Standard No. 301, Fuel System Integrity.

**911.7(2) *Passenger restraint/protection.*** Each automobile, multipurpose vehicle or school bus must provide passenger restraint/protection devices as required for that type of vehicle in the federal motor vehicle safety standards. Each bus must meet the standards listed in either “a” through “f” below or “g” below:

a. Standard No. 207, Seating Systems.

b. Standard No. 208, Occupant Crash Protection.

- c. Standard No. 209, Seat Belt Assemblies.
- d. Standard No. 210, Seat Belt Assembly Anchorages.
- e. Standard No. 213, Child Restraint Systems.
- f. Standard No. 225, Child Restraint Anchorage Systems.
- g. Standard No. 222, School Bus Passenger Seating and Crash Protection.

**911.7(3) Accessibility for persons with disabilities.** Each vehicle used for students with disabilities must comply with all applicable provisions of 49 CFR Part 38.

**911.7(4) Signage.** A vehicle must not be signed as a school bus.

**911.7(5) Department of education inspection.** Every vehicle must be inspected twice annually by the department of education school bus inspectors and officers of the Iowa state patrol to determine if the vehicle meets all vehicle standards set forth in this chapter.

The department of education will notify each regional transit system of the dates and locations of scheduled inspections. Inspections must be documented on a form prescribed jointly by the departments of transportation and education.

**911.7(6) Transfer to another public transit system.** When a public transit system purchases a used vehicle from another public transit system, the previous owner's department of education's bus inspections stickers must be removed. If the purchasing public transit system plans to use the vehicle for school transportation service, a new inspection must be performed on the vehicle.

[ARC 3691C, IAB 3/14/18, effective 4/18/18]

**761—911.8(321) Maintenance.** Regional transit system vehicles assigned to provide school transportation service must be maintained in a safe and operable condition. The following maintenance practices apply:

**911.8(1) FTA drug and alcohol testing of mechanics.** All personnel providing maintenance services on regional transit system vehicles are subject to drug and alcohol testing as required by the Federal Transit Administration in 49 CFR Part 655.

**911.8(2) Daily pretrip vehicle inspections.** Drivers of these vehicles must perform daily pretrip vehicle inspections using a form prescribed by the department. Regional transit systems must retain daily pretrip vehicle inspection reports and documentation of follow-up maintenance for one year.

**911.8(3) Annual vehicle inspection.** Maintenance personnel must annually inspect each vehicle. Regional transit systems must retain annual vehicle inspection records for one year.

[ARC 3691C, IAB 3/14/18, effective 4/18/18]

**761—911.9(321) Safety equipment.** Regional transit system vehicles assigned to provide school transportation service must carry the following safety equipment:

**911.9(1) Communication equipment.** Each vehicle must be equipped with a two-way radio, cellular telephone, or mobile data terminal tablet capable of emergency communication between the vehicle and the regional transit system's base of operations.

**911.9(2) First-aid/body fluids cleanup kit(s).** Each vehicle must be equipped with a first-aid kit of sufficient size and content for the capacity of the vehicle and, in addition, be equipped with a body fluid cleanup kit. These may be provided as separate kits or combined into one kit. The contents of the kit(s) must be contained in one or more moisture-proof and dustproof containers mounted in an accessible location within the driver's compartment and must be removable from the vehicle in an emergency.

**911.9(3) Fire extinguisher.** Each bus or school bus must be equipped with a minimum 5-pound capacity, dry chemical fire extinguisher. Each automobile and multipurpose vehicle must be equipped with an extinguisher of at least 2.5-pound capacity. Extinguishers must have a 2A-10BC rating. All fire extinguishers shall be inspected and maintained in accordance with the National Fire Protection Association requirements. The standards for portable extinguishers are available online from the National Fire Protection Association at [www.nfpa.org](http://www.nfpa.org).

**911.9(4) Seatbelt web cutter.** A seatbelt web cutter must be mounted or placed within reach of the driver.

**911.9(5) Roadside reflective triangles.** Each vehicle must be equipped with roadside reflective triangles for use in case of breakdown or emergency.

**911.9(6) Flashlight.** Each vehicle must be equipped with an operable flashlight or each driver must be assigned an operable flashlight to be in the vehicle at all times of operation.

**911.9(7) Reflective vest.** Each vehicle must be equipped with a reflective vest or each driver must be assigned a reflective vest that must be in the vehicle at all times of operation. Individual regional transit systems are to establish a policy for when the reflective vests must be worn.  
[ARC 3691C, IAB 3/14/18, effective 4/18/18]

**761—911.10(321) Operating policies.** School transportation services provided by regional transit systems must be designed to maximize the safety of student riders and must, at a minimum, meet the following standards:

**911.10(1) Passenger loading/unloading.** Unless prohibited by law, students transported in vehicles other than school buses must be loaded and unloaded on the same side of the street as their residence or other origin or destination. Students may be released only to the custody of a designated school official, parent or guardian, employee of the department of human services, or law enforcement official, unless other arrangements are made in advance.

**911.10(2) Student passenger behavior and discipline policy.** Each contract for school transportation service must include a policy relating to the behavior of students while they ride in vehicles. The regional transit system or school must provide instruction to all drivers assigned to school transportation service relative to the content and application of the policy. If a student is removed from a vehicle for one or more policy violations, the student may be released only to the custody of a school official, parent or guardian, employee of the department of human services or a law enforcement officer. In all cases, the school must be notified immediately of any such disciplinary action, and a written report must be filed with the school describing the circumstances resulting in the removal.

**911.10(3) Standing prohibited.** Under no circumstances shall a student be permitted or required to stand while a vehicle is in motion. Every student must be provided an appropriate seat at all times.

**911.10(4) Stops at rail crossings.** Every driver must make a complete stop before driving across the tracks of any railroad crossing, in accordance with Iowa Code section 321.343.

**911.10(5) Accident reporting.** If a driver is involved in a collision or other incident causing or having a potential to cause injuries to students, the regional transit system must immediately notify the school of the incident. The regional transit system must file all accident reports required by law. In addition, the regional transit system must complete a school bus accident report on a form prescribed by the department of education and submit it to the school or the department of education.

**911.10(6) Passenger instruction/evacuation drills.** Each school must provide students assigned to school transportation service with school bus passenger safety instruction and emergency evacuation drills at least twice each school year. These evacuation drills must involve a vehicle of the same type used to provide the school transportation service.

**911.10(7) Special training for drivers carrying students with disabilities.** Each school contracting for school transportation services for a student with one or more disabilities must provide the regional transit system with information on any special needs of the student and, if necessary, provide the assigned driver with appropriate information and training on how to appropriately respond to the needs of the student during transit and in the event of an emergency.

**911.10(8) Posttrip inspection.** After each trip that had students on board, the driver must perform a posttrip inspection of the interior of the vehicle. The posttrip inspection must include a walk-through to the back of the vehicle to ensure that no sleeping or hiding children are left behind.

[ARC 3691C, IAB 3/14/18, effective 4/18/18]

These rules are intended to implement Iowa Code sections 321.1, 321.189, 321.343, 321.375, 321.376, 321.377 and 324A.1.

[Filed 6/22/00, Notice 4/19/00—published 7/12/00, effective 8/16/00]

[Filed 6/2/04, Notice 4/28/04—published 6/23/04, effective 7/28/04]

[Filed 6/14/07, Notice 5/9/07—published 7/4/07, effective 8/8/07]

[Filed ARC 3691C (Notice ARC 3534C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

CHAPTER 922  
FEDERAL TRANSIT ASSISTANCE  
[Prior to 6/3/87, Transportation Department[820]—(09.B)Ch 3]

**761—922.1(324A) Projects for nonurbanized areas and private nonprofit transportation providers.**

**922.1(1) General information.**

*a.* Section 5310 of Title 49 United States Code established the enhanced mobility of seniors and individuals with disabilities program, a program of federal financial assistance for support of capital acquisitions for private nonprofit providers of specialized transportation services for seniors and persons with disabilities.

*b.* Section 5311 of Title 49 United States Code established the formula grants for rural areas program, a program of federal financial assistance for support of public transportation in rural areas with populations of less than 50,000, as defined by the U.S. Census Bureau.

*c.* Section 5339 of Title 49 United States Code established the bus and bus facilities program, a program of federal financial assistance for support of capital acquisitions for public transportation providers.

*d.* As required by Title 49 United States Code, the department has been designated by the governor to administer these programs within Iowa, subject to review by the Federal Transit Administration (FTA).

**922.1(2) State management plan.**

*a.* Sections 5310, 5311 and 5339 of Title 49 United States Code federal transit assistance programs within Iowa shall be administered according to the “Iowa State Management Plan for Administration of Funding and Grants Under the Federal Transit Administration, Sections 5310, 5311, 5316, 5317 and 5339 Programs,” dated March 2017, which has been prepared by the department and approved by the Federal Transit Administration in conformance with FTA Circulars 5100.1, 9040.1G and 9070.1G.

*b.* Copies of the state management plan are available from the Office of Public Transit, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)233-7870; or the department’s website at [www.iowadot.gov](http://www.iowadot.gov).

This rule is intended to implement Iowa Code chapter 324A.

[Editorial change: IAC Supplement 2/23/11; ARC 3692C, IAB 3/14/18, effective 4/18/18]

[Filed 2/20/86, Notice 1/1/86—published 3/12/86, effective 4/16/86]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 1/15/92, Notice 12/11/91—published 2/5/92, effective 3/11/92]

[Filed emergency 7/1/92—published 7/22/92, effective 7/27/92]

[Filed 1/27/94, Notice 12/22/93—published 2/16/94, effective 3/23/94]

[Editorial change: IAC Supplement 2/23/11]

[Filed ARC 3692C (Notice ARC 3536C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]



CHAPTER 923  
CAPITAL MATCH REVOLVING LOAN FUND  
[Prior to 6/3/87, Transportation Department[820]—(09,B)Ch 4]

**761—923.1(71GA,ch265) General information.**

**923.1(1) Scope of chapter.** The general assembly appropriated money from the petroleum overcharge fund to the department to be used as a revolving loan fund for transit capital purchases by public transit systems. The revolving loan fund will enable public transit systems to obtain the matching funds required to qualify for capital purchases under state or federally funded projects. The fund will provide multiyear interest-free loans to public transit systems to allow faster capital acquisitions. Loan recipients shall be required to demonstrate ability to repay the loan from budgeted funds or revenues.

**923.1(2) Information.** Requests for information about and for assistance with the preparation and submission of loan requests should be directed to the Office of Public Transit, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)233-7870. Information is also available on the department's website at [www.iowadot.gov](http://www.iowadot.gov).

[Editorial change: IAC Supplement 2/23/11; ARC 3693C, IAB 3/14/18, effective 4/18/18]

**761—923.2(71GA,ch265) Definitions.**

*“Department”* means the Iowa department of transportation.

*“Project”* means a concerted set of actions that will develop, maintain or improve one or more elements of the public transit system's service.

*“Public transit system”* means the same as defined in Iowa Code section 324A.1.

[ARC 3693C, IAB 3/14/18, effective 4/18/18]

**761—923.3(71GA,ch265) System eligibility.** A public transit system is eligible to request a capital assistance loan from the revolving loan fund provided that the public transit system complies with all of the following criteria:

**923.3(1)** The transit system abides by all applicable state and federal laws and regulations.

**923.3(2)** The transit system maintains primary documentation for all revenues and expenses for a period of at least three years.

**923.3(3)** The transit system maintains the system's policies, routes, schedules, fare structure, and budget in a manner that encourages public review, responsiveness to user concerns, energy conservation, and fiscal solvency.

[ARC 3693C, IAB 3/14/18, effective 4/18/18]

**761—923.4(71GA,ch265) Project eligibility.**

**923.4(1)** A project is eligible if it meets all of the following criteria:

*a.* The project is a transit-related project for a capital purchase, e.g., new or replacement vehicles, facilities, or both.

*b.* The project meets an identifiable transit need that has been included in the public transit system's planning or programming document.

*c.* The project is part of a statewide program of transit projects which has been adopted by the transportation commission.

*d.* The local funding needed for the project justifiably exceeds the public transit system's annual capital match funding capability.

**923.4(2)** A project to purchase vans for a vanpool, as defined in Iowa Code section 325A.12, may be submitted by an individual or a group through the appropriate public transit system. A vanpool project is eligible for an interest-free loan from the revolving loan fund only after funds for all other projects have been allocated.

[ARC 3693C, IAB 3/14/18, effective 4/18/18]

**761—923.5(71GA,ch265) Procedure.**

**923.5(1) *Funding request.*** The public transit system shall submit a funding application for the proposed project to either the department or to the Federal Transit Administration, as required by the type of funding requested.

**923.5(2) *Loan request.*** The public transit system shall normally submit a request for a revolving fund loan to the department when the annual grant application is made, but may submit a request at any time if a specific need arises. The request shall include, but not be limited to, the following topics and documents:

- a. A description and cost estimate of the proposed project.
- b. An explanation of the benefits, including projected energy conservation benefits, to be gained from the project.
- c. An explanation and justification of need for the loan.
- d. A proposed schedule of when funds will be needed for the project.
- e. A proposed loan repayment plan with schedule and source of funds.

**923.5(3) *Criteria for selection.*** The department shall review each loan request and shall evaluate the projects for funding. Based on the following criteria (in no particular order), preference shall be given to projects that:

- a. Foster coordination among transit services, such as a ground transportation center, a joint maintenance facility, or cooperative vehicle usage.
- b. Enhance local or regional economic development, such as a transit mall, passenger shelter facilities, or vehicles for extension of services.
- c. Increase federal funding to the state, such as accelerating purchase of replacement vehicles.
- d. Extend services to the transportation disadvantaged.
- e. Promote energy conservation, such as fuel efficiency.
- f. Require the loan as only a portion of the local matching funds required.

**923.5(4) *Approval.*** Based on available funds, the department shall approve loans for projects meeting the criteria in rule 761—923.4(71GA,ch265).

**923.5(5) *Agreement.*** Upon approval, the department shall prepare a loan contract and send it to the public transit system for execution.

**923.5(6) *Default.*** If a public transit system fails to make a loan payment as agreed in the contract, the department may, at its option, deduct the amount of any past due loan payment from state transit assistance payments allocated to that transit system.

[ARC 3693C, IAB 3/14/18, effective 4/18/18]

These rules are intended to implement 1985 Iowa Acts, chapter 265.

[Filed emergency 4/2/86—published 4/23/86, effective 4/4/86]

[Filed 6/10/86, Notice 4/23/86—published 7/2/86, effective 8/6/86]

[Filed emergency 10/9/86—published 11/5/86, effective 10/9/86]

[Filed 12/18/86, Notice 11/5/86—published 1/14/87, effective 2/18/87]

[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]

[Filed 1/15/92, Notice 12/11/91—published 2/5/92, effective 3/11/92]

[Filed emergency 7/1/92—published 7/22/92, effective 7/27/92]

[Filed 9/8/94, Notice 7/20/94—published 9/28/94, effective 11/2/94]

[Editorial change: IAC Supplement 2/23/11]

[Filed ARC 3693C (Notice ARC 3535C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

CHAPTER 8  
AUXILIARY PERSONNEL  
[Prior to 2/8/89, Veterinary Medicine, Board of[842] Ch 4]

**811—8.1(169,17A) Definitions.** As used in these rules, the following terms shall mean:

*“Accredited school of veterinary technology”* means a two-year college level training program providing basic training leading to a certificate of completion of a two-year program recognized and approved by the AVMA committee on accreditation of training for veterinary technicians or recognized and approved by the board.

*“Board”* means board of veterinary medicine.

*“Department”* shall mean the Iowa department of agriculture and land stewardship.

*“Veterinary assistant”* means an assistant employed by a licensed veterinarian for a purpose other than performing diagnosis, issuing prescriptions or performing surgery and includes, among other assistants, registered veterinary technicians.

*“Veterinary technician”* means any citizen of the United States who shall have graduated in veterinary technology from a two-year AVMA accredited school of veterinary technology; or in lieu thereof has assisted a licensed veterinarian for five years prior to 1980, or worked under the direction of a licensed veterinarian for at least three years, including at least one year of formal training approved by the board, in veterinary technology prior to 1981; and who shall have successfully passed an examination prescribed by the board.

**811—8.2(169) Registration of veterinary technicians.** All veterinary technicians shall be under the direct control of the board and shall be registered with the state veterinarian, bureau of animal industry, Iowa department of agriculture and land stewardship. Each veterinary technician must pass both the veterinary technician national examination and a veterinary technician state examination as approved by the board. Applications for registration shall be obtained from and remitted to the board. Applicants who have passed both examinations shall be issued a certificate by the board stating that the named candidate is registered as a veterinary technician.

[ARC 3696C, IAB 3/14/18, effective 4/18/18]

**811—8.3(169) Examination.** The veterinary technician state examination shall be given at least once annually at a site or sites to be designated by the board at least 60 days before the date of the examination. The board may provide for additional veterinary technician state examinations as deemed appropriate. In the event the board provides for additional examinations, the site or sites of the examination shall be designated by the board at least 60 days prior to the date of the examination.

**8.3(1)** An application fee in an amount determined by the board not to exceed \$45 shall accompany the application to take the veterinary technician state examination; both the fee and the application must be received by the board at least 30 days before the examination. An additional fee shall be submitted for the veterinary technician national examination when a professional examination service is utilized by the board. The additional fee shall be the charges for the examination by the professional examination service plus administrative costs in an amount determined by the board. The fee for the veterinary technician state examination may be waived for qualifying military service personnel upon request.

**8.3(2)** An applicant who fails to earn a passing score on the veterinary technician state examination shall be entitled to retake the examination not earlier than 90 days since the applicant last took the examination. The applicant must submit a new application and the application fee in accordance with subrule 8.3(1) to retake the veterinary technician state examination. An applicant is limited to five total attempts at the veterinary technician state examination; any additional applications to retake the examination beyond the five allowable attempts may be considered by the board and may be granted at the board's discretion.

[ARC 1984C, IAB 4/29/15, effective 6/3/15; ARC 3696C, IAB 3/14/18, effective 4/18/18]

**811—8.4** Reserved.

**811—8.5(169) Supervision.** All veterinary assistants, including veterinary technicians, shall be employed by and receive compensation from and be under the direct supervision of a licensed or license exempt veterinarian, and shall function at the same place of business as the veterinarian. Such supervision shall include, but not be limited to, the availability of the veterinarian on the premises.

**8.5(1) Veterinarian's responsibility:**

a. To personally examine the animal within 12 hours before the assistant carries out any procedures.

b. To direct, control and supervise the conduct of the assistant in the assistant's work.

**8.5(2) Veterinary assistant's responsibility:**

a. The veterinary assistant, including registered veterinarian technicians, shall not perform surgery; shall not make a diagnosis and prognosis of animal diseases; shall not prescribe drugs, medicine and appliances, and shall not administer rabies vaccine.

b. Under conditions of an emergency, a veterinary assistant including a registered veterinary technician may render without supervision such lifesaving aid and treatment as follows: administration of oxygen; maintenance of airways including the nonsurgical insertion of an endotracheal tube; and control of hemorrhage. Under conditions of emergency, a registered veterinary technician but not an unregistered veterinary assistant may render such additional lifesaving aid and treatment as follows: placement of an IV catheter and the administration of fluids; external cardiac massage; and the administration of corticosteroids. Emergency aid and treatment, if rendered to an animal not in the presence of a licensed veterinarian, shall only be continued under the direction of a licensed veterinarian, which in the case of emergency may include telephone or radio contact by a veterinarian en route to the site, until the veterinarian arrives in a timely manner. "Emergency" for the purpose of this rule means that the animal has been placed in a life-threatening condition where immediate treatment is necessary to sustain life.

**811—8.6(169) Revocation or suspension of veterinary technician's certificate.** The following shall be grounds for revocation or suspension of a certificate at the discretion of the board:

1. Fraud, misrepresentation or deception in obtaining a certificate.
2. Conviction of a felony, in which case the record of such conviction will be conclusive evidence.
3. Chronic inebriety or habitual use of drugs.
4. For having professional connection with, or lending one's name to any illegal practice of veterinary medicine and the various branches thereof.
5. Conduct reflecting unfavorably on the vocation of veterinary technology.
6. Conviction on the charge of cruelty to animals.
7. Failure to satisfy the continuing education requirements of rule 8.10(169,272C).

**811—8.7(169) Action against veterinarians.** The board of veterinary medicine shall take action against any veterinarian licensed to practice in the state of Iowa who:

1. Permits or directs any veterinary assistant, including a registered veterinary technician, to perform veterinary duties involving diagnosis, prescription or surgery.
2. Permits or directs any veterinary assistant, including a registered veterinary technician, to perform any act which would be a legal or ethical violation if committed by the veterinarian.

**811—8.8(169,272C) Disciplinary procedure.** Disciplinary action taken under rule 8.6(169) or 8.7(169) shall follow the procedure established by 811—10.50(169,272C). Where appropriate, references in 811—10.50(169,272C) to a person licensed to practice veterinary medicine shall be construed to mean persons certified as a veterinary assistant or technician.

**811—8.9(169,272C) Certification by endorsement.** On a case-by-case basis, the board may issue certification by endorsement and without examination to applicants who hold certification or licensure as veterinary technicians in another jurisdiction.

**811—8.10(169,272C) Continuing education.**

**8.10(1)** At least 30 hours of continuing education in courses approved by the board of veterinary medicine shall be completed triennially by each registered veterinary technician. The registrant has the responsibility for financing continuing education. These credit hours may be obtained by attending approved scientific seminars and meetings on the basis of one credit hour for each hour of attendance. Attendance at any board-approved national, state or regional meeting will be acceptable. Credit for qualified graduate college courses may be approved on the basis of multiplying each college credit hour by 10, to a maximum of 15 hours during any one triennial. A maximum of 10 hours during any one triennial may be achieved by the completion of approved home study courses.

**8.10(2)** Each registrant shall obtain the 30 credit hours between the registrant's certificate anniversary date and the last day of the following three-year period. However, a registrant who graduated from an accredited college of veterinary technology within three years of the issuance of an Iowa certificate is required to obtain only 20 credit hours for the first triennial. Continuing education credits in excess of 30 hours for any three-year period may be carried over to the next triennial period, but the total number of credits carried over shall not exceed 10 hours.

**8.10(3)** Completion of the continuing education will be reported to the secretary of the board of veterinary medicine on forms provided by the board by December 31 of the triennial anniversary year. The reporting form must be signed by the registrant and accompanied by an administration fee of \$15.

**8.10(4)** Compliance with this rule and subrule 8.6(7) is waived until January 1, 1993. Registrants whose certificate triennial anniversary dates fall in the year 1993 shall complete and report 10 credit hours. Registrants whose certificate triennial anniversary dates fall in the year 1994 shall complete and report 20 credit hours. All registrants whose certificate triennial anniversary dates fall in the year 1995 and subsequent years shall complete and report the full 30 credit hours.

**8.10(5)** The board may waive continuing education requirements for qualifying military service personnel upon request.

[ARC 1984C, IAB 4/29/15, effective 6/3/15]

These rules are intended to implement Iowa Code sections 17A.3, 169.4, 169.5, 169.9, 169.12, 169.20 and 272C.4.

[Filed 3/22/78, Notice 9/21/77—published 3/22/78, effective 4/26/78]

[Filed emergency 9/29/78—published 10/18/78, effective 9/29/78]

[Filed 7/1/80, Notice 10/31/79—published 7/23/80, effective 8/27/80]

[Filed 4/10/81, Notice 3/4/81—published 4/29/81, effective 6/3/81]

[Filed 12/2/83, Notice 10/26/83—published 12/21/83, effective 1/26/84]

[Filed 11/13/87, Notice 10/7/87—published 12/2/87, effective 1/6/88]

[Filed 1/20/89, Notice 11/16/88—published 2/8/89, effective 3/15/89]<sup>◇</sup>

[Filed 1/30/92, Notice 9/18/91—published 2/19/92, effective 3/25/92]

[Filed 10/6/94, Notice 7/6/94—published 10/26/94, effective 11/30/94]

[Filed ARC 1984C (Notice ARC 1756C, IAB 12/10/14), IAB 4/29/15, effective 6/3/15]

[Filed ARC 3696C (Notice ARC 3563C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

<sup>◇</sup> Two or more ARCs



## AMUSEMENT PARKS AND RIDES

## CHAPTER 61

## ADMINISTRATION OF IOWA CODE CHAPTER 88A

[Prior to 9/24/86, Labor, Bureau of [530]]

[Prior to 10/21/98, see 347—Ch 61]

**875—61.1(88A) Scope.** 875—Chapters 61 through 63 do not apply to the following:

**61.1(1)** A water park or water park attraction including, but not limited to, a water slide, wave action pool, and lazy river. This subrule does not apply to an amusement ride that propels patrons using a power source other than gravity even though water is present.

**61.1(2)** A live-animal ride.

**61.1(3)** A vessel inspected pursuant to Iowa Code chapter 462A.

**61.1(4)** An amusement structure in which the patrons navigate on their own power and the patrons do not ride, climb, or walk on a mechanical component.

**61.1(5)** A device that meets all of the following criteria:

- a. Was designed and built to be operated by a coin, card, or token;
- b. Was designed and built to be operated by the patron rather than an attendant;
- c. Operates on self-contained wiring that was installed by the manufacturer;
- d. Operates on less than 120 volts of electrical power; and
- e. Is within or is part of a structure subject to a state or local building code.

**61.1(6)** Playground equipment owned, maintained, and operated by any political subdivision of this state.

**61.1(7)** A concession booth, amusement device, or amusement ride that meets all of the following:

- a. Is owned and operated by a nonprofit organization or school; and
- b. Is located in a building subject to inspection by the state fire marshal or a local government.

**61.1(8)** Nonmechanized physical fitness and playground equipment unless a fee is charged to use the equipment.

**61.1(9)** Physical fitness equipment that does not meet the definition of “amusement device.”

**61.1(10)** A tramway used as a ski lift.

**61.1(11)** A scenic railway operating on standard-gauge rails.

**61.1(12)** A zip line or climbing wall located at a camp or retreat owned or operated by a nonprofit religious, educational or charitable institution or association.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter]

**875—61.2(88A) Definitions.** The definitions in this rule apply to 875—Chapters 61 through 63.

“*Air-supported structure*” means an amusement device that employs a high-strength fabric or film that achieves its strength, shape and stability from internal air pressure provided by a mechanical device such as an air blower or fan.

“*Amusement device*” means a climbing wall utilizing an auto-belay system; a bungee jump as defined in 875—Chapter 63; a device allowing a patron to jump on a trampoline while attached to one or more bungee cords; a dry slide; a mechanical bull; a zip line that does not allow the rider to touch the ground at all times; and an air-supported structure.

“*ANSI*” means the American National Standards Institute.

“*Assistant*” means a paid or volunteer person working under the direct supervision of an attendant or operator.

“*ASTM*” means the ASTM Standards on Amusement Rides and Devices published by ASTM International.

“*Attendant*” means a paid or volunteer person who controls patron restraints or the operation, starting, stopping, or speed of covered equipment.

“*Carnival*” means an enterprise offering amusement or entertainment to the public in, upon, or by means of amusement devices or rides or concession booths.

“*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, department of revenue, pursuant to Iowa Code chapter 272D.

“*Commissioner*” means the labor commissioner or the labor commissioner’s authorized designee.

“*Concession booth*” means a structure that is powered by electricity and offers amusements to the public at more than one fair or carnival, or at one fair or carnival for more than seven consecutive days. A structure or enclosure offering only goods, food or beverages, rather than amusements, is not a “concession booth.”

“*Covered equipment*” means an amusement ride, amusement device, concession booth or related electrical equipment that is covered by Iowa Code chapter 88A.

“*Fair*” means an enterprise principally devoted to the exhibition of products of agriculture or industry in connection with the operation of covered equipment.

“*Major breakdown*” means stoppage of operation from any cause that results in damage, failure, or breakage in a stress-bearing part of covered equipment.

“*Major modification*” means any change to the structure of or to an operational characteristic, capacity, classification, or mechanism of covered equipment. “Major modification” includes, but is not limited to, changing the mode of transportation from non-wheeled to a truck or flat-bed mount or changing the mode of assembly or other operational functions from manual to mechanical or hydraulic.

“*NFPA*” means the National Fire Protection Association.

“*Operator*” means a person, or the agent of a person, who owns or controls or has the duty to control the operation of covered equipment at a carnival or fair. “Operator” includes an agency of the state or any of its political subdivisions. “Operator” shall include a person who leases covered equipment and controls or has the duty to control its operation at a carnival or fair.

“*Related electrical equipment*” means a portable generator, blower, or other equipment necessary to the operation of an amusement ride, amusement device, or concession booth.

“*Reportable incident*” means an event described by one or more of the following:

1. Damage, failure or breakage of a stress-bearing part of an amusement ride or amusement device;
2. Cessation of covered equipment for more than 20 minutes with at least one rider aboard;
3. An occurrence that nearly resulted in personal injury; or
4. An occurrence that caused the operator to cease operations unexpectedly to avoid an injury or illness.

“*Rope lay*” means the length along the rope in which one strand makes a complete revolution around the rope.

“*Walkway*” means a public passage through a carnival, fair, or park.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter]

**875—61.3(88A) Owner and operator requirements.** No person shall operate covered equipment at a carnival or fair unless the person holds a current operating permit and the covered equipment has passed an Iowa inspection.

**61.3(1) Operating permit.** No later than May 1 and at least 14 days before operation begins each calendar year, the operator of covered equipment shall apply to the commissioner for an operating permit. Application shall be made on a form provided by the commissioner. Each of the following shall be submitted with the completed operating permit application:

- a. The applicable fee;
  - b. A certificate of insurance issued by an insurance company authorized to do business in Iowa.
- The certificate of insurance shall:

(1) Certify a policy in the minimum amount of \$1 million for bodily injury, death, or property damage in any one occurrence;

- (2) List the specific pieces of equipment that are covered and, if applicable, those that are not covered; and
- (3) Include “Division of Labor Services—Amusements” as a certificate holder;
  - c. The operator’s itinerary identifying the covered equipment to be operated and the dates and locations where each will be operated;
  - d. General design criteria, safety factors, materials utilized, and stress analysis unless the amusement ride or amusement device was granted an Iowa amusement inspection sticker during the previous calendar year;
  - e. Certification of compliance with applicable training and maintenance requirements;
  - f. With an application submitted after May 1, proof that the applicant could not have reasonably complied with the May 1 deadline and proof that the application was filed immediately after need for the permit was known;
  - g. Separately for each bungee jump:
    - (1) A site operating manual;
    - (2) A report which is prepared and sealed by a professional engineer who is licensed in Iowa and which certifies that the design and construction of the equipment and structure are suitable for the intended use and conform to Iowa law, recognized engineering practices, procedures, standards and specifications;
    - (3) Site plan drawings depicting the preparation area, the jump space, the landing area, the recovery area and other features to be included in the approved operating site;
    - (4) Specifications of equipment and structures; and
    - (5) Depictions of the location, specifications, dimensions, and type of air bag, pool or body of water where the jumper will land.

**61.3(2) Changes to information submitted with application.** The operator shall immediately notify the commissioner of any changes to the operator’s itinerary. The operator shall promptly notify the commissioner of other changes to information provided with the operating permit application.

**61.3(3) Leases.** The requirements of this subrule apply when covered equipment is leased for use at a fair or carnival.

a. The owner shall notify the commissioner within 48 hours of leasing the covered equipment. The notification shall include the name, address, and contact information for the lessee and lessor, a description of the covered equipment, and the dates and location of its intended operation.

b. The lessor shall give the lessee a copy of the manual for the leased covered equipment and shall train the lessee or the lessee’s designated representatives on the use of the equipment.

c. The lessee shall obtain an operating permit.

**61.3(4) Personal injuries and deaths.**

a. The operator shall immediately report by telephone any accident that results in death or medical care beyond first aid.

b. Within 48 hours after an operator is notified of a claim or report to the operator’s insurance provider, the operator shall submit a duplicate copy of the report or claim to the commissioner.

c. The commissioner may require that the scene of an accident be secured and not disturbed to any greater extent than necessary for removal of the deceased or injured person. If covered equipment is removed from service by the commissioner, the covered equipment shall be returned to service only upon the commissioner’s authorization.

**61.3(5) Major breakdown report.** The operator shall report a major breakdown of covered equipment to the commissioner immediately and provide a detailed report in writing within 48 hours. The commissioner may order the covered equipment to be withheld from operation, and in such case, the commissioner shall conduct an immediate investigation. The covered equipment shall be released for repair and operation only after the commissioner’s investigation is complete.

**61.3(6) Advance notice of major modification.** The operator shall notify the commissioner in writing at least ten days prior to a major modification. If requested by the commissioner, the operator shall provide plans, diagrams, and ride analysis documentation consistent with ASTM F2291-15.

**61.3(7) Technical data.** If requested by the commissioner, the operator shall provide an English language version of the following:

*a.* Data concerning constant, reversible, or eccentric forces generated by acceleration, deceleration, wind, centrifugal action, or inertia.

*b.* Stress analysis and other data pertinent to the structural materials, design, structure, factors of safety or performance characteristics.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter; ARC 3685C, IAB 3/14/18, effective 4/18/18]

**875—61.4(88A) Inspections.** Pursuant to Iowa Code chapter 88A, covered equipment must pass an inspection at least annually. Inspections will be performed according to the rules set forth and standards adopted in 875—Chapters 61 to 63.

**61.4(1) Inspection types.** In addition to the inspections listed below, an inspection may be conducted by the commissioner at any time. The fee schedule for annual inspections set forth in Iowa Code section 88A.4 shall apply to all inspections performed by division of labor services inspectors. No person shall operate covered equipment at a fair or carnival unless the covered equipment has passed an inspection in the current calendar year.

*a. Annual inspection by owner.* At the discretion of the commissioner, the owner of an air-supported structure may be designated by the commissioner to perform the annual inspection of the owner's air-supported structure, blower, and related electrical equipment. An owner designated pursuant to this paragraph shall perform the inspection according to applicable standards. The owner shall submit in the format required by the commissioner an affidavit attesting to the performance of the inspection, correction of code violations, and other required information. A designation pursuant to this paragraph shall terminate on December 31 of the year of issuance.

*b. Annual inspection by a division of labor services inspector.* Unless an inspection is waived pursuant to Iowa Code section 88A.13, or the inspection is performed by the owner pursuant to paragraph 61.4(1) "a," a division of labor services inspector shall inspect covered equipment prior to operation.

*c. Major modification inspection.* After covered equipment has undergone a major modification, the covered equipment must pass an inspection by a division of labor inspector before it is put back into use.

**61.4(2) Safety order.** If the division of labor services inspector finds a code violation, the inspector will issue a safety order requiring that the condition be corrected. The deadline for correction of the code violation shall be set forth in the safety order. If the inspector finds one or more code violations pertaining to more than one-half of the seating capacity of an amusement ride, the amusement ride shall not be operated until the violations are corrected. If code violations pertain to one-half or less of the seating capacity of an amusement ride, the amusement ride may be shut down at the discretion of the inspector.

**61.4(3) Cessation order.** If the inspector identifies covered equipment that is hazardous or unsafe, the inspector shall issue a cessation order. The commissioner shall establish that the code violation is corrected before operation of the covered equipment is resumed.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter; ARC 3685C, IAB 3/14/18, effective 4/18/18]

**875—61.5(88A) Amusement inspection sticker.** Covered equipment shall not be operated without a current sticker.

**61.5(1)** After covered equipment has passed an annual inspection by the division of labor services inspector, the division of labor services inspector shall affix an amusement inspection sticker to a basic part of the covered equipment in such a manner as to be readily accessible by the inspector.

**61.5(2)** After the commissioner receives satisfactory proof of inspection from an owner designated by the labor commissioner pursuant to paragraph 61.4(1) "a," the commissioner shall mail the sticker to the owner. The owner shall properly affix the sticker to a basic part of the air-supported structure or blower before operation.

**61.5(3)** After covered equipment passes a major-modification inspection, a new amusement inspection sticker will be issued.

**61.5(4)** Before covered equipment is sold, the seller shall remove the amusement inspection sticker. If a current amusement inspection sticker is no longer legible, the operator may request a replacement sticker.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter]

**875—61.6(88A,252J,261,272D) Termination, denial, suspension, or revocation of an operating permit.**

**61.6(1)** All active operating permits shall terminate automatically on December 31 of the year of issuance.

**61.6(2)** The commissioner may suspend or revoke an operating permit for any of the following reasons:

- a. Negligence in the operation of covered equipment;
- b. Repeated failure to perform or document proper daily inspections;
- c. Misrepresentation of material information required as a part of the operating permit application package;
- d. Failure to comply with a safety order or cessation order issued by the commissioner;
- e. Operation of covered equipment in disregard of public health, safety and welfare;
- f. Termination of the required insurance coverage;
- g. Failure to pay a liquidated debt owed to the commissioner;
- h. Receipt by the commissioner of a certificate of noncompliance;
- i. Failure of an operator to comply with the proper procedures;
- j. Failure of an operator to provide an adequate number of properly trained and qualified assistants and attendants; or
- k. Submission of a false affidavit of annual inspection by the owner of an air-supported structure.

**61.6(3)** The commissioner may deny an application for an operating permit if the application packet is inadequate or for any reason set forth as grounds for suspension or revocation of an operating permit.  
[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter]

**875—61.7(17A,88A,252J,261,272D) Procedures for revocation, suspension, or denial of an operating permit or amusement inspection sticker.** The procedures set forth in this rule govern the revocation, suspension or denial of an operating permit or amusement inspection sticker.

**61.7(1)** If the commissioner initiates revocation, suspension or denial due to the receipt of a certificate of noncompliance, the applicable procedures of Iowa Code chapter 252J, 261, or 272D shall apply.

**61.7(2)** In the event that immediate action is required due to imminent danger to the public health, safety or welfare, the following procedures shall apply:

- a. The commissioner shall prepare a safety order describing the hazardous condition and shall give the operator, or the operator's representative on site, a copy of the safety order.
- b. The commissioner shall remove the amusement inspection sticker or stickers from covered equipment as necessary to protect the public health, safety or welfare.
- c. The commissioner shall proceed as quickly as feasible to give the operator an opportunity for a hearing as set forth in subrule 61.7(3).

**61.7(3)** In all other cases, the following procedures shall apply:

- a. The commissioner shall serve a notice by restricted certified mail to the address listed on the operating permit application or by other service as permitted by Iowa Code chapter 17A.
- b. The operator shall have 20 days to file a written notice of contest with the commissioner. If the operator does not file a written notice of contest within 20 days of receipt of the notice, the action stated in the notice shall automatically be effective.
- c. The hearing procedures in 875—Chapter 1 shall govern.
- d. Within five business days of final agency action revoking or suspending an operating permit, the operator shall forfeit the operating permit to the commissioner.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter]

**875—61.8(88A) Payments.** All fees are nonrefundable. Cash is not accepted. Based on reasonable justification, the commissioner may notify an individual operator that the operator's check will not be accepted.

[ARC 2428C, IAB 3/2/16, effective 4/6/16; see Delay note at end of chapter; ARC 3685C, IAB 3/14/18, effective 4/18/18]

These rules are intended to implement Iowa Code chapters 17A, 88A, 252J, 261, and 272D.

[Filed 2/21/73, amended 12/20/73, 4/8/75, 6/19/75]

[Filed 3/5/76, Notice 1/26/76—published 3/22/76, effective 4/30/76]

[Filed emergency 9/5/86—published 9/24/86, effective 9/24/86]

[Filed emergency 8/30/88—published 9/21/88, effective 8/30/88]

[Filed 12/13/06, Notice 11/8/06—published 1/3/07, effective 2/7/07]

[Filed 4/16/07, Notice 2/28/07—published 5/9/07, effective 6/13/07]

[Filed ARC 8395B (Notice ARC 8241B, IAB 10/21/09), IAB 12/16/09, effective 1/20/10]

[Filed ARC 2428C (Notice ARC 2354C, IAB 1/6/16), IAB 3/2/16, effective 4/6/16]<sup>1</sup>

[Filed ARC 3685C (Notice ARC 3539C, IAB 1/3/18), IAB 3/14/18, effective 4/18/18]

<sup>1</sup> April 6, 2016, effective date of the rescission of former Chapter 61 and the adoption of new Chapter 61 herein [ARC 2428C] delayed 70 days by the Administrative Rules Review Committee at its meeting held March 4, 2016; delay lifted at the meeting held April 8, 2016.

## CONSTRUCTION—REGISTRATION AND BONDING

## CHAPTER 150

## CONSTRUCTION CONTRACTOR REGISTRATION

[Prior to 10/21/98, see 347—Ch 150]

**875—150.1(91C) Scope.** This chapter implements Iowa Code chapter 91C. The rules in this chapter apply to all construction contractors, except for a person who earns less than \$2,000 annually or who performs work or has work performed on the person's own property.

**875—150.2(91C) Definitions.**

*"Commissioner"* means the labor commissioner of the division of labor services of the workforce development department or the commissioner's designee.

*"Construction"* means new work, additions, alterations, reconstruction, installations, repairs and demolitions. Construction activities are generally administered or managed from a relatively fixed place of business, but the actual construction work is performed at one or more different sites which may be dispersed geographically. Examples of construction activities, adopted by reference, are in 871—23.82(96) for purposes of the Iowa employment security law. For work on structures that are both located in an area that is subject to a disaster emergency proclamation pursuant to Iowa Code section 29C.6 and damaged by circumstances related to those that caused the disaster emergency proclamation, "construction" includes asbestos abatement.

*"Contractor"* means a person who engages in the business of construction as the term is defined in 871—23.82(96), for purposes of the Iowa employment security law, including subcontractors and special trade contractors.

*"Division"* means the division of labor services of the workforce development department.

*"File"* means deliver to the division.

*"Out-of-state contractor"* means a contractor whose principal place of business is in another state, and who contracts to perform construction in this state.

*"Principal place of business"* means the state in which a substantial part of the contractor's business is transacted and from which the centralized supervision is exercised. Factors to be reviewed include:

1. State designated as home office on documents filed with governmental agencies.
2. State where payroll is prepared.
3. State where business transactions are performed.
4. State where officers, owners, or partners reside and work.
5. State in which bank accounts are located.
6. State in which fixed business property is located.
7. State where management decisions are made.

*"Same phase of construction"* means in the same type of construction operations or trade, such as, but not limited to, electrical work; masonry, stonework, tile setting and plastering; roofing; sheet metal work; excavation work; concrete work; glasswork; painting, paper hanging and decorating; plumbing, heating and air conditioning work; carpentry work; and miscellaneous special trade contractors.

*"Working days"* means Mondays through Fridays but shall not include Saturdays, Sundays or federal or state holidays. In computing 15 working days, the day of receipt of any notice shall not be included, and the last day of the 15 working days shall be included.

[ARC 8812B, IAB 6/2/10, effective 7/1/10; ARC 8984B, IAB 8/11/10, effective 9/15/10; ARC 3686C, IAB 3/14/18, effective 4/18/18]

**875—150.3(91C) Registration required.** Before performing any construction work in this state, a contractor shall be registered with the division. A joint venture is an independent entity and shall be registered independently.

**875—150.4(91C) Application.** A contractor that is covered by the license requirements of Iowa Code chapter 105 shall apply for a contractor registration number by using the application system of the Iowa plumbing and mechanical systems board. All other contractors shall file an application with the

division on forms provided by the division. The application shall contain the applicable information and documents specified in this rule.

**150.4(1) Name.** The name of the contractor.

**150.4(2) Place of business.** The complete mailing address of the principal place of business of the contractor.

**150.4(3) Telephone number.** The business telephone number of the contractor.

**150.4(4) Business classification.** The type of business entity of the contractor (i.e., corporation, partnership, sole proprietorship, trust, etc.).

**150.4(5) Ownership information.**

*a.* If the contractor is a corporation, the name, address, telephone number, and position of each officer of the corporation.

*b.* If the contractor is other than a corporation, the name, address, and telephone number of each owner.

**150.4(6) Workers' compensation coverage information.**

*a.* A certificate of insurance from the insurer showing proof of workers' compensation insurance, the effective dates of coverage, and listing the division of labor as a certificate holder;

*b.* Employer's release from the insurance requirements under workers' compensation law form provided to self-insured employers by the commissioner of insurance under Iowa Code section 87.11; or

*c.* A statement that the contractor is not required to carry workers' compensation coverage.

**150.4(7) Account number.** The employer account number issued by the unemployment insurance services division of the workforce development department before the contractor applies for a contractor registration number.

**150.4(8) Business description.** A description of the business to include:

*a.* The employer's North American Industry Classification System (NAICS) code; or

*b.* The principal products and services provided.

**150.4(9) Fee or fee exemption.** A contractor who is eligible to register without paying a fee shall submit a completed fee exemption form. All other contractors must submit the nonrefundable fee as set forth below.

*a.* The standard fee is \$50 per year.

*b.* Contractors who apply for a contractor registration number through the Iowa plumbing and mechanical systems board must pay a fee that is prorated in accordance with the length of the registration period.

**150.4(10) Social security number.** The contractor, if a natural person, shall include the contractor's social security number.

**150.4(11) Out-of-state contractor bond.** An out-of-state contractor shall:

*a.* File a \$25,000 surety bond that is prepared using the bond form provided by the division, or

*b.* Provide a copy of a letter from the Iowa department of transportation stating that the contractor is prequalified to bid on projects for the department of transportation pursuant to Iowa Code section 314.1.

[ARC 8812B, IAB 6/2/10, effective 7/1/10; ARC 8984B, IAB 8/11/10, effective 9/15/10; ARC 3059C, IAB 5/10/17, effective 6/14/17; ARC 3686C, IAB 3/14/18, effective 4/18/18]

### **875—150.5(91C) Amendments to application.**

**150.5(1)** A contractor shall report to the commissioner any change in the information originally reported on or with the application within 15 working days of the change, except that the contractor shall notify the commissioner of changes to workers' compensation coverage within ten days prior to any change in coverage.

**150.5(2)** After the time specified in subrule 150.5(1), with good cause shown the commissioner may determine that an amendment may be made to correct an application.

**150.5(3)** Amendments to applications shall not be permitted where a change occurs in the business classification, such as, but not limited to, a change from a sole proprietorship to a corporation.

**875—150.6(91C) Fee.**

**150.6(1) *New applications.*** A new application deposited in the U.S. mail shall be accompanied by the fee effective on the date the application is postmarked. A new application delivered in any other manner shall be accompanied by the fee effective on the date the application is received by the division.

**150.6(2) *Renewal applications.*** A timely renewal application shall be accompanied by the fee effective on the expiration date of the contractor's expiring registration. An application for renewal deposited in the U.S. mail after the expiration date of the contractor's expiring registration shall be accompanied by the fee effective on the date the application is postmarked. An application for renewal delivered to the division in a manner other than U.S. mail and after the expiration date of the contractor's expiring registration shall be accompanied by the fee effective on the date the application is received by the division.

**150.6(3) *Fee exemption.*** Rescinded IAB 5/10/17, effective 6/14/17.

**150.6(4) *Amendments to applications.*** A fee is not required for a permissible amendment to an application.

[ARC 7876B, IAB 6/17/09, effective 7/1/09; ARC 8035B, IAB 8/12/09, effective 9/16/09; ARC 3059C, IAB 5/10/17, effective 6/14/17]

**875—150.7(91C) Registration number issuance.** Within 30 days of receipt of a completed application, the commissioner will issue to the contractor a registration number. The registration number will consist of the letter "C" followed by six unique digits.

**875—150.8(91C) Workers' compensation insurance cancellation notifications.**

**150.8(1) *Insurance company coverage.*** The division shall be notified by the insurance company carrying the contractor's workers' compensation insurance at the time of cancellation. The notice shall contain:

- a. The name of the insurance carrier;
- b. The name of the insured contractor; and
- c. The date the workers' compensation coverage cancellation is effective.

**150.8(2) *Self-insured contractors.*** The contractor shall notify the division ten days prior to any cessation in self-insurance.

**150.8(3) *Noninsured contractors.*** The contractor shall notify the division whenever the required notice is not posted or in any change in insurance status.

**875—150.9(91C) Investigations and complaints.**

**150.9(1) *Investigations.*** Investigations may take many forms to determine if there is compliance with the law. Investigations shall take place at the times and in the places as the commissioner may direct. The commissioner may interview persons at the work site and utilize other reasonable investigatory techniques. The conduct of the investigation shall be such as to preclude unreasonable disruption of the operations of the work site. Investigations may be conducted without prior notice by correspondence, telephone conversations, or review of materials submitted to the division. At the initiation of an investigation at the contractor's establishment, the investigator shall present credentials, explain the nature and purpose of the investigation, and seek the consent of the owner, operator or agent in charge of the establishment. In the event the investigator is not permitted to fully conduct an investigation, the commissioner may seek an administrative warrant, if necessary.

**150.9(2) *Complaints.*** Complaints in which the complainant provides a name and address made to the commissioner in writing shall receive a written response as to the results of the investigation. A complainant's name and other identifying information shall not be released if the complaint was included as a part of another complaint where the complainant's identity would be protected under other statutes or rules (i.e., a complaint filed under both Iowa Code chapters 88 and 91C).

**875—150.10(91C) Citations/penalties and appeal hearings.**

**150.10(1) *Citations.*** The commissioner shall issue a citation to a contractor where an investigation reveals the contractor has violated:

- a. The requirement that the contractor be registered;
- b. The requirement that the contractor's registration information be substantially complete and accurate; or
- c. The requirement that an out-of-state contractor file a bond with the division.

**150.10(2) Penalties.** If a citation is issued, the commissioner shall notify the contractor by certified mail of the proposed administrative penalty, if any. The administrative penalties shall be not more than \$500 in the case of the first violation and not more than \$5,000 per violation in the case of a second or subsequent violation. In proposing a penalty, due consideration will be given to knowledge of the alleged violation, knowledge of requirements of the law, and nature and extent of the alleged violation.

**150.10(3) Appeal.** The contractor shall have 15 working days within which to file a notice of contest of the citation or proposed penalty. The notice of contest shall be filed with the commissioner who shall forward it to the employment appeal board.

**150.10(4) Appeal procedures.** The rules of procedure of the employment appeal board shall apply to administrative hearings on citations and penalties.

### **875—150.11(91C) Revocation of registrations and appeal hearings.**

**150.11(1) Reason for revocation.** The commissioner shall seek revocation of a contractor's registration where an investigation reveals the contractor failed to meet the conditions of registration at the time of issuance or no longer meets the conditions.

**150.11(2) Notice of revocation.** The commissioner shall serve a notice of intent to revoke on the contractor by personal service or by restricted certified mail to the address listed in the application or by other service as permitted in the Iowa Rules of Civil Procedure. The notice shall set the time for a fact-finding hearing conducted in accordance with Iowa Code chapter 17A.

**150.11(3) Hearing.** The purpose of the fact-finding hearing is to ensure the contractor is not in compliance before the registration is revoked. All hearings shall be held in the offices of the division. A telephone interview may be conducted upon request.

**150.11(4) Hearing procedures.** Administrative hearing rules at 875—Chapter 1 shall be applicable to the fact-finding hearings.

**150.11(5) Decision.** The commissioner shall serve the decision on the contractor by certified mail to the address listed on the application or to another address provided by the contractor. If the certified mail is returned unclaimed or undelivered, the commissioner shall send the decision to the address by first-class mail.

**150.11(6) Effective date of revocation.** Revocations shall become effective 21 days after certified mailing of the decision.

**150.11(7) Suspension.** The division and the commissioner find the public health, safety or welfare imperatively requires emergency action where a construction contractor fails to maintain compliance with the laws of this state relating to workers' compensation as required in subrule 150.4(6) due to the financial impact upon the public and any worker who might be injured. Therefore, a construction contractor's registration may be suspended effective upon issuance of the subrule 150.11(2) notice of revocation. Upon application showing good cause and proof of compliance with the workers' compensation laws as required in subrule 150.4(6), the commissioner may alter the finding and temporarily reinstate a registration number pending hearing on the revocation. In cases of suspension pending a revocation hearing, the hearing shall be instituted and determined promptly.

**150.11(8) Appeal.** The contractor shall have 15 working days from receipt of the decision issued pursuant to subrule 150.11(5) to file a notice of contest of decision. The notice of contest shall be filed with the commissioner who shall forward it to the employment appeal board.

**150.11(9) Appeal procedures.** The rules of procedure of the employment appeal board shall apply to appealed decisions.

**150.11(10) Effect of revocation.** A contractor whose registration is revoked may reapply for a new registration number if all requirements for registration eligibility are met.

**150.11(11) Relinquishing registration certificate.** A contractor shall return the original registration certificate to the division when a revocation or suspension becomes final.

**875—150.12(91C) Concurrent actions.** Actions under rules 875—150.10(91C) and 150.11(91C) may proceed at the same time against a contractor.

**875—150.13(91C) Out-of-state contractor bonds.** Rescinded IAB 6/2/10, effective 7/1/10.

**875—150.14(91C) Project bonds.** Rescinded IAB 6/2/10, effective 7/1/10.

**875—150.15(91C) Blanket bonds.** Rescinded IAB 6/2/10, effective 7/1/10.

**875—150.16(91C) Bond release.**

**150.16(1) Notifications.** Prior to releasing a bond, the commissioner will notify the department of revenue, the unemployment insurance services division of the workforce development department, and applicable state subdivisions of the intent to release the bond. The commissioner shall provide ten days for the filing of objections to the release of the bond. The commissioner may deem any failure to respond to the notice within the time provided as an approval of the release.

**150.16(2) Conditions for release.** A bond shall not be released until the contractor has made payment of all taxes, including contributions due under the unemployment compensation insurance system, penalties, interest, and fees, which may accrue to the state of Iowa or its subdivisions on account of the execution and performance of the contract or approval for the release is obtained from the appropriate agencies.

These rules are intended to implement Iowa Code chapter 91C as amended by 2010 Iowa Acts, House File 2522.

[Filed 12/9/88, Notice 10/5/88—published 12/28/88, effective 2/15/89]<sup>1</sup>

[Filed emergency 4/26/89—published 5/17/89, effective 4/26/89]

[Filed 10/26/89, Notice 5/17/89—published 11/15/89, effective 12/29/89]<sup>◇</sup>

[Filed 2/7/97, Notice 8/14/96—published 2/26/97, effective 4/4/97]

[Filed emergency 5/4/99 after Notice 3/24/99—published 6/2/99, effective 7/1/99]

[Filed emergency 6/28/06—published 7/19/06, effective 7/1/06]

[Filed 11/3/06, Notice 9/27/06—published 11/22/06, effective 1/1/07]

[Filed 11/30/06, Notice 7/19/06—published 12/20/06, effective 1/24/07]

[Filed emergency 6/25/08—published 7/16/08, effective 6/25/08]

[Filed Emergency ARC 7876B, IAB 6/17/09, effective 7/1/09]

[Filed ARC 8035B (Notice ARC 7875B, IAB 6/17/09), IAB 8/12/09, effective 9/16/09]

[Filed Emergency ARC 8812B, IAB 6/2/10, effective 7/1/10]

[Filed ARC 8984B (Notice ARC 8818B, IAB 6/2/10), IAB 8/11/10, effective 9/15/10]

[Filed ARC 3059C (Notice ARC 2965C, IAB 3/15/17), IAB 5/10/17, effective 6/14/17]

[Filed ARC 3686C (Notice ARC 3565C, IAB 1/17/18), IAB 3/14/18, effective 4/18/18]

<sup>◇</sup> Two or more ARCs

<sup>1</sup> Effective date (2/15/89) delayed 70 days by the Administrative Rules Review Committee at its January 5, 1989, meeting.