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OF GOVERNMENTAL
AGENCIES



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INTRODUCTION

The Illinois Register is the official state document for publishing public notice of rulemaking activity initiated by State governmental agencies. The table of contents is arranged categorically by rulemaking activity and alphabetically by agency within each category.

Rulemaking activity consists of proposed or adopted new rules; amendments to or repealers of existing rules; and rules promulgated by emergency or peremptory action. Executive Orders and Proclamations issued by the Governor; notices of public information required by State Statute; and activities (meeting agendas; Statements of Objection or Recommendation, etc.) of the Joint Committee on Administrative Rules (JCAR), a legislative oversight committee which monitors the rulemaking activities of State Agencies; is also published in the Register.

The Register is a weekly update of the Illinois Administrative Code (a compilation of the rules adopted by State agencies). The most recent edition of the Code, along with the Register, comprise the most current accounting of State agencies' rulemakings.

The Illinois Register is the property of the State of Illinois, granted by the authority of the Illinois Administrative Procedure Act [5 ILCS 100/1-1, et seq.].

2008 REGISTER SCHEDULE VOLUME #32

| <u>Issue #</u> | <u>Rules Due Date</u> | <u>Date of Issue</u> |
|----------------|-----------------------|----------------------|
| 1 | December 21, 2007* | January 4, 2008 |
| 2 | December 31, 2007 | January 11, 2008 |
| 3 | January 7, 2008 | January 18, 2008 |
| 4 | January 14, 2008 | January 25, 2008 |
| 5 | January 22, 2008 | February 1, 2008 |
| 6 | January 28, 2008 | February 8, 2008 |
| 7 | February 4, 2008 | February 15, 2008 |
| 8 | February 11, 2008 | February 22, 2008 |
| 9 | February 19, 2008 | February 29, 2008 |
| 10 | February 25, 2008 | March 7, 2008 |
| 11 | March 3, 2008 | March 14, 2008 |
| 12 | March 10, 2008 | March 21, 2008 |
| 13 | March 17, 2008 | March 28, 2008 |
| 14 | March 24, 2008 | April 4, 2008 |
| 15 | March 31, 2008 | April 11, 2008 |
| 16 | April 7, 2008 | April 18, 2008 |
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| 24 | June 2, 2008 | June 13, 2008 |
| 25 | June 9, 2008 | June 20, 2008 |
| 26 | June 16, 2008 | June 27, 2008 |
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| 28 | June 30, 2008 | July 11, 2008 |
| 29 | July 7, 2008 | July 18, 2008 |
| 30 | July 14, 2008 | July 25, 2008 |
| 31 | July 21, 2008 | August 1, 2008 |
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Editor's Note: The Secretary of State Index Department is providing this opportunity to notify you that the next filing period for your Regulatory Agenda will occur from April 21, 2008 to July 1, 2008.

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Community Care Program
- 2) Code Citation: 89 Ill. Adm. Code 240
- 3)

| <u>Section Numbers:</u> | <u>Proposed Action:</u> |
|-------------------------|-------------------------|
| 240.210 | Amend |
| 240.728 | Amend |
| 240.729 | Repeal |
| 240.730 | Amend |
| 240.1505 | New |
| 240.1510 | Amend |
| 240.1520 | Amend |
| 240.1525 | New |
| 240.1530 | Amend |
| 240.1535 | Amend |
| 240.1550 | Amend |
| 240.1555 | Amend |
| 240.1560 | Amend |
| 240.1600 | Amend |
| 240.1605 | Amend |
| 240.1615 | New |
| 240.1620 | Repeal |
| 240.1625 | Repeal |
| 240.1630 | Repeal |
| 240.1635 | Repeal |
| 240.1640 | Repeal |
| 240.1645 | Amend |
- 4) Statutory Authority: 20 ILCS 105/4.01(11) and 4.02, as amended by Public Acts 95-298 (effective August 20, 2007) and 95-0565 (effective June 1, 2008)
- 5) A Complete Description of the Subjects and Issues Involved: Section 240.210: Updates terminology as required by Public Act 95-298 to reflect the increased range of services allowed to be provided by homecare aides consistent with prohibitions under the Nurse Practice Act and Public Act 95-565.

Section 240.728: Provides clarification to minimize impact of future rate adjustments on applicants/clients. Deletes references to obsolete maximum monthly service dollar listings.

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

Section 240.729: Repeals rule that is now redundant given revisions made in Section 240.728.

Section 240.730: Adds necessary language to clarify use of a plan of care consistent with available services and service cost maximums under the Community Care Program in accordance with Public Act 95-0565.

Section 240.1505: Lists the administrative requirements for certification as a qualified provider agency under the Community Care Program. These changes will improve compliance with the federal requirement to assure open enrollment of providers for Medicaid services.

Section 240.1510: Updates provider requirements regarding access to confidential program records, maintenance of vehicle insurance, and completion of background checks for excluded providers and workers under the Community Care Program. Adds new provider requirements to improve general oversight of the program and to maintain health, safety, and welfare of clients receiving in-home and community-based services, including quality assurance improvement efforts consistent with federal Title XIX waiver funding requirements, compliance with collective bargaining agreements, expansion of disaster operations planning, increased supervision over direct client contact, emphasizing mandated reporting responsibilities, limitations on use of restraints, and goals for training. Deletes redundant and superfluous language that has been incorporated in other Sections for consistency purposes.

Section 240.1520: Updates provider responsibilities regarding maintenance of mandatory levels of insurance coverage, compliance with plan of care requirements and monitoring of client health and functional ability, preparation procedures for client billing, documentation requirements for audit and oversight purposes, notification of changes in organizational structure and contact information, and prohibitions on client contact under the Community Care Program. Revises terminology and deletes redundant or superfluous language that has been incorporated into other Sections for consistency purposes.

Section 240.1525: Establishes standard requirements for in-home service provider business offices and management training. Includes existing provisions regarding annual audit reports that have been re-ordered for consistency purposes.

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

Section 240.1530: Updates terminology as required by Public Act 95-298 and to reflect the increased range of services allowed to be provided by homecare aides under Public Act 95-565. Revises Department standard for supervision of homecare aides at provider agencies under the Community Care Program. Addresses service, transportation, and billing requirements, as well as use of family caregivers.

Section 240.1535: Updates terminology as required by Public Act 95-298 and to reflect the increased range of services allowed to be provided by homecare aides under Public Act 95-565. Increases required hours of training for staff supervisors and homecare aides. Lists mandatory and preferred topics for training and competency evaluations. Upgrades educational and experience qualification standards for homecare aides.

Section 240.1550: Updates a code reference and adds the Americans with Disabilities Act to the list of standards applicable to adult day service providers. Revises language to reflect preferred terminology in reference to persons with disabilities. Changes criteria for hot water temperature, telephone system, meal quality, and transportation at adult day service facilities. Includes existing provisions regarding monitoring of client health and functional ability, client billing procedures, and management training which have been re-ordered for consistency purposes.

Section 240.1555: Increases required hours of training for staff supervisors and homecare aides. Lists mandatory and preferred topics for adult day service staff.

Section 240.1560: Addresses responsibilities of program nurse on staff at adult day service providers. Upgrades educational and licensure requirements for drivers/escorts and nutrition staff. Expands oversight and training requirements to include students and student interns who may participate in an adult day service program.

Section 240.1600: Explains the certification and recertification process under which a prospective or current provider agency will be initially determined or subsequently re-determined as qualified for the award or renewal of a contract to provide services under the Community Care Program. Eliminates obsolete references.

Section 240.1605: Eliminates obsolete references to existing procurement system and establishes emergency certification procedure to determine qualified providers for services under the Community Care Program.

Section 240.1615: Establishes procedure for modification of contractual service areas for certified provider agencies under the Community Care Program.

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

Section 240.1620: Repeals obsolete rule on issuance of provider proposal and guidelines.

Section 240.1625: Repeals obsolete rule regarding content of provider proposal and guidelines.

Section 240.1630: Repeals obsolete rule regarding the criteria for number of provider contracts awarded.

Section 240.1635: Repeals obsolete rule regarding evaluation of provider proposals.

Section 240.1640: Repeals obsolete rule regarding determination and notification of provider awards.

Section 240.1645: Revises objection procedure to encompass provider certification decisions. Eliminates obsolete references to procurement action and the award of points on proposals. Lists examples of circumstances that do not constitute an appealable basis for objection.

- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: Recommendations to the Department made by the Department of Healthcare and Family Services; the subcommittees of the Community Care Program Advisory Committee; the Illinois Adult Day Services Association; the Illinois Association of Community Care Program Homecare Providers; and the Service Employees International Unions, Local 880
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? Yes
- 10) Are there any other proposed rulemakings pending on this Part? Yes

| <u>Section Numbers:</u> | <u>Proposed Action:</u> | <u>Illinois Register Citation:</u> |
|-------------------------|-------------------------|---------------------------------------|
| 240.1800 | Amend | 31 Ill. Reg. 16375; December 14, 2007 |
| 240.865 | Amend | 31 Ill. Reg. 16599; December 21, 2007 |
| 240.920 | Amend | 31 Ill. Reg. 16599; December 21, 2007 |
| 240.950 | Amend | 31 Ill. Reg. 16599; December 21, 2007 |

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

- 11) Statement of Statewide Policy Objectives: This rulemaking does not create or enlarge any State mandate.
- 12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may submit written comments on this proposed rulemaking within 45 days after the date of publication of this Notice to:

Karen Alice Kloppe
Deputy General Counsel
Illinois Department on Aging
421 E. Capitol Avenue, #100
Springfield, IL 62701-1789

217/785-3346
- 13) Initial Regulatory Flexibility Analysis:
 - A) Types of small businesses, small municipalities and not for profit corporations affected: Current and prospective service provider agencies for the Community Care Program
 - B) Reporting, bookkeeping or other procedures required for compliance: Reporting, bookkeeping, and other procedures commensurate with any such requirements established under the Community Care Program
 - C) Types of professional skills necessary for compliance: Professional skills commensurate with any such requirements established under the Community Care Program
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was in part summarized on the regulatory agenda submitted by the Department for July 2007. Some parts of this rulemaking implement new public acts that were enacted after this date.

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER II: DEPARTMENT ON AGING

PART 240
COMMUNITY CARE PROGRAM

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- 240.1330 General Vendor and CCU Responsibilities (Repealed)
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- 240.1397 Purchases and Contracts (Repealed)
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- 240.1510 Provider Administrative Minimum Standards
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- [240.1525](#) [Standard Requirements for In-home Service Providers](#)
- 240.1530 General [In-home ServiceHomemaker](#) Staffing Requirements
- 240.1535 [In-home ServiceHomemaker](#) Staff Positions, Qualifications, [Training](#) and Responsibilities
- 240.1540 General Chore-Housekeeping Staffing Requirements (Repealed)
- 240.1545 Chore-Housekeeping Staff Positions, Qualifications and Responsibilities

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

| | |
|----------|--|
| | (Repealed) |
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| 240.1625 | Content of Provider Proposal and Guidelines (Repealed) |
| 240.1630 | Criteria for Number of Provider Contracts Awarded (Repealed) |
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| 240.1640 | Determination and Notification of Provider Awards (Repealed) |
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240.2040 Minimum Direct Service Worker Costs for Homemaker Service
240.2050 Cost Categories for Homemaker Service

AUTHORITY: Implementing Section 4.02 and authorized by Section 4.01(11) of the Illinois Act on the Aging [20 ILCS 105/4.02 and 4.01(11)].

SOURCE: Emergency rules adopted at 4 Ill. Reg. 1, p. 67, effective December 20, 1979, for a maximum of 150 days; adopted at 4 Ill. Reg. 17, p. 151, effective April 25, 1980; amended at 4 Ill. Reg. 43, p. 86, effective October 15, 1980; emergency amendment at 5 Ill. Reg. 1900, effective February 18, 1981, for a maximum of 150 days; amended at 5 Ill. Reg. 12090, effective October 26, 1981; emergency amendment at 6 Ill. Reg. 8455, effective July 6, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 14953, effective December 1, 1982; amended at 7 Ill. Reg. 8697, effective July 20, 1983; codified at 8 Ill. Reg. 2633; amended at 9 Ill. Reg. 1739, effective January 29, 1985; amended at 9 Ill. Reg. 10208, effective July 1, 1985; emergency amendment at 9 Ill. Reg. 14011, effective August 29, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 5076, effective March 15, 1986; recodified at 12 Ill. Reg. 7980; amended at 13 Ill. Reg. 11193, effective July 1, 1989; emergency amendment at 13 Ill. Reg. 13638, effective August 18, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 17327, effective November 1, 1989; amended at 14 Ill. Reg. 1233, effective January 12, 1990; amended at 14 Ill. Reg. 10732, effective July 1, 1990; emergency amendment at 15 Ill. Reg. 2838, effective February 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 10351, effective July 1,

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1991; emergency amendment at 15 Ill. Reg. 14593, effective October 1, 1991, for a maximum of 150 days; emergency amendment at 15 Ill. Reg. 17398, effective November 15, 1991, for a maximum of 150 days; emergency amendment suspended at 16 Ill. Reg. 1744; emergency amendment modified in response to a suspension by the Joint Committee on Administrative Rules and reinstated at 16 Ill. Reg. 2943; amended at 15 Ill. Reg. 18568, effective December 13, 1991; emergency amendment at 16 Ill. Reg. 2630, effective February 1, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 2901, effective February 6, 1992, to expire June 30, 1992; emergency amendment at 16 Ill. Reg. 4069, effective February 28, 1992, to expire June 30, 1992; amended at 16 Ill. Reg. 11403, effective June 30, 1992; emergency amendment at 16 Ill. Reg. 11625, effective July 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 11731, effective June 30, 1992; emergency rule added at 16 Ill. Reg. 12615, effective July 23, 1992, for a maximum of 150 days; modified at 16 Ill. Reg. 16680; amended at 16 Ill. Reg. 14565, effective September 8, 1992; amended at 16 Ill. Reg. 18767, effective November 27, 1992; amended at 17 Ill. Reg. 224, effective December 29, 1992; amended at 17 Ill. Reg. 6090, effective April 7, 1993; amended at 18 Ill. Reg. 609, effective February 1, 1994; emergency amendment at 18 Ill. Reg. 5348, effective March 22, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 13375, effective August 19, 1994; amended at 19 Ill. Reg. 9085, effective July 1, 1995; emergency amendment at 19 Ill. Reg. 10186, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 12693, effective August 25, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16031, effective November 20, 1995; amended at 19 Ill. Reg. 16523, effective December 1, 1995; amended at 20 Ill. Reg. 1493, effective January 10, 1996; emergency amendment at 20 Ill. Reg. 5388, effective March 22, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 8995, effective July 1, 1996; amended at 20 Ill. Reg. 10597, effective August 1, 1996; amended at 21 Ill. Reg. 887, effective January 10, 1997; amended at 21 Ill. Reg. 6183, effective May 15, 1997; amended at 21 Ill. Reg. 12418, effective September 1, 1997; amended at 22 Ill. Reg. 3415, effective February 1, 1998; amended at 23 Ill. Reg. 2496, effective February 1, 1999; amended at 23 Ill. Reg. 5642, effective May 1, 1999; amended at 26 Ill. Reg. 9668, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 10829, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17358, effective November 25, 2002; emergency amendment at 28 Ill. Reg. 923, effective December 26, 2003, for a maximum of 150 days; amended at 28 Ill. Reg. 7611, effective May 21, 2004; emergency amendment at 30 Ill. Reg. 10117, effective June 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 11767, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 16281, effective September 29, 2006; amended at 30 Ill. Reg. 17756, effective October 26, 2006; amended at 32 Ill. Reg. 7588, effective May 5, 2008; amended at 32 Ill. Reg. _____, effective _____.

SUBPART B: SERVICE DEFINITIONS

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Section 240.210 In-homeHomemaker Service

In-home service, also referred to as homemakerHomemaker service, is defined as general non-medical support by supervised homecare aides, or homemakers, who have received specialized training in the provision of in-homehomemaker services. The purpose of providing in-homehomemaker service is to maintain, strengthen and safeguard the functioning of individuals in their own homes in accordance with the authorized plan of care.

- a) Specific service components of in-homehomemaker service as permitted under the Nurse Practice Act [225 ILCS 65] shall include the following:
- 1) Teaching/performing of meal planning and preparation; routine housekeeping skills/tasks (e.g., making and changing beds, dusting, washing dishes, vacuuming, cleaning and waxing floors, keeping the kitchen and bathroom clean and laundering the client's linens and clothing); shopping skills/tasks; and home maintenance and repairs.
 - 2) Performing/assisting with essential shopping/errands may include handling the client's money (proper accounting to the client of money handled and provision of receipts are required). These tasks shall be:
 - A) performed as specifically required by the plan of care; and;
 - B) monitored by the homecarehomemaker supervisor.
 - 3) Assisting with self-administered medication thatwhich shall be limited to:
 - A) reminding the client to take his/her medications;
 - B) reading instructions for utilization;
 - C) uncapping medication containers; and;
 - D) providing the proper liquid and utensil with which to take medications.
 - 4) Assisting with following a written special diet plan and reinforcement of diet maintenance (can only be provided under the direction of a physician and as required by the plan of care).

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- 5) Observing client's functioning and condition and reporting to the supervisor and as defined by the plan of care.
- 6) Performing/assisting with personal care tasks (e.g., shaving, hair shampooing and combing, bathing and sponge bath, shower bath or tub bath, toileting, dressing, nail care, respiratory services, brushing and cleaning teeth or dentures and preparation of appropriate supplies, positioning/transferring client, and assisting client with exercise/range of motion) as defined by the plan of care.
- 7) Escort/transportation to medical facilities, or for essential errands/shopping, or for essential client shopping and individual business with or on behalf of the client as defined by specified in the plan of care.
- ~~b) Homemaker service may include transportation to medical facilities or for essential errands/shopping or for essential client business with or on behalf of the client as specified in the plan of care.~~
- be) Unit of Service
- 1) One unit of in-home~~homemaker~~ service is one hour of direct service provided to the client in the client's home, or while providing transportation/escort to medical facilities, or running errands and/or shopping in behalf of the client.
- 2) For services that~~which~~ the provider was unable to provide due to either the client's absence without prior provider notification or refusal to admit the worker into the home to provide service (see Section 240.350), one unit of documented in-home~~homemaker~~ service per occurrence will be reimbursed to the provider at a maximum of 2 units per client per State fiscal year.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART G: NON-FINANCIAL REQUIREMENTS

Section 240.728 Maximum Payment Levels for In-home and Adult Day~~Homemaker~~ Service

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Maximum monthly service dollars are calculated according to the applicant's/client's total Determination of Need score. ~~Subject to adequate appropriation, These maximum monthly service dollars will be adjusted by~~ the Department will adjust the maximum monthly service dollars to be consistent with any future unit rate adjustments for Community Care Program (CCP) providers.

- ~~a) Individuals scoring from 29 thru 32 points shall be eligible for services costing no less than \$1 and not to exceed \$211 monthly.~~
- ~~b) Individuals scoring from 33 thru 36 points shall be eligible for services costing no less than \$1 and not to exceed \$350 monthly.~~
- ~~c) Individuals scoring from 37 thru 45 points shall be eligible for services costing no less than \$1 and not to exceed \$533 monthly.~~
- ~~d) Individuals scoring from 46 thru 56 points shall be eligible for services costing no less than \$1 and not to exceed \$665 monthly.~~
- ~~e) Individuals scoring from 57 thru 67 points shall be eligible for services costing no less than \$1 and not to exceed \$873 monthly.~~
- ~~f) Individuals scoring from 68 thru 78 points shall be eligible for services costing no less than \$1 and not to exceed \$1,007 monthly.~~
- ~~g) Individuals scoring from 79 thru 87 points shall be eligible for services costing no less than \$1 and not to exceed \$1,371 monthly.~~
- ~~h) Individuals scoring from 88 thru 100 points shall be eligible for services costing no less than \$1 and not to exceed \$1,598 monthly.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 240.729 Maximum Payment Levels for Adult Day Care Service (Repealed)

~~Applicable service maximum levels for Community Care Program clients who, based on an approved plan of care, receive adult day care service are:~~

~~DON SCORE RANGE~~

~~SERVICE MAXIMUM LEVEL~~

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| | |
|-------------------|-------------------|
| 29-32 | \$ 236 |
| 33-36 | 590 |
| 37-45 | 708 |
| 46-56 | 828 |
| 57-67 | 944 |
| 68-78 | 1,007 |
| 79-87 | 1,371 |
| 88-100 | 1,598 |

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 240.730 Plan of Care

- a) Services are to be offered to each applicant/client who meets the minimum required scores on the ~~Community Care Program (CCP)~~ Determination of Need form ~~required by Sections 240.720 or 240.725~~; who meets all other eligibility requirements; for whom an adequate plan of care has been developed; and whose service costs are within the allowable maximums. Case managers and clients shall develop the plan of care in the best interest of the client, based on services selected by the client from among those available in the community. Maximum monthly service dollars are only available to fund services provided through the CCP.
- b) If a plan of care cannot be developed that adequately meets the applicant's/client's needs within the allowable maximums for cost of service, ~~CCP~~Community Care Program services shall be denied or services terminated, as appropriate to the case.
- c) Each applicant/client must be advised by the Case Coordination Unit (CCU) of his/her right to refuse the offered services, to choose to enter a long-term care facility or to choose neither.
- d) Services ~~that which~~ the applicant/client has been determined to need by the CCU are not actually to be provided until the Physician/Nurse Practitioner/Registered Nurse/Christian Science Practitioner agrees that the plan of care is adequate (meets the applicant/client's determined needs) to protect the health and safety of the applicant/client. It shall be the responsibility of the applicant/client to provide the endorsement from the applicant's/client's Physician/Nurse Practitioner/Registered Nurse/Christian Science Practitioner.

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- e) The allowable monthly cost for services provided to an eligible individual and paid for through the CCP Community Care Program cannot exceed the maximum monthly cost as determined by the score attained on the CCP Determination of Need that which is determined by the CCU based on current, full and complete information on the specific needs of the individual. A plan of care shall be based upon the number of days in a month.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART O: PROVIDERS

Section 240.1505 Administrative Requirements for Certification

- a) In order to qualify for certification as a provider of CCP services, a provider agency must, to the satisfaction of the Department, meet the following administrative requirements:
- 1) Serve a geographic area no smaller than a county, except in Cook County. The Department reserves the right to adjust this geographic area requirement to assure that:
- A) no geographic area remains unserved; and
- B) the following entities are not excluded from participation as service providers in the CCP:
- i) entities serving limited- or non-English-speaking clients; and
- ii) locally based entities that are unable to serve outside legally designated geographic areas that are smaller than a county.
- 2) Submit a request for certification, in the form and manner prescribed by the Department, including all required supporting compliance material or other information documenting its administrative and operational ability, and institute all necessary corrective action based on the outcome of any review.

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- 3) Document the legal structure under which it is organized to do business as set forth in Section 240.1310(e).
- 4) Provide a list of the directors, officers or owners, as applicable to the legal structure of the provider agency.
- 5) Verify experience in providing service comparable to the CCP as defined in Subpart B of this Part, for which certification is requested and is consistent with the requirements set forth in this Part.
 - A) Required Experience
 - i) For prospective Emergency Home Response Service provider agencies: A minimum of five years experience in business operations providing Emergency Home Response Service.
 - ii) For prospective Adult Day Service provider agencies: A minimum of two years experience in business operations providing Adult Day Service.
 - iii) For prospective In-home Service Providers: A minimum of three years experience in business operations providing In-home Service, one of which must be in Illinois.
 - B) The Department reserves the right to:
 - i) waive the experience requirements specified in subsection (a)(5)(A) if the provider agency submits proof of current accreditation or certification by an appropriate national organization for the service for which Department certification is being requested.
 - ii) adjust the experience requirement (e.g., substituting management team experience for agency experience) when it is in the best interests of the CCP. The Department will continue to assure, to the extent possible, that any adjustment of the experience requirement will occur only

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when the health, safety and welfare of CCP clients and the quality of services provided will not be adversely affected.

- 6) Disclosure of information regarding past business practices of the provider agency and its affiliates, including the managers, directors or owners, relevant to the service applied for, involving, but not limited to, the following circumstances:
 - A) denial, suspension, revocation or termination for cause of a license or contract, or any other enforcement action, such as civil court or criminal action;
 - B) termination of a contract or surrender of a license before expiration or allowing a contract or a license to expire in lieu of enforcement action;
 - C) any federal or state Medicaid or Medicare sanctions or penalties relating to the operation of the agency, including, but not limited to, Medicaid abuse or fraud;
 - D) any federal or state civil and/or criminal felony convictions;
 - E) operation of an agency that has been decertified in any state under Medicare or Medicaid; or
 - F) citations for client abuse, neglect, injury, financial exploitation or inadequate care in any state.
- 7) Document its written policies and procedures in compliance with the applicable administrative standards imposed on provider agencies under the CCP, as set forth in Section 240.1510(a).
- 8) Document its ability to comply with all applicable responsibilities imposed on provider agencies under the CCP, as set forth in Section 240.1520, including proof of required insurance coverages.
- 9) Submit audited financial reports from the last complete business fiscal year.

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- 10) Submit proof that it is fiscally sound, as that term is defined in Section 240.160, by verifying assets sufficient to cover 90 days of operating expenses, as defined by the agency business plan. In the alternative, the provider agency may document its ability to obtain such assets.
- 11) Provide assurance that its business operations comply with the service, staffing and training requirements imposed on provider agencies under this Part.
- 12) Provide a minimum of two references or letters of recommendation from individuals/businesses, in addition to any provided by an Area Agency on Aging, attesting to the provider agency's qualifications relevant to providing CCP services.
- 13) Comply with all applicable federal, State and local laws, regulations, rules, service standards and policies or procedures pertaining to the provider agency in its business operations and to the services provided under the CCP.
- b) If a provider agency is not able or is unwilling to meet the administrative requirements in subsection (a), the Department shall deny its request for certification.
- c) The Department reserves the right to accept documentation of Illinois Department of Public Health (DPH) home service licensure for applicable administrative requirements. (See 77 Ill. Adm. Code 245.Subpart C.)

(Source: Added at 32 Ill. Reg. _____, effective _____)

Section 240.1510 Provider Administrative Minimum Standards

a) The provider shall establish and comply with~~ensure observance of~~ written policies and procedures, including to comply with the following:

- a+) Confidentiality of client records is maintained as required by Section 240.340 of this Part, including:-
- 1) Ensure access to client records is limited to specific areas within the office and only available to personnel with need for the information.

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2) Establish and maintain current and archived files in a secure and confidential manner.

b2) The type and amount of service is provided in accordance with the Client Agreement and Plan of Care as developed and authorized by the Case Coordination Unit (CCU).

c3) Money handling activities related to necessary shopping/errand activities, including receipt procedures, are monitored.

d4) Each job category includes~~has~~ a job description and a wage range and the agency has personnel policies that include benefits, promotion and evaluation criteria so:-

1A) Each employee is provided a written job description that applies to his/her job category.

2B) A copy of current written personnel policies for his/her specific job category shall be available to all employees.

3C) Each employee is informed of the wage range for the specific job category at the time of employment and any subsequent revisions.

4D) Employee benefits and grievance procedures are clearly stated in writing and comply with both State and federal~~Federal~~ regulations.

5E) Personnel records are maintained for each employee and include at least the following:

Ai) employee application;

Bii) annual face-to-face performance evaluation;

Ciii) documentation of participation in initial training, in-service and other pertinent training (orientation in agency policies) in accordance with Department training required by Sections 240.1535 and 240.1555 of this Part;

Div) documentation of supervisory home and on-site~~home and on-site~~ visits, quarterly

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conferences and evaluations;

- ~~E~~v) documentation to support qualifications; ~~and~~
 - ~~F~~v) documentation of vehicle insurance for those employees who provide client transportation in their own vehicles;
 - ~~G~~) documentation that the websites for the federal Department of Health and Human Services and the Illinois Department of Healthcare and Family Services, Office of Inspector General, were checked for excluded providers;
 - ~~H~~) documentation of a criminal background check and waiver, if applicable, as required by the Illinois Healthcare Worker Background Check Act [225 ILCS 46]; and
 - ~~I~~) documentation of annual influenza vaccination for those employees having direct contact with clients, unless certified by the employee's personal physician that such vaccination would be contraindicated. This requirement shall apply in areas of the State where the Director has been advised by the Illinois Department of Public Health that there is an adequate supply of vaccine through public clinics and where such vaccines would be available at no cost to the employee.
- ~~e~~5) All Department required documentation to support units of service requested for reimbursement shall be retained for a minimum of ~~six~~three years from the termination date of the provider's contract with the Department.
- ~~f~~6) Ongoing quality improvement to comply with Medicaid waiver quality assurance regulations, reviewed at least annually, through:
- ~~1~~A) ~~development~~Development, administration and evaluation of client/family satisfaction surveys;
 - ~~2~~B) ~~staff~~Staff and community agency surveys;
 - ~~3~~C) ~~program~~Program and service reviews; and

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- ~~4D)~~ [implementationImplementation](#) of changes based upon program and service review findings [and submission of documentation of such changes to the Department, in accordance with Department policy.](#)
- ~~g7)~~ U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) Regulation (29 CFR 1910.1030).
- ~~h8)~~ [National Labor Relations Act \(29 USC 151-169\) and any applicable collective bargaining agreements.](#)
- ~~i)~~ [U.S. Department of Homeland Security, U.S. Citizenship and Department of Labor, Immigration and Naturalization Services \(8 USC 1324\(a\) et seq.\).](#)
- ~~j9)~~ Drug Free Workplace Act [30 ILCS 580].
- ~~k10)~~ Patient Self-Determination Act (42 USC 1396(a) et seq.).
- ~~l11)~~ Health Care Surrogate Act [755 ILCS 40].
- ~~m12)~~ Control the spread of infectious diseases [and compliance with universal precautions.](#)
- ~~n13)~~ Assure non-discrimination in accordance with Section 240.320 of this Part and the Department's civil rights program.
- ~~o14)~~ Develop, maintain and protect administrative and client records, [including observance of confidentiality in the maintenance and transmission of records, as required by the Health Insurance Portability and Accountability Act of 1996 \(HIPAA\) \(42 USC 1320d et seq.\).](#)
- ~~p15)~~ Receive and resolve complaints.
- ~~q16)~~ [Develop an all hazards disaster operations plan to respondRespond](#) to emergency situations, including, but not limited to, care in a medical emergency, [home or site-related emergencies \(i.e., late pick-up of clients\), client-related emergencies \(i.e., clients leaving the site unattended\),](#) weather-related emergencies and vehicle/transportation emergencies.

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- r) Adequate supervision of all persons, both staff and volunteers, having direct contact with applicants/clients.
- s) Mandated reporting of all conditions or circumstances that place the applicant/client, or the applicant's/client's household, in imminent danger (e.g., situations of abuse or neglect), as required by 89 Ill. Adm. Code 270.
- t) Use of restraints, only as specified by Department policy.
- u) Participate in all Department-mandated training for staff and volunteers, including, but not limited to:
 - 1) Training on universal precautions as required by the U.S. Department of Labor, Occupational Safety and Health Administration (29 CFR 1910.1030);
 - 2) Training on emergency procedures; and
 - 3) Training for abuse, neglect, exploitation and incident reporting.
- v) Report and regularly update, as required by law, any registry of individuals certified as homecare aides that is administered by the State of Illinois.
- b) ~~Management staff from any applicant agency selected for a CCP adult day service contract shall be required to complete adult day service management training.~~
 - 1) ~~Training shall be completed by the provider prior to the award of a CCP adult day service contract from the Department.~~
 - 2) ~~At a minimum, the provider Program Administrator or Program Coordinator/Director, if also functioning as the Program Administrator, shall complete this training.~~
 - 3) ~~Adult day service provider agencies are exempt from this training requirement if the agency has a current CCP contract to provide adult day service, or:~~
 - A) ~~has prior adult day service experience of at least one year prior to application; and~~

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- ~~B) has served an average caseload of at least 10 clients per day during that time; and~~
- ~~C) is providing the adult day service on the date the application is signed.~~

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 240.1520 Provider Responsibilities

- a) ~~Community Care Program (CCP)~~ services shall be purchased only from providers ~~certified~~~~determined capable and competent~~ by the Department to provide such services, ~~as described in Section 240.1635 of this Part.~~
- b) Providers shall carry general liability insurance in the single limit minimum amount of ~~\$1,000,000~~~~\$100,000~~ per occurrence, ~~\$3,000,000 in the aggregate.~~ ~~(The policies or current letters documenting all insurance coverage shall be available to the Department upon request.)~~
- c) Providers shall also carry the following insurance coverages:
- 1) ~~worker's compensation for direct service staff;~~
 - 2) volunteer protection equivalent to employees' coverage, ~~(including coverage for volunteer drivers/escorts); and~~
 - 3) motor vehicle liability, uninsured motorist and medical payments, if ~~agency staff transport clients in agency vehicles, or proof of minimum motor vehicle liability, uninsured motorist and medical payments, if agency staff transport clients in their own vehicles.~~
- d) ~~The policies or current letters documenting all provider agency insurance coverage and policies or current letters documenting staff coverage specified in subsection (b) or (c) shall be available to the Department upon request.~~
- ~~ed)~~ All providers of CCP services must comply with all applicable local, State, and ~~federal~~~~Federal~~ statutes, rules and regulations.

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- fe) A provider shall provide services to all CCP clients referred by the Case Coordination Unit (CCU), with the following exceptions:
- 1) ~~The client does not meet the adult day service provider's admission criteria.~~
 - 12) The plan of care is determined to be inappropriate in the professional judgement of the provider.
 - A) The provider shall immediately notify the CCU of the provider's assessment and evaluation of the situation.
 - B) The provider and the CCU shall work together to determine if a plan of care that adequately meets the client's needs can be developed.
 - C) In the event the provider and the CCU cannot reach an agreement, the Department shall be contacted and shall determine the final resolution.
 - 23) The provider is unable to accept all CCP referrals.
 - A) The provider shall request a cap on the number of clients to be served (service cap), in writing, to the Department.
 - B) The Department will not approve a service cap for a contractor that is the only provider of ~~in-home~~homemaker service in the contract area or when it is not in the best interest of the program.
 - C) Upon approval of the request, the provider assumes responsibility for managing intake to maintain the cap.
- gf) ~~A provider shall not deviate from the client's plan of care without receipt of written instruction from the Department or the CCU, except in cases of emergency, client refusal of service or client failure to be home to receive service.~~ Any temporary change or deviation from the plan of care must be documented by the provider in the client's file. A provider shall not deviate from the client's plan of care without receipt of verbal or written instruction from the Department or the

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CCU, except in cases of emergency, client refusal of service or client failure to be home to receive service.

- hg) It shall be the responsibility of the provider to advise the CCU of any change in the client's physical/mental/environmental needs that the provider, through the direct service worker/supervisor, has observed, when the change would affect the client's eligibility or service level or would necessitate a change in the plan of care. ~~It is the adult day service provider's responsibility to advise the primary caregiver and/or appropriate professional of any changes in the client's health or functional ability.~~
- ih) All providers shall reply to requests by a client, by telephone or in writing, within 15 calendar days from the date of the request. The request and the response shall be documented in the client's file.
- ji) The provider shall be responsible for the collection from the client of the incurred expense for care provided to the client in the following manner:
- 1) The provider shall be responsible for billing the clients for whom they provide CCP services by the 15th day of the month following the provision of service, and in the manner prescribed by the Department in this subsection ~~(j)(1)~~.
 - A) The billing shall be based, for each client, upon the units of service provided and the fixed fee share rate for the client's incurred expense for care.
 - B) Billing must be received by the client no later than 60 calendar days from the date specified in subsection ~~(j)(1)~~.
 - C) A provider who fails to bill the client within 60 calendar days shall forfeit the right to collect the incurred expense for care. The client shall not be required to pay the expense and client services shall not be discontinued for failure to pay.
 - 2) Providers shall not require clients to pay a greater share of the cost of services prescribed in the plan of care than required by the Client Agreement.

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3) If a client requests additional service from the provider other than that allowed by the Client Agreement, the Department will not be billed for those additional units of service.

kj) Providers may accept partial or full payment from a third party for a client's incurred expense. However, the liability for the proportionate share, if third party payment is not received, remains with the client as indicated by the expense for care agreement executed by the client and included as an integral part of the Client Agreement.

lk) Providers have the option of not billing a client for the incurred expense for care. The client must be notified in advance if billing resumes.

ml) Providers shall respond verbally or in writing to the client on any question presented to the provider, either verbally or in writing, regarding the validity of a billing. If the question is not resolved to the satisfaction of the client, the provider shall advise the client of his/her right to appeal the question, and the provider shall assist the client in filing an appeal if requested or needed. The provider shall also advise the client that non-payment shall result in discontinuance of CCP services. Providers may not discontinue services until authorized to do so by the CCU (refer to Section 240.935 of this Part).

nm) Providers shall electronically submit a Vendor Request for Payment (VRFP)~~form~~ that shall be received by the Department no later than the 15th day of the month following the month in which services were provided. The VRFP~~form~~ shall state the number of units of service provided to each identified client during the service month. Reimbursement to the provider by the Department will be adjusted by calculating and deducting the client's incurred expense for care based upon the fixed fee share rate.

on) Providers shall bill the Department for service rendered to clients in increments of full or one-half units only. ~~Adult day service providers shall bill for not less than one nor more than two units of agency provided transportation to/from the adult day service site per client for each 24-hour period in which adult day service is provided to each client (refer to Section 240.1950 of this Part).~~

po) The provider shall advise the CCU of any failure by a client to pay a monthly bill rendered by the provider for services provided to the client for more than 30 calendar days from the date of the initial monthly billing. The provider may

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request the CCU to discontinue service to the client in default as stated above (refer to Sections 240.875 and 240.935 of this Part).

- gp) If the client makes payment to the provider for incurred monthly expense that has already been reimbursed to the provider by the Department, the provider shall reimburse the Department within 30 calendar days from the date of receipt of payment from the client.
- rq) Providers shall provide the Department with an annual audit report to be completed by an independent Certified Public Accountant and in accordance with 74 Ill. Adm. Code 420.Subpart D ~~and the Department on Aging audit guidelines in this subsection (q). 1)The annual audit shall assure that homemaker providers are in compliance with the financial reporting requirements as outlined in Section 240.2020 of this Part. A Certified Public Accountant's (CPA's) opinion concerning the cost report shall be submitted with the audit. The CPA's opinion may be limited to: A)the provider prepared the cost report by using acceptable accounting methods to allocate cost; and B)the cost reports are supported by provider accounting records.~~ 2)The audit report shall be filed at the offices of the Illinois Department on Aging, 421 East Capitol Avenue, #100, Springfield, Illinois 62701-1789, within six months from the date of the close of the provider's business fiscal year.
- sf) Providers must accept all correspondence from the Department. Failure to do so may lead to contract action (refer to Section 240.1665).
- t) Records
 - 1) Providers must maintain records for administration, audit, budgeting, evaluation, operation and planning efforts by the Department in offering CCP services, including:
 - A) records of all CCP referrals to the provider, including the disposition of each referral;
 - B) client records, which shall include, but are not limited to, applicable forms as required by the Department;
 - C) administrative records, including:

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- i) data used by the Department to provide information to the public;
 - ii) service utilization;
 - iii) complaint resolution; and
 - iv) billing and payment information, plus the underlying documentation to support the units of service submitted to the Department for reimbursement.
- 2) These records shall be available at all times to the Department, the Illinois Department of Healthcare and Family Service (HFS), the U.S. Department of Health and Human Services (HHS), and/or any designees, and shall be maintained for a period of at least 6 years from the termination date of any contractual agreement with the Department.
- u) Providers must notify the Department within 7 days of any change in agency or contact information (e.g., address, telephone, fax, email address, contact person, authorized representative, etc.).
 - 1) Providers must notify the Department at least 30 days in advance of any relocation of their administrative office.
 - 2) Providers must submit documentation of changes in provider name, corporate structure and/or Federal Employer Identification Number to the Office of General Counsel. This documentation shall be reviewed to determine if an assignment of contract has occurred (see Section 240.1310(h)).
- v) Providers must conduct criminal background checks, as required by the Illinois Healthcare Worker Background Check Act [225 ILCS 46], and check the HHS exclusion database and the Department of Healthcare and Family Services Office of Inspector General database on all agency staff and volunteers having face-to-face contact with CCP clients.
 - 1) Provider agencies shall comply with the requirements of the Health Care Worker Background Check Act.

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- 2) Staff refusing to submit to a background check shall not have contact with CCP clients in any capacity.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 240.1525 Standard Requirements for In-home Service Providers

- a) In-home service providers shall maintain a physical facility in each Planning and Service Area (PSA) in which service is provided or have a facility in a neighboring PSA of sufficient capacity to serve all contiguous areas. The facility must be located in a properly zoned location for a business, cannot be operated from a private residence, and must have all of the following:
 - 1) a designated locked storage space for client records;
 - 2) accessibility of records for all clients served in the PSA when required by Department review staff or designees;
 - 3) a primary business telephone listed under the name of the business locally that allows for reliable, dependable and accessible communication;
 - 4) internet, facsimile and email access; and
 - 5) sufficient office space, office equipment and office support to fulfill the requirements of the contract.
- b) The in-home service provider shall include, as part of the annual audit report required by the Department, an independent Certified Public Accountant's (CPA's) opinion concerning the provider's compliance with the financial reporting requirements outlined in Section 240.2020. The CPA's opinion may be limited to assurances that:
 - 1) the provider prepared the cost report by using acceptable accounting methods to allocate cost; and
 - 2) the cost reports are supported by provider accounting records.
- c) Management staff of the in-home service provider shall be required to complete in-home service management training prior to the award of a CCP in-home

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service contract from the Department. At a minimum, the individual responsible for administration of the CCP in-home services program shall complete this training.

(Source: Added at 32 Ill. Reg. _____, effective _____)

Section 240.1530 General In-home Service~~Homemaker~~ Staffing Requirements

- a) Each in-home service~~homemaker~~ provider shall have specified staff to carry out the following functions:
- 1a) A designated individual who has responsibility for administration of the Community Care Program (CCP) in-home service~~homemaker~~ program.
- 2b) Qualified in-home service~~homemaker~~ staff to meet the needs of all cases referred for the provision of in-home~~homemaker~~ services. In determining what services are sufficient, the Department shall look to whether in-home~~homemaker~~ services are adequate. Inadequate in-home~~homemaker~~ services are characterized by delays or interruptions in the provision of in-home~~homemaker~~ services or by failure to provide in-home~~homemaker~~ services as required by the plan of care.
- be) The in-home service~~homemaker~~ provider shall assign responsibilities to staff, including which include the following:
- 1) Planning and administration of the in-home service~~homemaker~~ program; assuring adequate staff to provide required services at all times; serving as liaison between the staff and the community; implementing policies according to regulations promulgated by the Department that~~which~~ govern the program; recommending policy and program changes to the Department; and recruiting, training and supervising staff.
- 2) Supervising of homecare aides~~workers~~ shall be accomplished by qualified staff who have responsibility to ensure that the aides~~workers~~ are scheduled and that assignments are kept.
- c) Each in-home service provider shall ensure that supervisors maintain a maximum 15-minute response time when homecare aides they supervise are serving in a client's home.

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- d) In-home serviceHomemaker providers shall not subcontractsub-contract for management, supervisory or in-homehomemaker staffpersonnel.
- e) In-home service providers shall make one hour service segments available when needed to meet applicant/client needs.
- f) In-home service providers must use an electronic timekeeping system to assure accurate payroll and prompt knowledge of missed or delayed appointments within 6 months after a policy is issued by the Department pursuant to this subsection.
- g) In-home service providers shall make evening and weekend service available to CCP clients as required by the plan of care.
- 1) Evening service shall be available until at least 8 p.m. Monday through Friday.
 - 2) Weekend service shall be available between 8 a.m. and 8 p.m. on Saturday and Sunday.
 - 3) Provider offices are not required to be open for business during evening and weekend hours; however, a supervisor must be on-call and available whenever service is being provided.
- h) In-home service providers shall provide escort/transportation when required by the plan of care.
- i) In-home service providers shall not impose additional restrictions on the hiring of family caregivers of applicants/clients, or homecare aides who are recommended by applicants/clients, when they have met all other agency employment requirements.
- 1) A family caregiver shall not be required to care for other applicants/clients served by the in-home service provider agency.
 - 2) A family caregiver cannot be the spouse of, or otherwise legally responsible for, an applicant/client.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

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Section 240.1535 In-home ServiceHomemaker Staff Positions, Qualifications, Training and Responsibilitiesa) HomecareHomemaker Supervisor1) Activities of a homecarehomemaker supervisor shall include:

- A) documenting client contacts and activities related to client services in the client's file;
- B) preparing or reviewing reports and service calendars;
- C) monitoring receipt procedures in the conduct of essential shopping and errands as stated in the plan of care;
- D) providing input to the case manager on the services that are needed for each client as a result of conferences with the homecare aidehomemaker or in-home visits;
- E) planning, preparing, and documenting contact and quarterly worker-conferences with each assigned homecare aidehomemaker;
- F) evaluating each assigned homecare aidehomemaker annually;
- G) coordinating the homecare aide'shomemaker's activities with other components of the plan of care as required;
- H) making and documenting semi-annual in-home supervisory visits to a client's home for each assigned homecare aidehomemaker;
- I) making home visits, as necessary, to provide hands-on training and assistance; and
- J) initiating and/or participating in client staffing discussions with the case manager, as necessary.

2) Qualifications for a homecarehomemaker supervisor shall include:

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- A) a high school diploma or general education diploma; or
- B) combination of skills and experience ~~that~~which indicate that the applicant has the ability to perform the supervisory activities.
- 3) ~~Homecare supervisors~~Homemaker supervisor shall meet the following training requirements:
- A) Within 90 calendar days from the date of employment with the provider agency in a ~~homecare~~homemaker supervisor position, each supervisor shall complete Department sponsored ~~Community Care Program (CCP)~~ training on policy and procedures, billings, evaluations, ~~homecare aide~~worker and client files (~~homemaker supervisors who have received supervisor training prior to May 1, 1999 shall be exempt from this training~~); and
- B) Within each calendar year, each supervisor shall complete ~~2412~~ hours of documented in-service training on aging related subjects, including documented participation in in-house staff training and/or local, ~~State~~state, regional or national conferences. In-service supervisor training shall include at least 16 hours of training selected from among the following topics: ~~For partial years of employment, training shall be prorated to equal 1.5 hours for each full month of employment.~~
- i) Promoting client dignity, independence, self-determination, privacy, choice and rights;
- ii) Client-centered care planning;
- iii) Special characteristics of the elderly population; physical, emotional and developmental needs of the client;
- iv) Recognizing client abuse, neglect and/or exploitation; abuse and neglect prevention and reporting requirements;
- v) Communication skills;

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- vi) [Universal precautions, blood-borne pathogens and infection control;](#)
 - vii) [Fire and life safety, including emergency procedures to be implemented under the agency's all hazards disaster operations plan;](#)
 - viii) [Dealing with adverse behaviors; mental illness, depression and aggression;](#)
 - ix) [Family dynamics;](#)
 - x) [Diseases of the elderly; understanding Alzheimer's disease and dementia;](#)
 - xi) [Body mechanics and normal range of motion, transfer techniques and positioning;](#)
 - xii) [Chronic illness, death and dying;](#)
 - xiii) [Penalties for fraud and abuse;](#)
 - xiv) [Appropriate and safe techniques in performing and assisting with personal care;](#)
 - xv) [First aid and/or cardiopulmonary resuscitation \(CPR\); and/or](#)
 - xvi) [Understanding advance directives.](#)
- b) [HomecareHomemaker](#) Staff
- 1) Activities of [homecare aideshomemaker staff](#) include the following:
 - A) following a client's written plan of care;
 - B) carrying out duties as assigned by the supervisor;
 - C) observing the client's functioning and reporting to the

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- ~~homecare~~~~homemaker~~ supervisor;
- D) providing necessary receipts and documentation in the conduct of essential shopping/errands;
- E) maintaining records of daily activities, observations, and direct hours of service; and
- F) attending initial training, in-service training sessions and staff conferences.
- 2) Qualifications of a ~~homecare aide~~~~homemaker~~ shall include one of the following types of education or experience:
- A) ~~one of the following types of education or experience~~:
- Ai) a high school diploma or general education diploma; or
- Bii) one year of ~~homemaker/chore housekeeping~~ direct in-home service work experience in the CCP, employment in a comparable human service capacity program, or for a dependent child or adult family member; or
- Ciii) demonstration of continued progress towards meeting the educational requirement of a general education diploma by current registration and evidence of successful completion of course work (successful completion means achievement of a grade of "C" or higher); ~~or~~
- ~~iv)~~ ~~service as a Community Care Program chore housekeeping direct service worker prior to the effective date of this Section; and~~
- ~~B)~~ ~~having a basic knowledge of home management skills; and~~
- 3C) Homecare aides shall meet the following training requirements~~in addition~~:
- Ai) new employees shall receive ~~2415~~ hours of initial pre-service training, ~~including~~~~excluding~~ agency orientation of not more than 2

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hours, prior to assignment to provide services to a CCP client without a supervisor or trainer present (not to exceed a six month period from the training to first assignment). Initial homecare aide training shall be subject to a competency evaluation conducted by the agency and include all in-home services (see Section 240.210), as well as the following additional topics:

- i) The homecare aide's job responsibilities and limitations;
- ii) Communication skills, including communicating with special client populations such as the hearing impaired and clients with dementia or other special needs;
- iii) Observation, reporting and documentation of client status and of the service furnished;
- iv) Performance of personal care tasks for clients, including bathing, skin care, hair care, nail care, mouth care, shaving, dressing, feeding, assistance with ambulation, exercise and transfers, positioning, bladder and bowel care, and medication reminding;
- v) Ability to assist in the use of specific adaptive equipment, if the aide will be working with clients who use the device;
- vi) Basic hygiene and basic infection control practices;
- vii) Maintenance of a clean, safe and healthy environment;
- viii) Basic personal and environmental safety precautions;
- ix) Recognizing emergencies and knowledge of emergency procedures;
- x) Confidentiality of client personal, financial and health information; and
- xi) Knowledge and understanding of abuse and neglect prevention and reporting requirements;

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- Bii) initial training may be exempt if a new employee:worker
- i) has had previous documented and supervised training within the past two years prior to this employment, equivalent to 2415 hours of homecare aidefor homemaker initial training; ~~or equivalent to 12 hours for chore-housekeeping initial training prior to the effective date of this Section~~; or
 - ii) has successfully completed RN, LPN, MD or CNA training in the past and has been employed in the field within the past two years; or
 - iii) has been employed as a CCP homecare aide within the past year; and
- Ciii) thereafter, a minimum of 12three hours per calendar yearquarter of face-to-face in-service training shall be mandatory for all homecare aidesworkers. Initial training shall fulfill the first three hours ofquarter in-service training requiredrequirement for new employees, except when the initial training is exempt for previous documented and supervised training as described in subsection (B)(b)(2)(C)(ii) above. In-service training for homecare aides shall include at least nine hours of training selected from among the following topics: Training hours in excess of three hours may be carried forward to satisfy training requirements in the following quarter(s):
- i) Promoting client dignity, independence, self-determination, privacy, choice and rights;
 - ii) Special characteristics of the elderly population; physical, emotional and developmental needs of the client;
 - iii) Recognizing client abuse, neglect and/or exploitation; abuse and neglect prevention and reporting requirements;
 - iv) Confidentiality of client information;

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- vi) [Communication skills;](#)
- vi) [Universal precautions, blood-borne pathogens and infection control;](#)
- vii) [Fire and life safety, including emergency procedures to be implemented under the agency's all hazards disaster operations plan;](#)
- viii) [Dealing with adverse behaviors; mental illness, depression and aggression;](#)
- ix) [Family dynamics;](#)
- x) [Diseases of the elderly; understanding Alzheimer's Disease and dementia;](#)
- xi) [Body mechanics and normal range of motion, transfer techniques and positioning;](#)
- xii) [Chronic illness, death and dying;](#)
- xiii) [Penalties for fraud and abuse;](#)
- xiv) [Cultural diversity;](#)
- xv) [Food, nutrition and meal planning and preparation, including special diets;](#)
- xvi) [Maintenance of a clean, safe and healthy environment, including laundry and house cleaning skills;](#)
- xvii) [Appropriate and safe techniques in performing and assisting with personal care;](#)
- xviii) [Assistance with self-administered medications;](#)

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xix) Recognizing changes in bodily functions that should be reported to the supervisor;

xx) First aid and/or CPR; and/or

xxi) Understanding advance directives.

D) Progress toward certification in a related field (e.g., CNA) may be used for up to three hours of in-service training per calendar year.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 240.1550 Standard Requirements for Adult Day Service Providers

a) An adult day service provider shall have on file and utilize written procedures to:

1) ~~manage~~Manage storage and administration of medications, including:

A) ~~storing~~Storing and locking medications; ~~;~~

B) ~~labeling~~Labeling medications brought to the adult day service provider's site; ~~and~~;

C) ~~ensuring~~Ensuring that:

i) prescribed medication is administered by an appropriately licensed professional to those adult day service clients who are determined to be unable to self-administer medications;

ii) judgment of a client's inability to self-administer medications shall be documented by a physician's order or the ~~Case Coordination Unit (CCU)~~ plan of care and/or the adult day service plan of care by the program nurse;

iii) administration of all medications administered by the adult day service provider staff (prescription and non-prescription) are recorded in the client's case record; and

iv) physician orders for medication are utilized and filed in the

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client's case record.

b) A facility ~~that~~^{which} houses an adult day service program (including satellite sites) shall meet the following criteria:

- 1) A separate identifiable area must be designated for sole use by the adult day service program, and a schedule established and posted for usage of any common program areas shared with other programs.
- 2) There shall be a minimum of 40 square feet of activity area per client. (Multiple-use areas must be pro-rated on both time and client basis.) The activity area in the square feet per client requirement is exclusive of exit passages and fire escapes, administrative space, storage areas, bathrooms, kitchen used for meal preparation, space required for equipment and gymnasiums or other areas when used exclusively for active sports.
- 3) All adult day service providers shall comply with the applicable provisions of the following codes and standards. Any incorporation by reference in this Section ~~of these rules~~ or regulations of any agency of the United States or of any standards of a nationally recognized organization or association includes no new amendments or editions made after the date specified.

A) State of Illinois Codes and Standards

| | Code or Standard | Agency |
|-----|---|---|
| i) | Ill. Plumbing Code (77 Ill. Adm. Code 890) | Department of Public Health, Environmental Health Protection or their authorized local designee |
| ii) | Illinois Accessibility Code (71 Ill. Adm. Code 400) Environmental Barriers Act [410 ILCS 25] | Capital Development Board offers guidance to design professionals and building code officials regarding the interpretation and application of the Illinois Accessibility Code |

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NOTE: It shall be incumbent upon the provider to assure that their facility meets all applicable requirements as promulgated by the Capital Development Board. (No written documentation thereof shall be required.)

- | | | |
|------|--|---|
| iii) | Fire Prevention and Safety (41 Ill. Adm. Code 100) | Office of State Fire Marshal |
| iv) | Illinois Vehicle Code [625 ILCS 5] | Secretary of State of Illinois |
| v) | Food Service Sanitation (77 Ill. Adm. Code 750) | Department of Public Health, Environmental Health Protection or their authorized local designee |

B) Other Codes and References

- | | | |
|-----|---|---|
| i) | National Fire Protection Association (NFPA 101 Life Safety Code, 2006 1985 edition: Chapter 10, Section 7 and Chapter 11, Section 7) | National Fire Protection Association and Office of State Fire Marshal shall inspect |
| ii) | <u>Americans with Disabilities Act (42 USC 12101 et seq.)</u> | |

- C) In addition to compliance with the standards set forth herein, all applicable local and state building, fire, health and safety codes, ordinances and regulations ~~that~~which are enforced by city, county or other local jurisdictions in which the facility is, or will be, located must be observed and documented through required inspections by appropriate officials.

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- 4) Each facility shall have posted an emergency plan for evacuation and shall conduct quarterly fire drills in accordance with subsection (b)(3)(B)(i). Documentation of the dates of the fire drills must be on file at the facility.
- 5) Each facility shall maintain room temperatures in the facility of not less than 70 degrees Fahrenheit and not more than 85 degrees Fahrenheit by utilizing heating system/air conditioning/circulating fans.
- 6) Each facility shall designate a dining area (equipped with a sufficient number of chairs and table space) to accommodate the daily number of clients.
- 7) Each facility shall have at least one bathroom facility that is physically accessible to ~~disabled~~ persons with disabilities for up to 12 clients and a minimum of two bathroom facilities (one physically-accessible to ~~disabled~~ persons with disabilities) to serve 13 or more clients.
- 8) Each facility shall have space for office equipment and storage of supplies.
- 9) Hot water temperatures shall be controlled to not exceed 110+19 degrees but not less than 10099 degrees Fahrenheit in the bathroom facilities.
- 10) Unsupervised clients~~Clients~~ shall not be allowed in the kitchen if water temperatures are not controlled as required in subsection (b)(9) above. Clients should not be allowed in areas where supplies/medications are stored or where a microwave is in use unless supervised.
- 11) Each facility shall have at least one quiet place equipped with a reclining chair, cot or bed where a client may rest.
- 12) Exit areas shall be clear of equipment and debris at all times and shall be equipped with monitoring or signaling devices to alert staff to clients leaving the facility unattended.
- 13) One landline telephone, with direct access to a 911 emergency response system, if available in the area, shall be immediately available within the client activity area. A list of emergency numbers shall be posted by the telephone.

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- 14) Supplies and equipment for emergency first aid shall be immediately accessible to ~~allocated~~ client activity areas.
- c) An adult day service provider (including each satellite site) shall meet the following criteria relative to meals provided to clients (prepared on-site or contractual):
 - 1) The adult day service provider shall provide to each client one meal at mid-day meeting a minimum of 33 percent of the Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences ~~at least one-third of the adult "Recommended Dietary Allowances" established by the Food and Nutrition Board of the National Research Council—National Academy of Sciences~~ (10th Revised Edition). Supplementary nutritious snacks shall also be provided. The adult day service provider shall provide modified diets as directed by the client's physician.
 - 2) Adult day service providers (whether meals are prepared on-site or contractually) shall:
 - A) Have menus approved and so documented by the registered dietitian. Menus shall reflect portion sizes as appropriate.
 - B) Post menus in advance in a location visible to the client(s) within the adult day service facility.
 - C) Assure that menus are planned for a minimum of four weeks on a menu form.
 - D) Develop methods and follow written procedures to control portion sizes and to meet the one-third daily dietary reference intakes recommended ~~dietary allowances (refer to subsection (b)(3)(B)(ii) above)~~.
 - E) One employee at each adult day service site, either handling/preparing or supervising the handling/preparing of foods, shall meet Food Service Sanitation guidelines issued by the Illinois Department of Public Health.

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- F) Have on file and follow written procedures for receiving and storing food ~~that~~^{which} must include:
- i) verification of food quantities;
 - ii) checking and documentation of food temperatures at time of delivery and serving;
 - iii) equipment to be utilized;
 - iv) procedures to follow for foods that arrive above or below temperature, deteriorated food and food shortages.
- G) Ensure that catered meals are transported in equipment that maintains temperatures of hot food at 140 degrees Fahrenheit, or above, and cold foods at 41 degrees Fahrenheit, or below. Foods shall be maintained and served at the above temperatures at the adult day service site.
- H) Ensure that potentially hazardous foods (i.e., food that consists in whole or in part of milk, milk products, eggs, meat, poultry, fish, shellfish, ~~edible crustacea~~, or other ingredients, including synthetic ingredients, in a form capable of supporting rapid and progressive growth of infectious or toxigenic microorganisms) intended to be served cold shall be pre-chilled and transported/maintained at a temperature of 41 degrees Fahrenheit, or below. Potentially hazardous food intended to be served hot shall be transported/maintained at a temperature of 140 degrees Fahrenheit, or above.
- I) Ensure that potentially hazardous foods prepared on-site shall be prepared in accordance with required cooking temperatures as specified by the Illinois Department of Public Health (77 Ill. Adm. Code 750) and maintained until service at 140 degrees Fahrenheit, or above, for hot foods and 41 degrees Fahrenheit, or below, for cold foods.
- J) If food is prepared by a caterer, ~~the ensure that the registered dietitian has inspected the caterer's location and receives~~

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~~documentation that the caterer's operation complies with all health, sanitary and safety regulations.~~ The adult day service provider shall keep a copy of the current caterer's inspection certificates/letters on file to verify that the operation complies with all health, safety and sanitation regulations.

- d) An adult day service provider (including each satellite site) shall meet the following criteria relative to transportation provided to clients (provided or contractual):
- 1) Adult day service provider vehicles that transport clients shall be equipped with a working two-way communications device and written procedures to be followed in the event of an emergency ~~(refer to Section 240.1510(h)).~~
 - 2) Vehicles shall display a safety sticker indicating current compliance with the inspection requirements of the Illinois Vehicle Code.
 - 3) Vehicles shall carry current registration and proof of vehicle insurance at all times.
 - 4) An adult day service provider shall have on file and utilize written procedures to ensure, to the extent possible, that safe client transportation is provided.
 - 5) The transportation driver/escort or other adult day service or contractual staff, shall inspect the vehicle after each one-way trip to or from the adult day service site, to collect anything that has been inadvertently left in the vehicle.
- e) Adult day service providers shall acquire and have on file an emergency contact and a recent photograph of each client for emergency purposes.
- f) An adult day service provider shall provide services to all CCP clients referred by the CCU, except:
- 1) clients who do not meet the adult day service provider's admission criteria; and

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- 2) current clients whose condition warrants discharge under the adult day service provider's discharge criteria.
- g) It is the adult day service provider's responsibility to advise the primary caregiver and/or appropriate professional of any changes in the client's health or functional ability.
- h) Management staff of the adult day service provider shall be required to complete adult day service management training.
 - 1) Training shall be completed by the provider prior to the award of a CCP adult day service contract from the Department.
 - 2) At a minimum, the provider Program Administrator, or Program Coordinator/Director if also functioning as the Program Administrator, shall complete this training.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 240.1555 General Adult Day Service Staffing Requirements

- a) A separate and identifiable staff must be designated for sole use by the adult day service program.
- b) Each adult day service provider shall have adequate personnel in number and skill (a minimum of two staff persons) at the adult day service site to meet the ratio required in subsection (c) and to provide for:
 - 1) program and fiscal administration;
 - 2) nursing and personal care services;
 - 3) nutritional services;
 - 4) planned therapeutic/recreational activities;
 - 5) obtaining prompt services of emergency personnel and hospitalization, if needed;

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- 6) immediately notifying the client's authorized representative or family member of any illness, accident or injury to the participant;
 - 7) provision/arrangement of transportation services to and from the adult day service site;
 - 8) ~~adequate~~ record keeping;
 - 9) development, implementation and semi-annual review of individualized plans of care;
 - 10) program evaluation and marketing;
 - 11) supervision and evaluation of staff;
 - 12) monitoring and meeting staff training needs; and
 - 13) maintenance of a clean and safe physical environment.
- c) The minimum ratio of full-time staff (qualified adult day service staff, trained volunteers or substitutes) or full-time equivalent (FTE) staff present at the adult day service site to clients, when clients are in attendance, shall be:

| Staff | Clients |
|-------|----------|
| 2 | 1 to 12 |
| 3 | 13 to 20 |
| 4 | 21 to 28 |
| 5 | 29 to 35 |
| 6 | 36 to 45 |

- 1) Add one additional staff person for each ~~six~~seven additional clients.
- 2) Fifty percent or more of a staff member's time shall be spent in on-site direct service or supervision on behalf of one or more clients in order to be considered in the ratio.
- 3) Staff included in the staff-client ratio shall include only those who work on site, are actively involved with the clients, and are immediately available in the activity area to meet the clients' needs. ~~Exceptions from the~~

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~~mandated ratio of staff to clients can be made only with prior Department approval.~~

- d) Each adult day service employee shall have:
- 1) Initial training totaling a minimum of ~~2412~~ hours ~~face-to-face~~ training within the first week of employment (exclusive of orientation). A worker may be exempted from initial training by the provider if the worker has had previous documented training equivalent to ~~2412~~ hours, with another CCP contracted agency, or in a related field, within the past two years prior to this employment or holds a valid, active CNA, RN, or LPN license, and/or a BA, BS, BSW or higher degree. Initial training shall include at least 18 hours of training selected from the following topics:
 - A) Purpose and goals of adult day service;
 - B) Facility, environmental and safety considerations;
 - C) Assistance with activities of daily living;
 - D) Basic principles of personal care;
 - E) Dealing with adverse behaviors: wandering, aggression, mental illness and depression;
 - F) Promoting client dignity, independence, self-determination, privacy, choice and rights;
 - G) Understanding aging and functionally-impaired persons;
 - H) Recognizing client abuse, neglect and/or exploitation; abuse and neglect prevention and reporting requirements;
 - D) Confidentiality of client information;
 - J) Communication skills;
 - K) Universal precautions, blood-borne pathogens and infection control;

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- L) Fire and life safety, including emergency procedures to be implemented under the agency's all hazards disaster operations plan;
- M) Family dynamics;
- N) Understanding Alzheimer's disease and dementia;
- O) Body mechanics and normal range of motion, transfer techniques and positioning;
- P) Cultural diversity;
- Q) Recognizing changes in bodily functions that should be reported to the supervisor;
- R) Nutrition and safe food handling; and/or
- S) CPR and first aid.

- 2) A minimum of 12 hours continuing education per year shall be mandatory for all adult day service employees. Initial training shall fulfill the in-service training requirement for new employees except when the worker is exempted from initial training as described in subsection (d)(1)~~above or~~ licensed under programs regulated by the Department of Financial and Professional Regulation. In-service training shall include at least nine hours of training selected from among the following topics:

- A) responding to emergency situations, including, but not limited to, site-related emergencies (e.g., late pick-up of clients), client-related emergencies (e.g., clients leaving the site unattended), choking prevention and intervention techniques;
- B) Appropriate and safe techniques in performing and assisting with personal care;
- C) Developing and improving client centered activities;

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- D) Positive client behavior support;
- E) Promoting client dignity, independence, self-determination, privacy, choice and rights;
- F) Special characteristics of the elderly population; physical, emotional and developmental needs of the client;
- G) Recognizing client abuse, neglect and/or exploitation; abuse and neglect prevention and reporting requirements;
- H) Confidentiality of client information;
- I) Communication skills;
- J) Universal precautions, blood-borne pathogens and infection control;
- K) Fire and life safety, including emergency procedures to be implemented under the agency's all hazards disaster operations plan;
- L) Dealing with adverse behaviors; mental illness, depression, aggression and wandering;
- M) Family dynamics;
- N) Diseases of the elderly; understanding Alzheimer's Disease and dementia;
- O) Body mechanics and normal range of motion, transfer techniques and positioning;
- P) Chronic illness, death and dying;
- Q) Penalties for fraud and abuse;
- R) Cultural diversity;

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- S) Recognizing changes in bodily functions that should be reported to the supervisor;
 - T) CPR and first aid;
 - U) Understanding advance directives; and/or
 - V) Nutrition and safe food handling.
- 3) Progress toward certification in a related field (e.g., CNA) may be used for up to three hours of in-service training per calendar year.
- 3) ~~Training on universal precautions, as appropriate to the adult day service site and as required by the U.S. Department of Labor, Occupational Safety and Health Administration (29 CFR 1910.1030).~~
- 4) ~~Training on emergency procedures as delineated in Sections 240.1510(h)(5) and 240.1550(d) and (e) of this Part, respectively.~~
- e) ~~At Drivers of adult day service vehicles that transport clients, and at~~ least two program adult day service staff, shall be certified in ~~cardiopulmonary resuscitation (CPR)~~ cardiopulmonary resuscitation and trained in first aid, and at least one ~~of such~~ trained staff shall be on-site when clients are present.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 240.1560 Adult Day Service Staff

- a) The following staff shall be required of all adult day service providers (with specified exceptions):
- 1) An Adult Day Service Program Administrator shall:
 - A) Meet the following qualifications:
 - i) have a bachelor's degree in a health or human services or related field (including social or health sciences, public administration or physical education) or be a Registered Nurse or Health Services Administrator; or

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- ii) demonstrate two years of progressively responsible supervisory experience in a program serving the elderly for each year of education being replaced (up to four) in the disciplines defined in subsection (a)(1)(A)(i)~~above~~.
 - B) The responsibilities of the Administrator may be performed by the Program Coordinator/Director. If the Administrator's function is also performed by the Program Coordinator/Director, only the qualification requirements for Program Coordinator/Director apply.
- 2) An Adult Day Service Program Coordinator/Director shall:
 - A) Meet the following qualifications:
 - i) have a bachelor's degree in health or human services, social or health sciences, physical education, or related field; or
 - ii) be a Registered Nurse; or
 - iii) demonstrate two years of progressively responsible supervisory experience in a program serving the elderly for each year of education being replaced (up to four) in the disciplines defined in subsection (a)(2)(A)(i)~~above~~.
 - B) Be on duty full time when clients are in attendance or have a qualified substitute (meets or exceeds the qualifications set out in subsection (a)(2)(A)(i) through (iii)~~of this Section~~).
- 3) A program nurse shall:
 - A) be a:
 - i) Registered Nurse (RN) licensed by the State of Illinois; or
 - ii) Licensed Practical Nurse (LPN) licensed by the State of Illinois under the supervision of an RN (RN may be contractual and must meet with the LPN at least monthly to

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review plans of care and medication administration records, and be available to provide direction as needed); and

- B) be on duty at least one-half of a full-time (FTE) work period each day when clients are in attendance, either as staff or on a contractual basis.
- ~~C) With written Department approval, the responsibilities of a program nurse may be performed by the Program Coordinator/Director or Administrator.~~ If the Program Nurse function is performed by the Program Administrator or Program Coordinator/Director, that person must be full time, and must meet the qualifications for a program nurse and fulfill responsibilities for all assigned positions.
- 4) A transportation Driver/Escort (provider employed or contractual) for those adult day service contractors who provide the transportation service component shall:
- A) meet all applicable requirements of the Illinois Vehicle Code [625 ILCS 5];
- B) be certified in CPR and trained in first aid; and
- C) have the appropriate driver's license or endorsements based upon the size and type of the vehicle being driven.
- 5) Nutrition Staff:
- A) Nutrition staff (provider employed or contractual) shall include:
- i) at least one staff person who meets the Food Service Sanitation guidelines issued by the Department of Public Health.
- ii) a Nutrition Consultant/Dietitian, either paid or in-kind, who shall be licensed by the Department of Financial and Professional Regulation ~~registered member of the American Dietetic Association~~ with experience in an

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agency setting; and who shall approve menus for adult day service providers to meet requirements stated in subsection (a)(5)(B) below.

- B) The nutrition staff is responsible for providing daily meals meeting requirements specified in Section 240.230(a)(5).
- b) The following optional staff, either contractual or employed by an adult day service provider, shall meet the specified qualifications:
- 1) A social service worker shall:
 - A) be under the direction of the Program Coordinator/Director;
 - B) possess a Bachelor's degree in Social Work or a related field and have at least one year's work experience, preferably with programs for the elderly and disabled; and
 - C) if the Social Service Worker function is performed by the Program Administrator or Program Coordinator/Director, that person must be full time, and must meet the qualifications for a social worker and fulfill responsibilities for all assigned positions.
 - 2) Program assistants shall have a high school diploma or general education diploma, or two years of prior documented experience working in programs for the elderly, or demonstrate continued progress towards meeting the educational requirement of a general education diploma by current registration and evidence of successful completion of course work.
 - 3) A medical consultant shall be a Medical Doctor (M.D.) licensed to practice medicine by the State of Illinois.
 - 4) A rehabilitation consultant shall:
 - A) have a bachelor's degree from an accredited program;
 - B) be licensed, registered or certified in accordance with requirements of the State of Illinois.

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- c) The following requirements shall apply to substitutes for staff positions and/or regularly scheduled volunteers/students/student interns utilized by an adult day service provider:
- 1) the adult day service provider shall have on file information documenting the same personal, health, administrative and professional qualifications for substitutes as are required of staff for whom they act as substitutes;
 - 2) persons agreeing to be available as substitutes or for use in emergencies shall sign a written statement kept on file at the adult day service site, certifying to their availability and agreement to serve in the particular capacity. The file of each person serving in this capacity shall contain such a statement for each calendar year of availability;
 - 3) volunteers/students/student interns shall complete an application indicating their reason for participation in the program and special skills;
 - 4) volunteers/students/student interns may serve in any capacity for which they are qualified (refer to subsection (c)(1)~~above~~);
 - 5) substitutes and volunteers/students/student interns shall be supervised by the staff person supervising the function to which the volunteer or substitute is assigned;
 - 6) substitutes and volunteers/students/student interns who are not used to meet program requirements are exempt from initial and in-service training requirements.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART P: PROVIDER PROCUREMENT

Section 240.1600 Provider Agency Certification~~Contract~~

- a) All services provided to Community Care Program clients shall be delivered in accordance with contracts entered into between certified~~the~~ provider agencies and the Department. ~~The Department shall operate, for services as described in Sections 240.210 and 240.230, under procurement policies described in this Subpart.~~

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- b) For purposes of administrative efficiency, the Department may initiate the provider certification process for the CCP by a specific service, on a geographic basis, or other criteria determined by the Department.
- c) Any willing and qualified provider agency interested in the opportunity to execute a contract with the Department for the provision of CCP services shall comply with the following certification procedures:
 - 1) A provider agency requesting initial certification of qualifications shall submit, in a form and manner prescribed by the Department, material documenting the ability to comply with administrative requirements, service specifications and any other administrative or operational information required by the Department for the applicable service.
 - A) The Department shall review the material submitted and, if necessary, may request additional information and/or conduct, or authorize a designee to conduct, an on-site review in order to determine compliance.
 - B) If additional information is requested by the Department, the provider agency has 30 calendar days from the date of request to submit this information.
 - C) After 60 calendar days, the provider agency's request for certification of qualifications will be closed and all information must be resubmitted to the Department.
 - 2) Provider agencies will be notified in writing of the results of the certification request. Those provider agencies determined by the Department to be qualified will be certified for a period of no more than three years and afforded the opportunity to execute a contract for the applicable service.
 - 3) The Department, or its designee, shall conduct a recertification review of each provider agency with a valid contract no less frequently than every three years to determine continued compliance with qualifications for the applicable service. The timing of recertification reviews shall be based

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upon the timing of the initial certification (see subsection (b)) or of the most recent recertification review.

- A) The Department, or its designee, shall notify each provider agency, in writing, at least 30 calendar days prior to the recertification review to request the material required for the recertification review. Any provider agency interested in renewing its contract shall submit, in a form and manner prescribed by the Department, material documenting the continued ability to comply with the administrative requirements, service specifications, and any other administrative or operational information required by the Department for the applicable service.
 - B) Provider agencies will be notified in writing of the results of the recertification review.
 - C) Those provider agencies determined by the Department to be qualified will be recertified for a period of no more than three years and afforded the opportunity to execute renewal of the contract for the applicable service.
- 4) Other factors that may influence initial certification or recertification of qualifications include, but are not limited to:
- A) pending or current Departmental on-notice or contract action for failure to adhere to contract requirements, including a history of contract non-compliance;
 - B) notification by another governmental entity of similar contract actions or non-compliance;
 - C) legal notification of financial insolvency, criminal indictment or conviction, or other legal issues that, in the opinion of the Department, would make the award of a contract contrary to the best interest of the State;
 - D) notification of complaints by the Attorney General's office, the Better Business Bureau or other consumer protection organizations; or

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- E) the current provider agency is not in good standing with the Department.
- 5) The Department may require completion of additional disclosure statements and/or background inquiries if there is reason to believe offenses have occurred since completion of previous disclosures and background inquiries.
- 6) The Director shall represent and act for the State in all matters pertaining to the Application for Certification process and contracts awarded. The Director receives all recommendations and has the ultimate decision making authority for the award of contracts. The Director reserves the right to reject any informality in the application when, in the Director's opinion, the best interest of the State will be served by the rejection.
- 7) Any provider agency denied initial certification of qualifications or recertification for the provision of CCP services shall be afforded the opportunity to resubmit another request to the Department. The provider agency may also object to the decision in a form and manner prescribed by the Department in the written notification of denial (see Section 240.1645).
- 8) Contracts will be issued to qualified provider agencies on a schedule determined by the Department, but no more frequently than semi-annually after initial certification.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 240.1605 Emergency Certification~~Procuring Provider Services~~

- a) ~~Although the Department is not required to competitively procure purchase of care service contracts (see 30 ILCS 500/1-10(b)(3)), in order to maximize competition and ensure that the best interests of the client population are met, the Department shall, whenever possible, solicit additional service providers through use of the Request for Proposal (RFP) process described in this Subpart.~~
- 1) ~~The Department shall open selected Planning and Service Areas (PSAs) every two years in order to review program needs and determine if~~

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~~geographic areas are in need of new providers and/or services. Each PSA will be opened at least once over an eight year cycle.~~

- 2) ~~Current Community Care Program (CCP) adult day service and homemaker service providers, in good standing, who are serving in the opened PSAs, must submit renewal proposals in order to retain current contractual service areas. Renewal proposals shall give current providers the opportunity to update information and service commitments contained in the provider's current proposals.~~
 - A) ~~Good standing is defined as no imposition of contract action, as outlined in Section 240.1665, within two years from the date the selected PSA is opened for review.~~
 - i) ~~Areas served by providers who are not in good standing shall be opened for competitive procurement; and~~
 - ii) ~~Providers who are not in good standing will be required to compete for current service areas in the procurement.~~
 - B) ~~Required time frames shall be established by the Department for submission of renewal proposals. Providers shall be notified in writing of the deadline for submission of renewal proposals.~~
 - i) ~~Areas served by providers who submit an untimely renewal proposal shall be opened for competitive procurement; and~~
 - ii) ~~Providers who submit untimely renewal proposals will be required to compete for current service areas in the procurement.~~
 - C) ~~Providers who submit a renewal proposal containing reductions in current service commitments will be required to compete for current service areas in the procurement.~~
- 3) ~~After review, the Department shall open for competitive procurement those geographic areas within the selected PSAs that are:~~
 - A) ~~in need of additional providers;~~

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- ~~B) being served by providers not in good standing; or~~
 - ~~C) being served by providers who submitted renewal proposals containing a reduction in service.~~
- ~~4) The Department reserves the right to a limited selection of Counties/Sub-Areas/Regions, in addition to those selected in subsection (a)(3) when the Department determines that additional providers are needed in these areas (e.g., when the caseload increases or when an existing provider terminates a contract in the area), that may exceed the random selection for Planning and Service Areas scheduled for procurement review.~~
- ~~5) The Department shall also solicit proposals whenever the Department determines it is necessary to ensure that the best interests of the client population are met.~~
- ~~6) The deadline for submission of proposal documents shall be advertised in the official State newspaper and shall be included in the proposal package sent to all applicants.~~
- b) ~~If, after evaluation of the responses to the Request for Proposal process, the Department determines not to make an award, or if time does not permit the use of an advertised procurement action, the Department shall secure needed services through any means of selection likely to result in a contract.~~
- 1) ~~The Department shall use the following emergency contracting process to obtain CCP homemaker service.~~
 - ~~A) The Department shall contact current CCP providers of homemaker service in the emergency contracting area in order to issue temporary negotiated contracts at established fixed unit rates (refer to Subpart S of this Part).~~
 - ~~B) If a current CCP homemaker provider in the emergency contracting area will not accept a temporary negotiated contract, the Department shall subsequently contact participants in the previous CCP procurement for that area whose proposals for homemaker service were evaluated and met the minimum~~

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requirements.

- C) ~~If no participants in the previous CCP procurement will accept a temporary negotiated contract, the Department shall contact current CCP providers of homemaker service in geographic areas contiguous to the emergency contracting area.~~
- D) ~~If the Department is unable to issue a temporary negotiated homemaker contract at established fixed unit rates, the Department shall issue a temporary negotiated homemaker contract at alternative unit rates.~~
 - i) ~~The Department shall advertise to obtain sealed bids for alternative unit rates.~~
 - ii) ~~If the Department has insufficient time to solicit for alternative unit rate bids through an advertised procurement, or if the Department determines not to accept an alternative unit rate bid resulting from the formal advertised bid solicitation, verbal bids for alternative unit rates shall be solicited from current CCP providers of homemaker service in the emergency contracting area.~~
 - iii) ~~If a current CCP homemaker provider does not submit a verbal bid for an alternative unit rate, or if the Department determines not to accept an alternative unit rate bid, verbal bids shall subsequently be solicited from participants in the previous CCP procurement for that area whose submitted proposals for homemaker services were evaluated and met minimum requirements.~~
 - iv) ~~If no participants in the previous CCP procurement submit a verbal bid for alternative unit rates, or if the Department determines not to accept an alternative unit rate bid, the Department shall contact current CCP providers of homemaker service in geographic areas contiguous to the emergency contracting area in order to solicit verbal bids for alternative unit rates.~~

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- 2) ~~The Department shall secure emergency adult day service through any means of selection likely to result in a contract.~~
- 3) ~~Contracts issued shall be effective until the County/Sub-Area/Region is opened for a scheduled eight year procurement cycle.~~
- e) The Department shall obtain CCP~~procure~~ services ~~through the emergency contracting process or~~ through any ~~other~~ means of selection likely to result in provider certification and subsequent issuance of a contract under the following circumstances:
- 1) service is immediately needed to prevent interruption of services to current clients; and/or
 - 2) service is immediately needed to protect a client's health, safety or welfare; and/or
 - 3) service is of such a nature or the market place is such that only one provider is reasonably capable and willing to perform the requisite services; and/or
 - 4) to establish new or additional services in an area in which the Department has determined an underserved population exists.
- b) The Department shall assure, to the extent possible, through the certification process, that any provider selected under the emergency circumstances included in subsection (a) is qualified to provide CCP services and that the health, safety and welfare of clients are protected.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 240.1615 Contractual Service Area Modifications

- a) To request approval to modify a contractual service area, a certified provider agency must submit in writing to the Department a plan of the proposed expansion or reduction and the revised boundaries of the agency's original service area.

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- b) The Department may approve or deny requests for contractual service area modification based upon one or more of the following reasons:
- 1) demonstrated ability or inability to comply with standards as illustrated by substantiated complaint history, review reports or prior contract actions;
 - 2) evidence of ability or inability to manage and supervise services throughout the current contractual service area;
 - 3) disruption of client care;
 - 4) failure to assure client freedom of choice; or
 - 5) failure to act in the best interest of the clients or the CCP.
- c) If the Department approves the service area modification, the provider agency's contract shall be amended to include the modified contractual service area.
- d) An agency shall provide a minimum of 60 days' notice to the Department prior to the proposed effective date of a contractual service area reduction.

(Source: Added at 32 Ill. Reg. _____, effective _____)

Section 240.1620 Issuance of Provider Proposal and Guidelines (Repealed)

- a) ~~Department procurement actions shall be advertised in the Official State Newspaper, except as specified in the emergency contracting process (refer to Section 240.1605(b)).~~
- 1) ~~Advertisements shall appear at least 3 times with the first and last advertisement at least 10 calendar days apart.~~
 - 2) ~~Advertisements shall indicate, specifically or in general, the Department's needs, while inviting individuals/agencies to request the Provider Proposal and Guidelines (refer to Section 240.1625).~~
- b) ~~The Department shall establish and maintain a mailing list of individuals/agencies who are interested in providing applicable services and have demonstrated that interest, in writing, to the Department.~~

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- 1) ~~All individuals/agencies on this mailing list will be notified of the Department's advertised procurement action. The Department shall send the Provider Proposal and Guidelines to all individuals/agencies who request these documents.~~
- 2) ~~The mailing list shall be maintained by the Department until the deadline for submission of proposals for the next scheduled procurement.~~
- 3) ~~Following the deadline for submission of proposals, individuals/agencies must again request, in writing, placement on the mailing list for the next advertised procurement action.~~
- e) ~~All current contractors will be notified of the Department's intent to procure.~~
 - 1) ~~The Department shall send the Provider Proposal and Guidelines to all current contractors who request these documents.~~
 - 2) ~~The Department shall ensure that the Provider Proposal and Guidelines are issued to current contractors whose service and service area are open for solicitation in the advertised procurement action.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 240.1625 Content of Provider Proposal and Guidelines (Repealed)

- a) ~~The Department Guidelines for Completion of the Provider Proposal shall contain the necessary information to enable a prospective provider to prepare a proposal, including:~~
 - 1) ~~a clear and accurate description of the service to be provided;~~
 - 2) ~~the submission process;~~
 - 3) ~~the review process;~~
 - 4) ~~general contract and competitive information;~~
 - 5) ~~the date, time and address of any bidders' conferences, when applicable;~~

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- ~~6) Department contact person;~~
- ~~7) evaluation factors and the weighting of those factors.~~
- b) ~~The Provider Proposal consists of the questions and requested attachments to be completed by the applicant and returned to the Department for consideration and scoring.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 240.1630 Criteria for Number of Provider Contracts Awarded (Repealed)

~~The Department will establish in advance, and publish in the official State newspaper, the notice of the Request for Proposal (RFP) for services and the Counties/Sub Areas/Regions to be opened for solicitation.~~

- a) ~~In each County/Sub Area/Region, the Department prefers to contract with at least 2 providers of homemaker service.~~
 - ~~1) If the Department determines that one provider is sufficient to provide adequate service to Community Care Program clients in a County/Sub Area/Region, or if the caseload size is not sufficient to support 2 providers in a County/Sub Area/Region, the Director may determine that it is in the best interests of the Community Care Program to contract with a single provider in a County/Sub Area/Region.~~
 - ~~2) Additional providers will be contracted with, on an as needed basis, to ensure that the best interests, as determined by the Department, of the client population are met.~~
- b) ~~The Department will not set any minimum or maximum number of adult day service contracts to be awarded within any County/Sub Area/Region and will entertain proposals for adult day service for a portion of a specified County/Sub Area/Region.~~
- e) ~~The Department may contract with additional providers in a contract area when it is demonstrated that the special needs of a racial and/or language minority and/or other population residing within that contract area can best be met by additional~~

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providers.

- d) ~~At no time can a provider serving an unrestricted contract area also serve a restricted contract area in the same County/Sub-Area/Region.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 240.1635 Evaluation of Provider Proposals (Repealed)

- a) ~~When determining if an applicant shall be awarded a contract, the Department shall evaluate the Provider Proposal. The quality criteria scored in the Provider Proposal are:~~
- 1) ~~Current community experience and history of comparable service provision in the solicited area;~~
 - 2) ~~Community board or ownership participation;~~
 - 3) ~~Optional service components;~~
 - 4) ~~Training of staff; and~~
 - 5) ~~Administration.~~
- b) ~~The Provider Proposal, containing items 1 through 5 in subsection (a) shall be scored by a Review Committee designated by the Director.~~
- e) ~~A proposal that does not respond to all requirements shall be deemed unresponsive and shall not be considered by the Department.~~
- d) ~~All proposals shall be considered as submitted and may not be amended or revised except as determined by the Department, in order to ensure adherence to rules and proposal commitments or upon submission by the applicant of supportive evidence of an apparent clerical mistake or informality disclosed prior to notification of award determination.~~
- 1) ~~The Director reserves the right to reject any informality in the proposal when, in the Director's opinion, the best interest of the State will be served by the rejection.~~

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- 2) ~~No corrections by the applicant shall be permitted to make unresponsive proposals responsive.~~
- 3) ~~Allowable administrative corrections will be made by the Department within 7 calendar days from the date of receipt of supportive documentation (e.g., work papers).~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 240.1640 Determination and Notification of Provider Awards (Repealed)

- a) ~~The Director shall represent and act for the State in all matters pertaining to the Request for Proposal (RFP) process and contracts awarded. The Director receives all scores, recommendations and has the ultimate decision making authority for the award of contracts.~~
- b) ~~After the evaluation of proposals has been completed, the Department shall notify each applicant, in writing, of the Department's intent to contract with the applicant or intent to reject the applicant's proposal.~~
- e) ~~The Department shall also provide all applicants with a copy of their individual score sheet and a copy of the score sheet received by any successful competitor in direct competition with the applicant. If the award decision included consideration of factors in addition to or other than score, a rationale statement also will be provided to applicants (e.g., event of a tie score). The notice and score sheet(s) shall be sent by certified mail, return receipt requested.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 240.1645 Objection to Certification Decision~~Procurement Action Determination~~

- a) A provider may file an objection in limited circumstances if a certification request is denied by the Department.
- b) Examples of circumstances that do not constitute an appealable basis for objection include:
 - 1) timing of initiation of certification process by the Department;

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- 2) termination of eligibility due to a provider's failure to comply with time frames for submitting a certification request under Section 240.1600(b);
- 3) review of new supporting documentation to establish eligibility for certification or recertification as a service provider under the CCP;
- 4) issues upon which the Department has already made a final administrative decision as a result of a previous objection or contract action involving the provider;
- 5) issues upon which an independent trier of fact has made a final determination or issued an order on a matter being appealed;
- 6) disputes as to service rates or the underlying methodology for calculating such rates;
- 7) duration of a service provider certification;
- 8) timing of the contract issuance process by the Department; or
- 9) other matters of general applicability that are not specifically adverse to the provider.

ca) Upon receipt of written notification of the Department's intent to contract or intent to reject the applicant's request for certification proposal (refer to Section 240.1600~~240.1640~~), the applicant may object to the certification decision~~procurement action~~.

- 1) An objection regarding a certification decision~~procurement action~~ must be in writing and must be received at the Department's Springfield office on or before the tenth calendar day from the date of the applicant's receipt of the notice of the objectionable action. If the objection is not received before the close of business on the tenth calendar day, ~~as specified above,~~ the objection shall be disregarded.
- 2) Each objection must contain a full and concise statement of the facts and circumstances of the action ~~that which~~ is alleged to be objectionable, legally or otherwise, and a statement of the relief sought. ~~The objection~~

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~~must pertain to points awarded on the applicant's Proposal or on a competitor's Proposal or to the rationale statement (refer to Section 240.1640(c)).~~

- A) The Department may request additional details at any time.
- B) Failure to supply any information requested by the Department will be cause for dismissal of the objection.

~~db)~~ Upon receipt of written objection, the Department shall immediately review the ~~certification decision~~~~procurement action~~ in question and shall issue a written response. The ~~certification decision~~~~procurement action~~ shall not be considered final until any relevant objections are resolved.

~~ee)~~ The decision of the Director is final and shall be sent by certified mail, return receipt requested, or by any other means that allows the Department to document and confirm receipt by the applicant of the decision.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

- 1) Heading of the Part: Service Quality and Customer Protection Applicable to Wireless Eligible Telecommunications Carriers
- 2) Code Citation: 83 Ill. Adm. Code 736
- 3)

| <u>Section Numbers:</u> | <u>Proposed Action:</u> |
|-------------------------|-------------------------|
| 736.100 | New Section |
| 736.105 | New Section |
| 736.110 | New Section |
| 736.115 | New Section |
| 736.120 | New Section |
| 736.300 | New Section |
| 736.305 | New Section |
| 736.310 | New Section |
| 736.500 | New Section |
| 736.505 | New Section |
| 736.510 | New Section |
| 736.515 | New Section |
| 736.520 | New Section |
| 736.525 | New Section |
| 736.530 | New Section |
| 736.540 | New Section |
| 736.550 | New Section |
| 736.555 | New Section |
| 736.610 | New Section |
| 736.620 | New Section |
| 736.630 | New Section |
| 736.640 | New Section |
| 736.650 | New Section |
| 736.660 | New Section |
| 736.670 | New Section |
| 736.680 | New Section |
| 736.685 | New Section |
| 736.690 | New Section |
| 736.695 | New Section |
| 736.700 | New Section |
| 736.705 | New Section |
| 736.710 | New Section |
| 736.APPENDIX A | New Section |

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736.APPENDIX B New Section

- 4) Statutory Authority: Implementing Sections 13-101, 13-304, 13-305, and 13-712 and authorized by Section 10-101 of the Public Utilities Act [220 ILCS 5/13-101, 13-304, 13-305, 13-712, and 10-101]
- 5) A Complete Description of the Subjects and Issues Involved: These proposed rules set out the service quality standards and the consumer protection requirements for those wireless telecommunications carriers that are eligible for federal universal service support pursuant to section 214(e)(2) of the Telecommunications Act of 1996. Among other items, the proposed rules provide engineering standards, payment options, and application and shut-off procedures.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this proposed rulemaking contain incorporations by reference? Yes
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: These proposed rules neither create nor expand any State mandate on units of local government, school districts, or community college districts.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments should be filed, within 45 days after the date of this issue of the *Illinois Register* in Docket 06-468, with:

Chief Clerk
Illinois Commerce Commission
527 East Capitol Avenue
Springfield IL 62701

217/782-7434

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- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: This rulemaking will affect any subject jurisdictional entities that are also small businesses as defined in the Illinois Administrative Procedure Act. These proposed rules will not affect any small municipalities or not for profit corporations.
 - B) Reporting, bookkeeping or other procedures required for compliance: Reporting
 - C) Types of professional skills necessary for compliance: Managerial and engineering skills
- 14) Regulatory Agenda on which this rulemaking was summarized: January 2008

The full text of the Proposed Rules begins on the next page:

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TITLE 83: PUBLIC UTILITIES
CHAPTER I: ILLINOIS COMMERCE COMMISSION
SUBCHAPTER f: TELEPHONE UTILITIES

PART 736

SERVICE QUALITY AND CUSTOMER PROTECTION APPLICABLE TO
WIRELESS ELIGIBLE TELECOMMUNICATIONS CARRIERS

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| 736.115 | Reporting |
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| 736.505 | Answering Time |
| 736.510 | Interoffice Trunks |
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SUBPART D: OTHER WETC REQUIREMENTS

Section

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| 736.550 | Obligation to Serve |
| 736.555 | Maps |
| 736.610 | Customer Billing |
| 736.620 | Deferred Payment Agreements |
| 736.630 | Applicants for Service |
| 736.640 | Present Customers |
| 736.650 | Deposits |
| 736.660 | Discontinuance or Refusal of Service |
| 736.670 | Illness Provision |
| 736.680 | Payment for Service |
| 736.685 | Past Due Bills |
| 736.690 | Service Restoration Charge |
| 736.695 | Dispute Procedures |
| 736.700 | Commission Complaint Procedures |
| 736.705 | Second Language |
| 736.710 | Customer Information Booklet |

736.APPENDIX A Notice of Discontinuance of Service

736.APPENDIX B Requirements to Avoid Shutoff of Service in the Event of Illness

AUTHORITY: Implementing Sections 13-101, 13-304, 13-305 and 13-712 and authorized by Section 10-101 of the Public Utilities Act [220 ILCS 5/13-101, 13-304, 13-305, 13-712 and 10-101].

SOURCE: Adopted at 32 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL

Section 736.100 Application of Part

This Part shall apply to all wireless eligible telecommunication carriers (WETC) offering or providing either competitive or noncompetitive telecommunications services as defined in Sections 13-209 and 13-210 of the Public Utilities Act [220 ILCS 5/13-209, 13-210]. This Part shall only apply to the relationship between a serving WETC and its end user. This Part shall not apply to the relationship between a serving WETC that provides wholesale facilities or services to another serving WETC for provisioning of services to its retail end user customers.

Section 736.105 Definitions

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As used in this Part, the following terms shall have these definitions:

"Act" means the Public Utilities Act [220 ILCS 5].

"Answer time" means a measurement in seconds from the point the carrier's telephone system receives the call until the call is answered by the carrier's representative or voice response unit and is ready to accept information. When the carrier uses a menu-driven system, the measurement begins once the menu-based system has transferred the customer into the carrier's telephone system until the call is answered by the carrier's representative.

"Assistance calls" means calls in which the operator provides assistance or instructions to the customer. Examples include rate quotes, credit requests, trouble reports, dial assistance, and dialing instructions.

"Business office" means those offices of the carrier where calls are answered and made. A business office typically employs representatives to assist customers for order entry and lookup on customers' orders and account records through the use of a computerized system.

"Busy hour" means the two consecutive half-hours each day during which the greatest volume of traffic is handled.

"Commission" means the Illinois Commerce Commission.

"Customer" means any person, building owner, firm, partnership, corporation, municipality, cooperative, organization, governmental agency, etc., provided with WETC telecommunications services as defined in Section 13-204 of the Act.

"Customer" may also be referred to as "end user."

"Customer premises equipment" or "CPE" means the equipment utilized by the customer to gain access to the wireless carrier's network – see "Handset".

"Dropped calls" means a wireless mobile phone call that is terminated unexpectedly and in the absence of disconnection initiated by either party to the call.

"Emergency situation" means a single event that causes an interruption of service or installations affecting end users of a WETC. The emergency situation shall

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begin with the first end user whose service is interrupted by the single event, and shall end with the restoration or installation of the service of all affected end users. The term single event shall include:

a declaration made by the applicable State or federal governmental agency that the area served by the WETC is either a State or federal disaster area;
or

an act of third parties, including acts of terrorism, vandalism, riot, civil unrest, or war, or acts of parties that are not agents, employees or contractors of the WETC; or

a severe storm, tornado, earthquake, flood or fire, including any severe storm, tornado, earthquake, flood or fire that prevents the WETC from restoring service due to impassable roads, downed power lines, or the closing off of affected areas by public safety officials.

The term "emergency situation" shall not include:

a single event caused by high temperature conditions alone; or

a single event caused, or exacerbated in scope and duration, by acts or omissions of the WETC, its agents, employees or contractors or by the condition of facilities, equipment, or premises owned or operated by the WETC; or

any service interruptions that occur during a single event listed in this definition, but are not caused by those single events; or

a single event that the WETC could have reasonably foreseen and taken precaution to prevent; provided, however, that in no event shall a WETC be required to undertake precautions that are technically infeasible or economically prohibitive.

This Part shall be construed as being content neutral as to whether a strike or other work stoppage is an "emergency situation". In the event of a strike or other work stoppage, the WETC's obligations to provide remedies for failure to comply with this Part shall, in the absence of a decision by a court of competent jurisdiction, be determined by the Commission on a case-by-case

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basis based upon the individual factual circumstances of each strike or other work stoppage. In making such a determination, and notwithstanding the definition of "emergency situation", the Commission shall not presume that a strike or other work stoppage is an act of an employee or of the WETC.

"End user" means any person, building owner, firm, partnership, corporation, municipality, cooperative, organization, governmental agency, etc., provided with WETC regulated telecommunications service for consumption, not for resale, as defined in Section 13-204 of the Act. "End user" may also be referred to as "customer".

"Handset" means the device employed by the end user to originate, route or terminate regulated telecommunications service over the WETC network. For the purposes of this Part, handsets are considered to be the equivalent of customer premises equipment (CPE), beyond the regulatory authority of the Commission, and subject to the terms and conditions of a contract or warranty involving the manufacturer, WETC and end user.

"Information call" means a call in which a customer will be connected to an information bureau by dialing the proper service code or number and will be given the directory number of the customer whom he or she desires to call, provided that the customer's number to be called is or will be published or listed in the information records. An "information call" is also referred to as directory assistance.

"Map" means a drawing showing a geographical area in which a WETC furnishes regulated telecommunications services.

"Regulated telecommunications service" means the ability to transmit and receive voice service over the WETC's network at the end user's residence or business location, as identified by the billing or designated address of the account. Regulated telecommunications service refers to Commission regulation, and does not include WETC network performance in other service territories (e.g., roaming) or from other cellular towers at locations away from the billing or designated address.

"Repair office" means an office to handle customers' reported telephone facility problems. Customers may call to request trouble verification tests, initiate trouble reports and obtain information on the status of open trouble reports.

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"Reporting entity" means a unit established by the WETC for the purpose of administering the customer service operations established by this Part.

"Signal strength" means the measure of how strongly a transmitted signal is being received, measured or predicted, at a reference point that is a significant distance from the transmitting antenna, measured in dB-microvolts per metre (dB μ V/m).

"Traffic" means call volume based on number and duration of messages.

"Trouble report" means any verbal or written report relating to difficulty or dissatisfaction with the operation of regulated telecommunications services to the WETC regarding the operation of the network affecting their regulated telecommunication service, including both service-affecting conditions or out of service conditions. One report shall be counted for a verbal or written report received. When several items are reported by one customer at the same time, and the group of troubles so reported is clearly related to a common cause, they are counted as one report.

"Wireless Eligible Telecommunications Carrier" or "WETC" means a wireless telecommunications carrier that has been designated by the Commission as eligible to receive federal universal service funds.

Section 736.110 Waivers

The Commission, on application of a company, customer, applicant or end user, or on its own motion, may grant a temporary or permanent waiver from this Part, or any subsections contained in this Part, in individual cases in which the Commission finds, after notice and hearing, that:

- a) The provision from which the waiver is granted is not statutorily mandated;
- b) No party will be injured by the granting of the waiver; and
- c) The rule from which the waiver is granted would, as applied to the particular case, be unreasonable or unnecessarily burdensome.

Section 736.115 Reporting

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- a) All reports required to be submitted to the Chief Engineer, Telecommunications Division of the Commission under this Part shall be verified by an authorized agent of the reporting carrier.
- b) Each WETC shall provide annually on July 1 to the Chief Engineer a service quality and consumer protection report consisting of information relative to the following Sections: Section 736.505(a), Operator Answer Time; Section 736.505(b), Business and Repair Answer Time; Section 736.515, Dropped Calls and Signal Strength; Section 736.520, Service Outages; Section 736.525, Installation Requests – Failure to Provide Service; and Section 736.530, Trouble Reports.

Section 736.120 Enforcement

Upon complaint or its own motion, the Commission may find, pursuant to a proceeding conducted under the authority of Section 10-101 of the Act, that a WETC has not met the requirements or standards established in this Part. Upon such a finding, the Commission may impose monetary penalties in its discretion under the authority granted it under the Act or choose to withdraw or withhold its positive recommendation, certification or designation to the Federal Communications Commission (FCC) regarding the WETC's eligibility to receive universal service funding.

SUBPART B: ENGINEERING

Section 736.300 Construction and Maintenance of Plant and Equipment

The WETC's outside plant shall be designed, constructed, maintained and operated in accordance with the provisions of 83 Ill. Adm. Code 305 and 265.

Section 736.305 Emergency Operation

- a) Each WETC shall make provisions to meet emergencies resulting from failures of commercial or power service, sudden and prolonged increases in traffic, illness of personnel, or fire, storm or other natural disasters. Each WETC shall inform employees as to procedures to be followed in the event of an emergency in order to prevent or minimize interruption or impairment of regulated telecommunications service.

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- b) Each WETC shall deploy backup battery power and permanent generators at all mobile telephone switching offices (MTSOs), and sufficient backup power at each cellular tower to permit a portable generator to be timely deployed in extended power outages. MTSO batteries shall be maintained in accordance with Institute of Electrical and Electronic Engineers (IEEE) standards as adopted in Section 736.310(b), and records verifying such maintenance shall be kept on site.

Section 736.310 Incorporation of National Codes and Standards

- a) The Commission adopts as its rules the following portions of the National Electric Safety Code (NESC) (1997 edition, approved June 6, 1996, published by the Institute of Electric and Electronic Engineers, Inc. (IEEE), 345 East 47th Street, New York, New York 10017):
 - 1) Section 2 (Definitions of Special Terms).
 - 2) Section 9 (Grounding Methods of Electric Supply and Communications Facilities).
- b) The Commission adopts as its rules the following publications of the IEEE:
 - 1) IEEE Std 1188-1996 (August 20, 1996), Institute of Electrical and Electronics Engineers, Inc., 3 Park Avenue, New York NY 10016-5997, Recommended Practice for Maintenance, Testing, and Replacement of Valve-Regulated Lead-Acid (VRLA) Batteries for Stationary Applications.
 - 2) IEEE Std 450-1995 (May 31, 1995), Institute of Electrical and Electronics Engineers, Inc., 3 Park Avenue, New York NY 10016-5997, Recommended Practice for Maintenance, Testing and Replacement of Lead Acid Batteries for Stationary Applications.
- c) These incorporations do not include any later amendments or editions.

SUBPART C: STANDARDS OF QUALITY OF SERVICE

Section 736.500 Adequacy of Service

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Each WETC shall comply with the applicable service quality and consumer protection provisions contained in the Cellular Telecommunications and Internet Association's (CTIA) Consumer Code for Wireless Service, except that compliance with Section Nine of that Code is not required by this Part. The Commission adopts the version in effect on January 25, 2007. The CTIA Code may be viewed on the Commission's web site at: <http://www.icc.illinois.gov>. This incorporation does not include any later amendments or editions.

Section 736.505 Answering Time

- a) Operator Offices
 - 1) Operator offices shall be staffed so that the average answer time, calculated on a monthly basis, shall not exceed 10 seconds for the following types of calls:
 - A) toll and assistance; and
 - B) information.
 - 2) Whenever the average answer time for either toll and assistance calls and/or information calls, calculated on a monthly basis, exceeds 10 seconds, the WETC shall take corrective action and report that action to the Commission within 15 business days after the end of the month in which the violation occurred.
- b) Business and Repair Offices
 - 1) Business offices (during normal business hours) and repair offices shall be staffed so that the average answer time, calculated on a monthly basis, shall not exceed 60 seconds. When a menu driven, automated or interactive system is utilized to answer any such call, the system shall provide, within the first menu of options, the option of transferring to a live attendant. This requirement shall apply separately to business offices and repair offices, if they are maintained separately.
 - 2) Whenever the average answer time for either business offices or repair offices (if maintained separately), calculated on a monthly basis, exceeds 60 seconds, the WETC shall take corrective action and report that action to the

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Commission within 15 business days after the end of the month in which the violation occurred.

- 3) WETCs shall maintain records of answer time performance at their business offices and repair offices. At a minimum, these records shall contain the following information collected on a monthly basis:
 - A) Total number of calls received;
 - B) Total number of calls answered; and
 - C) Average answer time.
- c) For purposes of this Section, "average answer time" shall be calculated by dividing the total number of call waiting seconds by the total number of reported monthly calls answered.

Section 736.510 Interoffice Trunks

- a) WETC facilities shall be engineered so that at least 98% of calls shall not encounter an All Trunks Busy (ATB) condition and at least 98% of properly dialed calls, during the busy hour, shall receive ringing signal or station busy tone on the first attempt. When the completion rate falls below 98% for three consecutive months, corrective action shall be initiated and that action reported to the Commission.
- b) For purposes of subsection (a), the information required to be reported shall be calculated by capturing total call attempts and calls that do not encounter an ATB condition that are going through trunk groups controlled by the reporting entity during the busy hour. Calls that do not encounter an ATB condition should be divided by Total Trunk Attempts to derive the percent of calls completed without encountering an ATB.

Section 736.515 Dropped Calls and Signal Strength

In their annual filing to the Chief Engineer, Telecommunications Division of the Commission, WETCs will provide information regarding both dropped calls and signal strength. This information should support a conclusion that planned development areas are experiencing

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operational problems, and that additional investment from the universal service fund will provide tangible benefit to end users.

Section 736.520 Service Outages and Notification

- a) All WETCs shall notify the Commission that they have experienced, on any facilities that they own, operate, lease or otherwise utilize, an outage of at least 30 minutes duration:
 - 1) Of a Mobile Switching Center (MSC);
 - 2) That potentially affects at least 900,000 user minutes of telephony;
 - 3) That affects at least 1,350 DS3 minutes;
 - 4) That potentially affects any special offices and facilities; or
 - 5) That potentially affects a 9-1-1 special facility, in which case they also shall notify, as soon as possible by telephone or other electronic means, any official who has been designated by the management of the affected 9-1-1 facility as the provider's contact person for communications outages at that facility, and they shall convey to that person all available information that may be useful to the management of the affected facility in mitigating the effects of the outage on callers to that facility.
- b) Each WETC shall notify the Commission of any service interruption described in subsection (a). The notification shall be made via telephone call to (217)558-6166 and shall consist of the following information:
 - 1) Affected Area Code/Prefix;
 - 2) Company name;
 - 3) Cause of interruption;
 - 4) Outage date and time;
 - 5) Restoration date and time;

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- 6) Effect on 9-1-1 service; and
 - 7) Name and number of person reporting the service interruption.
- c) A follow-up written report shall be provided to the Chief Engineer of the Telecommunications Division within 30 days after the service interruption, either via U.S. Postal Service, facsimile or e-mail.

Section 736.525 Installation Requests – Failure to Provide Service

WETCs shall annually report failures to provide service. The report shall include detailed information on the number of requests for service from applicants within its designated service areas that were unfulfilled for the reporting period. The WETC shall also describe its attempts to provide service to those applicants, and any investment plans that may mitigate the problem in the future.

Section 736.530 Trouble Reports

- a) WETC's shall annually compile and report trouble reports. The report shall provide separate totals for the number of complaints that the WETC's customers made to the FCC, as well as to its own network repair centers. The report shall also generally describe the nature of the complaints and outcome of the carrier's efforts to resolve the complaints. Trouble reports related to customer problems with handsets are not to be included in the calculation of WETC trouble reports.
- b) For purposes of maintaining records or reporting information relating to the requirement set forth in subsection (a), the information required to be so maintained or reported shall be calculated by dividing the number of customer-initiated network trouble reports in any given month that are cleared to network dispositions, less handset troubles, or emergency situations, by the total number of access lines in service. The rate shall be reported on a per 1000 access line basis.

Section 736.540 Directory Notification

WETCs shall, prior to entering into a contract with a customer, or prior to the conclusion of any applicable trial period, provide a written disclosure to the customer explaining that it will not provide a telephone directory to the customer, and that the customer's telephone number will not be published in any telephone directory. This disclosure and acknowledgment shall be made in a type face of 10-point or larger, and shall be otherwise clear and conspicuous.

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SUBPART D: OTHER WETC REQUIREMENTS

Section 736.550 Obligation to Serve

A WETC shall offer the nine services and functions that are supported by federal universal service support mechanisms, identified in the FCC's rules at 47 CFR 54.101(a) as of October 1, 2006, using either its own facilities or a combination of its own facilities and resale of another carrier's services (including the services offered by another eligible telecommunications carrier), upon a reasonable request for that service. The incorporation of federal rules in this Section does not include any later amendments or editions.

Section 730.555 Maps

- a) Each WETC shall have on file with the Commission a map of its designated ETC service area.
- b) A map filed after the effective date of this Part shall be in accordance with the WETC's ETC designation.
- c) Each map shall show the boundary lines of the area the WETC holds itself out to serve. Boundary lines shall be located by appropriate measurement to an identifiable location if that portion of the boundary line is not otherwise located on section lines, waterways, railroads or roads.
- d) The name of the WETC filing the map shall be placed at the left side of the top of the map, and the name of the exchange followed by the words "(Name of carrier) ETC Service Area" shall be placed at the right side of the top of the map. The first filing of a map shall be designated by the word "Original" placed just below the words "(Name of carrier) ETC Service Area Boundary Map". If the map is subsequently refiled, the words "First Revisions" shall be substituted for the word "Original", and on each subsequent refiling the next higher number shall be substituted for the ordinal preceding the word "Revision" on the last map filed. The docket number and the date of the order granting ETC Status shall also appear at the right side near the top of the map.
- e) Each WETC shall maintain and make available for public inspection a map of its ETC service area.

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Section 736.610 Customer Billing

- a) A WETC shall issue bills to customers on a monthly basis. Bills shall be itemized as set forth in subsection (b) of this Section.
- b) Itemization of charges
 - 1) All bills shall contain an itemization of charges. Itemization of every monthly billing shall include, but not be limited to:
 - A) the phone number of the appropriate WETC business office;
 - B) the due date of the bill; and
 - C) the separate listing of the following:
 - i) federal, State and local taxes; and
 - ii) federal universal service charges.
 - 2) Upon request, a WETC shall provide its customers with an itemization of service and equipment charges once every calendar year free of charge. This itemization shall also include the phone number of the local WETC business office that the customer may contact to receive further information concerning the service and equipment charges listed on the itemization.
- c) Customer bills sent through the United State mail shall be in envelopes and shall include return envelopes for payment of customer bills, unless the customer has elected to pay the bill electronically.
- d) Unbilled Service
 - 1) Bills for service supplied by a WETC must be rendered within one year after the date the service was supplied. No customer shall be liable for any amount of unbilled service after one year. A WETC is not restricted to this one year limitation on unbilled service if a WETC has reason to believe that the customer used a device or scheme to obtain service

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without payment and if the WETC has so notified the customer prior to disconnection.

- 2) When delinquency occurs following the issuance of a bill for previously unbilled service, except when the customer has avoided payment as described in subsection (d)(1), a WETC shall review the bill with the customer, and shall offer to accept payments toward the liquidation of the amount of unbilled service over a period mutually agreed to by the WETC and customer. This period of time shall be at least as long as the period over which the unbilled or underbilled service was provided.
- e) Refunds
- 1) In the event that a customer pays a bill as submitted by a WETC and that billing is later found to be incorrect due to an error in charging more than the published rate, in measuring the quantity or volume of service provided, or in charging for the incorrect class of service, the WETC shall refund the overcharge from the date of overpayment by the customer.
 - 2) The refund shall be accomplished by a credit on a subsequent bill for the WETC's service, or by check if the account is final.
 - 3) Interest on any refund shall be at the rate set by the Commission pursuant to 83 Ill. Adm. Code 735.120.
- f) If the WETC offers electronic billing, customers may elect to have their bills sent electronically. Electronic bills shall be transmitted with instructions for payment. Information sent electronically shall be deemed to satisfy any requirement in this Part that the information be printed or written on a customer bill. Bills rendered in accordance with this Section may be paid electronically, provided that nothing in this Section shall be construed to prevent a WETC from accepting payment electronically or by the use of a customer-preferred financially accredited credit or debit methodology.

Section 736.620 Deferred Payment Agreements

- a) Customers who are indebted to a WETC for past due service shall have the opportunity to make arrangements with the WETC to retire the delinquent amount by periodic payments (a Deferred Payment Agreement or DPA). All applicants

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for service and customers who have failed to make payment under a DPA during the past 12 months, who are indebted to a WETC for past due service, may have the opportunity, at the discretion of the WETC, to make arrangements to retire the debt by DPA.

- b) The terms and conditions of a DPA shall be determined by a WETC after consideration of the following:
 - 1) size of the past due account;
 - 2) customer's or applicant's ability to pay;
 - 3) customer's or applicant's payment history;
 - 4) reasons for the delinquency; and
 - 5) any other relevant factors relating to the circumstances of the customer's or applicant's service.
- c) The WETC shall allow the customer or applicant a minimum of four months from the date of the agreement in which to complete payment pursuant to a DPA.
- d) A DPA shall be in writing, with a copy provided to the applicant or customer, and shall conform to the following requirements:
 - 1) the applicant or customer shall be required to pay all future bills for the WETC's service by the due date; and
 - 2) the applicant or customer shall retire the delinquent amount according to the terms of the DPA.
- e) If an applicant or customer defaults upon any payment due under the DPA, all amounts owed pursuant to the agreement become payable immediately and a WETC shall have the right to discontinue service, pursuant to proper notice.

Section 736.630 Applicants for Service

- a) In addition to the disclosures required in the CTIA Consumer Code for Wireless Service, incorporated by Section 736.500, each WETC shall disclose in collateral

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or other disclosures at point of sale, or conclusion of any applicable trial period, all of the services and service plans it offers customers in its ETC area, including the rates and terms and conditions of those services and service plans.

- b) As a part of the first bill rendered for service to a new customer, a WETC shall provide the customer with a listing of all services and telephone equipment that shall be provided to that customer, with an itemization of any applicable monthly charges. If the customer notifies the WETC within 20 days after receiving his/her first bill that the customer does not desire to receive certain services or equipment, the WETC will delete those services or equipment from the customer's account. The customer shall be responsible for all monthly usage and installation charges incurred for the use of the service and equipment.
- c) A WETC shall establish a written procedure governing requirements for establishment of credit, available upon request.
- d) Credit Information
 - 1) If an applicant for service is unable to provide satisfactory credit information, the WETC shall offer to provide prepaid service or offer to provide service upon the payment of a deposit, pursuant to Section 736.650.
 - 2) If the verification of credit provides unsatisfactory credit information, the applicant will be informed of the reason or reasons, and if the applicant so requests, the WETC shall provide these reasons in writing to the applicant. Thereafter, the WETC may refuse to provide or continue service until the customer provides a deposit pursuant to Section 736.650. Alternatively, the WETC may offer prepaid service options

Section 736.640 Present Customers

- a) A WETC may request that the customer pre-pay for service or may request a deposit, pursuant to Section 736.650, from any customer during any 12 months that a customer receives service if the customer, during that period, pays late four times or has service discontinued for nonpayment two times.

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- b) A WETC requesting that the customer pre-pay for service or requesting a deposit for any of the reasons stated in this Section shall make that request within 45 days after the occurrence of the event giving rise to the request.
- c) A present customer whose service is terminated for nonpayment becomes an applicant for service and will be subject to the provisions of Section 736.630 for purposes of establishing service.

Section 736.650 Deposits

Conditions under which a WETC may request a deposit from applicants for service are set out in Section 736.630.

- a) Nothing in this Section shall prevent a WETC from offering pre-paid service options in lieu of requesting a deposit in order to provide service.
- b) The WETC shall establish a written procedure governing the methods by which deposits shall be calculated, available upon request. The amount of the deposit may be adjusted at the request of the customer, applicant or WETC at any time when the character or degree of use of the service materially changes or when it is clearly established that the character or degree of use of the service will materially change in the immediate future. The written procedure governing the methods by which deposits shall be calculated shall be based on objective criteria and the amount of deposits requested shall be reasonably related to the expected obligation of the customer for the service options available. The estimated deposit for an applicant may take into consideration past billing history for service of another company if service was provided within the State of Illinois and within 6 months after the application.
- c) A WETC may request that the requested deposit from any customer be paid before service is activated.
- d) Refund of Deposits
 - 1) Deposits plus interest shall be automatically refunded after being held for 12 months, so long as:
 - A) the customer has paid any past due bill for service owed to the same WETC;

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- B) service has not been discontinued for nonpayment;
 - C) the customer has not paid late four times; or
 - D) the WETC has not provided evidence that the customer used a device or scheme to obtain service without payment.
- 2) If the WETC does not return a customer's deposit after 12 months, the WETC shall provide the customer with the reasons the deposit is being retained, if the customer so requests.
- e) Deposits plus interest shall be refunded when service has been terminated for more than 30 days, less the amount of any unpaid bills for that service. When a deposit plus interest is applied to the liquidation of unpaid bills, the WETC shall provide the customer with a statement showing the amount of the unpaid bills liquidated by the deposit plus interest, and the balance remaining due either to the customer or to the WETC.
 - f) All deposit refunds shall be by separate check and not by credit to the customer's account unless the deposit is used to pay the customer's final bill. No refund of less than \$1 need be issued. When refunds are not deliverable, records shall be maintained to show a WETC's efforts toward locating the applicant or customer and delivering the refund.
 - g) At the option of the WETC, a deposit plus interest may be refunded, in whole or in part, at any time earlier than the times prescribed in this Section.
 - h) The rate of interest on deposits shall be the rate set by the Commission pursuant to 83 Ill. Adm. Code 735.120.
 - i) At the request of a customer, the WETC shall compute the accrued interest upon the deposit and pay that amount to the customer. The WETC need not make the payment more often than once in a 12 month period, nor sooner than 12 months after receipt of a deposit.

Section 736.660 Discontinuance or Refusal of Service

- a) The WETC may discontinue or refuse service for any of the following reasons:

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- 1) Failure to make or increase a deposit pursuant to Sections 736.630, 736.640 and 736.650;
 - 2) Failure to pay a past due bill owed to the WETC;
 - 3) Failure to make payment in accordance with the terms of a Deferred Payment Agreement;
 - 4) When a WETC has reason to believe that a customer has used a device or scheme to obtain service without payment, if the WETC has so notified the customer prior to disconnection;
 - 5) Violation of or noncompliance with a Commission order;
 - 6) Violation of or noncompliance with any rules of the WETC for which the WETC is authorized to discontinue service for violation or noncompliance on the part of the customer or user;
 - 7) Violation of or noncompliance with municipal ordinances and/or other laws pertaining to service; or
 - 8) The customer's use of equipment adversely affects the WETC's service to others. This disconnection may be done without notice to the customer or user.
- b) Discontinuance Procedures
- 1) The WETC may discontinue service to a customer for nonpayment only after it has mailed or delivered by other means a written notice of discontinuance, substantially in the form of Appendix A. Service shall not be discontinued until at least five days after delivery of this notice or eight days after the date on a mailed notice. The notice of discontinuance shall be delivered separately from any other written matter or bill.
 - 2) Notice of discontinuance shall not be mailed before the third business day following the due date shown on the bill.

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- 3) Notwithstanding anything else in this Section, the WETC may immediately discontinue service to a customer when, upon investigation, it has reason to believe that a customer has used a device or scheme to obtain service without payment and the WETC has notified the customer prior to disconnection.
- c) The notice shall remain in effect for 20 days after the date of discontinuance shown on the notice. The WETC shall not discontinue service beyond the 20 day period until at least five days after delivery of a new written notice of discontinuance or eight days after the date of a mailed notice. This provision shall not apply with respect to discontinuance pursuant to subsection (a)(4).
- d) In addition to the written notice, the WETC shall attempt to advise the customer when service is scheduled for discontinuance. The WETC shall not deliver more than two consecutive notices of discontinuance for past due bill without engaging in collection activity with the customer.
- e) Timing of the Discontinuance
 - 1) Services may be discontinued only during hours when a WETC has personnel on duty who are able to restore service within three hours after receipt of payment, at any standard restoration charge.
 - 2) Each WETC shall have personnel authorized to reconnect service available until at least 5 p.m. on business days if the conditions cited as grounds for discontinuance are corrected and any restoration charge is paid.
- f) Service shall not be discontinued, and shall be restored if discontinued, when a present customer who is indebted to the WETC enters into a DPA and complies with its terms.
- g) Service shall not be discontinued, and shall be restored if discontinued, for any reason that is the subject of a dispute or complaint pursuant to Section 736.670 and/or 736.680 while the dispute or complaint is pending and the complainant has complied with the provisions of those Sections.
- h) Service shall not be discontinued for an amount due the WETC that has not been included in a discontinuance notice.

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- i) Nothing in this Section shall be construed to prevent immediate discontinuance of service without notice or the refusal of service for reasons of public safety or health.

Section 736.670 Illness Provision

- a) Certificate of Illness
 - 1) A WETC shall postpone discontinuance of telephone service to a customer for 30 days after the date of certification by a licensed physician that discontinuance of service will aggravate an existing medical emergency or create a medical emergency for the customer or a permanent resident in the customer's household.
 - 2) Initial certification shall prohibit discontinuance of service for 30 days. Certification may be renewed by the customer for one additional 30 day period by providing another certificate to the WETC. Failure to renew the certificate shall entitle the WETC to initiate discontinuance procedures.
 - 3) Initial certification by the certifying physician may be by telephone if written certification is forwarded within five days.
- b) This certificate of medical emergency must be in writing on stationery that clearly sets forth the name of the doctor, hospital or medical clinic. The certificate shall show the name of the person whose illness would be aggravated, the nature of the medical emergency, and the name, title and signature of the licensed physician certifying the medical emergency.
- c) Within the first 30 days, the customer must enter into a Deferred Payment Agreement for the retirement of the unpaid balance of the account and keep the current account paid during the period that the unpaid balance is to be retired.
- d) In the event service is discontinued within 10 days prior to certification of illness by or for a qualifying resident, service shall be restored to that residence if a proper certification is thereafter made in accordance with the provisions of this Section.

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- e) Notice of discontinuance of service sent to residential customers shall include a notice substantially in the form of Appendix B.

Section 736.680 Payment for Service

- a) Payment to the WETC shall be made by the due date shown on the monthly bill and shall be by check, draft or other negotiable instrument denominated in U.S. dollars acceptable to the WETC or in United States currency, provided that nothing in this Section shall be construed to prevent a WETC from accepting payment electronically or by the use of a customer-preferred financially accredited credit or debit methodology.
- b) If the customer remits to the WETC on more than one occasion during a 12 month period a check, draft or other instrument that is dishonored, the WETC may refuse acceptance of further checks and place the customer on a "cash" basis. Under a "cash" basis, the WETC may refuse acceptance of anything as payment other than United States currency, U.S. Postal Service money orders, or an instrument denominated in U.S. dollars and guaranteed by or issued by a third party acceptable to the WETC. The WETC shall advise the customer in writing of the restriction and of the various options available in paying by "cash". The WETC may also offer prepaid service options.
- c) Receipt of a subsequently dishonored negotiable instrument in response to a notice of discontinuance shall not constitute payment of a customer's account and no WETC shall be required to issue additional notice prior to discontinuance. However, three business days must be allowed for redemption of the instrument.

Section 736.685 Past Due Bills

- a) The due date printed on the monthly bill shall not be less than 21 days after the date on the bill, if mailed, or the date of delivery as shown on the bill if delivered by other means.
- b) Payment made in person at the WETC's office or authorized agent shall be deemed received the date payment is made.
- c) Payment made in the WETC's night depository, if any, shall be deemed received on the next full business date.

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Section 736.690 Service Restoration Charge

- a) When service has been discontinued pursuant to Section 736.660, the WETC may charge and collect a restoration charge, if any, set forth in its terms and conditions of service contained in the contract between the WETC and the customer.
- b) When service has been discontinued for nonpayment and payment has not been received or satisfactory payment arrangements have not been made for a period of 10 calendar days, the WETC may consider the service terminated. Restoration may be considered as a new activation if payment has not been received within 10 days, at the WETC's option.

Section 736.695 Dispute Procedures

- a) The WETC shall make available at each of its offices where it transacts business with the public a customer service representative authorized to hear any dispute by an applicant, customer or user. These personnel shall consider the complainant's allegations and shall explain the complainant's account and the WETC's assertions in connection with the account. The personnel shall be authorized to act on behalf of the WETC in resolving the complaint and shall be available during all business hours for this duty.
- b) The WETC shall direct its personnel engaged in personal contact with an applicant, customer or user in the WETC service area seeking dispute resolution under the provisions of this Part to inform the person of his/her right to have the problem considered and acted upon by supervisory personnel of the WETC when any dispute cannot be resolved. The WETC shall further direct supervisory personnel to inform the applicant, complainant or user who expresses non-acceptance of the decision of the supervisory personnel of his/her right to have the problem, if arising under this Part, reviewed by the Commission and shall furnish the applicant, complainant or user with the telephone number and address of the Consumer Services Division of the Illinois Commerce Commission.
- c) When a customer disputes a particular bill, the WETC shall not discontinue service for nonpayment so long as the customer:
 - 1) pays the undisputed portion of the bill;
 - 2) pays all future periodic bills by the due date; and

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- 3) enters into discussions with the WETC to settle the dispute with dispatch.
- d) No late payment fee shall be charged on any disputed bill paid within 14 days after resolution of the dispute if the complaint was filed before the bill became past due.

Section 736.700 Commission Complaint Procedures

- a) Before the Commission will allow the filing of a formal complaint by a WETC applicant, customer, user or WETC, an informal complaint shall be filed with the Commission's Consumer Services Division.
- b) The informal complaint:
 - 1) should be in writing but may be initiated by telephone or in person at the offices of the Commission; and
 - 2) shall provide the following information to the Commission:
 - A) the name, address and telephone number of the applicant, customer or user;
 - B) the name of the WETC involved;
 - C) the nature of the complaint in a clear and concise manner; and
 - D) the specific relief requested.
- c) Upon receipt of the informal complaint, the Consumer Services Division shall:
 - 1) advise the WETC complained of that a complaint has been filed against it; the party complained of must respond to the Consumer Services Division within 14 days;
 - 2) review and investigate the complaint; and
 - 3) advise the parties of the results of the investigation within a reasonable time not to exceed 14 days following receipt of a complete response from

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the WETC. By agreement of the parties and the Consumer Services Division, these time limits may be extended.

- d) Service shall not be discontinued for the reason that is the subject of the complaint during the pendency of any proceeding (formal/informal) before the Commission pursuant to the provisions of this Section so long as the customer has complied with the provisions of Section 736.695(c).

Section 736.705 Second Language

When there is a demonstrated need for second language notices in the service area of any WETC, as determined by the Commission on the basis of census figures, the community area involved, and customer complaints and requests for second language notices, notices as set out in Appendices A and B shall be sent to customers located within the area and contain the following warning in the appropriate second language: "Important – This notice affects your rights and obligations and should be translated immediately. If you cannot find a person to translate for you, call your service provider immediately".

Section 736.710 Customer Information Booklet

A customer information booklet that contains a WETC's credit and collection practices shall be made available on the WETC's website and provided to all applicants for service, and shall be available at all business offices.

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Section 736.APPENDIX A Notice of Discontinuance of Service

IMPORTANT! READ THIS IMMEDIATELY

WETC NAME _____ CUSTOMER _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE # _____ ACCOUNT # _____

YOUR _____ (WETC) SERVICE WILL BE DISCONTINUED ON OR

AFTER _____ (Date) BECAUSE:

YOU OWE \$ _____ IN PAST DUE BILLS

YOU OWE \$ _____ FOR A DEPOSIT FOR TELEPHONE SERVICE

OTHER _____ (Specify)

TO AVOID DISCONTINUANCE OF _____ (WETC) SERVICE, YOU MUST

PAY \$ _____ BEFORE _____ (Date).

*** If you cannot pay the whole amount now, you may be able to get a payment plan with _____ (WETC) . Call us at Phone # _____ for more information.

*** _____ (WETC) has employees on duty from _____ A.M. to _____ P.M. to answer your questions or listen to your complaints. If you do not understand why you owe this money, or if you think there has been a mistake, call _____ (WETC) at Phone # _____ , as soon as possible. If the person you talk to cannot help you, ask to talk to a supervisor. If the supervisor cannot help you, call the Consumer Services Division of the Illinois Commerce Commission at 800-524-0795. Call before you are Discontinued!

*** IMPORTANT: If your services are Discontinued, you will have to pay \$ _____ before your service will be turned on again.

(Printed on Red Paper)

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Section 736.APPENDIX B Requirements to Avoid Shutoff of Service in the Event of Illness

Reverse Side (Printed on Red Paper)

IF DISCONTINUANCE OF SERVICE WILL AGGRAVATE OR CREATE A MEDICAL EMERGENCY FOR A RESIDENT OF YOUR HOUSEHOLD, WE WILL NOT DISCONTINUE YOUR SERVICE.

WHAT YOU MUST DO:

YOU MUST CONTACT A PHYSICIAN OR LOCAL BOARD OF HEALTH. THEY MUST CALL _____ (WETC) AT _____ (Phone) RIGHT AWAY. THEY ALSO MUST SEND A WRITTEN CONFIRMATION, SIGNED BY A PHYSICIAN, TO THE COMPANY WITHIN 5 DAYS THAT CONTAINS THE FOLLOWING INFORMATION:

Name of the person. A statement that the person is a resident of the premises in question; the name, business address and telephone number of the certifying physician; the nature of the illness; the period of time during which discontinuance of telephone WETC service will aggravate the illness.

HOW LONG IS THE CERTIFICATION VALID?

THE CERTIFICATION IS VALID FOR ONE MONTH. IT CAN ALSO BE RENEWED FOR ONE MONTH IF THE PHYSICIAN WRITES TO THE COMPANY AGAIN. IF THE CERTIFICATION IS NOT RENEWED, YOUR TELEPHONE SERVICE MAY BE DISCONTINUED AFTER THE FIRST MONTH.

FOR MORE INFORMATION CALL _____ (WETC) AT _____ (Phone) OR CALL:

CONSUMER SERVICES DIVISION

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800-524-0795

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- 1) Heading of the Part: Clean Air Set-Aside
- 2) Code Citation: 35 Ill. Adm. Code 274
- 3)

| <u>Section Numbers:</u> | <u>Proposed Action:</u> |
|-------------------------|-------------------------|
| 274.100 | New Section |
| 274.102 | New Section |
| 274.104 | New Section |
| 274.106 | New Section |
| 274.202 | New Section |
| 274.204 | New Section |
| 274.206 | New Section |
| 274.208 | New Section |
| 274.210 | New Section |
- 4) Statutory Authority: The Illinois Environmental Protection Act [415 ILCS 5/4]
- 5) A Complete Description of the Subjects and Issues Involved: This proposal addresses procedural rules for implementing the Clean Air Interstate Rule (CAIR) Clean Air Set-Asides (CASA). In the Fall of 2007, the Pollution Control Board adopted rules implementing federal CAIR NOx trading programs (35 Ill. Adm. Code 225, Subparts A, D, and E (R06-26)). This proposal provides procedures for the CASA NOx allowance portion of the CAIR regulation. The proposal includes provisions for the eligible sources and entities to apply for CASA NOx allowances and for the Illinois EPA to distribute such allowances, and to maintain a website that lists the allowances available, application deadlines, and other relevant information.
- 6) Published Studies or Reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? Yes
- 10) Are there any other proposed rulemakings pending on this Part? No

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- 11) Statement of Statewide Policy Objective: This proposed rulemaking does not create or enlarge a State mandate, as defined in Section 3(b) of the State Mandates Act [30 ILCS 805/3(b)].
- 12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: An Agency hearing on the proposed regulations is scheduled for June 11, 2008, at 1:30 pm, Illinois Environmental Protection Agency, Bowling Alley, 1021 North Grand Avenue East, Springfield, Illinois. Questions or written comments concerning this rulemaking should reference the CAIR CASA procedures and be sent to the address below. The comment period closes on July 11, 2008.

Annet Godiksen, Hearing Officer
Illinois Environmental Protection Agency
1021 North Grand Avenue East
P.O. Box 19276
Springfield, IL 62794-9276

217/782-5544

and

Rachel Doctors
Illinois Environmental Protection Agency
1021 North Grand Avenue East
P.O. Box 19276
Springfield, IL 62794-9276

217/782-5544

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: Any small business, small municipality, or not-for-profit that meets that applicable criteria pursuant to 35 Ill. Adm. Code Sections 225.455 through 225.475, Sections 225.555 through 225.575, may use the procedures to apply for CASA allowances.
- B) Reporting, bookkeeping or other procedures required for compliance: The proposed rulemaking does not impose any requirements in addition to those

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adopted in 35 Ill. Adm. Code 225. The proposal contains procedures for applying for a voluntary program.

- C) Types of Professional skills necessary for compliance: No professional skills beyond those currently required by the existing State and federal air pollution control regulations applicable to air pollution sources will be required.

- 14) Regulatory Agenda on which this rulemaking was summarized: December 2007

The full text of the Proposed Rules begins on the next page:

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TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE B: AIR POLLUTION
CHAPTER II: ENVIRONMENTAL PROTECTION AGENCYPART 274
CLEAN AIR SET-ASIDE

SUBPART A: GENERAL PROVISIONS

| | |
|---------|-----------------------------|
| Section | |
| 274.100 | Purpose |
| 274.102 | Definitions |
| 274.104 | Abbreviations and Acronyms |
| 274.106 | Incorporations by Reference |

SUBPART B: CLEAN AIR SET-ASIDE PROCEDURES

| | |
|---------|---|
| Section | |
| 274.200 | Eligible CAIR CASA Projects and NO _x Allowances Available for Distribution |
| 274.202 | CAIR CASA NO _x Allowance Database |
| 274.204 | Applications for CAIR CASA NO _x Allowances |
| 274.206 | Review of CAIR CASA Applications |
| 274.208 | Agency Action on CAIR CASA Applications |
| 274.210 | CAIR CASA NO _x Allowances Distribution |

AUTHORITY: Implementing and authorized by Section 4 of the Environmental Protection Act [415 ILCS 5/4].

SOURCE: Adopted at 32 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROVISIONS

Section 274.100 Purpose

This Part provides procedures for the determination and distribution of CASA Annual and Seasonal NO_x Allowances under 35 Ill. Adm. Code 225, Subparts D and E.

Section 274.102 Definitions

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Except as otherwise defined in this Part, definitions of terms used in this Part shall be those used in 35 Ill. Adm. Code 225.130, 35 Ill. Adm. Code 211 and 40 CFR 96.102 and 96.302, as incorporated by reference in Section 274.106.

Section 274.104 Abbreviations and Acronyms

| | |
|----------------------------|---|
| Agency | Illinois Environmental Protection Agency |
| CAIR | Clean Air Interstate Rule |
| CASA | Clean Air Set-Aside |
| NATS | NO _x Allowance Tracking System |
| NO _x | nitrogen oxides |
| NO _x allowances | CAIR NO _x allowances from the annual or seasonal CASA, as applicable |
| ORIS | Office of Regulatory Information Systems |
| USEPA | United States Environmental Protection Agency |

Section 274.106 Incorporations by Reference

The following materials are incorporated by reference. These incorporations do not include any later amendments or editions.

- a) 40 CFR 96, CAIR NO_x Annual Trading Program, subparts AA (excluding 40 CFR 96.104, 96.105(b)(2), and 96.106), BB, FF, GG, and HH (2007); and
- b) 40 CFR 96, CAIR NO_x Seasonal Trading Program, subparts AAAA (excluding 40 CFR 96.304, 96.305(b)(2), and 96.306), BBBB, FFFF, GGGG, and HHHH (2007).

SUBPART B: CLEAN AIR SET-ASIDE PROCEDURES

Section 274.200 Eligible CAIR CASA Projects and NO_x Allowances Available for Distribution

- a) The types of projects eligible for NO_x allowances from the annual CASA are defined by 35 Ill. Adm. Code 225.460.
- b) The types of projects eligible for NO_x allowances from the seasonal CASA are defined by 35 Ill. Adm. Code 225.560.

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- c) The number of NO_x allowances from the annual CASA available to the Agency for distribution will be determined pursuant to 35 Ill. Adm. Code 225.465 and 225.475.
- d) The number of NO_x allowances from the seasonal CASA available to the Agency for distribution will be determined pursuant to 35 Ill. Adm. Code 225.565 and 225.575.

Section 274.202 CAIR CASA NO_x Allowance Database

- a) The Agency will maintain a publicly-accessible website on which it will provide the following information about the NO_x allowances that are available for distribution in the applicable control periods:
 - 1) Number of NO_x allowances by CASA project category;
 - 2) Vintage;
 - 3) Application deadline; and
 - 4) Distribution date.
- b) Historical NO_x Allowance Distributions. The Agency will maintain a publicly-accessible website on which it will provide the following information about the NO_x allowance distributions that the Agency has made for at least the prior 15 control periods:
 - 1) Company or entity name;
 - 2) Project sponsor;
 - 3) ORIS code;
 - 4) CASA project category;
 - 5) NO_x allowances requested;
 - 6) NO_x allowances approved; and

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- 7) NO_x allowances distributed.
- c) The Agency will update the website with both seasonal and annual draft NO_x allowances distributions by September 8 of each year. Project sponsors will be given until September 15 of each year to submit comments. The website will be updated with the final NO_x allowances distributions by October 8 of each year.
- d) Official Record of Transactions. The official record of all NO_x allowance transactions shall be the USEPA CAIR NO_x Allowance Tracking System (NATS). Any discrepancies found by the CAIR designated representative or authorized account representative shall be reported pursuant to the applicable procedures in 40 CFR 96, as incorporated by reference in Section 274.106.

Section 274.204 Applications for CAIR CASA NO_x Allowances

- a) A project sponsor requesting annual or seasonal NO_x allowances must submit applications that meet the requirements of 35 Ill. Adm. Code 225.470 or 225.570. A new application must be submitted for each control period for which allowances are requested.
- b) Beginning with the 2009 control period and each control period thereafter, a project sponsor may request NO_x allowances from the CASA. CASA applications for annual and seasonal CASA projects must have a send date, e.g, postmark or ship date, of no later than May 1 of the control period for which the allowances are being requested. Such applications must be sent by U.S. registered or certified mail, return receipt requested, other trackable mail, or delivered in person to the Illinois Environmental Protection Agency, Bureau of Air, Compliance Section, 1021 North Grand Avenue East, Springfield, Illinois 62794-9276. Applications that are hand-delivered shall be delivered to and received for by the Illinois EPA, Bureau of Air, Manager of the Division of Air Pollution Control or his or her designee. Delivery by any other means or to another address will invalidate the application, unless resubmitted to the proper address by May 1 of the applicable control period.

Section 274.206 Review of CAIR CASA Applications

The Agency will determine, based on its review of the project sponsor's CASA applications, if:

- a) The project qualifies as a CASA project for the specified CASA project category

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and for the specific control period;

- b) The owner or operator of the CASA project:
 - 1) Commenced construction of the project on or after the dates listed in 35 Ill. Adm. Code 225.470(a) or 225.570(a), as applicable;
 - 2) Operated the project during an applicable seasonal or annual control period pursuant to 35 Ill. Adm. Code 225.470(b) or 225.570(b), as applicable; and
 - 3) Exceeded the maximum number of control periods for the project to receive NO_x allowances pursuant to 35 Ill. Adm. Code 225.470(d) or 225.570(d), as applicable;
- c) The NO_x allowance calculations are correct; and
- d) All information has been submitted as follows:
 - 1) For applications of projects that have not been previously approved, the documentation required by 35 Ill. Adm. Code 225.470(c) or 225.570(c), as applicable.
 - 2) For applications of projects previously approved, supporting information that includes:
 - A) A description of any changes or improvements;
 - B) The documentation required by subsections (c)(1), (c)(2), (c)(3), (c)(5), (c)(6), and (c)(7) of 35 Ill. Adm. Code 225.470 or 225.570, as applicable; and
 - C) A certification that all previously provided information that has not be amended remains complete and accurate.

Section 274.208 Agency Action on CAIR CASA Applications

- a) If the Agency finds that an application meets the applicable requirements, the Agency will notify the project sponsor in writing within 90 days after the

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Agency's receipt of the application that the application is deemed complete, and that the requested number of allowances is approvable pending other requests for allowances from the same project category.

- b) If the Agency finds that an application does not contain all required information pursuant to 35 Ill. Adm. Code 225.470 or 225.570, as applicable, the Agency will, within 90 days after the Agency's receipt of the application, send a written request via certified mail to the project sponsor requesting the submittal of additional information. The project sponsor will have 14 days from the date of receipt of notification to respond by U.S. registered or certified mail, return receipt requested, other trackable mail, or delivery in person to the Illinois Environmental Protection Agency, Bureau of Air, Compliance Section, 1021 North Grand Avenue East, Springfield, Illinois 62794-9276. Responses that are hand-delivered shall be delivered to and receipted for by the Illinois EPA, Bureau of Air, Manager of the Division of Air Pollution Control or his or her designee. If the project sponsor does not respond in a timely manner or does not respond with all the required information, the application is deemed denied and no allowances will be distributed. The Agency will notify the project sponsor of the modified distribution or denial via certified mail.
- c) If the Agency finds that an application is complete but does not meet the applicable requirements, the Agency will send a written notification via certified mail of the application's deficiencies to the project sponsor within 90 days after the Agency's receipt of the application. The project sponsor will have 14 days from the date of receipt of notification of deficiencies to respond via U.S. registered or certified mail, return receipt requested, other trackable mail, or delivery in person to the Illinois Environmental Protection Agency, Bureau of Air, Compliance Section, 1021 North Grand Avenue East, Springfield, Illinois 62794-9276. Responses that are hand-delivered shall be delivered to and receipted for by the Illinois EPA, Bureau of Air, Manager of the Division of Air Pollution Control or his or her designee. If the project sponsor does not respond in a timely manner or does not adequately address the deficiencies, the application is deemed denied and no allowances will be distributed. The Agency shall notify the project sponsor of the modified distribution or denial via certified mail.
- d) If the Agency finds that the number of NO_x allowances requested in the application is not approvable, the Agency will send written notification via certified mail to the project sponsor within 90 days after the Agency's receipt of the application. This notification will include the modified number of NO_x

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allowances that may be approved but not guaranteed due to availability. The project sponsor will be given 14 days from the date of receipt of notification to respond via U.S. registered or certified mail, return receipt requested, other trackable mail, or delivery in person to the Illinois Environmental Protection Agency, Bureau of Air, Compliance Section, 1021 North Grand Avenue East, Springfield, Illinois 62794-9276. Responses that are hand-delivered shall be delivered to and receipted for by the Illinois EPA, Bureau of Air, Manager of the Division of Air Pollution Control or his or her designee. If the project sponsor does not respond within the above timeframe, the Agency's determination of the modified total number of NO_x allowances will be considered accepted. Even if the project sponsor does respond within the above timeframe, the Agency may still decide that the additional information fails to support modifying the number of approvable NO_x allowances and use its original determination of approvable NO_x allowances rather than the number requested by the project sponsor. The Agency shall notify the project sponsor of the distribution via certified mail.

- e) Prior to making final NO_x allowance distributions, the Agency will review any information submitted in a timely manner by a project sponsor in response to a written notification as described in subsections (b), (c), and (d) of this Section. The Agency may send multiple written requests for information or response if time allows.

Section 274.210 CAIR CASA NO_x Allowances Distribution

- a) By September 1, 2009, and each September 1 thereafter, the Agency will calculate the possible NO_x allowance distribution based on the information submitted and other pertinent information in relation to the project, and the equations given for each CASA category pursuant to 35 Ill. Adm. Code 225.
- b) If there are sufficient NO_x allowances available in the applicable CASA project category, the Agency will allocate the number of NO_x allowances determined pursuant to the procedures of this Subpart. If there are fewer NO_x allowances than the number the Agency determines approvable for the project, the Agency will allocate the NO_x allowances on a pro-rata basis, as specified in 35 Ill. Adm. Code 225.475(b) and 225.575(b).
- c) The Agency will allocate NO_x allowances, with the oldest vintage NO_x allowances within a CASA NO_x project category being allocated first.

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- d) The Agency will keep track of any remaining NO_x allowances for the year and season by CASA NO_x project category.
- e) The Agency will notify USEPA of the annual and seasonal NO_x allowance distributions by October 1 of the year of the applicable control period.

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- 1) Heading of the Part: Boiler and Pressure Vessel Safety
- 2) Code Citation: 41 Ill. Adm. Code 120
- 3)

| <u>Section Numbers</u> : | <u>Proposed Action</u> : |
|--------------------------|--------------------------|
| 120.10 | Amendment |
| 120.11 | Amendment |
| 120.20 | Amendment |
| 120.105 | Repealed |
| 120.205 | Repealed |
| 120.1260 | Amendment |
| 120.1270 | Amendment |
- 4) Statutory Authority: Authorized by Sections 2 and 2.1 of the Boiler and Pressure Vessel Safety Act [432 ILCS 75/2 and 2.1]
- 5) A Complete Description of the Subjects and Issues Involved: The subjects involved in this rulemaking are boiler and pressure vessel installation, repair, maintenance, and inspection.
- 6) Any published studies or reports, and sources of underlying data used to compose this rulemaking: American Petroleum Institute and Field experience
- 7) Will this rulemaking replace any emergency rulemaking currently in effect: No
- 8) Does this rulemaking contain an automatic repealer date? No
- 9) Does this rulemaking contain incorporations by reference? Yes
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: The statewide policy objectives met by this rulemaking is the safety of the public who use boilers and pressure vessels.
- 12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may comment in writing to the following:

David Douin
Division of Boiler and Pressure Vessel Safety

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Office of the State Fire Marshal
1035 Stevenson Dr.
Springfield, IL 62703-4259

Facsimile: 217/785-4184

13) Initial Regulatory Flexibility Analysis:A) Types of small businesses, small municipalities and not for profit corporations affected:

- 1) Any small business that is in the business of installation, repair or maintenance of any regulated pressure vessels.
- 2) Municipalities that inspect regulated pressure vessels.
- 3) Not for profit corporations will be affected only to the extent that they have buildings with regulated pressure vessels that are installed, repaired or inspected.

B) Reporting, bookkeeping or other procedures required for compliance:

- 1) Individuals and companies that undertake the installation, inspection, repair or maintenance of regulated pressure vessels are required to maintain records on license, applications and individual regulated conveyance inspection, repair or maintenance.
- 2) Units of local government that undertake to permit and/or inspect regulated pressure vessels are required to maintain records on such activity.
- 3) Building owners in which regulated pressure vessels are located are required to keep records of inspection, repair, maintenance and new installations in those buildings.

C) Types of professional skills necessary for compliance: Individuals prove competence to inspect, install, repair and maintain regulated pressure vessels by either experience, education or testing that demonstrate conformance to national

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standards published for the particular type of conveyance the individual seeks to be licensed to perform inspections, repairs, maintenance or installation.

- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the 2 most recent regulatory agendas because: Amendments were not anticipated during the 2 most recent agendas.

The full text of the Proposed Amendments begins on the next page:

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TITLE 41: FIRE PROTECTION
CHAPTER I: STATE FIRE MARSHALPART 120
BOILER AND PRESSURE VESSEL SAFETY

SUBPART A: DEFINITIONS AND ADMINISTRATION

Section

| | |
|--------|--|
| 120.4 | Foreward (Repealed) |
| 120.7 | Kindly Observe the Following Briefs and Avoid Unnecessary Inconvenience (Repealed) |
| 120.10 | Definitions |
| 120.11 | Incorporation of National Standards |
| 120.15 | Fees |
| 120.20 | Administration |
| 120.30 | Inspectors, Examinations, Certificate of Competency and Commission |
| 120.41 | Special Inspector Trainee (Repealed) |

SUBPART B: CONSTRUCTION, INSTALLATION, INSPECTION,
MAINTENANCE, AND USE

Section

| | |
|---------|---|
| 120.100 | New Installations of Boilers, Miniature Boilers, Heating Boilers and Hot Water Supply Boilers |
| 120.105 | Boiler Exemptions (Repealed) |
| 120.200 | New Installations of Pressure Vessels |
| 120.205 | Pressure Vessel Exemptions (Repealed) |
| 120.300 | Existing Installations of Power Boilers |
| 120.400 | Existing Installations of Miniature Boilers (Repealed) |
| 120.500 | Operation of Boilers and Pressure Vessels |
| 120.600 | Existing Installation of Pressure Vessels |
| 120.700 | General Requirements for all Boilers and Pressure Vessels (Repealed) |
| 120.800 | Nuclear Power Plant Components (Repealed) |
| 120.900 | Flame Safeguard Requirements and Incorporated Standards (Repealed) |

SUBPART C: REPAIR AND ALTERATION

Section

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| | |
|----------|--|
| 120.1000 | Repairs and Alterations to Boilers and Pressure Vessels by Welding |
| 120.1010 | Authorization to Repair Boilers and Pressure Vessels |
| 120.1020 | Issuance and Renewal of the Certificate |
| 120.1030 | Changes to Certificates of Authorization |
| 120.1040 | Quality Control Requirements |
| 120.1041 | Repair and Alteration Requirements |

SUBPART D: STATE SPECIALS

Section

| | |
|----------|--|
| 120.1100 | Procedure for the Issuance of a State Special Permit |
|----------|--|

SUBPART E: REPAIR OF SAFETY AND SAFETY RELIEF VALVES

Section

| | |
|----------|---|
| 120.1200 | Authorization for Repair of Safety & Safety Relief Valves |
| 120.1210 | Authorization to Repair ASME and National Board Stamped Safety and Safety Relief Valves |
| 120.1220 | Issuance and Renewal of the Certificate |
| 120.1240 | Changes to Certificates of Authorization |
| 120.1250 | Repairs to Safety and Safety Relief Valves |
| 120.1260 | Quality Control System |
| 120.1270 | Nameplates |
| 120.1275 | Field Repair |
| 120.1280 | Performance Testing of Repaired Valves |
| 120.1285 | Training of Valve Repair Personnel |
| 120.1290 | ASME "V", "UV" or National Board "VR" Certificate Holders |

SUBPART F: OWNER-USER QUALITY CONTROL REQUIREMENTS

Section

| | |
|----------|--|
| 120.1300 | Introduction |
| 120.1301 | Authority and Responsibility |
| 120.1305 | Organization |
| 120.1310 | Inservice Inspection Program |
| 120.1320 | Drawings, Design Calculations, and Specification Control |
| 120.1325 | Material Control |
| 120.1330 | Examination and Inspection Program |
| 120.1335 | Correction of Nonconformities |

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120.1340 Welding
120.1345 Nondestructive Examination
120.1350 Calibration of Measurement and Test Equipment
120.1355 Records
120.1360 Inspectors

120.APPENDIX A Operational and Maintenance Log
 120.EXHIBIT A Hot Water Heating Boilers
 120.EXHIBIT B Steam Heating Boilers
120.APPENDIX B Record of Welded Repair (Repealed)

AUTHORITY: Implementing the Boiler and Pressure Vessel Safety Act [430 ILCS 75] and authorized by Sections 2 and 2.1 of the Boiler and Pressure Vessel Safety Act [430 ILCS 75/2 and 2.1].

SOURCE: Boiler and Pressure Vessel Safety Act Rules and Regulations adopted at 4 Ill. Reg. 7, p. 126, effective January 31, 1980; codified at 5 Ill. Reg. 10677; amended at 7 Ill. Reg. 6925, effective July 1, 1983; amended at 10 Ill. Reg. 9510, effective July 1, 1985; amended at 11 Ill. Reg. 16587, effective January 1, 1988; amended at 16 Ill. Reg. 6808, effective July 1, 1992; amended at 17 Ill. Reg. 14917, effective September 1, 1993; amended at 19 Ill. Reg. 11904, effective August 15, 1995; amended at 20 Ill. Reg. 9540, effective July 3, 1996; amended at 21 Ill. Reg. 997, effective January 1, 1997; amended at 23 Ill. Reg. 162, effective January 1, 1999; amended at 24 Ill. Reg. 18555, effective December 7, 2000; amended at 25 Ill. Reg. 11914, effective January 1, 2002; amended at 27 Ill. Reg. 518, effective January 01, 2003; emergency amendment at 27 Ill. Reg. 14855, effective September 2, 2003, for a maximum of 150 days; amended at 28 Ill. Reg. 1737, effective January 13, 2004; amended at 28 Ill. Reg. 13509, effective September 24, 2004; amended at 32 Ill. Reg. _____, effective _____.

SUBPART A: DEFINITIONS AND ADMINISTRATION

Section 120.10 Definitions

Act or the Act means the Boiler and Pressure Vessel Safety Act [430 ILCS 75].

Alteration means any change in the item described on the original Manufacturers' Data Report which affects the pressure containing capability of the boiler or pressure vessel. Non-physical changes such as an increase in the maximum allowable working pressure (internal or external) or design temperature of a boiler or pressure vessel shall be considered an alteration. A reduction in minimum

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temperature such that additional mechanical tests are required shall also be considered an alteration.

~~API 510 means the code for the maintenance, inspection, repair, alteration and re-rating of pressure vessels published by the American Petroleum Institute. API 510 means the Maintenance, Inspection, Rating, Repair and Alteration of Pressure Vessels as published by the American Petroleum Institute.~~

Approved means approved by the Board of Boiler and Pressure Vessel Rules.

ASME Code means the Boiler and Pressure Vessel Code of the American Society of Mechanical Engineers with ~~such~~ revisions, amendments and interpretations ~~thereof as are~~ made, approved and adopted by the Council of the Society and approved and adopted by the Board. Copies of the Code may be obtained from ~~the said~~ Society at ~~Three Park Avenue, New York NY 10016-5990, 345 E. 47th Street, New York, New York 10017.~~

Authorized Inspection Agency means one of the following:

A department or division established by a jurisdiction ~~that which~~ has adopted one or more Sections of the ASME Code and whose inspectors hold valid commissions issued by the National Board of Boiler and Pressure Vessel Inspectors;

~~An inspection agency of an insurance company which is authorized (licensed) to insure and is insuring boilers and pressure vessels in those jurisdictions which have examined the agency's inspectors to represent such jurisdictions as is evident by the issuance of a valid Certificate of Competency to the inspector; or~~

~~An insurance company authorized by the jurisdiction to insure boilers and pressure vessels that employs special inspectors who have met the requirements of this Part; or~~

An ~~owner-user~~ ~~owner or user~~ of boilers and pressure vessels who maintains a regularly established inspection department, whose organization and inspection procedures meet the requirements ~~of established by the Board and contained in~~ this Part.

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Authorized Repairer means a holder of a Certificate of Registration issued pursuant to the Boiler and Pressure Vessel Repairer Regulation Act.

Board means the Board of Boiler and Pressure Vessel Rules created by the Act and empowered to make, alter, amend and interpret rules and regulations for the safe construction, installation, inspection, alteration, and repair of boilers and pressure vessels and for establishing fees.

Boiler means a vessel intended for use in heating water or other liquids or for generating steam or other vapors under pressure or vacuum by the application of heat resulting from the combustion of fuels, electricity, or waste gases.

Certificate Inspection means an inspection, the report of which is used by the Chief Inspector as justification for issuing, withholding or revoking the inspection certificate. The Certificate Inspection shall be an internal inspection when required; otherwise, it shall be as complete an inspection as possible.

Certificate of Competency means a certificate issued to a person who has passed the examination [and meets all other requirements](#) prescribed by the Board.

Certificate of Registration means a certificate issued by the Office pursuant to the Boiler and Pressure Vessel Repairer Regulation Act.

Commission, ~~National Board~~ means the commission issued by the National Board to a holder of a Certificate of Competency who desires to make shop inspections or field inspections in accordance with the National Board bylaws and whose employer submits the inspector's application to the National Board for [thesueh](#) commission.

Condemned Boiler or Pressure Vessel means a boiler or pressure vessel that has been inspected and declared unsafe, or disqualified by legal requirements, by the Chief or Deputy Inspector.

Division means the Division of Boiler & Pressure Vessel Safety.

Electric Boiler means a boiler in which the source of heat is electricity.

Engineer means a registered professional engineer registered in accordance with the Illinois Professional Engineering Act [225 ILCS 325] or a person who

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graduated from an accredited college or university and either:

holds a mechanical engineering degree, or

has five years experience in a related field (e.g., civil engineering, ~~metallurgical~~~~metalurgical~~ engineering, industrial engineering, design engineering, maintenance engineering, project engineering or construction, maintenance, repair or operation of high pressure boilers and pressure vessels).

Existing Installation means and includes:

Any boiler installed and placed in operation within the State of Illinois before May 1, 1953.

Any hot water supply boiler installed and placed in operation within the State of Illinois on or before July 9, 1957.

Any pressure vessel installed and placed in operation within the State of Illinois on or before December 31, 1976.

External Inspection means an inspection made when a boiler or pressure vessel is in operation, if possible.

Heating Boiler means a steam boiler operated at pressures not exceeding 15 psig, or a hot water heating boiler operated at pressures not exceeding 160 psig and/or temperatures not exceeding 250° F. at or near the boiler outlet.

High Pressure Boiler means a boiler ~~generating steam~~~~where steam is generated~~ at a pressure in excess of 15 psig or a water boiler operated in excess of 160 psig and/or temperatures in excess of 250° F.

High-Temperature Water Boiler means a water boiler operating at pressures exceeding 160 psig and/or temperatures exceeding 250° F. at or near the boiler outlet.

Hot ~~Water Supply Boiler~~~~water supply boiler~~ means a boiler (including fired storage water heater) furnishing hot water to be used externally to itself at pressures not exceeding 160 psig and/or temperatures not exceeding 250° F. at or

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near the boiler outlet, except those exempted pursuant to the Boiler and Pressure Vessel Safety Act and this Part.

Inspection Certificate means a certification issued by the Chief Inspector for the operation of a boiler or pressure vessel, as required by the Act.

Inspector means the Chief Inspector or Deputy Inspector or Special Inspector or Owner-User Inspector.

Chief Inspector means the Chief Boiler and Pressure Vessel Inspector employed under the Act.

Deputy Inspector means any inspector employed under the provisions of the Act.

Special Inspector means an inspector holding an Illinois Certificate of Competency and who is regularly employed by an insurance company authorized to write boiler and pressure vessel insurance in this State.

Owner-User Inspector means an inspector described in Section 120.1360 continuously employed as an inspector by an Owner-User Inspection Agency.

Internal Inspection means as complete an examination as can reasonably be made of the internal and external surfaces of a boiler or pressure vessel while it is shut down and manhole plates, handhole plates or other inspection opening closures are removed as required by the inspector.

Jurisdiction means a state, commonwealth, county or municipality of the United States or a province of Canada ~~that~~ which has adopted one or more sections of the ASME Code and maintains a duly constituted Department, Bureau, or Division for the purpose of enforcement of ~~the~~ Code. In Illinois, the Division of Boiler and Pressure Vessel Safety is the jurisdiction, except for the City of Chicago.

Lined Potable Water Heater shall mean a water heater, with a corrosion resistant lining, used to supply potable hot water.

Low Pressure Boiler means a steam boiler operated at pressures not exceeding 15

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psig or a hot water boiler operated at pressures not exceeding 160 psig and/or temperatures not exceeding 250° F.

Miniature Boiler means any boiler ~~that~~which does not exceed any of the following limits:

16 inches inside diameter of shell;

20 square feet heating surface;

5 cubic feet gross volume, exclusive of casing and insulation;

100 psig maximum allowable working pressure.

National Board Inspection Code or NBIC means the Manual for Boiler and Pressure Vessel Inspectors published by the National Board. The NBIC is developed under the ANSI consensus process. Copies of the ~~NBIC Code~~ may be obtained from the National Board.

National Board means the National Board of Boiler and Pressure Vessel Inspectors, 1055 Crupper Avenue, Columbus, Ohio 43229, whose membership is composed of the Chief Inspectors of jurisdictions who are charged with the enforcement of the boiler and pressure vessel laws within their respective jurisdictions. ~~provisions of the ASME Code.~~

Nationally Recognized Testing Agency is an organization concerned with product evaluation that provides uniform testing, examination, listing and labeling under established, nationally recognized standards.

New Boiler Installations means ~~and includes~~ all boilers constructed, installed and placed in operation within the State of Illinois after May 1, 1953, and all hot water supply boilers installed and placed in operation after July 9, 1957.

New Pressure Vessel Installations means ~~and includes~~ any pressure vessel installed and placed in operation within the State of Illinois after December 31, 1976.

Non-Standard Boiler or Pressure Vessel means a boiler or pressure vessel that does not bear the ASME Code Symbol Stamp ~~or the API ASME Stamp.~~

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Office means the Office of the State Fire Marshal.

Operator means any individual who has charge of a boiler or pressure vessel as defined by the Act, and whose duties include operation and maintenance of such devices.

Owner or User means any person, firm or corporation legally responsible for the safe operation of any boiler or pressure vessel within the State.

Owner-User means an owner and user qualified under Section 15 of the Act.

Place of Public Assembly means a building or specific area, including outdoor areas, in which persons assemble for civic, educational, religious, social or recreational purposes or ~~that~~~~which~~ is provided by a common carrier for passengers awaiting transportation or in which persons are housed to receive medical, charitable or other care or treatment, or are held or detained for public, civic or correctional purposes.

Portable Boiler means an internally fired boiler ~~which is~~ primarily intended for temporary location and the construction and usage of which permits it to be readily moved from one location to another.

Power Boiler means a boiler in which steam or other vapor is generated at a pressure of more than 15 psig and includes a high-pressure, high-temperature water boiler.

Pressure Vessel means a vessel in which pressure is obtained from an external source, or by the application of heat from an indirect source or from a direct source other than those boilers ~~as~~ defined in this Section above.

PSIG means pounds per square inch gauge.

Reinstalled Boiler or Pressure Vessel means a boiler or pressure vessel removed from its original setting and reinstalled at the same location within the State of Illinois or at a new location without change of ownership.

Relief Valve means an automatic pressure relieving device actuated by the static pressure upstream of the valve ~~that~~~~which~~ opens further with the increase in

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pressure over the opening pressure. It is used primarily for liquid service.

Repair means work necessary to return a boiler or pressure vessel to a safe operating condition.

~~Re-rating~~Re-rating means a change in the maximum allowable working pressure or temperature of a boiler or pressure vessel, regardless of whether ~~or not~~ physical work is performed on the boiler or pressure vessel. ~~Re-rating~~Re-rating shall be considered an alteration.

Safety Relief Valve means an automatic pressure actuated relieving device suitable for use as a safety or relief valve, depending on application.

Safety Valve means an automatic pressure relieving device actuated by the static pressure upstream of the valve and characterized by full opening pop action. It is used for gas or vapor service.

Secondhand Boiler or Pressure Vessel means a boiler or pressure vessel ~~that~~which has changed both location and ownership since primary use.

Standard Boiler or Pressure Vessel means a boiler or pressure vessel ~~that~~which bears the ASME Code Symbol Stamp.

State Special means a boiler or pressure vessel of special construction that may not be constructed in accordance with the ASME Code. See ~~Subpart E~~, Section 120.1100 of this Part, for the procedures for granting a State Special.

~~Underwriters Laboratories (U.L.) means a non-profit independent organization testing for public safety. It maintains and operates laboratories for the examination and testing of devices, systems and materials to determine their relationship to life, fire and casualty hazards.~~

Welding or Arc Welding means a group of welding processes ~~in which~~wherein coalescence is produced by heating with an arc or arcs, with or without the application of pressure, and with or without the use of filler metal.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 120.11 Incorporation of National Standards

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Where standards are incorporated by reference in this Part, the incorporated material does not include any later editions or amendments.

- a) The Board hereby adopts the following nationally recognized standards and addenda:

ASME CSD-1 ~~2004a-1998~~ Controls and Safety Devices for Automatically Fired Boilers

~~NFPA 8501-97~~ ~~Single Burner Boilers—Furnaces~~

~~NFPA 8502-99~~ ~~Multiple Burner Boilers—Furnaces~~

~~NFPA 8503-97~~ ~~Pulverized Fuel Systems~~

NFPA 85 Boilers and Combustion System Hazard Code, 2004 Edition

ASME Boiler and Pressure Vessel Code, 2004 Edition with 2005, 2006 addenda(2001) with 2003 addenda:

Section I Power Boilers

Section II Material Specifications – Part A – Ferrous

Section II Material Specifications – Part B – Nonferrous

Section II Material Specifications – Part C – Welding Rods, Electrodes and Fillers Metals

Section II Material Specifications – Part D – Properties

Section IV Heating Boilers

Section V Nondestructive Examination

Section VI Recommended Rules for Care and Operation of Heating Boilers

Section VII Recommended Rules for Care of Power Boilers

Section VIII Pressure Vessels – Division 1, Including Appendix M

Section VIII Pressure Vessels – Division 2 – Alternative Rules

Section VIII Pressure Vessels – Division 3 – Alternative Rules for High Pressure Vessels

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Section IX Welding and Brazing Qualifications

Section X Fiberglass – Reinforced Plastic Pressure Vessels

National Board of Boiler ~~and~~ Pressure Vessel Inspectors

Inspection Code, 2004 Edition with 2005, 2006 addenda~~(2001) with 2003 addenda~~

American Petroleum Institute

API-510, Eighth Edition, First Supplement, "API Recommended Practice for Inspection, Repair, and Rating of Pressure Vessels in Petroleum Refining Service"

b) The materials described in subsection (a) can be obtained at the following locations:

API – American Petroleum Institute
1220 L Street, Northwest
Washington, D.C. ~~20005~~2005
www.api.org

ASME – American Society of Mechanical Engineers
United Engineering Center
~~Three Park Avenue~~345 East 47th Street
New York, New York 10017
www.asme.org

NB – National Board of Boiler ~~and~~ Pressure Vessel Inspectors
1055 Crupper Avenue
Columbus, Ohio 43229
www.nationalboard.org

NFPA – National Fire Protection Association
1 Batterymarch Park
Quincy, Massachusetts 02269-9101
www.nfpa.org

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 120.20 Administration

a) Applying State Serial Number. The State serial number on boilers shall be not less than $\frac{5}{16}$ " in height and shall be preceded by the letters "ILL", which shall

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also be not less than $\frac{5}{16}$ " in height. Boilers will be identified by a five digit number. The State serial number on pressure vessels shall be not less than $\frac{5}{16}$ " in height and shall be preceded by the letters "ILL" and the letter "U", which also shall be not less than $\frac{5}{16}$ " in height. Pressure vessels will be identified by a six digit number. The ~~inspector~~ Inspector shall make certain that the correct Illinois State serial number is affixed to the boiler or pressure vessel at the time of inspection.

- b) First Time Inspection. Effective January 1, 1999, all first time inspections of boilers and pressure vessels shall be performed by the Chief or a Deputy Inspector employed by the Division.
- c) Basis for Extending Certificate:
 - 1) The Chief Inspector is authorized to extend, for a period not exceeding one year, the time within which power boilers are required to be internally inspected, subject to the following conditions and qualifications:
 - A) The analysis and treatment of feedwater for ~~such~~ power boilers shall be under the supervision of a person qualified in the field of water chemistry.
 - B) The analysis and treatment of the boiler feedwater shall be for the purpose of controlling and limiting serious deteriorating, encrusting and sludging factors affecting the safety of the boiler.
 - 2) The owner or user of ~~such~~ power boilers must maintain, for examination by the inspector, accurate records of ~~such~~ chemical and physical laboratory ~~analyses~~ analysis of samples of the boiler water taken at regular intervals of not more than 24 hours operation and of the treatment applied. These records must specify dates and times of analyses, by whom analyzed, and the treatment applied at that time, and should be certified by the responsible authority. These records will adequately show the conditions of ~~the~~ ~~such~~ water and any constituents or characteristics ~~that~~ ~~which~~ are capable of producing corrosion or other deterioration of the boiler or its parts.
 - 3) The Chief Inspector is authorized to review the qualifications of the supervisor and the acceptability of supervision in accordance with the

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foregoing.

- 4) Application for extension shall be by letter setting forth facts establishing compliance with the foregoing conditions and qualifications, and shall be accompanied by the report of external inspection.
- d) Unsafe Boilers or Pressure Vessels. Any boiler or pressure vessel having been inspected and declared unsafe by an inspector shall have the Inspection Certificate suspended.
- e) Factors of Safety for Existing Installations. An inspector shall increase the factors of safety if the condition of a boiler or pressure vessel warrants it. If the owner or user does not concur with the inspector's decision, the owner or user may appeal to the Board.
- f) Frequency of Inspection of Boilers and Pressure Vessels:
 - 1) Power boilers and high temperature water boilers shall receive a certificate inspection annually, which shall be an internal inspection where conditions permit. Such boilers shall also be inspected externally annually while under representative operating conditions, if possible.
 - 2) Low pressure steam and hot water heating boilers and hot water supply boilers ~~shall be inspected both internally and externally every two years where conditions permit and~~ shall receive a certificate inspection every two years. Groups of heating and hot water supply boilers connected together shall be registered as one unit and receive one Inspection Certificate when the following conditions are met:
 - A) No unit exceeds 400,000 BTU input;
 - B) All units being considered in the assembled modular unit are connected to a common header or manifold; and
 - C) No more than 8 units can be grouped together and registered as one unit.
 - 3) Inspection of the flame safeguard equipment shall be in conjunction with the regular inspections of boilers.

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- 4) Pressure vessels subject to internal corrosion shall receive a certificate inspection every three years. This inspection shall be external and internal where conditions permit. However, owner-users qualified in accordance with Section 15 of the Act shall have the option of using API-510 or the NBIC for inspection intervals.
- 5) Pressure vessels not subject to internal corrosion shall receive a certificate inspection every three years. However, owner-users qualified in accordance with Section 15 of the Act shall have the option of using API-510 or the NBIC for inspection intervals.
- g) Inspection and Inspection Certificate Fees:
 - 1) If a boiler or pressure vessel shall, upon inspection, be found to be suitable and to conform to this Part, the owner or user shall pay the fees as established by the Board for each boiler and pressure vessel inspected before an Inspection Certificate shall be issued.
 - 2) If the owner or user of each boiler or pressure vessel required to be inspected refuses or fails to allow an inspection to be made or refuses or fails to pay the appropriate fees, the Inspection Certificate shall be suspended by the Chief Inspector until the owner or user complies with the requirements.
 - 3) The owner or user who causes a boiler or pressure vessel to be operated without a valid Inspection Certificate shall be subject to the penalty as provided in the Act.
- h) Inspectors to Have ~~None~~ Other Interests. It is prohibited for any employee of the Division of Boiler and Pressure Vessel Safety to accept any compensation or remuneration from any source for acting as a ~~consultant, engineer, safety engineer, safety specialist~~ consultant, engineer, safety engineer, safety specialist, etc., or under any other title. Employees of this Division shall not be engaged in the sale of any article or device that is related to boilers or pressure vessels and shall devote their full time to inspection work.
- i) Installing Used or Second-hand Boilers or Pressure Vessels. A certificate inspection shall be made of all used or second-hand boilers or pressure vessels

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prior to operation in this State. ~~When~~~~In a case where~~ a boiler or pressure vessel is moved and reinstalled, the fittings and appurtenances shall be upgraded to comply with the rules for new installations.

- j) Inspectors to Notify Chief Inspector of ~~Defective Boilers~~~~defective boilers~~ and ~~Pressure Vessels~~~~pressure vessels~~. If an inspector finds that a boiler or pressure vessel or any of the appurtenances are in an unsafe condition, the inspector shall immediately notify the Chief Inspector and submit a report of the defects.
- k) Insurance Agencies to Notify the Chief Inspector of New, Cancelled or Suspended Risks. All ~~insurance agencies~~~~Insurance Agencies~~ shall notify the Chief Inspector within 30 days of all boiler or pressure vessel risks written, cancelled, not renewed or suspended in Illinois.
- l) Manufacturers Data Reports to ~~be~~~~Be~~ Filed. Effective January 1, 1974, Manufacturers Data Reports on boilers and, as amended December 31, 1976, for pressure vessels, ~~that~~~~which~~ are to be installed in the State of Illinois (unless otherwise exempted by this Part) shall be filed with the Chief Inspector through the National Board. It is intended that each boiler and pressure vessel ~~for which a report is~~~~so~~ filed should be assigned a National Board number.
- m) Boilers and Pressure Vessels without ASME Stamping. If the boiler or pressure vessel does not bear the ASME stamping, then the drawings, data and material showing all details of construction shall be submitted to the Chief Inspector and ~~the Chief Inspector's~~~~his~~ approval ~~shall be~~ obtained before installation in this State. The Chief Inspector shall grant ~~his~~ approval if the construction, materials and inspection requirements meet the rules, except for ASME stamping.
- n) Notification of Inspection. The owner or user shall prepare each boiler or pressure vessel for internal inspection and shall prepare for and apply a hydrostatic test whenever necessary, on the date specified by an inspector, which ~~date~~ shall be not less than 7 days after the date of notification.
- o) Owner to Notify Chief Inspector in Case of Accident. Any owner or user, which includes any person, firm, partnership, corporation, or governmental entity, that knowingly fails to notify the Chief Inspector within 24 hours, or on the next business day, of an accident, explosion, event, or incident that serves to render a boiler or pressure vessel inoperative because of damage or failure or that involves any bodily injury or death to any person is guilty of a Class B misdemeanor, if a

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natural person, or a business offense punishable by a fine of not less than \$501 and not more than \$10,000, if a corporation or governmental entity.

- p) Penalties. Any person, firm, partnership or corporation violating any of the provisions of this Part shall be subject to the penalties provided in the Boiler and Pressure Vessel Safety Act.
- q) Registration of Boilers and Pressure Vessels. All owners or users of boilers and pressure vessels subject to the Act now in use or installed ready for use in the State of Illinois shall notify the Chief Inspector in writing giving the location, type, capacity, age and date of installation.
- r) Removal of Safety Appliances:
- 1) No person, except under the direction of an inspector, shall attempt to remove or shall do any work upon safety appliances required by this Part while a boiler or pressure vessel is in operation. Should any of these appliances be repaired during an outage of a boiler or pressure vessel, they must be reinstalled and in proper working order before the object is again placed in service.
 - 2) No person shall in any manner load the safety valve or valves to maintain a working pressure in excess of that stated on the Inspection Certificate.
- s) Stamping of Boilers and Pressure Vessels. Each boiler or pressure vessel subject to the Act shall be identified by a serial number of the State of Illinois. The number will be assigned by the Chief Inspector and applied to the boiler or pressure vessel by the inspector at the time of inspection. Also, the Code required stamping shall be kept free of paint and lagging so that it will be plainly visible and easily read by the inspector.
- t) Submission of Inspection Reports. Inspection Reports to be submitted by Special Inspectors:
- 1) Inspection Reports shall be submitted within 1030 days from the date of inspection.
 - 2) All Inspection Reports shall be completed with all pertinent information as required, including location and actual conditions observed.

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- 3) A 90 day period beyond the expiration date marked on the Inspection Certificate will be used in determining boilers and pressure vessels past due for inspection for divisional reporting purposes. This 90 day period is for the administrative processing of inspection reports, invoices and Inspection Certificates. Inspections shall be performed prior to the expiration date on the Inspection Certificate.
- 4)3) Validity of Inspection Certificate. ~~No Inspection Certificate issued for a boiler or pressure vessel inspected by a Special Inspector shall be valid after the boiler or pressure vessel for which it was issued shall cease to be insured by a duly authorized insurance company.~~ The Chief Inspector may at any time suspend an Inspection Certificate when the boiler or pressure vessel for which it was issued may not continue to be operated without menace to public safety, or when the boiler or pressure vessel is found not to comply with this Part. A Special Inspector shall have authority to request suspension of an Inspection Certificate for boilers or pressure vessels insured by the employing company. ~~Suspension~~ Sueh suspension of an Inspection Certificate shall continue in effect until ~~thesueh~~ boiler or pressure vessel has ~~shall have~~ been made to conform to this Part.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

SUBPART B: CONSTRUCTION, INSTALLATION, INSPECTION,
MAINTENANCE, AND USE

Section 120.105 Boiler Exemptions (Repealed)

~~The following boilers shall be exempt from registration and inspection as required by this Part:~~

- a) ~~Boilers exempted pursuant to Section 5 of the Boiler and Pressure Vessel Safety Act (Ill. Rev. Stat. 1991, ch. 111½, par. 3206, as amended by PA 87-1169) [430 ILCS 75/5, as amended by PA 87-1169].~~
- b) ~~Hot water supply boilers which are directly fired with oil, gas or electricity when none of the following limitations are exceeded:~~
- 1) ~~Heat input of 200,000 BTU per hour.~~

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- 2) ~~Water temperature of 200 degrees Fahrenheit.~~
- 3) ~~Nominal water containing capacity of 120 U.S. gallons.~~
- e) ~~Coil type hot water boilers where the water can flash into steam when released directly to the atmosphere through a manually operated nozzle provided the following conditions are met:~~
 - 1) ~~There is no drum, headers or other steam space.~~
 - 2) ~~No steam is generated within the coil.~~
 - 3) ~~Outside diameter of tubing does not exceed 1 inch.~~
 - 4) ~~Pipe size does not exceed 3/4 inch NPS.~~
 - 5) ~~Water capacity of unit does not exceed 6 U.S. gallons.~~
 - 6) ~~Water temperature does not exceed 350 degrees Fahrenheit.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

Section 120.205 Pressure Vessel Exemptions (Repealed)

~~The following pressure vessels shall be exempt from registration and inspection as required by this Part.~~

- a) ~~Pressure vessels exempt pursuant to Section 5 of the Boiler and Pressure Vessel Safety Act [430 ILCS 75/5].~~
- b) ~~Pressure vessels operated at a pressure not exceeding 15 psig with no limitations on size.~~
- e) ~~Pressure vessels that do not exceed:~~
 - 1) ~~A volume of 15 cubic feet and 250 psig when not located in a place of public assembly.~~

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- 2) ~~A volume of 5 cubic feet and 250 psig when located in a place of public assembly.~~
- 3) ~~A volume of 1-½ cubic feet or an inside diameter of 6 inches with no limitation on pressure.~~
- d) ~~Those classes of vessels not within the scope of ASME Code Section VIII, Division 1 as defined in the introduction under paragraph U-1.~~
- e) ~~Water conditioning equipment used for the removal of minerals, chemicals or organic or inorganic particulates from water by means other than application of heat; e.g., water softeners, water filters, dealkalizers and demineralizers.~~

(Source: Repealed at 32 Ill. Reg. _____, effective _____)

SUBPART E: REPAIR OF SAFETY AND SAFETY RELIEF VALVES

Section 120.1260 Quality Control System

- a) General
 - 1) Before issuance or renewal of the Certificate of Authorization, the applicant must meet all requirements, including an acceptable written Quality Control System ~~that~~~~which~~ shall include, but not be limited to, material control, fabrication, welding, nondestructive examination, testing and inspection.
 - 2) The written Quality Control System shall also include provisions for making revisions, posting and dating changes in the program, enabling the system to be kept current as required.
 - 3) The description and information of the system may be brief or voluminous, depending upon the circumstances.
 - 4) In general, the Quality Control System shall describe and explain what documents and procedures the repair firm will use to validate a valve repair.
 - 5) A review of the applicant's Quality Control System will be performed by a

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representative of the Division. The review will include a demonstration of the implementation of the provisions of the applicant's Quality Control ~~System~~system.

- 6) Each applicant to whom a Certificate of Authorization is issued shall maintain thereafter an up to date copy of ~~its~~this accepted Quality Control System Manual with the Division. Revisions to the Quality Control System Manual shall not be implemented until ~~these~~such revisions are accepted by the Division.

- b) The following are the minimum requirements of the Division for a written Quality Control System for repairs of ASME safety and safety relief valves. It is essential that each valve repair organization develop its own Quality Control System ~~that~~which meets the requirements of its organization. For this reason, it is not possible to develop one Quality Control System ~~that~~which could apply to more than one organization. Some of these requirements are:
 - 1) Title Page – The title page shall include the name and address of the company to which the Certificate of Authorization is to be issued. It shall also list the Sections of the ASME Code to which the repairs will apply.
 - 2) Revision Log – A revision log is required to assure revision control of the Quality Control System Manual. The log shall contain sufficient space for date, description and section of revision, company approval and Division acceptance.
 - 3) Contents ~~Page~~page – The contents page shall list and reference, by paragraph and page number, the subjects and exhibits contained ~~in the manual~~in the manual~~therein~~.
 - 4) Statement of Authority and Responsibility – A statement of authority and responsibility shall appear on company letterhead, dated and signed by an officer of the company verifying the following:
 - A) If there is a disagreement in the implementation of the written Quality Control System, the matter is referred to a higher authority in the company for resolution; and
 - B) The title of the individual authorized to approve revisions to the

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written Quality Control System and the method by which ~~such~~ revisions are to be submitted to the Division for acceptance before implementation.

- 5) Organizational Chart – The organizational chart shall include all departments or divisions within the company that perform functions affecting the quality of the valve repair and show the relationship among the various departments or divisions.
- 6) Scope of Work – The scope of work section shall clearly indicate the scope and type of valve repairs the organization is capable of and intends to carry out, and shall include the type and sizes of valves ~~that~~which can be repaired. In addition, the testing media (steam, air, water, etc.) and pressure ranges should be included. The scope can be limited by engineering, machine tools, welding processes, heat treatment facilities, testing facilities, non-destructive examination (NDE) techniques or qualified personnel.
- 7) Drawings and Specification Control – The drawings and specification control system shall provide procedures assuring that the latest applicable drawings, specifications and manufacturer's available instructions required are used for valve repair, inspection and testing.
 - A) Specific reference shall be made to the materials used for the repair of the various valve parts (PG-73.2.3, Section I and UG-136(b)(3), Section VIII, Division 1 of the ASME Code).
 - B) Mechanical requirements shall comply with the ASME Code. See applicable Code Section.
- 8) Material and Part Control – The material and part control section shall describe procurement of parts from the original valve manufacturer or their designated representative, if applicable, and of material with request for mill test certification as required. It shall also describe receiving, storage and issuance, as well as the following:
 - A) State the title of the individual responsible for the procurement of all material and parts.

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- B) State the title of the individual responsible for certification and other records as required.
- C) All incoming material and parts shall be checked for conformance with the purchase order and, ~~when~~ ~~where~~ applicable, the material specifications or drawings. Indicate how ~~the~~ material or part is identified and how ~~identity~~ ~~identity~~ is maintained by the Quality Control System.
- D) All critical parts shall be fabricated by the valve manufacturer ~~or to his specifications~~. Critical parts are defined as any part ~~that~~ ~~which~~ may affect the flow passage, capacity, pressure rating or valve function.
- 9) Repair and Inspection Program – The repair and inspection program section shall include reference to a document (such as a report, traveler or checklist) ~~that~~ ~~which~~ outlines the specific repair and inspection procedures to be used in the repair of safety and safety relief valves. Provisions shall be made to retain this document for a period of at least five years as a part of quality control traceability documents.
- A) Each valve or group of valves shall be accompanied by the document referred to ~~in subsection (b)(9) above~~ for processing through the plant.
- B) The document referred to ~~in subsection (b)(9) above~~ shall include material check, reference to items such as the welding procedure specifications (WPS), fit-ups, NDE technique, heat treatment, and pressure test methods to be used. There shall be a space for "sign-offs" at each operation to verify that each step has been properly performed for each valve.
- C) The system shall include a method of controlling the repair or replacement of critical valve parts. The method of identifying each spring shall be indicated.
- 10) Welding, NDE and Heat Treatment (when applicable) – When welded repairs are made by the Certificate holder, the Quality Control System Manual shall indicate the ~~title~~ ~~title~~ of the ~~person~~ ~~person(s)~~ responsible for

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the development and approval of the welding procedure specifications and their qualifications, and the qualifications of welders and welding operators. Welding procedures specifications and welders and welding operators shall be qualified to the requirements of the ASME Boiler and Pressure Vessel Code, Section IX. Similarly, NDE and heat treatment techniques must be covered in the Quality Control System Manual. When outside services are used, the Quality Control System Manual shall describe the system ~~by which, whereby~~ the use of ~~those such~~ services ~~meets meet~~ the requirements of the applicable Section of the ASME Code.

- 11) Valve Testing and Setting – The Quality Control System Manual shall include provisions that each valve shall be tested ~~and~~, set and all external adjustments sealed according to the requirements of the ~~valve manufacturer and as required by this Section~~ ~~applicable ASME Code Section~~. The seal shall identify the repair organization. Abbreviations or initials are permitted.
- 12) Valve Repair Nameplates – An effective valve stamping system shall be established to ensure proper stamping of each valve as required by Section 120.1270. The Quality Control System Manual shall include a description ~~of the nameplate~~ or a drawing ~~of the nameplate~~.
- 13) Calibration of Measurement and Test Gauges – The calibration of ~~the~~ measurement and test gauges system shall include the periodic calibration of measuring instruments and pressure gauges.
 - A) Pressure gauges used for setting valves are to be checked periodically (indicate time schedule) by the person authorized (indicate title). The method of gauge testing is to be indicated and results recorded.
 - B) Periodically, all master instruments shall be calibrated preferably, but not necessarily, to measuring equipment traceable to the National Bureau of Standards.
- 14) Controlled Copy – An up to date copy of the written Quality Control System Manual shall be submitted to the Division for review and acceptance. Revisions shall also be submitted for acceptance prior to being implemented.

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- 15) Nonconformities – The system shall establish measures for the identification, documentation, evaluation, segregation and disposition of nonconformities. A nonconformity is a condition of any material, item, product or process in which one or more characteristics do not conform to the established requirements. These may include, but are not limited to, data discrepancies, procedural and/or documentation deficiencies, or material defects. Also, the ~~title~~title(s) of the ~~individuals~~individual(s) involved in this process shall be included.
- 16) Sample Forms – Forms used in the Quality Control System shall be included in the manual with a written description. Forms exhibited shall be marked "SAMPLE" and completed in a manner typical of actual valve repair procedures.
- 17) Individuality Important – It is extremely important that the manual describe and the operation implement the system of each repair organization firm while meeting the requirements of this Subpart.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Section 120.1270 Nameplates

- a) When a safety or safety relief valve is repaired, a metal repair nameplate stamped with the information required by ~~subsection Section 120.1270(b)~~ and sealed by wire and lead or metal seal stamped to the valve either above, adjacent to or below the original stamping. See Section 120.1250(b) for exception.
- b) As a minimum, the information on the valve repair nameplate shall include the name of the repair organization and the date of repair. If set pressure has been changed, then it, as well as the blowdown (for "V" stamped valves), and new capacity shall be indicated. The original nameplate or stamping shall be marked out but left legible. The new capacity shall be based on that for which the valve was originally certified.
- c) Illegible or ~~Replacement of~~ Missing Nameplates
 - 1) When the information on the original manufacturer's or assembler's

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nameplate or stamping is illegible, the nameplate or stamping shall be augmented or replaced by a nameplate stamped "duplicate" ~~that, which~~ contains all information ~~that, which~~ originally appeared on the nameplate or valve, as required by the applicable Section of the ASME Code, except the "V" or "UV" symbol and the National Board mark. The repair organization's nameplate and other required data specified in ~~subsection Section 120.1270~~(b) will make the repair organization responsible to the owner and the Division ~~for that~~ the information on the duplicate nameplate ~~being is~~ correct.

- 2) When the original valve nameplate is missing, the repair organization is not authorized to perform repairs to the valve under the program unless positive identification can be made to that specific valve and verification that the valve was originally stamped with a "V" or "UV" stamp. Valves that can be positively identified shall be equipped with a duplicate nameplate as described in ~~subsection Section 120.1270~~(c)(1), in addition to the repair organization stamped nameplate. The repair organization responsibilities for accurate data as defined in ~~subsection Section 120.1270~~(c)(1) shall apply.
- 3) When a duplicate nameplate is affixed to a valve as required by ~~subsection Sections 120.1270~~(c)(1) or ~~120.1270~~(c)(2), it shall be marked "Sec I" or "Sec VIII", as applicable, to indicate the original ASME Code stamping.

(Source: Amended at 32 Ill. Reg. _____, effective _____)

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- 1) Heading of the Part: Community Care Program
- 2) Code Citation: 89 Ill. Adm. Code 240
- 3) Section Number: 240.1800 Adopted Action: Amendment
- 4) Statutory Authority: 20 ILCS 105/4.01(11) and 4.02 (as amended by Public Act 95-0565 (effective June 1, 2008))
- 5) Effective Date of Amendment: May 5, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: 31 Ill. Reg. 16375; December 14, 2007
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between proposal and final version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes
- 13) Will this amendment replace any emergency amendment currently in effect? No
- 14) Are there any amendments pending on this Part? Yes

| <u>Section Numbers:</u> | <u>Proposed Action:</u> | <u>Illinois Register Citation:</u> |
|-------------------------|-------------------------|---------------------------------------|
| 240.865 | Amend | 31 Ill. Reg. 16599; December 21, 2007 |
| 240.920 | Amend | 31 Ill. Reg. 16599; December 21, 2007 |
| 240.950 | Amend | 31 Ill. Reg. 16599; December 21, 2007 |
- 15) Summary and Purpose of Amendment: Updates rule regarding the Community Care Program Advisory Committee. Makes changes in the composition of the committee and

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qualifications of appointees to comply with required categories of representative constituencies committed to older adults. Revises provisions regarding terms of appointment, leadership, and meeting schedule of the committee. Addresses the scope of responsibilities of the committee in providing advice to the Department.

- 16) Information and questions regarding this adopted amendment shall be directed to:

Karen Alice Kloppe
Deputy General Counsel
Illinois Department on Aging
421 E. Capitol Avenue, #100
Springfield, Illinois 62701-1789

217/785-3346

The full text of the Adopted Amendment begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER II: DEPARTMENT ON AGING

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240.370 Voluntary Repayment

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- 240.445 Hearing Officer
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SUBPART M: CASE COORDINATION UNITS AND PROVIDERS

Section

240.1310 Standard Contractual Requirements for Case Coordination Units and Providers
240.1320 Vendor or Case Coordination Unit Fraud/Illegal or Criminal Acts
240.1330 General Vendor and CCU Responsibilities (Repealed)
240.1396 Payment for Services (Repealed)
240.1397 Purchases and Contracts (Repealed)
240.1398 Safeguarding Case Information (Repealed)
240.1399 Suspension/Termination of a Vendor or Case Coordination Unit (CCU)

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240.1400 Community Care Program Case Management
240.1410 Case Coordination Unit Administrative Minimum Standards
240.1420 Case Coordination Unit Responsibilities
240.1430 Case Management Staff Positions, Qualifications and Responsibilities
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SUBPART O: PROVIDERS

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240.1520 Provider Responsibilities
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240.1535 Homemaker Staff Positions, Qualifications and Responsibilities
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SUBPART R: ADVISORY COMMITTEE

Section

- 240.1800 Community Care Program Advisory Committee
- 240.1850 Technical Rate Review Advisory Committee (Repealed)

SUBPART S: PROVIDER RATES

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Section

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| 240.1940 | Fixed Unit Rates of Reimbursement for Adult Day Service and Transportation |
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SUBPART T: FINANCIAL REPORTING

Section

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| 240.2020 | Financial Reporting of Homemaker Service |
| 240.2030 | Unallowable Costs for Homemaker Service |
| 240.2040 | Minimum Direct Service Worker Costs for Homemaker Service |
| 240.2050 | Cost Categories for Homemaker Service |

AUTHORITY: Implementing Section 4.02 and authorized by Section 4.01(11) of the Illinois Act on the Aging [20 ILCS 105/4.02 and 4.01(11)].

SOURCE: Emergency rules adopted at 4 Ill. Reg. 1, p. 67, effective December 20, 1979, for a maximum of 150 days; adopted at 4 Ill. Reg. 17, p. 151, effective April 25, 1980; amended at 4 Ill. Reg. 43, p. 86, effective October 15, 1980; emergency amendment at 5 Ill. Reg. 1900, effective February 18, 1981, for a maximum of 150 days; amended at 5 Ill. Reg. 12090, effective October 26, 1981; emergency amendment at 6 Ill. Reg. 8455, effective July 6, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 14953, effective December 1, 1982; amended at 7 Ill. Reg. 8697, effective July 20, 1983; codified at 8 Ill. Reg. 2633; amended at 9 Ill. Reg. 1739, effective January 29, 1985; amended at 9 Ill. Reg. 10208, effective July 1, 1985; emergency amendment at 9 Ill. Reg. 14011, effective August 29, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 5076, effective March 15, 1986; recodified at 12 Ill. Reg. 7980; amended at 13 Ill. Reg. 11193, effective July 1, 1989; emergency amendment at 13 Ill. Reg. 13638, effective August 18, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 17327, effective November 1, 1989; amended at 14 Ill. Reg. 1233, effective January 12, 1990; amended at 14 Ill. Reg. 10732, effective July 1, 1990; emergency amendment at 15 Ill. Reg. 2838, effective February 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 10351, effective July 1, 1991; emergency amendment at 15 Ill. Reg. 14593, effective October 1, 1991, for a maximum of 150 days; emergency amendment at 15 Ill. Reg. 17398, effective November 15, 1991, for a maximum of 150 days; emergency amendment suspended at 16 Ill. Reg. 1744; emergency amendment modified in response to a suspension by the Joint Committee on Administrative

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Rules and reinstated at 16 Ill. Reg. 2943; amended at 15 Ill. Reg. 18568, effective December 13, 1991; emergency amendment at 16 Ill. Reg. 2630, effective February 1, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 2901, effective February 6, 1992, to expire June 30, 1992; emergency amendment at 16 Ill. Reg. 4069, effective February 28, 1992, to expire June 30, 1992; amended at 16 Ill. Reg. 11403, effective June 30, 1992; emergency amendment at 16 Ill. Reg. 11625, effective July 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 11731, effective June 30, 1992; emergency rule added at 16 Ill. Reg. 12615, effective July 23, 1992, for a maximum of 150 days; modified at 16 Ill. Reg. 16680; amended at 16 Ill. Reg. 14565, effective September 8, 1992; amended at 16 Ill. Reg. 18767, effective November 27, 1992; amended at 17 Ill. Reg. 224, effective December 29, 1992; amended at 17 Ill. Reg. 6090, effective April 7, 1993; amended at 18 Ill. Reg. 609, effective February 1, 1994; emergency amendment at 18 Ill. Reg. 5348, effective March 22, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 13375, effective August 19, 1994; amended at 19 Ill. Reg. 9085, effective July 1, 1995; emergency amendment at 19 Ill. Reg. 10186, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 12693, effective August 25, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16031, effective November 20, 1995; amended at 19 Ill. Reg. 16523, effective December 1, 1995; amended at 20 Ill. Reg. 1493, effective January 10, 1996; emergency amendment at 20 Ill. Reg. 5388, effective March 22, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 8995, effective July 1, 1996; amended at 20 Ill. Reg. 10597, effective August 1, 1996; amended at 21 Ill. Reg. 887, effective January 10, 1997; amended at 21 Ill. Reg. 6183, effective May 15, 1997; amended at 21 Ill. Reg. 12418, effective September 1, 1997; amended at 22 Ill. Reg. 3415, effective February 1, 1998; amended at 23 Ill. Reg. 2496, effective February 1, 1999; amended at 23 Ill. Reg. 5642, effective May 1, 1999; amended at 26 Ill. Reg. 9668, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 10829, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17358, effective November 25, 2002; emergency amendment at 28 Ill. Reg. 923, effective December 26, 2003, for a maximum of 150 days; amended at 28 Ill. Reg. 7611, effective May 21, 2004; emergency amendment at 30 Ill. Reg. 10117, effective June 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 11767, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 16281, effective September 29, 2006; amended at 30 Ill. Reg. 17756, effective October 26, 2006; amended at 32 Ill. Reg. 7588, effective May 5, 2008.

SUBPART R: ADVISORY COMMITTEE

Section 240.1800 Community Care Program Advisory Committee

- a) The Director shall appoint individuals to serve [on the Community Care Program Advisory Committee \(CCPAC\) that shall advise the Department on an advisory capacity to the Department to identify present and potential issues, including](#) rates

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of reimbursement for the Community Care Program (CCP) service delivery network services provided under the Community Care Program (CCP), and issues affecting the CCP service delivery network, and to recommend solution strategies. The CCPAC shall meet on a bi-monthly basis.

- b) Persons appointed to the CCPAC shall be appointed based upon their experience with the CCP, geographic representation, and willingness to serve. Representatives shall serve at their own expense and must abide by all applicable ethics laws. Representatives will be appointed to represent older adults and provider, advocacy, policy research and other constituencies committed to the delivery of high quality in-home and community-based services to older adults. Representatives shall be appointed to assure representation from with the following considerations:
- 1) adult day service providers the agency's/applicant's experience (years) in CCP;
 - 2) in-home service providers geographic representation;
 - 3) case coordination and case management unit equal in-home adult day service and case coordination unit provider representation, as well as two in-home care direct service staff and two representatives of Area Agencies on Aging;
 - 4) emergency home response providers at least two non-provider representatives from policy/advocacy/other services/research organizations; and
 - 5) statewide trade or labor unions that represent homecare aides and direct care staff; willingness to serve.
 - 6) area agencies on aging;
 - 7) adults over age 60;
 - 8) membership organizations representing older adults; and
 - 9) other organizational entities, providers of care, and/or individuals determined by the Director to have demonstrated interest and expertise in

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the fields of in-home and community-based care.

- c) Nominations may be presented from any agency or State association with interest in the CCP.
- d) The Director, or designee, will serve as permanent Co-chair of the CCPAC Community Care Program Advisory Committee (CCPAC). One other Co-chair shall be nominated and approved annually by members of the CCPAC.
- e) The Director will designate Department staff to provide technical assistance and staff support to the Committee. Department representation will not constitute membership on the CCPAC.
- f) Terms~~Initial terms~~ of appointment will be for ~~either three or~~ four years. Members shall continue to serve until their replacements are named. Subsequent appointments will be for a single four year term. At no time can a member serve more than one consecutive term in any capacity on the Committee.
- g) The Department will fill vacancies that have a remaining term of over one year, and this replacement will occur through the annual replacement of expiring terms.
- h) All papers, issues, recommendations, reports and meeting memoranda will be advisory only. The Director, or designee, will make a written response/report, as requested, regarding issues before the CCPAC.
- i) The Director retains full decision making authority on the CCPAC Community Care Program regarding any recommendations presented by the CCPAC.

(Source: Amended at 32 Ill. Reg. 7588, effective May 5, 2008)

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- 1) Heading of the Part: Long-Term Care Insurance
- 2) Code Citation: 50 Ill. Adm. Code 2012
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 2012.10 | Amendment |
| 2012.20 | Amendment |
| 2012.30 | Amendment |
| 2012.40 | Amendment |
| 2012.50 | Amendment |
| 2012.55 | Amendment |
| 2012.60 | Amendment |
| 2012.62 | Amendment |
| 2012.64 | Amendment |
| 2012.65 | Amendment |
| 2012.70 | Amendment |
| 2012.80 | Amendment |
| 2012.83 | New Section |
| 2012.86 | New Section |
| 2012.90 | Amendment |
| 2012.95 | Amendment |
| 2012.100 | Amendment |
| 2012.110 | Amendment |
| 2012.112 | Amendment |
| 2012.115 | Amendment |
| 2012.120 | Amendment |
| 2012.121 | New Section |
| 2012.122 | Amendment |
| 2012.123 | Amendment |
| 2012.124 | Renumbered, New Section |
| 2012.125 | New Section |
| 2012.126 | Renumbered, New Section |
| 2012.127 | Amendment |
| 2012.128 | Amendment |
| 2012.129 | Amendment |
| 2012.130 | Amendment |
| 2012.140 | Amendment |
| 2012.150 | Amendment |
| 2012.EXHIBIT A | Amendment |

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| | |
|----------------|-------------|
| 2012.EXHIBIT B | Amendment |
| 2012.EXHIBIT C | Amendment |
| 2012.EXHIBIT D | Amendment |
| 2012.EXHIBIT E | Repeal |
| 2012.EXHIBIT F | Amendment |
| 2012.EXHIBIT G | Amendment |
| 2012.EXHIBIT H | Amendment |
| 2012.EXHIBIT I | Amendment |
| 2012.EXHIBIT J | Amendment |
| 2012.EXHIBIT K | New Section |

- 4) Statutory Authority: Implementing and authorized by Section 351A-11 of the Illinois Insurance Code [215 ILCS 5/351A-11]
- 5) Effective Date of Rulemaking: May 5, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rulemaking, including any material incorporated by reference, is on file in the principal office of the Division of Insurance and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: 31 Ill. Reg. 10805; August 3, 2007
- 10) Has JCAR issued a Statement of Objection to this Rulemaking? No
- 11) Differences between proposal and final version:
 - a) In the main source note and all Section source notes, change "31" to "32".
 - b) Section 2012.30, in the definition of "Exceptional Increase", on the second line of the first indented paragraph, add "found in Section 2012.112 of this Part" following "increases".
 - c) Section 2012.40 has been reorganized and restructured in order to permit the Division to distinctly separate provisional requirements that are effective until January 1, 2009, from those that will become effective after that date.

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- d) Section 2012.50(b)(8), delete "A)" and bring text up. On the second line, change "other than the state of policy issue" to "other than in the state in which the policy was issued".
- e) Section 2012.50(b)(8), change "i)" to "A)" and change "state of policy issue" to "state in which the policy was issued".
- f) Section 2012.50(b)(8), change "ii)" to "B)".
- g) Section 2012.50(b)(8)(B), deleted all proposed text.
- h) Section 2012.50(i) and (j), the Division added the following new subsections:
- "i) Except for subsections (a)(1), (b)(8) and (9) and (g), which become effective January 1, 2009, subsections (a) through (h) become effective July 1, 2008.
- j) For policies issued from July 1, 2008 through January 1, 2009, the following requirements taken from subsections (a)(1), (b)(8) and (g) apply:
- 1) For purposes of subsection (a), no individual long-term care insurance policy or certificate issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable".
- 2) Subsection (b) is not intended to prohibit exclusions and limitations for payment of services provided outside the United States.
- 3) For purposes of subsection (g), no traditional long-term care insurance policy shall:
- A) be cancelled, nonrenewed or otherwise terminated on grounds of the age or deterioration of the mental or physical health of the insured individual or certificateholder;

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B) contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by new or other coverage, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

C) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

4) There is no requirement for subsection (b)(9) prior to January 1, 2009. "

- i) Section 2012.60(j), on the last line, add "as amended (26 USC 7702B)" following "1986," and deleted "as amended" at the end.
- j) Section 2012.65(d), on the first line, strike "herein" and add "in Section 2012.30 of this Part" in lieu thereof.
- k) Section 2012.121(a)(2), on the last line, change "within one year from July 1, 2008" to "by July 1, 2009".
- l) Section 2012.121(b)(2), on the fourth line, add "as prescribed in 42 USC 1396p" following "programs".
- m) Section 2012.122(c)(5), delete "Except" and change "with" to "With". Also delete "qualified".
- n) Section 2012.125(b), on the second line change "2007" to "2008".
- o) Section 2012.125(e), on the third, change "to (d)" to "through (e)".
- p) Section 2012.125 (i), the Division added the following new subsection:
 - "i) The provisions of this Section apply on and after January 1, 2009."
- q) Section 2012.126, following "(a)" add "Coverage Reduction Options". Also add a "1)" in front of the "Every long-term care" language and indent accordingly. Change subsection "1)" and "2)" labels to "A)" and "B)" and change "3)" to "2)".

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- r) Section 2012.126(g) change "2008" to "2009".
 - s) Section 2012.127(c), on the fourth line, and in subsection 2012.127(d)(3) on the first line, change "on" to "upon".
 - t) Section 2012.127(d)(2), on the fifth line, strike "lapses" and add "lapsing". Also strike "of " and add "after" in lieu thereof.
 - u) Section 2012.127(d)(3), on the seventh line, change "increase" to "so increased". Add "This subsection (d)(3) becomes effective on January 1, 2009." following "increased.". Finally, under the table, on the last line of the indented paragraph, change "insure" to "insured".
 - v) Section 2012.127(h)(1); and twice in subsection 2012.(h)(2), change "2007" to "2008".
 - w) Section 2012.127(h)(3), on the third and last line, change "2008" to "2009".
 - x) Section 2012.129(c), on the last line, following" Treasury" add "under the authority of Section 7702B of the IRS Code (26 USC 7702B)".
 - y) Section 2012.150, on the first line, add "or" following "insurer" and strike "and".
- 12) Have all changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Rulemaking: The title of this Part has changed and the requirements now adopted bring our State regulation in-line with the NAIC model on Long-Term Care regulation. Illinois amendments include provisions that ensure Illinois compliance with federal long-term care partnership requirements should Illinois elect to become a Partnership state. Other significant changes include incontestability period and non-forfeiture provisions, producer training provisions, disclosure of availability of new long-term care services, and a new contingent benefit upon lapse provision, among others.

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- 16) Information and questions regarding this adopted rulemaking shall be directed to:

William McAndrew, Assistant Deputy Director
L/A&H Compliance Unit
Department of Financial and Professional Regulation
Division of Insurance
320 West Washington Street
Springfield, Illinois 62767-0001

217/782-4254

The full text of the Adopted Amendments begins on the next page:

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TITLE 50: INSURANCE

CHAPTER I: DEPARTMENT OF [FINANCIAL AND PROFESSIONAL REGULATION](#)
[INSURANCE](#)

SUBCHAPTER Z: ACCIDENT AND HEALTH INSURANCE

PART 2012

[TRADITIONAL](#) LONG-TERM CARE INSURANCE

Section

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| 2012.10 | Purpose |
| 2012.20 | Applicability and Scope |
| 2012.30 | Definitions |
| 2012.40 | Policy Definitions |
| 2012.50 | Policy Practices and Provisions |
| 2012.55 | Unintentional Lapse |
| 2012.60 | Required Disclosure Provisions |
| 2012.62 | Required Disclosure of Rating Practices to Consumers |
| 2012.64 | Initial Filing Requirements |
| 2012.65 | Prohibition Against Post Claims Underwriting |
| 2012.70 | Minimum Standards for Home Health and Community Care Benefits in Traditional Long-Term Care Insurance Policies |
| 2012.80 | Requirement to Offer Inflation Protection |
| 2012.83 | Incontestability Period |
| 2012.86 | Nonforfeiture Benefits |
| 2012.90 | Requirements for Application Forms and Replacement Coverage |
| 2012.95 | Reporting Requirements |
| 2012.100 | Filing Requirement |
| 2012.110 | Loss Ratio |
| 2012.112 | Premium Rate Schedule Increases |
| 2012.115 | Filing Requirements for Advertising |
| 2012.120 | Reserve Standards |
| 2012.121 | Producer Training Requirements |
| 2012.122 | Standards for Marketing |
| 2012.123 | Suitability |
| 2012.124 126 | Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates |
| 2012.125 | Availability of New Services or Providers |
| 2012.126 124 | Right to Reduce Coverage and Lower Premiums Appropriateness of Recommended Purchase |

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| 2012.127 | Requirement to Offer Nonforfeiture Benefit Requirement |
| 2012.128 | Standards for Benefit Triggers |
| 2012.129 | Additional Standards for Benefit Triggers for Qualified Long-Term Care |
| 2012.130 | Standard Format Outline of Coverage Requirements |
| 2012.140 | Requirement to Deliver Shopper's Guide |
| 2012.150 | Penalties |
| 2012.EXHIBIT A | Replacement Notice for Other Than Direct Response Solicitations |
| 2012.EXHIBIT B | Replacement Notice for Direct Response Solicitations |
| 2012.EXHIBIT C | Standard Format Outline of Coverage |
| 2012.EXHIBIT D | Rescission Reporting Format |
| 2012.EXHIBIT E | Class of Insurance – Accident and Health (Repealed) |
| 2012.EXHIBIT F | Traditional Long-Term Care Insurance Personal Worksheet |
| 2012.EXHIBIT G | Things You Should Know Before You Buy Traditional Long-Term Care Insurance |
| 2012.EXHIBIT H | Traditional Long-Term Care Insurance Suitability Letter |
| 2012.EXHIBIT I | Claims Denial Reporting: Long-Term Care Insurance Form Format |
| 2012.EXHIBIT J | Potential Rate Increase Disclosure |
| 2012.EXHIBIT K | Replacement and Lapse Reporting Form |

AUTHORITY: Implementing and authorized by Section 351A-11 of the Illinois Insurance Code [215 ILCS 5/351A-11].

SOURCE: Adopted at 14 Ill. Reg. 10345, effective June 15, 1990; amended at 18 Ill. Reg. 2238, effective February 1, 1994; amended at 19 Ill. Reg. 2832, effective July 1, 1995; emergency amendment at 19 Ill. Reg. 8403, effective June 13, 1995; emergency expired September 1, 1995; amended at 19 Ill. Reg. 14421, effective October 3, 1995; amended at 22 Ill. Reg. 2105, effective January 6, 1998; amended at 26 Ill. Reg. 8835, effective July 1, 2002; amended at 32 Ill. Reg. 7600, effective May 5, 2008.

Section 2012.10 Purpose

The purpose of this Part is to implement Article XIXA of the Illinois Insurance Code, to promote the public interest, to promote the availability of ~~traditional~~ long-term care insurance coverage, to protect applicants for ~~traditional~~ long-term care insurance 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 ~~traditional~~ long-term care insurance.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.20 Applicability and Scope

- a) Except as otherwise specifically provided ~~in subsection (b) of this Section~~, this Part applies to all ~~traditional~~ long-term care insurance policies including qualified long-term care insurance contracts and life insurance policies that accelerate benefits for ~~traditional~~ long-term care insurance delivered or issued for delivery in this State by any insurer on or after June 15, 1990. Certain provisions of this Part apply only to qualified long-term care insurance contracts as noted.
- b) Additionally, this Part is intended to apply to policies having indemnity benefits that are triggered by activities of daily living and sold as disability income insurance, if:
- 1) The benefits of the disability income policy are dependent upon or vary in amount based on the receipt of ~~traditional~~ long-term care services;
 - 2) The disability income policy is advertised, marketed or offered as insurance for ~~traditional~~ long-term care services; or
 - 3) Benefits under the policy may commence after the policyholder has reached Social Security's normal retirement age unless benefits are designed to replace lost income or pay for specific expenses other than ~~traditional~~ long-term care services.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.30 Definitions

Accelerated ~~Long-Term Care Benefit~~ ~~Life Product~~ means a life insurance policy, contract, rider endorsement or amendment ~~that~~ which contains benefits providing payment from life or endowment or annuity benefits in advance of the time they would otherwise be payable at any time during the insured's lifetime as an indemnity for ~~traditional~~ long-term care.

Applicant as defined in Section 351A-1 of the Illinois Insurance Code *means:*

in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits;

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in the case of a group long-term care insurance policy, the proposed certificateholder.

~~Assistive Equipment may include, but is not limited to, tangible personal property with a useful life of at least one year, expressly designed and used for increasing independent functioning in specific tasks or activities of independent living in the home that directly results in a demonstrated decrease in need for assistance from another individual in performing certain tasks or activities.~~

Certificate as defined in Section 351A-1 of the Illinois Insurance Code [215 ILCS 5/351A-1] *means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this State.*

Chronically Ill Individual, for all long-term care policies that are marketed as "qualified" pursuant to the Internal Revenue Code of 1986, as amended (26 USC 7702B(c)(2)(A)), means any individual who has been certified by a licensed health care practitioner as:

being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in the preceding paragraph, or

requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term does not include any individual otherwise meeting the requirements of this definition unless within the preceding 12-month period a licensed health care practitioner has certified that the individual meets these requirements.

Code means the Illinois Insurance Code [215 ILCS 5].

Director means the Director of the Illinois Department of Financial and Professional Regulation-Division of Insurance.

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~~*Director as defined in Section 351A-1 of the Illinois Insurance Code [215 ILCS 5/351 A-1] means the Director of Insurance.*~~

Division means the Illinois Department of Financial and Professional Regulation-Division of Insurance.

Exceptional Increase means only those increases filed by an insurer as exceptional for which the Director determines 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 to increased and unexpected utilization that affects the majority of insurers of similar products.

Except as provided in Section 2012.112, exceptional increases are subject to the same requirements as other premium rate schedule increases found in Section 2012.112 of this Part.

The Director 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 Director, in determining that the necessary basis for exceptional increase exists, shall also determine any potential offsets to higher claims costs.

~~Electronic Home Response Services may include, but is not limited to, services designed to provide a 24 hour per day emergency communication link to assistance outside the home for individuals so severely disabled that they are incapable of using conventional or modified communication devices such as the telephone, and who have no other persons available in the home should an emergency arise.~~

~~*Group Long-Term Care Insurance*, as defined in Section 351A-1 of the ~~Illinois Insurance~~ Code [215 ILCS 5/351A-1], ~~means a~~ *traditional* long-term care insurance policy which is delivered or issued for delivery in this State and issued to one of the following:~~

~~*One or more employers or labor organizations, or to a trust or to the trustee(s) of a fund established by one or more employers or labor*~~

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organizations, or a 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.

Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

~~is~~ composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

~~has~~ been maintained in good faith for purposes other than obtaining insurance.

An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this State, the association or associations, or the insurer of the association or associations, shall file evidence with the Director that the association or associations have at the outset a minimum of 100 members 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 by-laws which provide that:

the association or associations hold regular meetings not less than annually to further purposes of the members;

except for credit unions, the association or associations collect dues or solicit contributions from members; and

the members have voting privileges and representation on the governing board and committees.

Thirty days after such filing the association or associations will be deemed to satisfy such organizational requirements, unless the Director makes a finding that the association or associations do not satisfy those organizational requirements.

A group other than as described in subparagraphs under the definition of Group Long-Term Care Insurance, subject to a finding by the Director

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that:

~~the~~*The* issuance of the group policy is not contrary to the best interest of the public;

~~the~~*The* issuance of the group policy would result in economies of acquisition or administration; and

~~the~~*The* benefits are reasonable in relation to the premiums charged.

~~The standards to be used by the Director for determining whether a group is eligible shall include, but not be limited to: the policy shall not contain broad or misleading exclusions; premiums for group policies are less than premiums for individual policies; and the loss ratio complies with the requirements of Section 2012.110.~~

~~Homemaker Service may include, but is not limited to, nonmedical support provided by trained and professionally supervised homemakers to maintain, strengthen and safeguard the functioning of individuals in their own homes.~~

~~Incidental, as used in Section 2012.112(j) of this Part, means that the value of the long-term care benefit provided is less than 10% 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.~~

~~Insurer includes: insurance companies; fraternal benefit societies; nonprofit health, hospital, and medical service corporations; prepaid health plans; health maintenance organizations or any similar organization.~~

~~Maintenance Home Health Care Services may include, but is not limited to, medically related services provided in the home in accordance with services prescribed by a physician. Specific components of maintenance home health care may include: nursing services, physical, respiratory or speech therapy; medical/health care services provided by a home health care aide.~~

~~Maintenance or Personal Care Services, within the meaning of the internal Revenue Code of 1986, as amended (26 USC 7702B(c)(3)), 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~~

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(including the protection from threats to health and safety due to severe cognitive impairment).

Policy, as defined in Section 351A-1 of the Illinois Insurance Code [215 ILCS 5/351A-1], means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in this State by an insurer, fraternal benefit society, non-profit health, hospital, or medical service corporation, prepaid health plan, health maintenance organization or any similar organization.

Qualified Actuary means a member in good standing of the American Academy of Actuaries.

Qualified Long-Term Care Contract means any insurance contract that provides only coverage of qualified long-term care services and is guaranteed renewable, and does not provide for cash surrender value or other money that can be paid, assigned, pledged or borrowed. Dividends and refunds, other than refunds paid upon death of the insured or complete surrender or cancellation of the contract, may only be used to reduce future premiums or increase future benefits. Qualified long-term care contracts do not pay or reimburse expenses that are reimbursable under Medicare, except when Medicare is a secondary payor or when the contract makes payments per diem or on another periodic basis without regard to actual expenses, and must satisfy consumer protective provisions for long-term care insurance.

Qualified Long-Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitation services, and maintenance or personal care services that are required by a chronically ill individual, that are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

Respite Service may include, but is not limited to, temporary care for insureds aimed at relieving stress for the insureds' families. Respite service shall be provided for vacation, rest, errands, family crisis or emergency.

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 of "Group Long-Term Care Insurance" found in Section 351A-1(e)(1)

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of the Code 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, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

~~Traditional~~ *Long-Term Care Insurance*, as defined in Section 351A-1 of the ~~Illinois Insurance~~ Code [215 ILCS 5/351A-1], means any accident and health insurance policy or rider 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 services, provided in a setting other than an acute care unit of a hospital. ~~The~~ *Such* term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of function 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 organization, 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, hospital confinement indemnity coverage, major medical expense coverage, disability income ~~or related asset~~-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may include benefits for care and treatment in accordance with the tenets and practices of any established church or religious denomination which teaches reliance on spiritual treatment through prayer for healing.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.40 Policy Definitions

- a) For policies issued after January 1, 2009, 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

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requirements.

"Activities of Daily Living" means at least bathing, continence, dressing, eating, toileting and transferring.

"Acute Condition" means a condition that causes the individual to be medically unstable. Such individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

"Adult Day Care" means a program, for 6 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.

"Assistive Equipment" may include, but is not limited to, tangible personal property with a useful life of at least one year, expressly designed and used for increasing independent functioning in specific tasks or activities of independent living in the home that directly results in a demonstrated decrease in need for assistance from another individual in performing certain tasks or activities.

"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.

"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.

"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).

"Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

"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.

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"Electronic Home Response Services" may include, but are not limited to, services designed to provide a 24 hour per day emergency communication link to assistance outside the home for individuals so severely disabled that they are incapable of using conventional or modified communication devices such as the telephone, and who have no other persons available in the home should an emergency arise.

"Hands-on Assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

"Home Health Care Services" means medical and nonmedical services provided to ill, disabled or infirmed persons in their residences. Examples of such services may include, but are not limited to, homemaker services, assistance with activities of daily living and respite care services.

"Homemaker Service" may include, but is not limited to, non-medical support provided by trained and professionally supervised homemakers to maintain, strengthen and safeguard the functioning of individuals in their own homes.

"Licensed Health Care Practitioner" means any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets requirements as may be prescribed by the Secretary.

"Maintenance Home Health Care Services" may include, but is not limited to, medically related services provided in the home in accordance with services prescribed by a physician. Specific components of maintenance home health care may include: nursing services; physical, respiratory or speech therapy; and medical/health care services provided by a home health care aide.

"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 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.

"Mental or Nervous Disorder" shall not be defined to include more than neurosis,

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psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder.

"Personal Care" means the provision of hands-on services to assist an individual with activities of daily living, such as bathing, eating, dressing, transferring and toileting.

"Plan of Care" in qualified plans means the specific type and frequency of all services required to maintain the individual in the community, the service providers, and the cost of services. The plan of care shall be specified in writing by a licensed health care provider.

"Respite Service" may include, but is not limited to, temporary care for insureds aimed at relieving stress for the insureds' families. Respite service shall be provided for vacation, rest, errands, family crisis or emergency.

"Skilled Nursing Care", "Intermediate Care", "Personal Care", "Home Care", "Specialized Care", "Assisted Living Care" and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

"Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

"Transferring" means moving into or out of a bed, chair or wheelchair.

- b) For policies issued after January 1, 2009, all providers of services, including, but not limited to, "skilled nursing facility", "intermediate care facility", "extended care facility", "specialized care providers", "assisted living facility", "convalescent nursing home", "personal care facility", and "home care agency" shall be defined in relation to the services and facilities required to be available and the licensure, certification, registration or degree status of those providing or supervising the services. When the definition requires that the provider be appropriately licensed, certified or registered, it shall also state what requirements a provider must meet in lieu of licensure, certification or registration when the state in which the service is to be furnished does not require a provider of these services to be licensed, certified or registered, or when the state licenses, certifies or registers the provider of services under another name.

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c) For policies issued prior to January 1, 2009, no ~~No~~ insurance policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a traditional long-term care policy unless the policy or subscriber contract contains definitions or terms that are not more restrictive than the requirements of this Section.

"Activities of Daily Living" means at least bathing, continence, dressing, eating, toileting and transferring.

"Acute Condition" means a condition that causes the individual to be medically unstable. Such individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

"Adult Day Care" means a program for 6 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.

All providers of services, including but not limited to skilled nursing facility, intermediate care facility, convalescent nursing home, personal care facility, and home care agency shall be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified.

"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.

"Chronically Ill Individual", for all traditional long-term care policies that are marketed as "qualified" pursuant to the Internal Revenue Code of 1986, as amended (26 USC 7702B(c)(2)(A)), the term "chronically ill individual" means any individual who has been certified by a licensed health care practitioner as:

Ⓜ) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity,

Ⓜ) requiring substantial supervision to protect such individual from threats to

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health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed health care practitioner has certified that such individual meets such requirements.

"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~~judgement as it relates to safety awareness.

"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).

"Dressing" means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

"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.

"Exceptional Increase" means only those increases filed by an insurer as exceptional for which the Director determines the need for the premium rate increase is justified:

Due to changes in laws or regulations applicable to traditional 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 proved in Section 2012.112, exceptional increases are subject to the same requirements as other premium rate schedule increases.

The Director 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.

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The Director, in determining that the necessary basis for exceptional increase exists, shall also determine any potential offsets to higher claims costs.

"Hands-on Assistance" means physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform the activity of daily living.

"Home Health Care Services" means medical and nonmedical services provided to ill, disabled or ~~infirm~~~~informed~~ persons in their residences. Examples of such services may include but are not limited to homemaker services, assistance with activities of daily living and respite care services.

"Incidental", as used in Section 2012.112(j), means that the value of the traditional long-term care benefit provided is less than 10% 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.

"Licensed Health Care Practitioner" means any physician (as defined in Section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets requirements as may be prescribed by the Secretary.

"Maintenance or Personal Care Services" within the meaning of the internal Revenue Code of 1986, as amended (26 USC 7702B(c)(3)), 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).

"Medicare" means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as ~~Then~~~~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. ~~42 U.S.C.A. Section 1395 et seq., including the "Medicare Catastrophic Coverage Act of 1988."~~

"Mental or Nervous Disorder" shall not be defined to include more than neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or

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disorder ~~of any kind~~.

"Personal Care" means the provision of hands-on services to assist an individual with activities of daily living, such as bathing, eating, dressing, transferring and toileting.

"Plan of Care" in qualified plans means the specific type and frequency of all services required to maintain the individual in the community, the service providers, and the cost of services. The plan of care shall be specified in writing by a licensed health care provider.

"Qualified Actuary" means a member in good standing of the American Academy of Actuaries.

"Qualified Long-Term Care Contract" means any insurance contract that provides only coverage of qualified long-term care services and is: guaranteed renewable; does not provide for cash surrender value or other money that can be paid, assigned, pledged or borrowed; dividends and refunds, other than refunds paid upon death of the insured or complete surrender or cancellation of the contract may only be used to reduce future premiums or increase future benefits; contract does not pay or reimburse expenses that are reimbursable under Medicare, except when Medicare is a secondary payor or when the contract makes payments per diem or on another periodic basis without regard to actual expenses; and consumer protective provisions for traditional long-term care insurance are satisfied.

"Qualified Long-Term Care Services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitation services, and maintenance or personal care services that are required by a chronically ill individual and provided pursuant to a plan of care prescribed by a licensed health care practitioner.

"Similar Policy Forms" means all of the traditional long-term care insurance policies and certificates issued by an insurer in the same traditional long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition found in Section 2012.30 are not considered similar to certificates or policies otherwise issued as traditional long-term care insurance, but are similar to other comparable certificates with the same traditional long-term care benefit classifications. For purposes of determining similar policy

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forms, traditional long-term care benefit classifications are defined as follows: institutional traditional long-term care benefits only, non-institutional traditional long-term care benefits only, or comprehensive traditional long-term care benefits.

"Skilled Nursing Care", "Intermediate Care", "Personal Care", "Home Care", and other services shall be defined in relation to the level of skill required, the nature of the care and the setting in which care must be delivered.

"Toileting" means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

"Transferring" means moving into or out of a bed, chair or wheelchair.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.50 Policy Practices and Provisions

- a) Renewability. The terms "guaranteed renewable" and "noncancellable" shall not be used in any ~~group and individual direct response or individual~~ ~~traditional~~ long-term care insurance policy or certificate without explanatory language in accordance with the disclosure requirements of Section 2012.70 of this Part.
- 1) A policy issued to an individual shall not contain renewal provisions other than "guaranteed renewable" or "noncancellable". ~~No such policy or certificate issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable."~~
 - 2) The term "guaranteed renewable" may be used only when the insured has the right to continue the ~~traditional~~ 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, except that rates may be revised by the insurer on a class basis.
 - 3) The term "noncancellable" may be used only when the insured has the right to continue the ~~traditional~~ 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

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premium rate.

- 4) The term "level premium" may only be used when the insurer does not have the right to change the premium.
 - 5) In addition to the other requirements of subsection (a) of this Section, a qualified long-term care insurance contract shall be guaranteed renewable, within the meaning of Section 7702B(b)(1)(C) of as required by the Internal Revenue Code of 1986, as amended ~~(26 USC 7702B(b)(1)(C))~~.
- b) Limitations and Exclusions. A policy may not~~No policy may~~ be delivered or issued for delivery in this State as ~~traditional~~ long-term care insurance if thesuch policy limits or excludes coverage by type of illness, treatment, medical condition or accident, except as follows:
- 1) Preexisting conditions or diseases;
 - 2) Mental or nervous disorders; however, this shall not permit exclusion or limitation of benefits on the basis of Alzheimer's Disease or senile dementia;
 - 3) Alcoholism and drug addiction;
 - 4) Illness, treatment or medical condition arising out of:
 - A) war or act of war (whether declared or undeclared);
 - B) participation in a felony, riot or insurrection;
 - C) service in the armed forces or units auxiliary thereto;
 - D) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury; or
 - E) 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

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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 traditional long-term care insurance or health insurance policy;
- 7) In the case of a tax 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;
- 8) This subsection (b) is not intended to prohibit exclusions and limitations by type of provider for payment of services provided outside the United States. However, no long term care issuer may deny a claim because services are provided in a state other than in the state in which the policy was issued under the following conditions:
 - A) When the state other than the state in which the policy was issued does not have the provider licensing, certification or registration required in the policy, but when the provider satisfies the policy requirements outlined for providers in lieu of licensure, certification or registration; or
 - B) When the state other than the state of policy issue licenses, certifies or registers the provider under another name.
- 9) This subsection (b) is not intended to prohibit territorial limitations.
- c) Extension of Benefits. Termination of ~~traditional~~ long-term care insurance shall be without prejudice to any benefits payable for institutionalization if such institutionalization began while the ~~traditional~~ long-term care insurance was in force and continues without interruption after termination. Such extension of benefits beyond the period the ~~traditional~~ 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.

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d) Continuation or Conversion

- 1) Group ~~traditional~~ long-term care insurance issued in this State on or after February 1, 1994 shall provide covered individuals with a basis for continuation or conversion of coverage.
- 2) For the purposes of this Section, "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 ~~and~~/or facilities may provide continuation benefits which are substantially equivalent to the benefits of the existing group policy. The Director ~~shall make, in making~~ a determination as to the substantial equivalency of benefits, and in doing so shall take into consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity.
- 3) For the purposes of this Section, "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.
- 4) For the purposes of this Section, "converted policy" means an individual policy of ~~traditional~~ long-term care insurance providing benefits identical to or benefits determined by the Director 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 the provision of benefits and services, or contains incentives to use certain providers and/or facilities, the Director, in making a determination as to the substantial equivalency of benefits, shall take into

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consideration the differences between managed care and non-managed care plans, including, but not limited to, provider system arrangements, service availability, benefit levels and administrative complexity. [The converted policy offered shall be on a form that is available for general sale in this State.](#)

- 5) 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 thirty-one 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 guaranteed renewable.
- 6) 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.
- 7) Continuation of coverage or issuance of a converted policy shall be mandatory, except where:
 - A) Termination of group coverage resulted from an individual's failure to make any required payment of premium or contribution when due; or
 - B) The terminating coverage is replaced not later than 31 days after termination, by group coverage effective on the day following the termination of coverage:
 - i) Providing benefits identical to or benefits [determined by the Director to be substantially similar to, or equivalent in design and actuarially equivalent in value](#) in excess of, those provided by the terminating coverage; and
 - ii) The premium for which is calculated in a manner consistent with the requirements of subsection (d)(6) of this Section.

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- 8) Notwithstanding any other provision of this Section, a converted policy issued to an individual who at the time of conversion is covered by another ~~traditional~~ long-term care insurance policy ~~that~~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% 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.
 - 9) 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.
 - 10) Notwithstanding any other provision of this Section, any insured individual whose eligibility for group ~~traditional~~ long-term care coverage is based upon his or her 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.
 - 11) For the purposes of this Section, 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.
- e) Discontinuance and Replacement
- If a group ~~traditional~~ long-term care policy is replaced by another group ~~traditional~~ 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:
- 1) Shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and

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- 2) Shall not vary or otherwise depend on the individual's health or disability status, claim experience or use of ~~traditional~~ long-term care services.
- f) The premiums charged to an insured ~~for traditional 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.
- g) No ~~traditional~~ long-term care insurance policy shall: ~~1) be cancelled, nonrenewed or otherwise terminated on grounds of the age or deterioration of the mental or physical health of the insured individual or certificateholder; 2) contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by new, or other coverage except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; 3) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.~~
- h) Electronic Enrollment for Group Policies
 - 1) In the case of a group defined in Section ~~351A-1(e) of the Code~~ 2012.30 of this Part, any requirement that a signature of an insured be obtained by an insurance 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 assure the accuracy, retention and prompt retrieval of records; and
 - C) The telephonic or electronic enrollment provides necessary and reasonable safeguards to assure that the confidentiality of individually identifiable information and privileged information is maintained.
 - 2) Upon request of the Director the insurer shall make available records that

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will demonstrate the insurer's ability to confirm enrollment and coverage amounts.

- i) Except for subsections (a)(1), (b)(8) and (9) and (g), which become effective January 1, 2009, subsections (a) through (h) become effective July 1, 2008.
- j) For policies issued from July 1, 2008 through January 1, 2009, the following requirements taken from subsections (a)(1), (b)(8) and (g) apply:
 - 1) For purposes of subsection (a), no individual long-term care insurance policy or certificate issued to an individual shall contain renewal provisions less favorable to the insured than "guaranteed renewable".
 - 2) Subsection (b) is not intended to prohibit exclusions and limitations for payment of services provided outside the United States.
 - 3) For purposes of subsection (g), no traditional long-term care insurance policy shall:
 - A) be cancelled, nonrenewed or otherwise terminated on grounds of the age or deterioration of the mental or physical health of the insured individual or certificateholder;
 - B) contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by new or other coverage, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;
 - C) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
 - 4) There is no requirement for subsection (b)(9) prior to January 1, 2009.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.55 Unintentional Lapse

Each insurer offering ~~traditional~~ long-term care insurance shall, as a protection against

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unintentional lapse, comply with the following:

- a) Notice before lapse or termination.
 - 1) No individual ~~traditional~~ long-term care policy or certificate shall be issued until the insurer has received from the applicant 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 ~~traditional~~ 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 also notify the insured of the right to change this written designation, no less often than once every 2 years.
 - 2) When the policyholder or certificateholder pays premium for a ~~traditional~~ long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in subsection (a)(1)~~-above~~ need not be met until 60 days after the policyholder or certificateholder 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.
 - 3) Lapse or termination for nonpayment of premium. No individual ~~traditional~~ 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 subsection (a)(1)~~-above~~, at the

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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 shall not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing.

- b) In addition to the requirements of subsection (a) ~~above~~, a ~~traditional~~ long-term care insurance policy or certificate shall include a provision ~~that~~~~which~~ provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof ~~that the policyholder or certificateholder was cognitively impaired or had a cognitive impairment, the loss of functional capacity before the grace period contained in the policy expired or if the insured would otherwise qualify for benefits under the contract~~. This option shall be available to the insured if requested within 5 months after termination and shall allow for the collection of past due premium ~~when 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~~ contained in the policy and certificate.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.60 Required Disclosure Provisions

- a) Renewability. Individual ~~traditional~~ long-term care insurance policies shall contain a renewability provision. ~~The~~~~Such~~ provision shall be ~~appropriately~~ captioned ~~as a Renewal~~, shall appear on the first page of the policy, and shall clearly state that the coverage is guaranteed renewable or noncancellable. This provision shall not apply to policies which do not contain a renewability provision and under which the right to renew is reserved solely to the policyholder. A ~~traditional~~ long-term care insurance policy or certificate, other than one where the insurer does not have the right to change the premium, shall include a statement that premium rates may change.
- b) Riders and Endorsements. Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured under an individual ~~traditional~~ long-term care insurance policy, all riders or endorsements added to an individual ~~traditional~~ long-term care insurance policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the individual insured. After the date of

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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 are 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.

- c) Payment of Benefits. A ~~traditional~~ long-term care insurance policy or certificate ~~that~~ ~~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.
- d) ~~Limitations~~ ~~Preexisting Conditions~~: If a ~~traditional~~ long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled "Preexisting Condition Limitations-". Limitations to preexisting conditions shall be in accordance with Section 351A-5 of the ~~Illinois Insurance~~ Code ~~[215 ILCS 5/351A-5]~~.
- e) Other Limitations or Conditions on Eligibility for Benefits. In addition to complying with Section 351A-6 of the ~~Illinois Insurance~~ Code, beginning August 30, 1990, a ~~traditional~~ long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in Section 351A-6 shall set forth a description of such 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-".
- f) Disclosure Requirements for Accelerated Life Products
 - 1) Policy Summary

At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy ~~that~~ ~~which~~ provides ~~traditional~~ long-term care benefits within the policy or by rider. This requirement does not apply to qualified long-term care insurance contracts. 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

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all applicable requirements, the summary shall also include:

- A) an explanation of how the ~~traditional~~ 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 exclusion, reductions and limitations on benefits of ~~traditional~~ long-term care; and
- D) if applicable to the policy type, the summary shall also include:
 - i) disclosure of the effects of exercising other rights under the policy;
 - ii) disclosure of guarantees related to ~~traditional~~ long-term care costs of insurance charges; and
 - iii) current and projected maximum lifetime benefits.

2) Benefit Reports

Any time a ~~traditional~~ long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The Such report shall include:

- A) any ~~traditional~~ long-term care benefits paid during the month;
- B) an explanation of any changes in the policy, including changes in death benefits or cash values, due to ~~traditional~~ long-term care benefits being paid out; and
- C) the amount of ~~traditional~~ long-term care benefits existing or remaining.

3) Outline of Coverage

The Outline of Coverage should include an example filled out in John Doe

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form ~~that~~which illustrates how the ~~traditional~~ long-term care benefit is calculated. Refer to Section 2012.110 and Exhibit C for format and content requirements.

- g4)** Disclosure of Tax Consequences. With regard to life insurance policies that provide an accelerated benefit for ~~traditional~~ 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. This disclosure statement shall be prominently displayed on the first page of the policy or rider and any other related documents. This subsection ~~(g)(4)~~ shall not apply to qualified long-term care insurance contracts.
- hg)** Benefit Triggers. Activities of daily living and cognitive impairment shall be used to measure an insured's need for ~~traditional~~ 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 functional dependency in order to be eligible for benefits, this too shall be specified.
- ih)** A qualified long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in ~~Section 2012~~.Exhibit C(3) of this Part that indicates that the policy is intended to be a qualified long-term care insurance contract under Section 7702B(b) within the meaning of the Internal Revenue Code of 1986, as amended (26 USC 7702B(b)).
- ji)** A nonqualified traditional long-term care insurance contract shall include a disclosure statement in the policy and in the outline of coverage as contained in ~~Section 2012~~.Exhibit C(3) of this Part. The disclosure statement shall indicate that ~~indicates~~ that the policy is not intended to be a qualified long-term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended (26 USC 7702B).

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.62 Required Disclosure of Rating Practices to Consumers

- a) This Section shall apply as follows:
- 1) Except as provided in subsection (a)(2), this Section applies to any ~~traditional~~ long-term care policy issued in this State on or after January 1, 2003.
 - 2) For certificates issued on or after July 1, 2002, under a group ~~traditional~~ long-term care insurance policy as defined in Section ~~351A-1(e)(1) of the Code that 2012.30, which policy~~ was in force prior to July 1, 2002, the provisions of this Section shall apply on the policy anniversary following July 1, 2003.
- b) 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 subsection (b) of this Section~~ this subsection (b) 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 Section to the applicant no later than at the time of delivery of the policy or certificate.
- 1) A statement that the policy may be subject to rate increases in the future;
 - 2) An explanation of potential future premium rate revisions, and the policyholder's or certificateholder's option in the event of a premium rate revision;
 - 3) The premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;
 - 4) A general explanation for applying premium rate or rate schedule adjustments that shall include:
 - A) A description of when premium rate or rate schedule adjustments will be effective (e.g., next anniversary date, next billing date, etc.); and
 - B) The right to a revised premium rate or rate schedule as provided in

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subsection (b)(3)(2) of this Section if the premium rate or rate schedule is changed;

5) Required Rate Information

- A) Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this State or any other state that, at a minimum, identifies:
- i) The policy forms for which premium rates have been increased;
 - ii) The calendar years when the form was available for purchase; and
 - iii) 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.
- B) The insurer may, in a fair manner, provide additional explanatory information related to the rate increases.
- C) 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 ~~traditional~~ long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.
- D) If an acquiring insurer files for a rate increase on a ~~traditional~~ long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before July 1, 2002, 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 nonaffiliated selling company shall include the disclosure of that rate increase in accordance with subsection (b)(5)(A) of this Section.

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- E) If the acquiring insurer in subsection (b)(5)(D) of this Section 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 subsection (b)(5)(D) of this Section, the acquiring insurer shall make all disclosures required by subsection (b)(5)(A) of this Section, including disclosure of the earlier rate increase referenced in subsection (b)(5)(D) of this Section.
- c) 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 subsections (b)(1) and (5) of this Section. 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.
- d) An insurer shall use Exhibits F and J to comply with the requirements of subsections ~~(b) and (c)(a) and (b)~~ of this Section.
- e) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificateholders, 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 subsection (b) of this Section when the rate increase is implemented.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.64 Initial Filing Requirements

- a) This Section applies to any ~~traditional~~ long-term care policy issued in this State on or after January 1, 2003.
- b) An insurer shall provide the information listed in ~~this~~ subsection (b) ~~of this Section~~ to the Director 30 days prior to making a ~~traditional~~ long-term care insurance form available for sale.
- 1) A copy of the disclosure documents required in Section 2012.62; and

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- 2) An actuarial certification consisting of at least the following:
- A) 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;
 - B) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
 - C) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
 - D) A complete description of the basis for contract reserves that are anticipated to be held under the form, to include:
 - i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;
 - ii) A statement that the assumptions used for reserves contain reasonable margins for adverse experience;
 - iii) A statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and
 - iv) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses. If such a statement cannot be made, a complete description of the situations where this does not occur must be provided and shall include an aggregate distribution of anticipated issues that may be used as long as the underlying gross premiums maintain a reasonably consistent relationship. In the event that gross premiums for a certain age group appear to be inconsistent with this requirement, the Director may request a demonstration under [subsection \(c\)Section 2012.64\(e\)](#)

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based on a standard age distribution; and

- E) 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.
- c) The Director 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. In the event the Director asks for additional information pursuant to this subsection (c), the ~~30 day January 1, 2003~~ timeframe identified in ~~subsection~~ Section 2012.64(b)(a) does not include the period during which the insurer is preparing the requested information.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.65 Prohibition Against Post Claims Underwriting

- a) All applications for ~~traditional~~ long-term care insurance policies or certificates except those which are guaranteed issue shall contain unambiguous questions designed to ascertain the health condition of the applicant.
- 1) If an application for ~~traditional~~ 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.
- 2) If the medications listed in ~~the~~ such application were known by the insurer, or ~~should be known~~ were included in the insurers underwriting standards 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.
- b) Except for policies or certificates ~~that~~ which are guaranteed issue:

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- 1) The following language shall be set out ~~conspicuously and in close conjunction within bold face type on the same page as~~ the applicant's signature block on an application for a traditional long-term care insurance policy or certificate:

Caution: If your answers on this application are incorrect or untrue, [company] may have the right to deny benefits or rescind your policy.

- 2) The following language shall be set out on the ~~traditional~~ long-term care insurance policy or certificate at the time of delivery:

Caution: The issuance of this ~~traditional~~ 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 may have 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]

- 3) Prior to issuance of a ~~traditional~~ long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:

- A) A report of a physical examination;
- B) An assessment of functional capacity;
- C) An attending physician's statement; or
- D) Copies of medical records.

- c) 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 unless it was retained by the applicant at the time of application.

- d) Every insurer, as defined ~~in Section 2012.30 of this Part~~ ~~herein~~, selling or issuing ~~traditional~~ 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

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Director of Insurance in the format prescribed in Exhibit D.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

**Section 2012.70 Minimum Standards for Home Health and Community Care Benefits in
~~Traditional~~ Long-Term Care Insurance Policies**

- a) A ~~traditional~~ long-term care insurance policy or certificate may not, if it provides benefits for home health care or community care services, limit or exclude benefits:
- 1) By requiring that the insured/claimant would need skilled care in a skilled nursing facility if home health care services were not provided;
 - 2) By requiring that the insured/claimant first or simultaneously receive nursing and/or therapeutic services in a home or community or institutional setting before home health care services are covered;
 - 3) By limiting eligible services to services provided by registered nurses or licensed practical nurses;
 - 4) 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 his or her licensure or certification;
 - 5) By requiring that the insured/claimant have an acute condition before home health care services are covered;
 - 6) By excluding coverage for personal care services provided by a home health aide;
 - 7) 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;
 - 8) By limiting benefits to services provided by Medicare-certified agencies or providers;

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- 9) By excluding coverage for adult day care services.
- b) A ~~traditional~~ long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.
- c) 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.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.80 Requirement to Offer Inflation Protection

- a) No insurer may offer a ~~traditional~~ long-term care insurance policy unless the insurer also offers to the policyholder in addition to any other inflation protection 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 ~~traditional~~ 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:
 - 1) Increases benefit levels annually (in a manner so that the increases are compounded annually at a rate not less than 5%);
 - 2) 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% for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or
 - 3) Covers a specified percentage of actual or reasonable charges and does not

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include a maximum specified indemnity amount or limit.

- b) Where the policy is issued to a group, the required offer in subsection (a) ~~above~~ shall be made to the group policyholder; except, if the policy is issued to a discretionary group, as defined in Section 351A-1(e)(4) of the Code, other than to a continuing care retirement community, the offering shall be made to each proposed certificateholder.
- c) The offer in subsection (a) ~~above~~ shall not be required of life insurance policies or riders containing accelerated ~~traditional~~ long-term care benefits.
- d) Insurers shall include the following information in the outline of coverage:
 - 1) 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.
 - 2) 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.~~
 - 3) An insurer may use a reasonable hypothetical or a graphic demonstration for the purposes of this disclosure.
- e) Inflation protection benefit increases under a policy which contains such 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.
- f) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. ~~The~~Such offer shall disclose in a conspicuous manner~~bold face type~~ that the premium may change in the future unless the premium is guaranteed to remain constant.
- g) Inflation protection as provided in subsection (a)(1) of this Section shall be

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included in a ~~traditional~~ long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required by this Section hereunder. 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 plan(s) _____, and I reject inflation protection."

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.83 Incontestability Period

- a) For a policy or certificate that has been in force for less than 6 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.
- b) For a policy or certificate that has been in force for at least 6 months but less than 2 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 that pertains to the condition for which benefits are sought.
- c) After a policy or certificate has been in force for 2 years, it is not contestable upon the grounds of misrepresentation alone; the 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.
- d) A long-term care insurance policy or certificate may be field issued based on medical or health status if the compensation to the field issuer is not based on the number of policies or certificates issued. For purposes of this Section, "field issued" means a policy or certificate issued by a producer or an agent or a third-party administrator pursuant to the underwriting authority granted to the producer, agent or third party administrator by an insurer and using the insurer's underwriting guidelines.
- e) 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.

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- f) In the event of the death of the insured, this Section 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 Section 224(1)(c) of the Code. In all other situations, this Section shall apply to life insurance policies that accelerate benefits for long-term care.

(Source: Added at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.86 Nonforfeiture Benefits

- a) Except as provided in subsection (b), a long-term care insurance policy may not be delivered or issued for delivery in this State unless the policyholder or certificateholder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit as specified in Section 2012.127 of this Part. 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 certificateholder 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.
- b) When a group long-term care insurance policy is issued, the offer required in subsection (a) shall be made to the group policyholder. However, if the policy is issued as group long-term care insurance as defined in Section 351A-1(e)(4) of the Code, other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificateholder.

(Source: Added at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.90 Requirements for Application Forms and Replacement Coverage

- a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another ~~traditional~~ long-term care insurance policy or certificate in force or whether a ~~traditional~~ long-term care policy or certificate is intended to replace any other accident and sickness or ~~traditional~~ long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer, except where the coverage is sold without an

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insurance producer, containing such questions may be used. With regard to a replacement policy issued to a group defined by [Section 351A-1\(e\)\(1\) of the Code](#)~~Section 2012.30 of this Part~~ the following questions may be modified only to the extent necessary to elicit information about health or ~~traditional~~ long-term care insurance policies other than the group policy being replaced; provided, however, that the certificateholder has been notified of the replacement.

- 1) Do you have another ~~traditional~~ long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?
 - 2) Did you have another ~~traditional~~ long-term care insurance policy or certificate in force during the last 12 months?
 - A) If so, with which company?
 - B) If that policy lapsed, when did it lapse?
 - 3) Are you covered by Medicaid?
 - 4) Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?
- b) Insurance producers shall list any other health insurance policies they have sold to the applicant.
- 1) List policies sold which are still in force.
 - 2) List policies sold in the past 5 years which are no longer in force.
- c) 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 insurance producer, shall furnish the applicant, prior to issuance or delivery of the individual ~~traditional~~ long-term care insurance policy, a notice regarding replacement of accident and sickness or ~~traditional~~ 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 as set forth in Exhibit A of this Part.

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- d) Direct Response Solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or ~~traditional~~ long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided as set forth in Exhibit B of this Part.
- e) Where replacement is intended, the replacing insurer shall provide written notice to the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of insured and policy number or address including zip code. Notice shall be made within 5 working days from the date the application is received by the insurer or the date the policy issued, whichever is sooner.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.95 Reporting Requirements

All insurers shall:

- a) Maintain records for each insurance producer of that producer's amount of replacement sales as a percent of the producer's total annual sales and the amount of lapses of ~~traditional~~ long-term care insurance policies sold by the insurance producer as a percent of the producer's total ~~renewing~~ sales. ~~Total renewing sales means policies in force at the end of the calendar year prior to the year of lapse.~~
- b) Report annually by June 30 the 10% of its insurance producers with the greatest percentages of lapses and replacements as measured by subsection (a) ~~above as provided in Exhibit K of this Part. The reports shall include lapses and replacements that occur in the most recent calendar year ending December 31. Only insurance producers with at least 10 total renewing sales, or 5 new sales in the report period shall be included in the lapse report.~~
- c) 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 as provided in Exhibit K of this Part.
- d) 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 as provided in Exhibit K of this Part.

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- e) ~~Report~~~~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, as provided by. Please see Exhibit I of this Part.
- f) For purposes of this Section:
- 1) "Policy" means only ~~traditional~~ long-term care insurance;
 - 2) Subject to subsection (f)(3) of this Section, "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;
 - 3) "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
 - 4) "Report" means on a Statewide basis.
- g) Reports required under this Section shall be filed with the Director.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.100 Filing Requirement

Prior to an insurer offering ~~traditional~~ group ~~traditional~~ long-term care insurance to a resident of this State pursuant to Section 351A-2 of the ~~Illinois Insurance~~ Code ~~[215 ILCS 5/351A-2]~~, it shall file with the Director evidence that the group policy or certificate thereunder has been approved by a state that has adopted the National Association of Insurance Commissioners' model legislation on Long-Term Care Insurance and attendant regulations, 2301 McGee Street, Suite 800, Kansas City, Missouri 64108 (2000) (no subsequent dates or editions).

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.110 Loss Ratio

- a) This Section shall apply to all ~~traditional~~ long-term care insurance policies or certificates, except those covered under Sections 2012.64 and 2012.112.

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- b) Benefits under ~~traditional~~ long-term care insurance policies shall be deemed reasonable in relation to premiums ~~if provided~~ the ~~expected lifetime anticipated~~ loss ratio is at least 60%, calculated ~~in a manner that provides for adequate reserving of the long-term care insurance on the basis of the ratio of the present value of the expected benefits to the present value of the expected premiums over the entire period for which rates are computed to provide coverage.~~ In evaluating the ~~expected lifetime anticipated~~ loss ratio, due consideration shall be given to all relevant factors, including the following factors:
- 1) Statistical credibility of incurred claims experience and earned premiums; based on the following factors: claim rates, variability in transaction costs, and number of lives exposed.
 - 2) The period for which rates are computed to provide coverage;
 - 3) Experienced~~Experience~~ and projected trends;
 - 4) Concentration of experience within early policy duration;
 - 5) Expected claim fluctuation;
 - 6) Experience refunds, adjustments or dividends;
 - 7) Renewability features;
 - 8) Interest;
 - 9) Experimental nature of the coverage;
 - 10) Product features such as long elimination periods (period between when the claim arises and insured is eligible to receive benefits), high deductibles and high maximum limits.
- c) Subsection (b) of this Section shall not apply to life insurance policies that accelerate benefits for ~~traditional~~ long-term care. A life insurance policy that funds ~~traditional~~ 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:

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- 1) The interest credited internally to determine cash value accumulations, including ~~traditional~~ long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without ~~traditional~~ long-term care set forth in the policy;
- 2) The portion of the policy that provides life insurance benefits meets the nonforfeiture requirements of Section 229.2 of the ~~Illinois Insurance~~ Code [\[215 ILCS 5/229.2\]](#);
- 3) The policy meets the disclosure requirements of ~~Sections~~[Section 351A-9.1 and 351A-9.2 of the Code](#)~~2012-60~~;
- 4) Any policy illustration that meets the applicable requirements of 50 Ill. Adm. Code 1406;
- 5) An actuarial memorandum is filed with the Department that includes:
 - A) A description of the basis on which the ~~traditional~~ long-term care rates were determined;
 - B) A description of the basis for the reserves;
 - C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;
 - D) 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;
 - E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - F) The estimated average annual premium per policy and the average issue age;
 - G) 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

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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

- H) A description of the effect of the ~~traditional~~ 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 ~~traditional~~ long-term care claim status.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.112 Premium Rate Schedule Increases

- a) This Section shall apply as follows:
- 1) Except as provided in subsection (a)(2) of this Section, this Section applies to any ~~traditional~~ long-term care policy issued in this State on or after January 1, 2003.
 - 2) For certificates issued on or after July 1, 2002, under a group ~~traditional~~ long-term care insurance policy as defined in Section ~~351A-1(e)(1) of the Code 2012.30, if the~~ 351A-1(e)(1) of the Code 2012.30 policy was in force prior to July 1, 2002, the provisions of this Section shall apply on the policy anniversary following July 1, 2003.
- b) An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the Director at least 30 days prior to the notice to the policyholders and shall include:
- 1) Information required by Section 2012.62;
 - 2) Certification by a qualified actuary that:
 - A) If the requested premium rate schedule increase is implemented and the underlying assumptions that reflect moderately adverse conditions are realized, no further premium rate schedule increases are anticipated;

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- B) The premium rate filing is in compliance with the provisions of this Section;
- 3) An actuarial memorandum justifying the rate schedule change request that includes:
- A) 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;
 - i) Annual values for the 5 years preceding and the 3 years following the valuation date shall be provided separately;
 - ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
 - iii) The projections shall demonstrate compliance with subsection (c) of this Section; and
 - iv) 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 Director determines, as provided in the definition of "Exceptional Increase" found in Section 2012.30, that offsets may exist, the insurer shall use appropriate net projected experience;
 - B) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger the contingent benefit upon lapse;
 - C) 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;

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- D) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration; and
 - E) 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;
- 4) 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 Director; and
 - 5) Sufficient information for review by the Director of the premium rate schedule increase.
- c) All premium rate schedule increases shall be determined in accordance with the following requirements:
- 1) Exceptional increases shall provide that 70% of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
 - 2) 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:
 - A) The accumulated value of the initial earned premium times 58%;
 - B) 85% of the accumulated value of prior premium rate schedule increases on an earned basis;
 - C) The present value of future projected initial earned premiums times 58%; and
 - D) 85% of the present value of future projected premiums not in subsection (c)(2)(C) of this Section on an earned basis;

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- 3) In the event that a policy form has both exceptional and other increases, the values in subsections (c)(2)(B) and (D) of this Section will also include 70% for exceptional rate increase amounts; and
 - 4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in 50 Ill. Adm. Code 2004.20(e) (Accident and Health Reserves). The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.
- d) For each rate increase that is implemented, the insurer shall file for review by the Director updated projections, as defined in subsection (b)(3)(A) of this Section, annually for the next 3 years and include a comparison of actual results to projected values. The Director may extend the period to greater than 3 years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in subsection (k) of this Section, the projections required by this subsection (d) shall be provided to the policyholder in lieu of filing with the Director.
 - e) If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, lifetime projections, as defined in subsection (b)(3)(A) of this Section, shall be filed for review by the Director every 5 years following the end of the required period in subsection (d) of this Section. For group insurance policies that meet the conditions in subsection (k) of this Section, the projections required by this subsection (e) shall be provided to the policyholder in lieu of filing with the Director.
 - f) If the Director 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 subsection (c) of this Section, the Director:
 - 1) 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.

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- 2) Should give consideration to subsection (b)(3)(E) of this Section when determining whether the actual experience adequately matches the projected experience.
- g) 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:
- 1) A plan, subject to the Director's 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 Director may impose the condition in subsection (h) of this Section; and
 - 2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subsection (c) of this Section had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in subsections (c)(~~2~~)(A) and (c)(2)(C) of this Section.
- h) The Director 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) For a rate increase filing that meets the following criteria:
 - A) The rate increase is not the first rate increase requested for the specific policy form or forms;
 - B) The rate increase is not an exceptional increase; and
 - C) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.
 - 2) 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 Director may determine that a rate spiral exists. Following the

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determination that a rate spiral exists, the Director 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.

- A) The offer shall:
 - i) Be subject to the approval of the Director;
 - ii) Be based on actuarially sound principles, but not be based on attained age; and
 - iii) Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.
- B) 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:
 - i) The maximum rate increase determined based on the combined experience; and
 - ii) The maximum rate increase determined based only on the experience of the insured's originally issued form plus 10%.
- i) If the Director determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for ~~traditional~~ long-term care insurance, the Director may, in addition to the provisions of subsection (h) of this Section, prohibit the insurer from either of the following:
 - 1) Filing and marketing comparable coverage for a period of up to 5 years; or
 - 2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

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- j) Subsections (a) through (i) of this Section shall not apply to policies for which the ~~traditional~~ long-term care benefits provided by the policy are "Incidental", as defined in Section 2012.30, if the policy complies with all of the following provisions:
- 1) The interest credited internally to determine cash value accumulations, including ~~traditional~~ long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without ~~traditional~~ long-term care set forth in the policy;
 - 2) The portion of the policy that provides insurance benefits other than ~~traditional~~ long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:
 - A) Section 229.2 of the ~~Illinois Insurance~~ Code [215 ILCS 5/229.2];
 - B) Section 229.4 of the ~~Illinois Insurance~~ Code [215 ILCS 5/229.4];
 - 3) The policy meets the disclosure requirements of Sections 351A-9.1 and 9.2 of the Code~~2012.60, 2012.62 and 2012.64~~;
 - 4) The portion of the policy that provides insurance benefits other than ~~traditional~~ long-term care coverage meets the requirements as applicable in the following:
 - A) Policy illustrations as required by 50 Ill. Adm. Code 1406;
 - B) Disclosure requirements in 50 Ill. Adm. Code 1451;
 - 5) An actuarial memorandum is filed with the Director that includes:
 - A) A description of the basis on which the ~~traditional~~ long-term care rates were determined;
 - B) A description of the basis for the reserves;
 - C) A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

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- D) 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;
 - E) A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
 - F) The estimated average annual premium per policy and the average issue age;
 - G) 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
 - H) A description of the effect of the ~~traditional~~ 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 ~~traditional~~ long-term care claim status.
- k) Subsections (f) and (h) of this Section shall not apply to group insurance policies as defined in Section [351A-1\(e\)\(1\) of the Code](#) ~~if 2012.30 where:~~
- 1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
 - 2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than 20% of the total premium for the group in the calendar year prior to the year a rate increase is filed.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.115 Filing Requirements for Advertising

Every insurer, as defined herein, providing ~~traditional~~ long-term care insurance or benefits in this State shall comply with 50 Ill. Adm. Code 2002.180.

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(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.120 Reserve Standards

a) When ~~traditional~~ long-term care benefits are provided through the acceleration of benefits under group ~~orand~~ individual life policies or riders to such policies, policy reserves for such benefits shall be determined in accordance with Section 223 of the ~~Illinois Insurance Code [215 ILCS 5/223]~~. Claim reserves must also be established ~~in the case~~ when ~~thesuch~~ policy or rider is in claim status (see 50 Ill. Adm. Code 2004.40). Reserves for policies and riders subject to this subsection 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 reserves which differ from the reserves based on the multiple decrement approach by less than 5% for each combination of issue age and duration, or are greater than the reserves based on the multiple decrement approach, or if the reserves for this line of business are less than 5% of the statutory net worth of the company. The calculations may take into account the reduction in life insurance benefits due to the payment of ~~traditional~~ long-term care benefits. However, in no event shall the reserves for the ~~traditional~~ long-term care benefit and life insurance benefit be less than the reserves for the life insurance benefit assuming no ~~traditional~~ long-term care benefit. In the development and calculation of reserves for policies and riders subject to this subsection, 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:

- 1) Definition of insured events
- 2) Covered ~~traditional~~ long-term care facilities
- 3) Existence of home convalescence care coverage
- 4) Definition of facilities
- 5) Existence or absence of barriers to eligibility
- 6) Premium waiver provision

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- 7) Renewability
 - 8) Ability to raise premiums
 - 9) Marketing method
 - 10) Underwriting procedures
 - 11) Claims adjustment procedures
 - 12) Waiting period
 - 13) Maximum benefit
 - 14) Availability of eligible facilities
 - 15) Margins in claim costs
 - 16) Optional nature of benefit
 - 17) Delay in eligibility for benefit
 - 18) Inflation protection provisions
 - 19) Guaranteed insurability option
- b) The valuation morbidity table shall be accompanied by a statement declaring it as appropriate as a statutory valuation table by a member of the American Academy of Actuaries.
- c) When ~~traditional~~ long-term care benefits are provided other than as in subsection (a) ~~above~~, reserves shall be determined in accordance with Section 353a of the ~~Illinois Insurance~~ Code ~~[215 ILCS 5/353a]~~.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

[Section 2012.121 Producer Training Requirements](#)

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a) Long-Term Care Training Required

- 1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health and has completed a one-time training course. The training shall meet the requirements set forth in subsection (b).
- 2) An individual already licensed and selling, soliciting or negotiating long-term care insurance on July 1, 2008 may not continue to sell, solicit or negotiate long term care insurance unless the individual has completed a one-time training course, as set forth in subsection (b), by July 1, 2009.
- 3) In addition to the one-time training course required in subsection (a)(1) and (2), an individual who sells, solicits or negotiates long-term care insurance shall complete ongoing training as set forth in subsection (b).
- 4) The training requirements of subsection (b) may be approved as continuing education courses under Section 500-35(b)(1) of the Code.

b) Minimum Education and Training Requirements

- 1) The one-time training required by this Section shall be no less than 8 hours and the ongoing training required by this Section shall be no less than 4 hours in 24 months.
- 2) The training required under subsection (b)(1) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance Partnership programs as prescribed in 42 USC 1396p, including, but not limited to:
 - A) 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;
 - B) Available long-term care services and providers;
 - C) Changes or improvements in long-term care services or providers;

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- D) Alternatives to the purchase of private long-term care insurance;
 - E) The effect of inflation on benefits and the importance of inflation protection; and
 - F) Consumer suitability standards and guidelines.
- 3) The training required by this Section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by State or federal law.
- c) Verification of Training
- 1) Insurers subject to this Part shall obtain verification that a producer receives training required by subsection (a) of this Section before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the Director upon request.
 - 2) Insurers subject to this Part shall maintain records with respect to the training of their producers concerning the distribution of their Partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in subsection (b)(2)(A) as required by subsection (a) and that producers have demonstrated an understanding of the Partnership policies and their 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 Director upon request.
- d) The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this State.

(Source: Added at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.122 Standards for Marketing

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- a) Every insurer, as defined herein, marketing ~~traditional~~ long-term care insurance coverage in this State, directly or through its producers, shall:
- 1) Establish marketing procedures and producer training requirements to assure that: ~~any comparison of policies by its producers will be accurate.~~
 - A) Any marketing activities, including any comparison of policies, by its agents or other producers will be fair and accurate; and
 - B) ~~Excessive~~ Establish marketing procedures to assure that excessive insurance is not sold or issued.
 - 2) Display prominently by type or 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 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."
 - 3) Provide copies of the disclosure forms required in Section 2012.62(c) and Exhibits F and J of this Part to the applicant.
 - 4) Inquire of a prospective applicant or enrollee for ~~traditional~~ long-term care insurance, and otherwise make every reasonable effort to identify, whether the applicant or enrollee ~~they~~ already ~~has~~ have accident and sickness or ~~traditional~~ long-term care insurance and the types and amounts of any such insurance, except that, in the case of qualified ~~traditional~~ long-term care insurance contracts, an inquiry into whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance is not required.
 - 5) Every insurer or entity marketing ~~traditional~~ long-term care insurance shall establish auditable procedures for verifying compliance with this subsection.
 - 6) The insurer shall, at solicitation, provide written notice to the prospective policyholder and certificateholder of the Senior Health Insurance Program (SHIP) that such a program is available and the most current name, address and telephone number of the program. The current address and

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toll-free telephone number is 320 W. Washington Street, Springfield, Illinois 62767-0001, 1-800-548-9034.

- 7) For ~~traditional~~ long-term care health insurance policies and certificates, use the terms "noncancellable" or "level premium" only when the policy or certificate conforms to Section 2012.50(a)(3) of this Part.
 - 8) ~~Traditional long-term care insurance policies or certificates sold after July 1, 1995 that are not under the Illinois Long-Term Care Partnership Program shall include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: "THIS POLICY (CERTIFICATE) IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS POLICY (CERTIFICATE) IS AN APPROVED TRADITIONAL LONG-TERM CARE POLICY (CERTIFICATE) UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES APPROVED UNDER THE ILLINOIS TRADITIONAL LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966."~~9) Provide an explanation of the contingent benefit upon lapse provided for in Section 2012.127(d)(2) of this Part and, if applicable, the additional contingent benefit upon lapse provided to policies with fixed or limited premium paying periods in Section 2012.127(d)(3) of this Part.
- b) In addition to the practices prohibited in Article XXVI of the Code, [215 ILCS 5/Art. XXVI et seq.], the following acts and practices are prohibited:
- 1) 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.
 - 2) 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

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recommend the purchase of insurance.

- 3) 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.
 - 4) Misrepresentation. Misrepresenting a material fact in selling or offering to sell a ~~traditional~~ long-term care insurance policy.
- c) With respect to the obligations set forth in this subsection, the primary responsibility of an association when endorsing or procuring ~~traditional~~ long-term care insurance shall be to educate its members concerning ~~traditional~~ long-term care issues in general so that its members can make informed decisions. Associations should provide information regarding ~~traditional~~ long-term care insurance policies or certificates to ensure that members of such associations receive a balanced and complete explanation of the features in the policies or certificates that are being sold by the insurer.
- 1) The insurer shall file with this Department the following material:
 - A) The policy and certificate,
 - B) A corresponding outline of coverage, as referenced in Section 2012.130 and Exhibit C of this Part, and
 - C) All advertisements requested by the Department.
 - 2) The association shall disclose in any ~~traditional~~ long-term care insurance solicitation:
 - A) 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 the endorsement or sale of the policy or certificate to its members, and
 - B) A brief description of the processes under which such policies and the insurer issuing such policies were selected.

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- 3) If the association and the insurer have interlocking directorates or trustee arrangements, the association shall disclose such fact to its members.
- 4) The board of directors of associations shall review and approve such insurance policies as well as the compensation arrangements made with the insurer.
- 5) With respect to long-term care insurance contracts, the association shall also:
 - A) Engage the services of a person with expertise in ~~traditional~~ long-term care insurance, not affiliated with the insurer, to conduct an examination of the policies including its benefits, features, and rates and update such examination thereafter in the event of a material change;
 - B) Actively monitor the marketing efforts of the insurer and its agents; and
 - C) Review and approve all marketing materials or other insurance communications used to promote sales or sent to members regarding the policies or certificates.
- 6) No group ~~traditional~~ long-term care insurance policy or certificate may be issued to an association unless the insurer files with this Department the information required in this subsection (c).
- 7) The insurer shall not issue a ~~traditional~~ 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 subsection (c).
- d) ~~The insurer shall provide producer training as follows:~~
 - 1) ~~The insurer shall provide written evidence to the Department of Insurance that procedures are in place to assure that no producer will be authorized to market, sell, solicit, or otherwise contact any person for the purpose of marketing a traditional long-term care policy or certificate unless the producer has completed 6 hours of training on traditional long-term care~~

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~~insurance as prescribed in Exhibit E of this Part; the course shall be specifically titled "Traditional Long-Term Care Insurance Policy." The traditional long-term care course cannot be included as part of any other certified continuing education course; however, this course may satisfy a part of the continuing education requirements of Section 494.1(c) of the Illinois Insurance Code [215 ILCS 5/491.1(c)]. Insurers and producers shall maintain evidence of completion of the hours of training required and shall provide proof of completion upon request. Such proofs of completion shall be in the format prescribed by 50 Ill. Adm. Code 3119. Exhibit D, and shall be signed by the producer and the provider of the education attesting to the completion of the required training.~~

- 2) ~~The required training hours referenced in subsection 2012.122(d)(1) above may qualify as part of the continuing education requirements of Section 494.1(c) of the Illinois Insurance Code [215 ILCS 5/494.1(c)] only if the training course has been certified under 50 Ill. Adm. Code 3119.30. Each educational provider shall submit its request for certification to the Director on a form prescribed by 50 Ill. Adm. Code 3119. Exhibit B at least 30 days prior to any course being offered. All educational providers and training courses qualifying for continuing education credit shall be renewed on an annual basis.~~

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.123 Suitability

- a) This Section shall not apply to life insurance policies that accelerate benefits for ~~traditional~~ long-term care.
- b) Every insurer, health care service plan or other entity marketing ~~traditional~~ long-term care insurance (the "issuer") shall:
 - 1) Develop and use suitability standards to determine whether the purchase or replacement of ~~traditional~~ long-term care insurance is appropriate for the needs of the applicant;
 - 2) Train its insurance producers in the use of its suitability standards; and
 - 3) Maintain a copy of its suitability standards and make them available for

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inspection upon request by the Director.

- c) To determine whether the applicant meets the standards developed by the issuer:
- 1) The insurance producer and issuer shall develop procedures that take the following into consideration:
 - 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 ~~traditional~~ 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.
 - 2) The issuer, and where an insurance producer is involved, the insurance producer shall make reasonable efforts to obtain the information referenced in subsection (c)(1) of this Section. The efforts shall include presentation to the applicant, at or prior to application, of the "~~Traditional~~ Long-Term Care Insurance Personal Worksheet". The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Exhibit F of this Part, 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 Director.
 - 3) 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 ~~traditional~~ group ~~traditional~~ long-term care insurance to employees and their spouses.
 - 4) The sale or dissemination outside the company or agency by the issuer or insurance producer of information obtained through the personal worksheet in Exhibit F of this Part is prohibited.
- d) The issuer shall use the suitability standards it has developed pursuant to this

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Section in determining whether issuing ~~traditional~~ long-term care insurance coverage to an applicant is appropriate.

- e) Insurance producers shall use the suitability standards developed by the issuer in marketing ~~traditional~~ long-term care insurance.
- f) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy ~~Traditional~~ Long-Term Care Insurance" shall be provided. The form shall be in the format found in Exhibit G of this Part, in not less than 12 point type.
- g) 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 suitability letter similar to the one found in Exhibit H of this Part. 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.
- h) The issuer shall report annually to the Director the total number of applications received from residents of this State, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.~~124~~126 Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates

If a ~~traditional~~ long-term care insurance policy or certificate replaces another ~~traditional~~ long-term care policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions and probationary periods in the new ~~traditional~~ long-term care policy for similar benefits to the extent that similar exclusions have been satisfied under the original policy.

(Source: Section 2012.126 renumbered to Section 2012.124 and amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.125 Availability of New Services or Providers

- a) An insurer shall notify policyholders of the availability of a new long-term care policy series that provides coverage for new long-term care services or providers that are material in nature and not previously available through the insurer to the general public. The notice shall be provided within 12 months after the date the new policy series is made available for sale in this State. New long-term care services or providers that are material in nature shall not include changes to policy structure or benefits or provisions that are minor in nature. Examples of when notification need not be provided include changes in elimination periods, benefit periods and benefit amounts.
- b) Notwithstanding subsection (a), notification is not required for any policy issued prior to July 2008, or to any policyholder or certificateholder who is currently eligible for benefits, within an elimination period or on claim, or who previously has been in claim status, or who would not be eligible to apply for coverage due to issue age limitations under the new policy. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.
- c) The insurer shall make the new coverage available in one of the following ways:
- 1) By adding a rider to the existing policy and charging a separate premium for the new rider based on the insured's attained age;
 - 2) By exchanging the existing policy or certificate for one with an issue age based on the present age of the insured and recognizing past insured status by granting premium credits toward the premiums for the new policy or certificate. The premium credits shall be based on premiums paid or reserves held for the prior policy or certificate;
 - 3) By exchanging the existing policy or certificate for a new policy or certificate in which consideration for past insured status shall be recognized by setting the premium for the new policy or certificate at the issue age of the policy or certificate being exchanged. The cost for the new policy or certificate may recognize the difference in reserves between the new policy or certificate and the original policy or certificate; or

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- 4) By an alternative program (such as underwriting concessions) developed by the insurer that meets the intent of this Section if the program is filed with and approved by the Director.
- d) An insurer is not required to notify policyholders of a new proprietary policy series created and filed for use in a limited distribution channel. For purposes of this subsection, "limited distribution channel" means through a discrete entity, such as a financial institution or brokerage, for which specialized products are available that are not available for sale to the general public. Policyholders that purchased such a proprietary policy shall be notified when a new long-term care policy series that provides coverage for new long-term care services or providers that are material in nature is made available to that limited distribution channel.
- e) Policies issued pursuant to this Section shall be considered exchanges and not replacements. These exchanges shall not be subject to Sections 2012.90 and 2012.123 of this Part, and the reporting requirements of Section 2012.95(a) through (e) of this Part.
- f) When the policy is offered through an employer, labor organization or professional, trade or occupational association, the required notification in subsection (a) shall be made to the offering entity. However, if the policy is issued to a group defined in Section 351A-1(e)(4) of the Code, the notification shall be made to each certificateholder.
- g) Nothing in this Section shall prohibit an insurer from offering any policy, rider, certificate or coverage change to any policyholder or certificateholder. However, upon request, any policyholder may apply for currently available coverage that includes the new services or providers. The insurer may require that policyholders meet all eligibility requirements, including underwriting and payment of the required premium to add new services or providers.
- h) This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- i) The provisions of this Section apply on and after January 1, 2009.

(Source: Added at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.~~126124~~ Right to Reduce Coverage and Lower PremiumsAppropriateness of

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Recommended Purchase

- a) Coverage Reduction Options
 - 1) Every long-term care insurance policy and certificate shall include a provision that allows the policyholder or certificateholder to reduce coverage and lower the policy or certificate premium in at least one of the following ways:
 - A) Reducing the maximum benefit; or
 - B) Reducing the daily, weekly or monthly benefit amount.
 - 2) The insurer may also offer other reduction options that are consistent with the policy or certificate design or the carrier's administrative processes.
- b) The provision shall include a description of the ways in which coverage may be reduced and the process for requesting and implementing a reduction in coverage.
- c) The age 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.
- d) 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.
- e) If a policy or certificate is about to lapse, the insurer shall provide a written reminder to the policyholder or certificateholder of his or her right to reduce coverage and premiums in the notice required by Section 2012.55(a)(3) of this Part.
- f) This Section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- g) The requirements of this Section shall apply to any long-term care policy issued in this State on or after July 2009.

~~In recommending the purchase or replacement of any traditional long-term care insurance policy or certificate, an insurance producer shall make efforts to determine the appropriateness of a recommended purchase or replacement.~~

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(Source: Section 2012.124 renumbered to Section 2012.126 and amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.127 ~~Requirement to Offer~~ Nonforfeiture Benefit Requirement

- a) ~~No policy or certificate may be delivered or issued for delivery in this State unless the policy or certificate includes a written offer at the time of issue for nonforfeiture benefits to the defaulting or lapsing policyholder or certificate holder.~~ This Section does not apply to life insurance policies or riders containing accelerated ~~traditional~~ long-term care benefits.
- b) To comply with the requirement to offer a nonforfeiture benefit pursuant to Section 2012.86 of this Part:
- 1) 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 Section 2012.127(e); ~~and(e).~~
 - 2) 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.
- c) If the offer required to be made under Section 2012.86 of this Part is rejected, the insurer shall provide the contingent benefit upon lapse described in this Section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit upon lapse in subsection (d)(3) shall still apply.
- db) After rejection of the offer required under Section 2012.86 of this Part, for individual and group policies without nonforfeiture benefits issued afterAfter July 1, 2002, ~~if the offer of a nonforfeiture benefit is rejected,~~ the insurer shall provide the contingent benefit upon lapse ~~as follows:~~
- 1) In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

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- 21) ~~A~~The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level that 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 ~~after~~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

| <u>Issue Age</u> | <u>Percent Increase Over Initial Premium</u> |
|------------------|--|
| 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% |

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| | |
|-------------|-----|
| 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% |

- 3) A contingent benefit upon lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that 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, the policy or certificate lapsing within 120 days after the due date of the premium so increased, and the ratio in subsection (d)(5)(B) being 40% or more. Unless otherwise required, policyholders shall be notified at least 30 days prior to the due date of the premium reflecting the rate increase. This subsection (d)(3) becomes effective January 1, 2009.

Triggers for a Substantial Premium Increase

| <u>Issue Age</u> | <u>Percent Increase Over Initial Premium</u> |
|------------------|--|
| <u>Under 65</u> | <u>50%</u> |
| <u>65-80</u> | <u>30%</u> |
| <u>Over 80</u> | <u>10%</u> |

This provision shall be in addition to the contingent benefit provided by subsection (d)(2) and, when both are triggered, the benefit provided shall be at the option of the insured.

- 42) On or before the effective date of a substantial premium increase as defined in subsection Section 2012.127(d)(2)(b)(1), the insurer shall:

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- A) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
- B) Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection Section 2012.127 (e)(e). This option may be elected at any time during the 120-day period referenced in subsection Section 2012.127(d)(2)(b)(1); and
- C) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection Section 2012.127(d)(2)(b)(1) shall be deemed to be the election of the offer to convert in subsection Section 2012.127(d)(4) unless the automatic option in subsection (d)(5)(C) applies(b)(2)(B).
- 3) ~~In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.~~
- 5) On or before the effective date of a substantial premium increase, as defined in subsection (d)(3), the insurer shall:
- A) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;
- B) Offer to convert the coverage to a paid-up status when the amount payable for each benefit is 90% of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in subsection (d)(3); and
- C) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in subsection (d)(3) shall be deemed to be the election of the offer to convert in subsection (d)(5)(B) if the ratio is 40% or more.

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- ee) Benefits continued as nonforfeiture benefits, including contingent benefits upon lapse in accordance with subsection (d)(2), but not subsection (d)(3), are described as follows:
- 1) For purposes of this Section, attained age rating is defined as a schedule of premiums starting from the issue date which increases age at least 1% per year prior to age 50, and at least 3% per year beyond age 50.
 - 2) For purposes of this Section, the nonforfeiture benefit including the contingent benefit upon lapse shall be a shortened benefit period providing paid-up traditional 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 subsection (e)(e)(3) of this Section.
 - 3) The standard nonforfeiture credit for an offered nonforfeiture benefit will be equal to 100% 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 subsection (f)(d) of this Section.
 - 4) No policy or certificate which includes a nonforfeiture benefit shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date except that, for a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:
 - A) The end of the tenth year following the policy or certificate issue date; or
 - B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.
 - 5) Nonforfeiture credits may be used for all care and services qualifying for

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benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

- fd) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.
- ge) There shall be no difference in the minimum nonforfeiture benefits as required under which are offered under the requirements of this Section for group and individual policies.
- hf) The requirements of this Section shall apply to any traditional long-term care policy issued in this State, and shall apply as follows~~except for~~:
- 1) Except as provided in subsections (h)(2) and (3), the provisions of this Section apply to any long-term care policy issued in this State on or after July 2008. Life insurance policies or riders containing accelerated long-term care benefits; or
 - 2) For certificates issued on or after July 2008, under a group long-term care insurance policy issued to one or more employers or labor organizations, or to a trust or to the trustee or trustees of a fund established by one or more employers or labor organizations, or a 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, which policy was in force in July 2008, the provisions of this Section shall not apply. A group traditional long-term care insurance policy that was in force prior to July 1, 2002.
 - 3) The last sentence in subsection (c) and all of subsections (d)(3) and (d)(4) shall apply to any long-term care insurance policy or certificate issued in this State after January 2009, except new certificates on a group policy issued to one or more employers or labor organizations, or to a trust or to the trustee or trustees of a fund established by one or more employers or labor organizations, or a 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, after July 2009.

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- ig) 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 Sections~~Section~~ 2012.110 or 2012.112 of this Part, whichever is applicable, treating the policy as a whole.
- jh) To determine whether contingent nonforfeiture upon lapse provisions are triggered under subsection ~~Section 2012.127(d)(2) or (d)(3)(b)(4)~~, 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.
- ki) A nonforfeiture benefit for qualified long-term care insurance contracts that are level premium contracts shall be offered that meets the following requirements:
- 1) The nonforfeiture provision shall be appropriately captioned;
 - 2) 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 Director for the same contract form; and
 - 3) The nonforfeiture provision shall provide at least one of the following:
 - A) Reduced paid-up insurance;
 - B) Extended term insurance;
 - C) Shortened benefit period; or
 - D) Other similar offerings approved by the Director.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.128 Standards for Benefit Triggers

- a) A ~~traditional~~ long-term care insurance policy shall condition the payment of

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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 3 of the activities of daily living or the presence of cognitive impairment.

- b) Insurers may use activities of daily living to trigger covered benefits as long as they are defined in the policy. Activities of daily living shall include but not be limited to the following, as defined in Section 2012.40 of this Part and in the policy:
 - 1) Bathing;
 - 2) Continence;
 - 3) Dressing;
 - 4) Eating;
 - 5) Toileting; and
 - 6) Transferring.
- c) 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 subsections (a) and (b) of this Section.
- d) For purposes of this Section the determination of a deficiency shall not be more restrictive than:
 - 1) Requiring the hands-on assistance of another person to perform the prescribed activities of daily living; or
 - 2) If the deficiency is due to the presence of a cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.
- e) Assessments of activities of daily living and cognitive impairment shall be

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performed by licensed or certified professionals, such as physicians, nurses or social workers.

- f) ~~Long~~~~Traditional long~~-term care insurance policies shall include a clear description of the process for appealing and resolving benefit determinations.
- g) The requirements set forth in this Section shall apply as follows:
 - 1) Except as provided in subsection (g)(2) of this Section, the provisions of this Section apply to a ~~traditional~~ long-term care policy issued in this State.
 - 2) For certificates issued under a ~~traditional~~ group ~~traditional~~ long-term care insurance policy as defined in Section ~~351A-1(e)(1) of the Code~~~~2012.30 of this Part~~, the provisions of this Section shall not apply.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.129 Additional Standards for Benefit Triggers for Qualified Long-Term Care

- a) 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, ~~as defined in Section 2012.40~~.
- b) 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.
- c) Certifications regarding activities of daily living and cognitive impairment required pursuant to subsection (b) of this Section 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 under the authority of Section 7702B of the IRS Code (26 USC 7702B)~~a licensed health care practitioner, as defined in Section 2012.40~~.
- d) Certifications required pursuant to subsection (b) of this Section may be

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performed by a licensed health care practitioner 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.

- e) Qualified long-term care insurance contracts shall include a clear description of the process for appealing and resolving disputes with respect to benefit determinations.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.130 Standard Format Outline of Coverage Requirements

This Section implements, interprets and makes specific the provisions of Section 351A-8 of the Illinois Insurance Code ~~[215 ILCS 5/351A-8]~~ in prescribing a standard format and the content of an outline of coverage.

- a) The outline of coverage shall be a free-standing document, using no smaller than ten point type.
- b) The outline of coverage shall contain no material ~~of an advertising nature~~ not contained within the policy itself.
- c) 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.
- d) Use of the text and sequence of text of the standard format outline of coverage is mandatory unless otherwise specifically indicated.
- e) The standard format, including style, arrangement and overall appearance, and the content of an outline of coverage appears in Exhibit C of this Part.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.140 Requirement to Deliver Shopper's Guide

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- a) A ~~traditional~~ long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Director shall be provided to all prospective applicants of a ~~traditional~~ long-term care insurance policy or certificate.
- 1) In the case of ~~an~~ insurance producer solicitations, a producer must deliver the shopper's guide prior to the presentation of an application or enrollment form.
 - 2) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.
- b) Life insurance policies or riders containing accelerated traditional long-term care benefits are not required to furnish the above-referenced guide, but shall furnish the policy summary required under Section ~~351A-9.1 of the Code~~ 2012.60(f)(1) of this Part.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

Section 2012.150 Penalties

In addition to any other penalties provided by the laws of this State any insurer ~~and~~ any insurance producer found to have violated any requirement of this State relating to the regulation of ~~traditional~~ long-term care insurance or the marketing of such insurance shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT A Replacement Notice for Other Than Direct Response Solicitations**NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE**

[Insurance Company 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 ~~traditional~~ long-term care insurance policy to be issued by [Company Name] Insurance Company. Your new policy provides ~~30~~ 30+0 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 ~~traditional~~ long-term care insurance coverage you have, and terminate your policy only if, after due consideration, you find that purchase of this ~~traditional~~ long-term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT [BROKER OR OTHER REPRESENTATIVE]:
(Use additional sheets as necessary)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent

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(depleted) under the original policy.

3. If you are replacing existing ~~traditional~~ long-term care insurance coverage you may wish to secure the advice of your present insurer or its insurance 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 Insurance Producer, ~~Broker or Other Representative Agent~~) [Type Name and Address of Insurance Producer ~~or Other Representative of Agent or Broker~~]

The above "Notice to Applicant" was delivered to me on:

(Applicant's Signature)

(Date)

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT B Replacement Notice for Direct Response Solicitations**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 ~~traditional~~ long-term care insurance and replace it with the ~~traditional~~ long-term care insurance policy delivered herewith issued by [Company Name] Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or ~~traditional~~ long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this ~~traditional~~ long-term 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 probation 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 ~~traditional~~ long-term care insurance coverage you may wish to secure the advice of your present insurer or its insurance 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.

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4. [To be included only if the application is attached to the policy.] If, after due consideration, you still wish to terminate you 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)

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT C Standard Format Outline of Coverage

[COMPANY NAME]

[ADDRESS – CITY & STATE]

[TELEPHONE NUMBER]

~~TRADITIONAL~~ 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 language substantially similar, must appear as follows in the outline of coverage.]

~~Traditional long-term care insurance policies or certificates sold after July 1, 1995 that are not under the Illinois Long-Term Care Partnership Program shall include a statement on the outline of coverage, the policy or certificate application, and the front page of the policy or certificate in bold type and in a separate box as follows: "THIS POLICY (CERTIFICATE) IS NOT APPROVED FOR MEDICAID ASSET PROTECTION UNDER THE ILLINOIS LONG-TERM CARE PARTNERSHIP PROGRAM. HOWEVER, THIS POLICY (CERTIFICATE) IS AN APPROVED TRADITIONAL LONG-TERM CARE POLICY (CERTIFICATE) UNDER STATE INSURANCE REGULATIONS. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES APPROVED UNDER THE ILLINOIS TRADITIONAL LONG-TERM CARE PARTNERSHIP PROGRAM, CALL THE SENIOR HELPLINE AT THE DEPARTMENT ON AGING AT 1-800-252-8966."~~

Caution: The issuance of this ~~traditional~~ 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]).

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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 ~~traditional~~ long-term care insurance contract within the meaning of the Internal Revenue Code of 1986, as amended (26 USC 7702B(b)).

OR

Federal Tax Implications of this [POLICY] [CERTIFICATE]. This [POLICY] [CERTIFICATE] is not intended to be a federally tax-qualified ~~traditional~~ long-term care insurance contract within the meaning of the Internal Revenue Code of 1986 as amended (26 USC 7702B(b)). 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 ~~traditional~~ long-term care health insurance policies or certificates include 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.**

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- 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 include continuation/conversion provisions applicable to the certificate and group policy;]**
 - c) **[Include waiver of premium provisions or state that there are no 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 insurance producers] Neither [insert company name] nor its insurance

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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. ~~TRADITIONAL~~ 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 deductible(s), waiting periods, elimination periods and benefit maximums.]
- b) [Institutional benefits, by skill level.]
- c) [Non-institutional 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 ~~traditional~~ long-term care and must be defined and described as part of the outline of coverage.]

[Any additional benefit triggers must also be explained in this Section. If these benefit 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 functional dependency in order to be eligible for benefits, this too must be specified.]

10. LIMITATIONS AND EXCLUSIONS.

[Describe:

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- a) Preexisting conditions;
- b) Non-eligible facilities/provider;
- c) Non-eligible levels of care (e.g., unlicensed providers, care or treatment provided by a family member, etc.);
- d) Exclusions/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 [number 9\(8\)](#) 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 cost of ~~traditional~~ 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

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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 ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING ~~TRADITIONAL~~-LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR ~~TRADITIONAL~~-LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

16. GRAPHIC COMPARISON.

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.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT D Rescission Reporting Format

RESCISSION REPORTING FORMS FOR
~~TRADITIONAL~~ LONG-TERM CARE POLICIES
FOR THE STATE OF ILLINOIS
FOR THE REPORTING YEAR 20[]

Company Name: _____

Address: _____

Phone Number: _____

Due: ~~March 1~~ June 30 annually

Instructions:

The purpose of this form is to report all rescissions of ~~traditional~~ 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:

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Signature

Name and Title (please type)

Date

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT E Class of Insurance – Accident and Health (Repealed)

~~Course of Study Content Requirements for a course entitled "Traditional Long-Term Care Insurance Policy":~~

- ~~a) Reasons for the interest in traditional long-term care~~
- ~~b) Sources for providing traditional long-term care~~
- ~~c) Medicaid~~
- ~~d) Life-Care facilities~~
- ~~e) Insurance policies providing traditional long-term care coverage~~

(Source: Repealed at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT F ~~Traditional~~ Long-Term Care Insurance Personal Worksheet

People buy ~~traditional~~ long-term care insurance for many reasons. Some don't want to use their own assets to pay for ~~traditional~~ 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 ~~traditional~~ long-term care insurance may be expensive, and may not be right for everyone.

The company will ask you to fill out this worksheet to help you and the company decide if you should buy this policy. By State law, the insurance company must fill out part of the information on this worksheet.

Premium Information

Policy Form Number(s) _____

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 ~~traditional~~ long-term care insurance since [year] and has sold this policy since [year]. [The company has never raised its rates for any ~~traditional~~ 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.]

[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

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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 were raised, for example, by 20%?]

What is your annual income? (check one)

Under \$10,000 \$[10-20,000] \$[20-30,000]
 \$[30-50,000] Over \$50,000

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.

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What elimination period are you considering? Number of day _____ 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 traditional-long-term care.

Disclosure Statement

Form with checkboxes for disclosure statement: 'The answers to the questions above describe my financial situation', 'I choose not to complete this information', and 'I acknowledge that the carrier and/or its agent (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. [For direct mail situations, use the following: I acknowledge that I have reviewed this form including their premium, premium rate increase history and potential for premium increases in the future.] I understand the above disclosures. I understand that the rates for this policy may increase in the future. (This box must be checked).'

Signed: _____

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(Applicant)

(Date)

I explained to the applicant the importance of completing this information.

Signed: _____
(Insurance Producer) (Date)

Insurance Producer's Printed Name: _____]

[\[Choose the appropriate sentences depending on whether this is a direct mail or insurance producer sale.\]](#)

[In order for us to process your application, please return this signed statement to [name of company], along with your application.]

[My insurance producer has advised me that this policy does not appear to be suitable for me. However, I still want the company to consider my application.]

Signed: _____
(Applicant) (Date)

~~[Choose the appropriate sentences depending on whether this is a direct mail or insurance producer sale.](#)~~

The company may contact you to verify your answers.

[When the ~~Traditional~~ Long-Term Care Insurance Personal Worksheet is furnished to employees and their spouses under employer group policies, the text from the heading "Disclosure Statement" to the end of the page may be removed.]

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT G Things You Should Know Before You Buy ~~Traditional~~ Long-Term Care Insurance**~~Traditional~~
Long-Term
Care Insurance**

- A ~~traditional~~ 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.] [\[For single premium policies, delete this bullet; for noncancellable policies, delete the second sentence only.\]](#)

~~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 ~~traditional~~ long-term care

Medicaid

- Medicaid will generally pay for ~~traditional~~ 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 ~~traditional~~ 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 ~~traditional~~ long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or State Medicaid agency.

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- | | |
|--------------------|--|
| Shopper's Guide | <ul style="list-style-type: none">• Make sure the insurance company or insurance producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Traditional Long-Term Care Insurance." Read it carefully. If you have decided to apply for traditional 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 | <ul style="list-style-type: none">• Free counseling and additional information about traditional long-term care insurance is 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. |
| <u>Facilities</u> | <ul style="list-style-type: none">• <u>Some long-term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long-term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.</u> |

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT H ~~Traditional~~ Long-Term Care Insurance Suitability Letter

Dear [Applicant]:

Your recent application for ~~traditional~~ long-term care insurance included a "personal worksheet", which asked questions about your finances and your reasons for buying ~~traditional~~ 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 ~~traditional~~ 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 ~~traditional~~ 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.]

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 ~~traditional~~ long-term care insurance may not be a suitable purchase,] I wish to purchase this coverage. Please resume review of my application.

~~[Delete the phrase in brackets if the applicant did not answer the questions about income.]~~

~~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

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Please return to [issuer] at [address] by [date].

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT I Claims Denial Reporting Form: Long-Term Care Insurance Format

For the State of Illinois For the Reporting Year of: _____

Company Name: _____ Due: June 30 annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____ Phone Number: _____

Line of Business: Individual Group

Instructions

The purpose of this format is to report all ~~traditional~~ long-term care claim denials under in force ~~traditional~~ long-term care insurance policies. "Denied" means a claim that is not paid for any reason other than for claims not paid for failure to meet the waiting period or because of an applicable preexisting condition.

| | | State Data | Nationwide Data ¹ |
|---|---|------------|------------------------------|
| 1 | Total Number of Traditional Long-Term Care Claims Reported | | |
| 2 | Total Number of Traditional 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 Traditional Long-Term Care Claims Denied for Reporting Purposes (Line 2 Minus Line 3 Minus Line 4) | | |
| 6 | Percentage of Traditional Long-Term Care Claims Denied of Those Reported (Line 5 Divided By Line 1) | | |

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| | | | |
|----|--|--|--|
| 7 | Number of Traditional Long-Term Care Claims Denied due to: | | |
| 8 | • Traditional Long-Term Care Services Not Covered under the Policy ² | | |
| 9 | • Provider/Facility Not Qualified under the Policy ³ | | |
| 10 | Benefit Eligibility Criteria Not Met ⁴ | | |
| 11 | • Other | | |

¹ The nationwide data may be viewed as a more representative and credible indicator where the data for claims and denied for your state are small in number.

² Example – home health care claim filed under a nursing home only policy.

³ Example – a facility that does not meet the minimum level of care requirements or the licensing requirements as outlined in the policy.

⁴ Example – a benefit trigger not met, certification by a licensed health care practitioner not provided, no plan of care.

(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

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Section 2012.EXHIBIT J Potential Rate Increase Disclosure**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:**~~Traditional~~ 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] [\$].

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.

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- 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.)

*** 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 ~~traditional~~ 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 premium.
- 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.)

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| Contingent Nonforfeiture Cumulative Premium Increase over Initial Premium That qualifies for Contingent Nonforfeiture | |
|--|---------------------------------------|
| (Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.) | |
| Issue Age | Percent Increase Over Initial Premium |
| 29 and under | 200% |
| 30-34 | 190% |
| 35-39 | 170% |
| 40-44 | 150% |
| 45-49 | 130% |
| 50-54 | 110% |
| 55-59 | 90% |
| 60 | 70% |
| 61 | 66% |
| 62 | 62% |
| 63 | 58% |
| 64 | 54% |
| 65 | 50% |
| 66 | 48% |
| 67 | 46% |
| 68 | 44% |
| 69 | 42% |
| 70 | 40% |
| 71 | 38% |
| 72 | 36% |
| 73 | 34% |
| 74 | 32% |

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| | |
|-------------|-----|
| 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% |

[The following contingent nonforfeiture disclosure need only be included for those limited pay policies to which Section 2012.127(d)(3) and (d)(5) of this Part are applicable.]

In addition to the contingent nonforfeiture benefits described in this Exhibit, the following reduced paid-up contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced paid up benefit AND the contingent benefit described are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced paid-up contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the following chart:

Triggers for a Substantial Premium Increase

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| <u>Issue Age</u> | <u>Percent Increase Over Initial Premium</u> |
|------------------|--|
| <u>Under 65</u> | <u>50%</u> |
| <u>65-80</u> | <u>30%</u> |
| <u>Over 80</u> | <u>10%</u> |

2. You stop paying your premiums within 120 days after the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option, your coverage will be converted to reduced paid-up status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- a. The total lifetime amount of benefits your reduced paid-up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your paid-up policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced paid-up policy.

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(Source: Amended at 32 Ill. Reg. 7600, effective May 5, 2008)

|

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

Section 2012.EXHIBIT K Replacement and Lapse Reporting Form

Long-Term Care Insurance
Replacement and Lapse Reporting Form

For the State of _____

Reporting Year of _____

Company Name: _____ Due: June 30 annually

Company Address: _____

Company NAIC Number: _____

Contact Person: _____

Phone Number: _____

Instructions

The purpose of this form is to report on a statewide basis information regarding long-term care insurance policy replacements and lapses. Specifically, every insurer shall maintain records for each agent on that agent's amount of long-term care insurance replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales. The tables below should be used to report the 10% of the insurer's agents with the greatest percentages of replacements and lapses.

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

| <u>Agent's Name</u> | <u>Number of Policies Sold By This Agent</u> | <u>Number of Policies Replaced By This Agent</u> | <u>Number of Replacements As % of Number Sold By This Agent</u> |
|---------------------|--|--|---|
| | | | |

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

| <u>Agent's Name</u> | <u>Number of Policies Sold By This Agent</u> | <u>Number of Policies Lapsed By This Agent</u> | <u>Number of Lapses As % of Number Sold By This Agent</u> |
|---------------------|--|--|---|
| | | | |

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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) _____%

(Source: Added at 32 Ill. Reg. 7600, effective May 5, 2008)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Long-Term Care Partnership Insurance
- 2) Code Citation: 50 Ill. Adm. Code 2018
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 2018.10 | Repealed |
| 2018.20 | Repealed |
| 2018.30 | Repealed |
| 2018.40 | Repealed |
| 2018.50 | Repealed |
| 2018.60 | Repealed |
| 2018.70 | Repealed |
| 2018.80 | Repealed |
| 2018.90 | Repealed |
| 2018.100 | Repealed |
| 2018.110 | Repealed |
| 2018.120 | Repealed |
| 2018.130 | Repealed |
| 2018.140 | Repealed |
| 2018.150 | Repealed |
| 2018.160 | Repealed |
| 2018.170 | Repealed |
| 2018.180 | Repealed |
| 2018.190 | Repealed |
| 2018.200 | Repealed |
| 2018.210 | Repealed |
| 2018.220 | Repealed |
| 2018.230 | Repealed |
| 2018.EXHIBIT A | Repealed |
| 2018.EXHIBIT B | Repealed |
| 2018.EXHIBIT C | Repealed |
| 2018.EXHIBIT D | Repealed |
- 4) Statutory Authority: Implementing the Partnership for Long-Term Care Act and authorized by Section 45 of that Act [320 ILCS 35]
- 5) Effective Date of Repealer: May 5, 2008
- 6) Does this repealer contain an automatic repeal date? No

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED REPEALER

- 7) Does this repealer contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's principal office of the Division of Insurance and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: 31 Ill. Reg. 10916; August 3, 2007
- 10) Has JCAR issued a Statement of Objection to this repealer? No
- 11) Differences between proposal and final version: None
- 12) Have all changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were made.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: With the adopted changes to Part 2012, federal partnership requirements are included directly in the Long-Term Care regulation. The existing Partnership requirements in Part 2018 would actually be in conflict with new federal requirements, and thus the Division is repealing this Part. Additionally, the authority pursuant to which this regulation was originally promulgated in 1994 has been repealed by PA 95-0200, effective August 16, 2007.
- 16) Information and questions regarding this adopted repealer shall be directed to:

William McAndrew, Assistant Deputy Director
L/A&H Compliance Unit
Department of Financial and Professional Regulation
Division of Insurance
320 West Washington Street
Springfield, Illinois 62767-0001

217/782-4254

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENT

- 1) Heading of the Part: Illinois Cares Rx Program
- 2) Code Citation: 89 Ill. Adm. Code 119
- 3) Section Number: 119.20 Adopted Action:
Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13].
- 5) Effective Date of Amendment: May 5, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: January 11, 2008; 32 Ill. Reg. 296
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences Between Proposal and Final Version: In Section 140.11(d), changed cross reference to "140.12(k)" to "140.12(l)".
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency amendments currently in effect? Yes
- 14) Are there any other amendments pending on this Part? No
- 15) Summary and Purpose of Amendment: Illinois Cares Rx (ICRx) income limits are set as hard dollar amounts in statute. Because the income limits are not indexed to the Federal Poverty Level (FPL), they remain constant. Each year, when members receive a Social Security Cost of Living Increase (COLA), some members' income increases beyond the dollar amount set in statute; this causes some members to lose coverage. For 2007, HFS implemented Administrative rules to disregard an amount of income equal to the 2005 and 2006 Social Security COLA. This change prevented members from losing benefits

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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as a result of these COLA increases. This adopted amendment allows the Department to continue to disregard the 2005 and 2006 COLAs, as well as the 2007 COLA for 2008. This change will prevent ICRx members who are currently eligible from losing coverage due to Social Security COLAs.

- 16) Information and questions regarding this adopted amendment shall be directed to:

Tamara Tanzillo Hoffman
Chief of Staff
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/557-7157

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMSPART 119
ILLINOIS CARES RX PROGRAM

| | |
|---------|--|
| Section | |
| 119.10 | Definitions |
| 119.20 | Eligibility |
| 119.30 | Low Income Subsidy |
| 119.40 | Automatic Enrollment of Program Beneficiaries |
| 119.50 | Assignment and Coordination of Benefits |
| 119.60 | Covered Services |
| 119.70 | Prior Authorization and Preferred Drug List (PDL) |
| 119.80 | Illinois Cares Rx Basic Covered Prescription Drugs |
| 119.90 | Co-Payments and Cost Sharing |
| 119.100 | Pharmacy Payment |
| 119.110 | Inspection and Disclosure of Records |
| 119.120 | Establishment of Liens |
| 119.130 | Penalties |
| 119.140 | Penalties (Repealed) |

AUTHORITY: Implementing the Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act [320 ILCS 25] and implementing and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Executive Order 2004-3.

SOURCE: Adopted by emergency rulemaking at 28 Ill. Reg. 13816, effective October 1, 2004, for a maximum of 150 days; adopted at 29 Ill. Reg. 4069, effective February 25, 2005; emergency amendment at 30 Ill. Reg. 482, effective January 1, 2006, for a maximum of 150 days; emergency amendment modified in response to the Joint Committee on Administrative Rules' Objection at 30 Ill. Reg. 5436, effective February 28, 2006, for the remainder of the maximum 150 days; amended at 30 Ill. Reg. 10274, effective May 26, 2006; amended at 31 Ill. Reg. 5537, effective March 26, 2007; emergency amendment at 32 Ill. Reg. 373, effective January 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 7717, effective May 5, 2008.

Section 119.20 Eligibility

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- a) Illinois Cares Rx Eligibility Qualifications
To be eligible for Illinois Cares Rx pharmaceutical benefits, an individual must meet all of the following requirements:
- 1) Be:
 - A) 65 years of age or older; or
 - B) a disabled person.
 - 2) Be domiciled in Illinois at the time of filing an application, and during the coverage period.
 - 3) Except for individuals choosing Illinois Cares Rx Rebate, be enrolled in a Coordinating Medicare Part D PDP if eligible for Medicare Part D.
 - 4) Except for individuals choosing Illinois Cares Rx Rebate, apply for all available subsidies under Medicare Part D. The Department may deem individuals to be compliant with this requirement in cases where the Department's data clearly indicates the individual would not be eligible for any low income subsidy.
 - 5) Have a maximum household income as described in subsection (a)(5)(A), (B) or (C). If any income eligibility limit set forth in subsection (a)(5)(A), (B) or (C) is less than 200 percent of the Federal Poverty Level (FPL) for any year, the income eligibility limit for that year for households of that size shall be income equal to or less than 200 percent of FPL.
 - A) less than \$21,218 for a household containing one person;
 - B) less than \$28,480 for a household containing two persons; or
 - C) less than \$35,740 for a household containing three or more persons.
 - 6) Individuals eligible for SeniorCare on December 31, 2005 will be automatically determined eligible for and enrolled in Illinois Cares Rx Plus for coverage year 2006; individuals eligible for Circuit Breaker

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Pharmaceutical Assistance on December 31, 2005 will be automatically determined eligible for and enrolled in Illinois Cares Rx Basic for coverage year 2006.

- b) Illinois Cares Rx Plus Eligibility Qualifications
To be eligible for Illinois Cares Rx Plus pharmaceutical benefits as described in Section 119.60(a), an individual must meet all of the eligibility requirements described in subsection (a) and meet all of the following requirements:
- 1) Be a U.S. citizen or qualify as an eligible non-citizen pursuant to 89 Ill. Adm. Code 120.310.
 - 2) Be 65 years of age or older.
 - 3) Have countable annual income at or below 200 percent of FPL guidelines published annually by the U.S. Department of Health and Human Services.
- c) Proof of Eligibility Qualifications
An applicant must submit proof of his or her eligibility qualifications as described in subsections (a) and (b).
- 1) Examples of proof of date of birth include:
 - A) a baptismal record; or
 - B) a birth certificate; or
 - C) a driver's license; or
 - D) an identification card from the Secretary of State's office; or
 - E) an insurance policy; or
 - F) naturalization papers.
 - 2) Examples of proof of disability include:

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- A) proof that an applicant is eligible to receive disability benefits under the federal Social Security Act of 1935 (see 42 USC 423); or
 - B) issuance of an Illinois Disabled Person Identification Card stating that an applicant is under a Class 2 disability, as defined in Section 4A of the Illinois Identification Card Act [15 ILCS 335/4A]; or
 - C) status of an applicant as a disabled person determined by a physician designated by the Department on Aging using the same standards as used by the Social Security Administration with the costs of any required examination paid by the applicant (see 42 USC 423); or
 - D) receipt by an applicant of Railroad (see 45 USC 231), Civil Service, or Veterans' total disability benefits (see 38 USC 101). (See 320 ILCS 25/3.14.)
- 3) Applicants age 64 and older who are ineligible for Medicare must submit proof of citizenship as set forth in section 6036 of the federal Deficit Reduction Act of 2005. This requirement becomes inapplicable if federal funding for these individuals becomes unavailable.
- d) **Income**
Income shall be based on income for the full calendar year prior to the year the applicant filed an application for pharmaceutical benefits, unless the applicant requests consideration of projected income as described in subsections (d)(1)(A), (B), (C), (D) and (E).
- 1) **Projected Income**
 - A) An applicant may request that projected income for the coverage year be used as current income in determining eligibility at the time an application is filed if projected income for the coverage year will be lower than current income for the coverage year. The application must include an itemized listing of current income for the coverage year and projected income for the coverage year, together with documentation for the lost sources of income used in calculating projected income. The Department on Aging will allow such a request and use projected income as current income in

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processing the application if its use will enable an applicant to qualify for this program.

- B) An applicant whose application has been denied for exceeding maximum household income eligibility qualifications may file a Schedule P requesting use of projected income for the coverage year as current income for the coverage year in re-determining eligibility if projected income for the coverage year will be lower than current income for the coverage year. The Schedule must include an itemized listing of current income for the coverage year and projected income for the coverage year, together with documentation for the lost sources of income used in calculating projected income. The Department on Aging will allow such a request and use projected income as current income in processing the application if its use will enable an applicant to qualify for this program.
- C) A beneficiary whose application has been approved for Illinois Cares Rx Basic may file a Schedule P requesting use of projected income for the coverage year as current income for the coverage year in redetermining the eligibility for Illinois Cares Rx Plus if projected income for the coverage year will be lower than current income for the coverage year. The Schedule must include an itemized listing of current income for the coverage year and projected income for the coverage year, together with documentation for the lost sources of income used in calculating projected income. The Department on Aging will allow such a request and use projected income as current income in processing the application if its use will enable a beneficiary to qualify for Illinois Cares Rx Plus.
- D) Amended applications for pharmaceutical assistance benefits must be filed on the appropriate paper forms approved by the Department on Aging prior to the expiration of the coverage year for the coverage year at issue.
- E) A beneficiary may not use projected income for two consecutive years, except in the case of hardship such as death, change in marital status or retirement.

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- 2) **Countable Income**
The earned and unearned income of the applicant and his or her spouse (if the spouse resides with the applicant) shall be counted when determining eligibility.
 - 3) **Assets shall not be considered.**
 - 4) **For applications processed after January 1, 2007, but received on or before December 31, 2007, 6.91 percent of the household income is exempt from consideration in determining eligibility. [For 2007 applications, postmarked on or before December 31, 2008, 10.44 percent of the household income is exempt from consideration in determining eligibility.](#)**
 - 5) **Illinois Cares Rx Plus participants shall be exempt from the requirements of 89 Ill. Adm. Code 102.210, Estate Claims, with regard to expenditures made for Illinois Cares Rx benefits.**
- e) **An individual who is eligible for medical assistance with a spenddown may participate in Illinois Cares Rx.**
 - f) **An individual who receives benefits from any of the Medicare Savings programs, the Qualified Medicare Beneficiary (QMB) program, the Specified Low Income Medicare Beneficiary (SLIB) program, or the Qualified Individual (QI) program, may participate in Illinois Cares Rx.**
 - g) **Application Process**
 - 1) **An application for pharmaceutical assistance benefits under the Act must be filed on the appropriate paper or electronic forms approved by the Department on Aging.**
 - 2) **Individuals shall apply by completing and submitting an application as specified by the Illinois Department on Aging.**
 - 3) **Spouses who live together in the same residence may apply on the same application as long as the application contains both signatures.**

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- 4) After eligibility is determined by the Illinois Department on Aging, notice of the outcome shall be sent to the applicant.
 - 5) An individual enrolled in Illinois Cares Rx shall receive coverage under his or her own name and unique Recipient Identification Number.
- h) Enrollment Periods
- 1) Enrollment shall be effective the first of the month no later than the second month after the date when the applicant was determined to be eligible for the program.
 - 2) The initial coverage period shall continue from the effective date of the enrollment through the end of the calendar year following the year in which the beneficiary filed the application for Illinois Cares Rx benefits.
 - 3) Individuals must reapply annually.
 - 4) Subsequent uninterrupted periods of enrollment shall be for 12 months and shall be coincident with the calendar year.
- i) Authorization of Illinois Cares Rx
- Once an individual has been determined eligible for Illinois Cares Rx, an Illinois Cares Rx identification card shall be sent to the individual, unless the individual elects to participate in the Illinois Cares Rx Rebate Program.
- j) Illinois Cares Rx coverage shall terminate:
- 1) at the end of a participant's coverage period unless the participant reapplies timely and is found to continue to be eligible;
 - 2) when a participant no longer resides in Illinois;
 - 3) when a participant becomes an inmate of a public institution;
 - 4) upon a participant's death;
 - 5) upon discovery that the initial determination of the participant's eligibility was incorrect; or

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- 6) when a participant not enrolled in Illinois Cares Rx Rebate fails to apply for any low income subsidy available under Medicare Part D, except in cases where the Department has deemed the individual to be compliant based on the Department's data.
- k) **Appeal Rights**
Any applicant or beneficiary aggrieved by action of the Department on Aging under the Act, whether in the denial of an application or amended application may request in writing that the Department on Aging reconsider its action, setting out the facts on which the request is based. The Department on Aging will consider the request and either affirm or modify its action.

(Source: Amended at 32 Ill. Reg. 7717, effective May 5, 2008)

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- 1) Heading of the Part: Medical Payment
- 2) Code Citation: 89 Ill. Adm. Code 140
- 3)

| | |
|-------------------------|------------------------|
| <u>Section Numbers:</u> | <u>Adopted Action:</u> |
| 140.11 | Amendment |
| 140.82 | Amendment |
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Amendments: May 5, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendments, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposals Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 1553 (Section 140.11) and January 11, 2008; 32 Ill. Reg. 298 (Section 140.82)
- 10) Has JCAR issued a Statement of Objection to these amendments? No
- 11) Differences Between Proposal and Final Version: This adopted rulemaking combines two rulemakings that were proposed separately. Only nonsubstantive technical changes were made to the combined rulemaking text.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will these amendments replace emergency amendments currently in effect? Yes, the Section 140.82 rulemaking proposed at 32 Ill. Reg. 298 had a companion emergency that became effective January 1, 2008 and was published at 32 Ill. Reg. 383.
- 14) Are there any other amendments pending on this Part? Yes

| | | |
|--------------------------|-------------------------|-------------------------------------|
| <u>Sections Numbers:</u> | <u>Proposed Action:</u> | <u>Illinois Register Citation:</u> |
| 140.6 | Amendment | October 5, 2007; 31 Ill. Reg. 13570 |

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| | | |
|----------|-----------|-----------------------------------|
| 140.24 | Amendment | April 18, 2008; 32 Ill. Reg. 6344 |
| 140.1001 | Amendment | April 18, 2008; 32 Ill. Reg. 6344 |
| 140.490 | Amendment | April 25, 2008; 32 Ill. Reg. 6869 |
| 140.494 | Amendment | April 25, 2008; 32 Ill. Reg. 6869 |

- 15) Summary and Purpose of Amendments: The amendment to Section 140.11 makes a change in order to comply with P.A. 95-0005, which removed the requirement that change of ownership for long term care facilities go through the Health Facilities Planning Board. Change of ownership notifications to the Department will come from the Illinois Department of Public Health. In addition, Section 140.82 reflects the change and any future changes to the federal tax threshold. The federal cap is 5.5 percent, effective January 1, 2008.
- 16) Information and questions regarding these adopted amendments shall be directed to:

Tamara Tanzillo Hoffman
Chief of Staff
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/557-7157

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER d: MEDICAL PROGRAMS

PART 140

MEDICAL PAYMENT

SUBPART A: GENERAL PROVISIONS

Section

- 140.1 Incorporation By Reference
- 140.2 Medical Assistance Programs
- 140.3 Covered Services Under Medical Assistance Programs
- 140.4 Covered Medical Services Under AFDC-MANG for non-pregnant persons who are 18 years of age or older (Repealed)
- 140.5 Covered Medical Services Under General Assistance
- 140.6 Medical Services Not Covered
- 140.7 Medical Assistance Provided to Individuals Under the Age of Eighteen Who Do Not Qualify for AFDC and Children Under Age Eight
- 140.8 Medical Assistance For Qualified Severely Impaired Individuals
- 140.9 Medical Assistance for a Pregnant Woman Who Would Not Be Categorically Eligible for AFDC/AFDC-MANG if the Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy
- 140.10 Medical Assistance Provided to Incarcerated Persons

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section

- 140.11 Enrollment Conditions for Medical Providers
- 140.12 Participation Requirements for Medical Providers
- 140.13 Definitions
- 140.14 Denial of Application to Participate in the Medical Assistance Program
- 140.15 Recovery of Money
- 140.16 Termination or Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.17 Suspension of a Vendor's Eligibility to Participate in the Medical Assistance Program
- 140.18 Effect of Termination or Revocation on Persons Associated with Vendor
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AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983;

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amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg.

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18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg. 7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140. Table H and 140. Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147. Table A and 147. Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29, 1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989;

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amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; Notice of Corrections to Adopted Amendment at 15 Ill. Reg. 1174; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill.

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Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment suspended at 17 Ill. Reg. 18902, effective October 12, 1993; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended at 18 Ill. Reg. 17286, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective

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September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective November 28, 1995; amended at 20 Ill. Reg. 1210, effective December 29, 1995; amended at 20 Ill. Reg. 4345, effective March 4, 1996; amended at 20 Ill. Reg. 5858, effective April 5, 1996; amended at 20 Ill. Reg. 6929, effective May 6, 1996; amended at 20 Ill. Reg. 7922, effective May 31, 1996; amended at 20 Ill. Reg. 9081, effective June 28, 1996; emergency amendment at 20 Ill. Reg. 9312, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 11332, effective August 1, 1996; amended at 20 Ill. Reg. 14845, effective October 31, 1996; emergency amendment at 21 Ill. Reg. 705, effective December 31, 1996, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 3734, effective March 5, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 4777, effective April 2, 1997; amended at 21 Ill. Reg. 6899, effective May 23, 1997; amended at 21 Ill. Reg. 9763, effective July 15, 1997; amended at 21 Ill. Reg. 11569, effective August 1, 1997; emergency amendment at 21 Ill. Reg. 13857, effective October 1, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 1416, effective December 29, 1997; amended at 22 Ill. Reg. 4412, effective February 27, 1998; amended at 22 Ill. Reg. 7024, effective April 1, 1998; amended at 22 Ill. Reg. 10606, effective June 1, 1998; emergency amendment at 22 Ill. Reg. 13117, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16302, effective August 28, 1998; amended at 22 Ill. Reg. 18979, effective September 30, 1998; amended at 22 Ill. Reg. 19898, effective October 30, 1998; emergency amendment at 22 Ill. Reg. 22108, effective December 1, 1998, for a maximum of 150 days; emergency expired April 29, 1999; amended at 23 Ill. Reg. 5796, effective April 30, 1999; amended at 23 Ill. Reg. 7122, effective June 1, 1999; emergency amendment at 23 Ill. Reg. 8236, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 9874, effective August 3, 1999; amended at 23 Ill. Reg. 12697, effective October 1, 1999; amended at 23 Ill. Reg. 13646, effective November 1, 1999; amended at 23 Ill. Reg. 14567, effective December 1, 1999; amended at 24 Ill. Reg. 661, effective January 3, 2000; amended at 24 Ill. Reg. 10277, effective July 1, 2000; emergency amendment at 24 Ill. Reg. 10436, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15086, effective October 1, 2000; amended at 24 Ill. Reg. 18320, effective December 1, 2000; emergency amendment at 24 Ill. Reg. 19344, effective December 15, 2000, for a maximum of 150 days; amended at 25 Ill. Reg. 3897, effective March 1, 2001; amended at 25 Ill. Reg. 6665, effective May 11, 2001; amended at 25 Ill. Reg. 8793, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 8850, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 11880, effective September 1, 2001; amended at 25 Ill. Reg. 12820, effective October 8, 2001; amended at 25 Ill. Reg. 14957, effective November 1, 2001; emergency amendment at 25 Ill. Reg. 16127, effective November 28, 2001, for a maximum of 150 days; emergency amendment at 25 Ill. Reg. 16292, effective December 3, 2001, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 514,

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effective January 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 663, effective January 7, 2002; amended at 26 Ill. Reg. 4781, effective March 15, 2002; emergency amendment at 26 Ill. Reg. 5984, effective April 15, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 7285, effective April 29, 2002; emergency amendment at 26 Ill. Reg. 8594, effective June 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11259, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 12461, effective July 29, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 16593, effective October 22, 2002; emergency amendment at 26 Ill. Reg. 12772, effective August 12, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13641, effective September 3, 2002; amended at 26 Ill. Reg. 14789, effective September 26, 2002; emergency amendment at 26 Ill. Reg. 15076, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16303, effective October 25, 2002; amended at 26 Ill. Reg. 17751, effective November 27, 2002; amended at 27 Ill. Reg. 768, effective January 3, 2003; amended at 27 Ill. Reg. 3041, effective February 10, 2003; amended at 27 Ill. Reg. 4364, effective February 24, 2003; amended at 27 Ill. Reg. 7823, effective May 1, 2003; amended at 27 Ill. Reg. 9157, effective June 2, 2003; emergency amendment at 27 Ill. Reg. 10813, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 13784, effective August 1, 2003; amended at 27 Ill. Reg. 14799, effective September 5, 2003; emergency amendment at 27 Ill. Reg. 15584, effective September 20, 2003, for a maximum of 150 days; emergency amendment at 27 Ill. Reg. 16161, effective October 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18629, effective November 26, 2003; amended at 28 Ill. Reg. 2744, effective February 1, 2004; amended at 28 Ill. Reg. 4958, effective March 3, 2004; emergency amendment at 28 Ill. Reg. 6622, effective April 19, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 7081, effective May 3, 2004; emergency amendment at 28 Ill. Reg. 8108, effective June 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 9640, effective July 1, 2004; emergency amendment at 28 Ill. Reg. 10135, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11161, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12198, effective August 11, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13775, effective October 1, 2004; amended at 28 Ill. Reg. 14804, effective October 27, 2004; amended at 28 Ill. Reg. 15513, effective November 24, 2004; amended at 29 Ill. Reg. 831, effective January 1, 2005; amended at 29 Ill. Reg. 6945, effective May 1, 2005; emergency amendment at 29 Ill. Reg. 8509, effective June 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 12534, effective August 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 14957, effective September 30, 2005; emergency amendment at 29 Ill. Reg. 15064, effective October 1, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 29 Ill. Reg. 15985, effective October 5, 2005, for the remainder of the maximum 150 days; emergency amendment at 29 Ill. Reg. 15610, effective October 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 16515, effective October 5, 2005, for a maximum of 150 days; amended at 30 Ill. Reg. 349, effective December 28, 2005; emergency amendment at 30 Ill.

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Reg. 573, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 796, effective January 1, 2006; amended at 30 Ill. Reg. 2802, effective February 24, 2006; amended at 30 Ill. Reg. 10370, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 12376, effective July 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 13909, effective August 2, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 14280, effective August 18, 2006; expedited correction at 31 Ill. Reg. 1745, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 17970, effective November 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 18648, effective November 27, 2006; emergency amendment at 30 Ill. Reg. 19400, effective December 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 388, effective December 29, 2006; emergency amendment at 31 Ill. Reg. 1580, effective January 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 2413, effective January 19, 2007; amended at 31 Ill. Reg. 5561, effective March 30, 2007; amended at 31 Ill. Reg. 6930, effective April 29, 2007; amended at 31 Ill. Reg. 8485, effective May 30, 2007; emergency amendment at 31 Ill. Reg. 10115, effective June 30, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 14749, effective October 22, 2007; emergency amendment at 32 Ill. Reg. 383, effective January 1, 2008, for a maximum of 150 days; peremptory amendment at 32 Ill. Reg. 6743, effective April 1, 2008; amended at 32 Ill. Reg. 7727, effective May 5, 2008.

SUBPART B: MEDICAL PROVIDER PARTICIPATION

Section 140.11 Enrollment Conditions for Medical Providers

- a) In order to enroll for participation, providers shall:
 - 1) Hold a valid, appropriate license where State law requires licensure of medical practitioners, agencies, institutions and other medical vendors;
 - 2) Be certified for participation in the Title XVIII Medicare program where federal or State rules and regulations require such certification for Title XIX participation;
 - 3) Be certified for Title XIX when federal or State rules and regulations so require;
 - 4) Provide enrollment information to the Department in the prescribed format, and notify the Department, in writing, immediately whenever there is a change in any such information which the provider has previously submitted;

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- 5) Provide disclosure, as requested by the Department, of all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business, enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to public aid recipients; and
- 6) Have a written provider agreement on file with the Department.
- b) Approval of a corporate entity such as a pharmacy, laboratory, durable medical equipment and supplies provider, medical transportation provider, nursing home or renal satellite facility, as a participant in the Medical Assistance Program, applies only to the entity's existing ownership, corporate structure and location; therefore, participation approval is not transferable.
- c) Except for children's hospitals described at 89 Ill. Adm. Code 149.50(c)(3), hospitals providing inpatient care that are certified under a single Medicare number shall be enrolled as an individual entity in the Medical Assistance Program. A children's hospital must be separately enrolled from the general care hospital with which it is affiliated.
- d) Upon notification from the Illinois [Department of Public Health of a change of ownership](#), ~~Health Facilities Planning Board that an exception for a change of ownership has been granted~~, the Department shall notify the prospective buyer of its obligation under Section 140.12(1)(~~k~~) to assume liability for repayment to the Department for overpayments made to the current owner or operator. Such notification shall inform the prospective buyer of all outstanding known liabilities due to the Department by the facility and of any known pending Department actions against the facility that may result in further liability. For long term care providers, when there is a change of ownership of a facility or a facility is leased to a new operator, the provider agreement shall be automatically assigned to the new owner or lessee. Such assigned agreement shall be subject to all conditions under which it was originally issued, including, but not limited to, any existing plans of correction, all requirements of participation as set forth in Section 140.12 or additional requirements imposed by the Department.
- e) For purposes of administrative efficiency, the Department may periodically require classes of providers to re-enroll in the Medical Assistance Program. Under such re-enrollments, the Department shall request classes of providers to submit updated enrollment information. Failure of a provider to submit such

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information within the requested time frames will result in the dis-enrollment of the provider from the Program. Such dis-enrollment shall have no effect on the future eligibility of the provider to participate in the Program and is intended only for purposes of the Department's efficient administration of the Program. A dis-enrolled provider may reapply to the Program and all such re-applications must meet the requirements for enrollment.

- f) For purposes of this Section, a vendor whose investor ownership has changed by 50 percent or more from the date the vendor was initially approved for enrollment in the Medical Assistance Program shall be required to submit a new application for enrollment in the Medical Assistance Program. All such applications must meet the requirements for enrollment.
- g) Anything in this Subpart B to the contrary notwithstanding, enrollment of a non-emergency transportation vendor, as defined in Section 140.13, shall be conditional for 180 days, during which time the Department may terminate the vendor's eligibility to participate in the Medical Assistance Program without cause. Upon termination of a non-emergency transportation vendor under this subsection (g), the following individuals shall be barred from participation in the Medical Assistance Program:
 - 1) individuals with management responsibility;
 - 2) all owners or partners in a partnership;
 - 3) all officers of a corporation or individuals owning, directly or indirectly, five percent or more of the shares of stock or other evidence of ownership in a corporation; or
 - 4) an owner of a sole proprietorship.
- h) Termination of eligibility, as described in subsection (g) of this Section, and resulting barrments are not subject to the Department's hearing process.

(Source: Amended at 32 Ill. Reg. 7727, effective May 5, 2008)

Section 140.82 Developmentally Disabled Care Provider Fund

- a) Purpose and Contents

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- 1) The Developmentally Disabled Care Provider Fund was created in the State Treasury on July 1, 1992, July 14, 1993 and July 1, 1995 (see 305 ILCS 5/5C-7). Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.
 - 2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and 305 ILCS 5/5C-2 and 7.
 - 3) The Fund shall consist of:
 - A) All monies collected or received by the Department under subsection (b) of this Section;
 - B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;
 - C) Any interest or penalty levied in conjunction with the administration of the Fund;
 - D) All other monies received for the Fund from any other source, including interest earned thereon; and
 - E) All monies transferred from the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund.
- b) **Provider Assessments**
Beginning on July 1, 1993, an assessment is imposed upon each developmentally disabled care provider in an amount equal to six percent, or the maximum allowed under federal regulation, whichever is less, of its adjusted gross developmentally disabled care revenue for the prior State fiscal year. The revenue for each year will be reported on the Developmentally Disabled Care Provider Tax form to be filed by a date designated by the Department. The Department reserves the right to audit the reported data. Effective January 1, 2008, the tax rate, allowed under federal regulation at 42 CFR 433.68(f)(3)(i), is 5.5 percent.
- c) **Payment of Assessment Due**

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- 1) The assessment described in subsection (b) of this Section shall be due and payable in quarterly installments, each equaling one-fourth of the assessment for the year, on September 30, December 31, March 31, and May 31 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the due dates. Assessment payments postmarked on the due date will be considered paid on time.
 - 2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.
- d) Reporting Requirements, Penalty, and Maintenance of Records
- 1) After June 30 of each State fiscal year, and on or before September 30 of the succeeding State fiscal year, every developmentally disabled care provider subject to an assessment under subsection (b) of this Section shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross developmentally disabled care revenue from the State fiscal year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the preceding July 1. If a developmentally disabled care provider operates or maintains more than one developmentally disabled care facility, a separate report shall be filed for each facility. In the case of a developmentally disabled care provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.
 - 2) If the developmentally disabled care provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the assessment imposed in subsection (b) of this Section a penalty assessment equal to 25 percent of the assessment imposed for the year.
 - 3) Every developmentally disabled care provider subject to an assessment under subsection (b) of this Section shall keep records and books that will permit the determination of adjusted gross developmentally disabled care revenue on a State fiscal year basis. All such books and records shall be

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maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

- 4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsection (d)(5) or (6) of this Section, an amended assessment report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.
 - 5) Submission of Financial Audit Statements. All developmentally disabled care providers are required to submit a copy of all financial statements audited by an external, independent auditor to the Department within 30 days after the close of such externally performed financial audits. If the provider's year end does not coincide with the June 30 ending date for the assessment report, the provider must submit all financial audits covering the tax report period. An amended assessment report must accompany such external financial audit statements if the data submitted on the initial tax report changes based upon the findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.
 - 6) Reconsideration of Adjusted Tax. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a developmentally disabled care provider, the developmentally disabled care provider may request a review or reconsideration of the adjusted assessment within 30 days after the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.
- e) Procedure for Partial Year Reporting/Operating Adjustments

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- 1) Cessation of business during the fiscal year in which the assessment is being paid. For a developmentally disabled care provider who ceases to conduct, operate, or maintain a facility for which the person is subject to assessment under subsection (b) of this Section, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) of this Section by a fraction, the numerator of which is the number of months in the year during which the provider conducts, operates, or maintains the facility and the denominator of which is 12. The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and shall pay with the final report the assessment for the year as so adjusted, to the extent not previously paid.
- 2) Commencing of business during the fiscal year in which the assessment is being paid. A developmentally disabled care provider who commences conducting, operating, or maintaining a facility for which the person is subject to assessment under subsection (b) of this Section, shall file an initial return for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (d) of this Section as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.
- 3) Partial Fiscal Year Operation Adjustment. For a developmentally disabled care provider that did not conduct, operate, or maintain a facility throughout the entire fiscal year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual developmentally disabled care revenue for the portion of the reporting period the facility was operational (dividing adjusted developmentally disabled care revenue by the number of months the facility was in operation and then multiplying that amount by 12). Developmentally disabled care revenue realized by a prior provider from the same facility during the fiscal year shall be used in the annualization

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equation, if available.

- 4) Change in Ownership and/or Operators. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the developmentally disabled care provider currently operating or maintaining the developmentally disabled care facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

- 1) Any facility that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent of the amount of the installment not paid on or before the due date, plus five percent of the portion thereof remaining unpaid on the last day of each monthly period thereafter, not to exceed 100 percent of the installment amount not paid on or before the due date. Reasonable cause may include but is not limited to:
 - A) a provider who has not been delinquent on payment of an assessment due; within the last three calendar years from the time the delinquency occurs;
 - B) a provider who can demonstrate to the Department's satisfaction that a payment was made prior to the due date; or
 - C) that the provider is a new owner/operator and the late payment occurred in the quarter in which the new owner/operator assumed control of the facility.
- 2) Within 30 days after the due date, the Department may begin recovery actions against delinquent facilities participating in the Medicaid Program.

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Payments may be withheld from the facility until the entire provider assessment, including any penalties, is satisfied, or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if the facility fails to comply with an agreement the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with the Department's rules at 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) of this Section will continue to accrue during the recoupment process. Recoupment proceedings against the same facility two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 30 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

- 3) If the facility does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months of the assessment due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment – Groups of Facilities

The Department may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of facilities when:

- 1) the State delays payments to facilities due to problems related to State cash flow; or
- 2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the assessment.

h) Delayed Payment – Individual Facilities

In addition to the provisions of subsection (g) of this Section, the Department may delay assessments for individual facilities that are unable to make timely

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payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) of this Section.

- 1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:
 - A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) of this Section would impose severe and irreparable harm to the clients served. Circumstances ~~that~~ which may create such emergencies include, but are not limited to, the following:
 - i) Department system errors (either automated system or clerical) ~~that~~ which have precluded payments, or ~~that~~ which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;
 - ii) cash flow problems encountered by a facility ~~that~~ which are unrelated to Department technical system problems and ~~that~~ which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.
 - B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:
 - i) 85 percent or more of their residents must be eligible for public assistance;
 - ii) a government-owned facility, ~~that~~ which meets the cash flow criteria under subsection (h)(1)(A)(ii) of this Section.
 - iii) a provider who has filed for Chapter 11 bankruptcy;

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thatwhich meets the cash flow criterion under subsection (h)(1)(A)(ii) of this Section.

- C) the facility must file a delay of payment request as defined in subsection (h)(3)(A) of this Section, and the request must include a Cash Position Statement thatwhich is based upon current assets, current liabilities and other data for a date thatwhich is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:
- i) the ratio of current assets divided by current liabilities is greater than 2.0;
 - ii) cash, ~~short-term~~short term investments and ~~long-term~~long term investments equal or exceed the total of accrued wages payable and the assessment payment. ~~Long-term~~Long term investments thatwhich are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;
 - iii) cash or other assets have been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.
- D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow the assessment funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.
- E) the facility must sign an agreement with the Department thatwhich specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

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- i) specific reason(s) for institution of the delayed payment provisions;
 - ii) specific dates on which payments must be received and the amount of payment ~~that~~which must be received on each specific date described;
 - iii) the interest or a statement of interest waiver as described in subsection (h)(5) of this Section that shall be due from the facility as a result of institution of the delayed payment provisions;
 - iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;
 - v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signator's knowledge; and
 - vi) such other terms and conditions that may be required by the Department.
- 2) A facility that does not meet the criteria listed in subsection (h)(1) may request a delayed payment schedule. The Department may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule is approved, all other conditions of this subsection (h) shall apply.
- 3) Approval Process
- A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement

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Analysis. The request must be received by the due date designated by the Department. Providers will be notified, in writing, of the due dates for submitting delay of payment requests. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests postmarked no later than the date of the telefax. The request must include:

- i) an explanation of the circumstances creating the need for the delayed payment provisions;
 - ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and
 - iii) specification of the specific arrangements requested by the facility.
- B) The facility shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.
- 4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) of this Section, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.
- 5) Interest. The delayed payments shall include interest at a rate not to

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exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) of this Section. The interest may be waived by the Department if the facility's current ratio, as described in subsection (h)(1)(C) of this Section, is 1.5 or less and the facility meets the criteria in subsections (h)(1)(A) and (B) of this Section. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) of this Section.

- 6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) of this Section shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.
- i) Administration and Enforcement Provisions
The Department shall administer and enforce 305 ILCS 5/5C-6 and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").
- j) Nothing in 305 ILCS 5/5C shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before July 1, 1995.
- k) Definitions
 - 1) "Adjusted gross developmentally disabled care revenue" means the developmentally disabled care provider's total revenue for inpatient residential services, less contractual allowances and discounts on patients' accounts, but does not include non-patient revenue from sources such as contributions, donations or bequests, investments, day training services, television and telephone service, rental of facility space, or sheltered care revenue. Adjusted gross developmentally disabled care revenue must be

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reported on an accrual basis for the tax reporting period. All patient revenue accrued during the tax reporting period must be included even though reimbursement may occur after the tax reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the facility's last two cost reports.

- 2) "Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by third party payors or patients, as appropriate, pursuant to agreements/contracts with the developmentally disabled care provider; courtesy and policy discounts provided to employees, medical staff and clergy; and charity care, but "contractual allowance" does not mean any Provider Participation fees/taxes paid to the Department.
- 3) "Department" means the Illinois Department of [Healthcare and Family Services](#)~~Public Aid~~.
- 4) "Developmentally disabled care facility" means an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.
- 5) "Developmentally disabled care provider" means a person conducting, operating, or maintaining a developmentally disabled care facility. For this purpose, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian or other representative appointed by order of any court.
- 6) "Facility" means all intermediate care facilities as defined under "Developmentally disabled care facility" (subsection (k)(4)).
- 7) "Fund" means the Developmentally Disabled Care Provider Fund.

(Source: Amended at 32 Ill. Reg. 7727, effective May 5, 2008)

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NOTICE OF ADOPTED AMENDMENT

- 1) Heading of the Part: Long Term Care Reimbursement Changes
- 2) Code Citation: 89 Ill. Adm. Code 153
- 3) Section Number: 153.125 Adopted Action: Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Amendment: May 5, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any materials incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: January 11, 2008; 32 Ill. Reg. 307
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences Between Proposal and Final Version: Punctuation was corrected.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this amendment replace any emergency amendment currently in effect? Yes
- 14) Are there any other amendments pending on this Part?

Section Number:
153.126

Proposed Action:
Amendment

Illinois Register Citation:
March 14, 2008; 32 Ill. Reg. 3566

- 15) Summary and Purpose of Amendment: In accordance with PA 95-707, effective January 1, 2008, support rates for nursing facilities will be computed using the most recent cost reports on file with the Department no later than April 1, 2005, updated for inflation to January 1, 2006. Also allows for the cost reports to be audited and adjusted accordingly.

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- 16) Information and questions regarding this adopted amendment shall be directed to:

Tamara Tanzillo Hoffman
Chief of Staff
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East, 3rd Floor
Springfield IL 62763-0002

217/557-7157

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER e: GENERAL TIME-LIMITED CHANGES

PART 153

LONG TERM CARE REIMBURSEMENT CHANGES

Section

| | |
|---------|---|
| 153.100 | Reimbursement for Long Term Care Services |
| 153.125 | Long Term Care Facility Rate Adjustments |
| 153.150 | Quality Assurance Review (Repealed) |

AUTHORITY: Implementing and authorized by Articles III, IV, V, VI and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and 12-13].

SOURCE: Emergency rules adopted at 18 Ill. Reg. 2159, effective January 18, 1994, for maximum of 150 days; adopted at 18 Ill. Reg. 10154, effective June 17, 1994; emergency amendment at 18 Ill. Reg. 11380, effective July 1, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16669, effective November 1, 1994; emergency amendment at 19 Ill. Reg. 10245, effective June 30, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16281, effective November 27, 1995; emergency amendment at 20 Ill. Reg. 9306, effective July 1, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 14840, effective November 1, 1996; emergency amendment at 21 Ill. Reg. 9568, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 13633, effective October 1, 1997; emergency amendment at 22 Ill. Reg. 13114, effective July 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 16285, effective August 28, 1998; amended at 22 Ill. Reg. 19872, effective October 30, 1998; emergency amendment at 23 Ill. Reg. 8229, effective July 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12794, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13638, effective November 1, 1999; emergency amendment at 24 Ill. Reg. 10421, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15071, effective October 1, 2000; emergency amendment at 25 Ill. Reg. 8867, effective July 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 14952, effective November 1, 2001; emergency amendment at 26 Ill. Reg. 6003, effective April 11, 2002, for a maximum of 150 days; emergency amendment repealed at 26 Ill. Reg. 12791, effective August 9, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 11087, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17817, effective November 27, 2002; emergency amendment at 27 Ill. Reg. 11088, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18880, effective November 26, 2003; emergency amendment at 28 Ill. Reg. 10218, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 15584, effective

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November 24, 2004; emergency amendment at 29 Ill. Reg. 1026, effective January 1, 2005, for a maximum of 150 days; emergency amendment at 29 Ill. Reg. 4740, effective March 18, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 6979, effective May 1, 2005; amended at 29 Ill. Reg. 12452, effective August 1, 2005; emergency amendment at 30 Ill. Reg. 616, effective January 1, 2006, for a maximum of 150 days; emergency amendment modified pursuant to Joint Committee on Administrative Rules Objection at 30 Ill. Reg. 7817, effective April 7, 2006, for the remainder of the maximum 150 days; amended at 30 Ill. Reg. 10417, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 11853, effective July 1, 2006, for a maximum of 150 days; emergency expired November 27, 2006; amended at 30 Ill. Reg. 14315, effective August 18, 2006; emergency amendment at 30 Ill. Reg. 18779, effective November 28, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 6954, effective April 26, 2007; emergency amendment at 32 Ill. Reg. 535, effective January 1, 2008, for a maximum of 150 days; emergency amendment at 32 Ill. Reg. 4105, effective March 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 7761, effective May 5, 2008.

Section 153.125 Long Term Care Facility Rate Adjustments

- a) Notwithstanding the provisions set forth in Section 153.100, long term care facility (SNF/ICF and ICF/MR) rates established on July 1, 1996 shall be increased by 6.8 percent for services provided on or after January 1, 1997.
- b) Notwithstanding the provisions set forth in Section 153.100, long term care facility (SNF/ICF and ICF/MR) rates and developmental training rates established on July 1, 1998, for services provided on or after that date, shall be increased by three percent. For nursing facilities (SNF/ICF) only, \$1.10 shall also be added to the nursing component of the rate.
- c) Notwithstanding the provisions set forth in Section 153.100, long term care facility (SNF/ICF and ICF/MR) rates and developmental training rates established on July 1, 1999, for services provided on or after that date, shall include:
 - 1) an increase of 1.6 percent for SNF/ICF, ICF/MR and developmental training rates;
 - 2) an additional increase of \$3.00 per resident day for ICF/MR rates; and
 - 3) an increase of \$10.02 per person, per month for developmental training rates.

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- d) Notwithstanding the provisions set forth in Section 153.100, SNF/ICF rates shall be increased by \$4.00 per resident day for services provided on or after October 1, 1999.
- e) Notwithstanding the provisions set forth in Section 153.100, SNF/ICF, ICF/MR and developmental training rates shall be increased 2.5 percent per resident day for services provided on or after July 1, 2000.
- f) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates effective on July 1, 2001 shall be computed using the most recent cost reports on file with the Department no later than April 1, 2000, updated for inflation to January 1, 2001.
 - 1) The Uniform Building Value shall be as defined in 89 Ill. Adm. Code 140.570(b)(10), except that, as of July 1, 2001, the definition of current year is the year 2000.
 - 2) The real estate tax bill that was due to be paid in 1999 by the nursing facility shall be used in determination of the capital component of the rate. The real estate tax component shall be removed from the capital rate if the facility's status changes so as to be exempt from assessment to pay real estate taxes.
 - 3) For rates effective July 1, 2001 only, rates shall be the greater of the rate computed for July 1, 2001 or the rate effective on June 30, 2001.
 - 4) All accounting records and other documentation necessary to support the costs and other information reported on the cost report to be used in accordance with rate setting under Section 153.125(f) shall be kept for a minimum of two years after the Department's final payment using rates that were based in part on that cost report.
- g) Notwithstanding the provisions set forth in Section 153.100, intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled nursing facilities for persons under 22 years of age (SNF/Ped), shall receive an increase in rates for residential services equal to a statewide average of 7.85 percent. Residential rates taking effect March 1, 2001, for services provided on or after that date, shall include an increase of 11.01 percent to the residential program rate component and an increase of 3.33 percent to the residential support

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rate component, each of which shall be adjusted by the geographical area adjuster, as defined by the Department of Human Services (DHS).

- h) For developmental training services provided on or after March 1, 2001, for residents of long term care facilities, rates shall include an increase of 9.05 percent and rates shall be adjusted by the geographical area adjuster, as defined by DHS.
- i) Notwithstanding the provisions set forth in Section 153.100, daily rates for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be increased by 2.247 percent for services provided during the period beginning on April 11, 2002, and ending on June 30, 2002.
- j) Notwithstanding the provisions set forth in Section 153.100, daily rates effective on July 1, 2002, for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be reduced to the level of the rates in effect on April 10, 2002.
- k) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates effective on July 1, 2002 will be 5.9 percent less than the rates in effect on June 30, 2002.
- l) Notwithstanding the provisions set forth in Section 153.100, daily rates effective on July 1, 2003, for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be increased by 3.59 percent.
- m) Notwithstanding the provisions set forth in Section 153.100, developmental training rates effective on July 1, 2003 shall be increased by 4 percent.
- n) Notwithstanding the provisions set forth in Section 153.100, pending the approvals described in this subsection (n), nursing facility (SNF/ICF) rates effective July 1, 2004 shall be 3.0 percent greater than the rates in effect on June 30, 2004. The increase is contingent on approval of both the payment methodologies required under Article 5A-12 of the Public Aid Code [305 ILCS 5/5A-12] and the waiver granted under 42 CFR 433.68.

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- o) Notwithstanding the provisions set forth in Section 153.100, the "Original Building Base Cost" for nursing facilities (SNF/ICF) which have been rented continuously from an unrelated party since prior to January 1, 1978, effective on July 1, 2004, shall be added to the capital rate calculation using the most recent cost reports on file with the Department no later than June 30, 2004. The "Original Building Base Cost" as defined in 89 Ill. Adm. Code 140.570 shall be calculated from the original lease information that is presently on file with the Department. This original lease information will be used to capitalize the oldest available lease payment from the unrelated party lease that has been in effect since prior to January 1, 1978, and continued to be in effect on December 31, 1999. Before the lease payment is capitalized, a 15 percent portion will be removed from the oldest available lease payment for movable equipment costs. After the lease payment is capitalized, a portion of the capitalized amount will be removed for land cost. The land cost portion is 4.88 percent. The remaining amount will be the facility's building cost. The construction/acquisition year for the building will be the date the pre-1978 lease began. The allowable cost of subsequent improvements to the building will be included in the original building base cost. The original building base cost will not change due to sales or leases of the facility after January 1, 1978.
- p) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates effective on January 1, 2005 will be 3.0 percent more than the rates in effect on December 31, 2004.
- q) Notwithstanding the provisions set forth in Section 153.100, nursing facility (SNF/ICF) rates shall be increased by the difference between a facility's per diem property, liability and malpractice insurance costs as reported in the cost report that was filed with the Department and used to establish rates effective July 1, 2001, and those same costs as reported in the facility's 2002 cost report. These costs shall be passed through to the facility without caps or limitations.
- r) Notwithstanding the provisions set forth in Section 153.100, daily rates effective on January 1, 2006 for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under 22 years of age (SNF/Ped), shall be increased by 3 percent.
- s) Notwithstanding the provisions set forth in Section 153.100, developmental training rates for intermediate care facilities for persons with developmental disabilities (ICF/MR), including skilled long term care facilities for persons under

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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22 years of age (SNF/Ped), effective on January 1, 2006 shall be increased by 3 percent.

- t) Notwithstanding the provisions set forth in Section 153.100, for facilities that are federally defined as Institutions for Mental Disease (see Section 145.30), a socio-development component rate equal to 6.6% of the nursing component rate as of January 1, 2006 shall be established and paid effective July 1, 2006. This rate shall become a part of the facility's nursing component of the Medicaid rate. While this rate may be adjusted by the Department, the rate shall not be reduced.
- u) Notwithstanding any other provision of this Section, for facilities licensed by the Department of Public Health under the Nursing Home Care Act as skilled nursing facilities or intermediate care facilities, the support component of the rates taking effect on January 1, 2008 shall be computed using the most recent cost reports on file with the Department of Healthcare and Family Services no later than April 1, 2005, updated for inflation to January 1, 2006.
- 1) Support rates taking effect on January 1, 2008 shall be adjusted based on audits of cost report data in accordance with 89 Ill. Adm. Code 140.582(b) and 140.590. The audited cost report data will be used to retroactively update the resulting support rate effective January 1, 2008, after the 45-day appeal period from Section 140.582(b) has passed.
 - 2) All accounting records and other documentation necessary to support the costs and other information reported on the cost report to be used in accordance with rate setting under this subsection (u) shall be kept for a minimum of two years after the Department's final payment using rates that were based in part on that cost report.

(Source: Amended at 32 Ill. Reg. 7761, effective May 5, 2008)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

- 1) Heading of the Part: Fiscal/Administrative Recordkeeping and Requirements
- 2) Code Citation: 89 Ill. Adm. Code 509
- 3) Section Number: 509.65 Adopted Action:
Amendment
- 4) Statutory Authority: Implementing and authorized by the Department of Human Services Act [20 ILCS 1305]
- 5) Effective Date of Amendment: April 30, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this amendment contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposal Published in the Illinois Register: October 12, 2007; 31 Ill. Reg. 14208
- 10) Has JCAR issued a Statement of Objection to this amendment? No
- 11) Differences between proposal and final version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were made.
- 13) Will this amendment replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendment: This rulemaking pertains to the Office of Contract Administration. The language pertaining to mailing notices is being amended to allow notices to be sent by a private carrier or registered or certified mail. This option is less expensive for the Department.
- 16) Information and questions regarding this adopted amendment shall be directed to:

DEPARTMENT OF HUMAN SERVICES

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Tracie Drew, Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Building, 3rd Floor
Springfield, Illinois 62762

217/785-9772

- 17) Does this amendment require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code [30 ILCS 50/5-25]? No

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER XX: DEPARTMENT OF HUMAN SERVICESPART 509
FISCAL/ADMINISTRATIVE RECORDKEEPING
AND REQUIREMENTS

| Section | |
|---------|---|
| 509.10 | Purpose |
| 509.15 | Definitions |
| 509.20 | Allowable/Unallowable Costs |
| 509.30 | Fiscal Requirements/Management |
| 509.40 | Accounting Requirements |
| 509.50 | Funding Suspension |
| 509.60 | Cancellation of Award/Agreement |
| 509.65 | Process for Suspension of Funding/Cancellation of Award/Agreement |
| 509.70 | On-Site Fiscal/Administrative Reviews |
| 509.80 | Administrative Requirements |
| 509.90 | Compliance with Life Safety Standards and Requirements |
| 509.100 | Prompt Payment Act |
| 509.110 | Accreditation |

AUTHORITY: Implementing and authorized by the Department of Human Services Act [20 ILCS 1305].

SOURCE: Adopted by emergency rulemaking at 24 Ill. Reg. 9250, effective June 14, 2000, for a maximum of 150 days; emergency expired November 10, 2000; adopted at 24 Ill. Reg. 18137, effective November 30, 2000; amended at 26 Ill. Reg. 8547, effective May 31, 2002; amended at 32 Ill. Reg. 7769, effective April 30, 2008.

Section 509.65 Process for Suspension of Funding/Cancellation of Award/Agreement

- a) Suspension/Cancellation. The process for suspension of funding pursuant to Section 509.50 and cancellation pursuant to Section 509.60 is as follows:
 - 1) Notice. The provider shall be notified, in writing, by the Department of the action taken, the reason for the action, and the effective date of the action. The Notice shall be sent by certified [mail](#), ~~or~~ registered mail, [or private carrier](#).

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- 2) Request for Review. The provider shall have 7 days from the receipt of the notice, as determined by the certified ~~mail~~, ~~or~~ registered mail, ~~or~~ private carrier receipt, to request a review of the suspension/cancellation action by the Secretary of the Department and to provide supportive information to the Secretary as to why the action should not occur. In the event that the request and information are not submitted within the 7-day period, the Department may proceed with the suspension or cancellation.
 - 3) Additional Information. To assist the Secretary in his/her review, the Department may request additional information from the provider or other sources. Any additional information requested from the provider must be submitted within the time period established by the Department. Failure of the provider to comply with the request for additional information in a timely manner may result in resolution of the issue without consideration of that information.
 - 4) Secretary's Decision. The Secretary may delegate the responsibility for investigation of the issue and fact finding. The Secretary shall issue a final written decision as expeditiously as possible after receiving the request for review, supportive information, and any additional information requested by the Department. The Secretary's final decision to suspend funding, in part or in whole, shall indicate terms and conditions for rescinding the suspension and reinstatement of funding. The decision of the Secretary is a final decision of the agency for purpose of the Administrative Review Law [735 ILCS 5/Art. III], if applicable.
- b) Cancellation of Funding.
- 1) Funding under this Part to a provider who is served a notice under subsection (a)(1) may be suspended summarily without opportunity to provide supportive information as provided in subsection (a)(2) if, in the Secretary's discretion, it is determined that immediate suspension is necessary because the risk of continuing funding is sufficient to seriously outweigh the general policy in favor of advance notice and the opportunity to provide supportive information. If the suspension is pending a final decision of cancellation under Section 509.60, the provider shall not incur costs chargeable to the Department after the effective date included in the notice. Opportunity to provide supportive information shall be provided

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according to the provisions of subsection (a)(2) following suspension pending cancellation of funding. If the Secretary finds for the provider, funding shall then be reinstated.

- 2) For all other actions for suspension or cancellation of funding, in whole or in part, suspension or cancellation shall occur after issuance of the Secretary's final written decision.

(Source: Amended at 32 Ill. Reg. 7769, effective April 30, 2008)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

- 1) Heading of the Part: Grants and Grant Funds Recovery
- 2) Code Citation: 89 Ill. Adm. Code 511
- 3) Section Number: 511.40 Adopted Action:
Amendment
- 4) Statutory Authority: Implementing and authorized by the Department of Human Services Act [20 ILCS 1305] and implementing Sections 7 and 8 of the Illinois Grant Funds Recovery Act [30 ILCS 705/7 and 8]
- 5) Effective Date of Amendment: April 30, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this amendment contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposal Published in the Illinois Register: October 12, 2007; 31 Ill. Reg. 14213
- 10) Has JCAR issued a Statement of Objection to this amendment? No
- 11) Differences between proposal and final version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were made.
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendment: This rulemaking pertains to the Office of Contract Administration. The language pertaining to mailing notices is being amended to mirror the process found in the Grant Funds Recovery Act.
- 16) Information and questions regarding this adopted amendment shall be directed to:

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

Tracie Drew, Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Building, 3rd Floor
Springfield, Illinois 62762

217/785-9772

- 17) Does this amendment require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code [30 ILCS 50/5-25]? No

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF HUMAN SERVICES

NOTICE OF ADOPTED AMENDMENT

TITLE 89: SOCIAL SERVICES
CHAPTER IV: DEPARTMENT OF HUMAN SERVICESPART 511
GRANTS AND GRANT FUNDS RECOVERY

| | |
|---------|--------------------------------|
| Section | |
| 511.10 | Purpose |
| 511.15 | Definitions |
| 511.20 | Responsibility |
| 511.30 | Criteria for Recovery of Funds |
| 511.40 | Process for Recovery of Funds |
| 511.50 | Methods of Recovery |
| 511.60 | Prompt Payment Act |

AUTHORITY: Implementing and authorized by the Department of Human Services Act [20 ILCS 1305] and implementing Sections 7 and 8 of the Illinois Grant Funds Recovery Act [30 ILCS 705/7 and 8].

SOURCE: Adopted by emergency rulemaking at 24 Ill. Reg. 9278, effective June 14, 2000, for a maximum of 150 days; adopted at 24 Ill. Reg. 17130, effective November 3, 2000; amended at 26 Ill. Reg. 8558, effective May 31, 2002; amended at 32 Ill. Reg. 7774, effective April 30, 2008.

Section 511.40 Process for Recovery of Funds

If the Department believes that grant funds received by the provider are subject to recovery, the process outlined in the Grant Funds Recovery Act shall be followed:

- a) The provider will be notified, in writing, by the Department of the amount subject for recovery. This notice will constitute an intent to recover by the Department. The notice will indicate the opportunity for an informal hearing to determine the facts and issues regarding the recoverable funds and who to contact to request an informal hearing.
- b) The provider must notify the Department in writing within 15 calendar days after receipt of the Department's letter that they are requesting an informal hearing.
- c) If the provider does not file a request for an informal hearing, the Department

DEPARTMENT OF HUMAN SERVICES

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may initiate the recovery.

- d) If the informal hearing does not resolve the issues or if the provider does not request a hearing within the specified time in subsection (b), the Department will notify the provider in writing of the intent to recover. The letter will specify the amount to be recovered, the specific facts that permit recovery, and the right to a formal appeal. If the provider requests a hearing, then the Department will take no action to recover funds until at least 35 days after the Department has issued the final recovery order.
- e) An agency electing to file an appeal in accord with subsection (d) shall notify the Department, in writing, of its request for a formal hearing, within 35 days from the receipt of the letter.
- f) If the provider does not file an appeal, the Department may initiate the recovery.
- g) The hearing shall be presided over by an administrative law judge chosen by the Department.
- h) The provider shall have the burden of proof to show cause why no recovery should occur.
- i) If the decision of the hearing officer/administrative law judge is in favor of recovery, the Secretary shall approve the decision prior to implementing a recovery.
- j) The Secretary may elect to adopt, modify or reverse the recommended decision.
- k) The decision by the Secretary shall constitute the final administrative decision as defined in accordance with Section 3-101 of the Administrative Review Law [735 ILCS 5/3-101].
- l) *All written notices sent under this Section shall be sent by certified mail. Notices will be deemed received 5 days after the notice or mailing is deposited in the United States mail, properly addressed with the grantee's current business address and with sufficient U.S. postage affixed [30 ILCS 705/8(f)]. based on the date signed for by the recipient or the recipient's representative.*

(Source: Amended at 32 Ill. Reg. 7774, effective April 30, 2008)

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED RULES

- 1) Heading of the Part: Conservation Stewardship Program
- 2) Code Citation: 17 Ill. Adm. Code 2580
- 3)

| <u>Section Numbers:</u> | <u>Adopted Action:</u> |
|-------------------------|------------------------|
| 2580.10 | New Section |
| 2580.20 | New Section |
| 2580.30 | New Section |
| 2580.40 | New Section |
| 2580.50 | New Section |
| 2580.60 | New Section |
| 2580.70 | New Section |
| 2580.80 | New Section |
| 2580.90 | New Section |
| 2580.100 | New Section |
| 2580.110 | New Section |
| 2580.120 | New Section |
| 2580.130 | New Section |
| 2580.140 | New Section |
| 2580.150 | New Section |
| 2580.160 | New Section |
| 2580.170 | New Section |
| 2580.180 | New Section |
- 4) Statutory Authority: Implementing and authorized by the Conservation Stewardship Law [35 ILCS 200/Art. 10, Div. 16]
- 5) Effective Date of Rules: April 30, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rules, including all material incorporated by reference, is on file in the Department of Natural Resources' principal office and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: December 21, 2007; 31 Ill. Reg. 16682

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED RULES

- 10) Has JCAR issued a Statement of Objection to these rules? No
- 11) Differences between proposal and final version: No substantive language changes were made. However, changes were made to correct grammatical, spelling and formatting errors and to remove redundant language.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? Yes

| <u>Section Numbers:</u> | <u>Emergency Action:</u> | <u>Illinois Register Citation:</u> |
|-------------------------|--------------------------|---------------------------------------|
| 2580.10 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.20 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.30 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.40 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.50 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.60 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.70 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.80 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.90 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.100 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.110 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.120 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.130 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.140 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.150 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.160 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.170 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |
| 2580.180 | New Section | 31 Ill. Reg. 16751; December 21, 2007 |

- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Rulemaking: This Part was proposed to implement the Conservation Stewardship Law (Senate Bill 17), which was signed into law on October 1, 2007. This law encourages landowners to preserve or create wooded acreage, wetlands, and prairies by giving them a property tax break for their participation in the Conservation Stewardship Program. This Part establishes the rules and regulations for qualification, application, and participation in this program.

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- 16) Information and questions regarding these adopted rules shall be directed to:

Jack Price, Legal Counsel
Department of Natural Resources
One Natural Resources Way
Springfield IL 62702-1271

217/782-1809

The full text of the Adopted Rules begins on the next page:

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF ADOPTED RULES

TITLE 17: CONSERVATION

CHAPTER I: DEPARTMENT OF NATURAL RESOURCES

SUBCHAPTER f: ADMINISTRATIVE SERVICES

PART 2580

CONSERVATION STEWARDSHIP PROGRAM

Section

| | |
|----------|--|
| 2580.10 | Definitions |
| 2580.20 | Eligibility |
| 2580.30 | Conservation Management Plan Development |
| 2580.40 | Taxpayer Contact Information |
| 2580.50 | Location of Managed Land |
| 2580.60 | Map of Managed Land |
| 2580.70 | Description of Managed Land |
| 2580.80 | Recent History of Managed Land |
| 2580.90 | Plants and Animals Present |
| 2580.100 | Adjacent Land Use |
| 2580.110 | Management Objectives |
| 2580.120 | Management Practices |
| 2580.130 | Protection Measures |
| 2580.140 | Exotic Species |
| 2580.150 | Uses of Managed Lands to be Allowed by Landowner |
| 2580.160 | Taxpayer Signature |
| 2580.170 | Plan Review and Appeal Procedures |
| 2580.180 | Conservation Management Plan Non-Compliance |

AUTHORITY: Implementing and authorized by the Conservation Stewardship Law [35 ILCS 200/Art. 10, Div. 16].

SOURCE: Adopted by emergency rulemaking at 31 Ill. Reg. 16751, effective December 6, 2007; adopted at 32 Ill. Reg. 7778, effective April 30, 2008.

Section 2580.10 Definitions

"Conservation Management Plan" means a plan approved by the Department of Natural Resources that specifies conservation and management practices, including uses that will be conducted to preserve and restore unimproved land.

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"Contiguous" means not separated by anything other than rivers, streams, road or right-of-way easement.

"Department" means the Illinois Department of Natural Resources.

"Managed Land" means unimproved land of 5 contiguous acres or more that is subject to a conservation management plan.

"Materially Disturbs the Land" means to degrade the natural state of the land.

"Unimproved Land" means woodlands, prairie, wetlands or other vacant and undeveloped land that is not used for any residential or commercial purpose that materially disturbs the land.

"Wooded Acreage" means unimproved land that is predominately tree and shrub cover.

Section 2580.20 Eligibility

- a) Conservation management plans will be accepted only for unimproved land of 5 contiguous acres or more. Unimproved land in Cook County is not eligible for the special valuation under this Section.
- b) A taxpayer may apply for reassessment under this Section, and shall not be penalized for doing so, if the taxpayer owns land:
 - 1) included in a forestry management plan under Section 10-150 of the Property Tax Code [35 ILCS 200/10-150];
 - 2) registered or encumbered by conservation rights under Section 10-166 of the Property Tax Code [35 ILCS 200/10-166]; or
 - 3) registered as a Land and Water Reserve under Section 16 of the Natural Areas Preservation Act [525 ILCS 30/16].
- c) A taxpayer may apply for reassessment of land formerly assessed as farmland under Sections 10-110 through 10-145 of the Property Tax Code [35 ILCS 200/10-110 through 10-145] during the first year in which the land is not used for farm purposes as defined in Section 1-60 of the Property Tax Code. The special

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valuation offered under this Section cannot be applied to land formerly assessed as farmland until the second year in which the land is not used for farm purposes.

Section 2580.30 Conservation Management Plan Development

- a) A taxpayer requesting special valuation of unimproved land under this Section must first submit a conservation management plan for that land to the Department for review. The submission of an application for a conservation management plan under Section 10-415 of the Property Tax Code [35 ILCS 200/10-415] or of a forestry management plan under Section 10-150 of the Property Tax Code shall be treated as compliance with the requirements of that plan until the Department can review the application. The conservation management plan may be prepared by the taxpayer or his/her representative and shall include those items listed under Sections 2580.40 through 2580.160. The Department shall provide a means for submittal of conservation management plans via the Internet at <http://dnr.state.il.us>. Conservation management plans may also be submitted to the Department as a hard copy via standard means of delivery. Conservation management plans submitted in hard copy should be sent to:

Conservation Stewardship Program
Office of Resource Conservation
Illinois Department of Natural Resources
One Natural Resources Way
Springfield IL 62702-1271

- b) A taxpayer whose eligibility is based on Section 2580.20(b) shall not be required to submit an original conservation management plan if a management plan prepared as a condition of the programs listed in Section 2580.20(b) has been approved by the Department.
- c) Management plans prepared for participation in other conservation programs administered by the Department and approved by the Department will be accepted as a conservation management plan provided that the plan includes a description of the managed land and specifies the conservation and management practices to be implemented on the managed land as required by Section 10-410 of the Property Tax Code.

Section 2580.40 Taxpayer Contact Information

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The taxpayer's name, mailing address and phone numbers shall be included in the conservation management plan. An electronic mail (e-mail) address may be included at the taxpayer's discretion.

Section 2580.50 Location of Managed Land

The location of the managed land for which the conservation management plan is prepared shall include the section, township, range, principal meridian and county name. The property index number or parcel number (where used by the County Assessor's Office) shall also be provided.

Section 2580.60 Map of Managed Land

A map of the managed land and vicinity shall be included. The map shall be at a minimum scale of 2 inches to the mile and shall depict an area large enough to include local landmarks (roads, streams, municipalities, etc.) that will allow a reviewer to locate the managed land within a larger landscape.

Section 2580.70 Description of Managed Land

The size in acres of the managed land shall be specified in the conservation management plan. The conservation management plan shall also include a description of the habitat type (woodland, wetland, prairie, etc.) that currently exists on the managed land.

Section 2580.80 Recent History of Managed Land

The conservation management plan shall include a description of the recent (up to 10 years, if known) uses of the managed land and any natural resource management that has been implemented on the managed land during that time.

Section 2580.90 Plants and Animals Present

A list of the plants and animals known to exist on the managed land shall be included. The list shall include the names of plants and animals that can be identified by the taxpayer or other users of the managed land or a general listing of types of plants and animals (large trees, tall grasses, birds, small animals, fish, etc.).

Section 2580.100 Adjacent Land Use

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The conservation management plan shall include a general description of the present uses of land adjoining the managed land (residential, agricultural, forest, grassland, public roadway, etc.). The use of adjoining land to the north, south, east, and west of the managed land shall be specified.

Section 2580.110 Management Objectives

The conservation management plan shall include a description of the general management objectives to be pursued on the managed land, for example, maintenance of existing habitat types, conversion/restoration to historic habitat type (e.g., woodland, wetland, prairie), reduction of erosion. If more than one management objective is to be pursued, each shall be described and the portion of the managed land on which each will be applied shall be specified and delineated on the map included in the conservation management plan.

Section 2580.120 Management Practices

- a) The specific management practices (herbicide application, planting, prescribed burning, tree thinning, water control structures, etc.) that will be used to achieve the management objectives shall be described. If a management practice is to be implemented on only a portion of the managed land, the portion on which each practice will be applied shall be specified and delineated on the map included in the conservation management plan.
- b) The description of management practices to be implemented on the managed land shall include a detailed annual implementation schedule for the first two years of management. That schedule shall specify the times at which each management practice will be implemented, the portion of the managed land on which each management practice will be implemented, and the identity of the persons who will implement each management practice (the taxpayer, a private contractor, volunteers from a conservation organization, or others).
- c) The description of management practices to be implemented on the managed land shall include a general annual implementation schedule for the third through fifth years of management. That schedule shall list the management practices that will be implemented on the managed land during each of the calendar years.

Section 2580.130 Protection Measures

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The conservation management plan shall include a description of any known or foreseeable threats to the managed land that may affect management decisions (injurious insects, disease, contaminants or other environmental problems, wildfire risk, nearby development, etc.). Protective measures that will be used to minimize or mitigate negative effects of those threats shall be described.

Section 2580.140 Exotic Species

Exotic plants that have been identified on the managed land shall be listed in the conservation management plan. The conservation management plan shall include a description of practicable management practices specifically intended to reduce or eliminate exotic plants from the managed land. No conservation management plan shall include the intentional introduction of exotic plants. For the purposes of this Part, exotic plants shall be those included on a list maintained by the Department available at <http://dnr.state.il.us> or by writing to the Conservation Stewardship Program at the address listed in Section 2580.30(a).

Section 2580.150 Uses of Managed Land to be Allowed by Landowner

The uses and activities that the landowner intends to allow on the managed land shall be described (hunting, hiking, mushroom collecting, fishing, birding, nut and berry collection, firewood collection, etc.). Enrollment of managed land in the Conservation Stewardship Program creates no obligation on the part of the landowner to allow public access to or use of the managed land.

Section 2580.160 Taxpayer Signature

A conservation management plan submitted as a hard copy shall be signed and dated by the taxpayer. A conservation management plan submitted via the Internet shall include the electronic signature of the taxpayer. The Department shall provide a certification form that may be signed by the taxpayer and sent to the Department in lieu of an electronic signature.

Section 2580.170 Plan Review and Appeal Procedures

- a) The Department will review all conservation management plans received from taxpayers to determine compliance with the Conservation Stewardship Law and other applicable laws and regulations including, but not limited to, the Illinois Endangered Species Protection Act [520 ILCS 10] and the Illinois Natural Areas Preservation Act [525 ILCS 30].

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- b) Upon receipt of an application for a conservation management plan, the Department shall certify to the Department of Revenue the application as being an approved plan for the purpose of the Conservation Stewardship Law (see 35 ILCS 200/10-415(e)). The conservation management plan will be reviewed by the Department. If the plan meets all requirements of the Act, the Department will notify the Department of Revenue of the acceptance of the plan and will provide a copy of the plan to the Department of Revenue. If the plan does not satisfy the requirements of the Act, the Department will provide the taxpayer an explanation of the deficiencies and give a date by which a revised plan must be submitted to the Department to maintain eligibility for the special valuation. No more than 90 days will be allowed for revision of a conservation management plan that does not meet the requirements of the Act on first submission. If the taxpayer fails to submit a revised conservation management plan by the specified date, the Department will notify the Department of Revenue to remove the taxpayer from the list of those qualified for the special valuation.
- c) Pursuant to Section 10-415(e) of the Property Tax Code, a taxpayer may appeal the denial of a conservation management plan to an independent 3-member panel to be established within the Department. A taxpayer who wishes to appeal the denial of a conservation management plan shall send notice of the intent to appeal to Office of Legal Counsel, ATTN: Conservation Management Appeals, at the address listed in Section 2580.30(a).
- d) Procedures governing the hearing of appeals are set forth in 17 Ill. Adm. Code 2530 – Revocation Procedures for Conservation Offenses.

Section 2580.180 Conservation Management Plan Non-Compliance

- a) If the Department determines, based on field inspections or other reasonable evidence, that the land no longer meets the criteria under the Conservation Stewardship Law, the Department shall withdraw all or a portion of the land from the special valuation.
- b) The chief county assessment officer shall notify the Department when the property no longer qualifies for the special valuation because the property no longer meets the land use or minimum acreage requirements.
- c) The chief county assessment officer shall notify the Department when he or she has reasonable evidence that shows non-compliance with the approved

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conservation management plan. Reasonable evidence must be based on, but not limited to, visual inspection of the property, evidence of improper land use, or the taxpayer's refusal to respond to the chief county assessment officer's request for information about the land use or other similar information pertinent to the continued special valuation of the land. Notification shall be made, in writing, to the Department. Upon receipt, the Department shall, within a reasonable length of time, visually inspect the property and pertinent conservation management plans and shall determine if the owner is complying with the approved management plan. Within 15 days after inspecting the property, the Department shall notify the chief county assessment officer and the Illinois Department of Revenue of its determination. If the property is found to be non-compliant, the chief county assessment officer shall remove the property from the special valuation.

POLLUTION CONTROL BOARD

NOTICE OF ADOPTED RULES

- 1) Heading of the Part: Procedures for Reporting Releases of Radionuclides at Nuclear Power Plants
- 2) Code Citation: 35 Ill. Adm. Code 1010
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 1010.100 | New Section |
| 1010.102 | New Section |
| 1010.104 | New Section |
| 1010.106 | New Section |
| 1010.108 | New Section |
| 1010.200 | New Section |
| 1010.202 | New Section |
| 1010.204 | New Section |
- 4) Statutory Authority: 415 ILCS 5/13.6
- 5) Effective Date of Rules: May 2, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rules, including any material incorporated by reference, are on file in the Board's Chicago office at the James R. Thompson Center, 100 W. Randolph, Suite 11-500 and are available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: December 21, 2007; 31 Ill. Reg. 16685
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between proposal and final version:

In Section 1010.202(a)(3) – After "prescribed by Agency", added ", and must be submitted to addresses prescribed by the Agency".

In Section 1010.204(b) – Removed the subsection labels "1)" and "2)".

POLLUTION CONTROL BOARD

NOTICE OF ADOPTED RULES

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements letter issued by JCAR? No agreements were necessary.
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Rules: For a more detailed description of this rulemaking, see the Board's April 17, 2008, opinion and order in *Procedures Required by P. A. 94-849 for Reporting Releases of Radionuclides at Nuclear Power Plants: New 35 Ill. Adm. Code 1010* (R07-20). These new rules are driven by amendments to the Environmental Protection Act (Act) in Public Act 94-849, which, in adding Section 13.6 to the Act [415 ILCS 5/13.6 (2006)], required the Agency to propose rules to the Board to establish standards for detecting and reporting unpermitted releases of radionuclides from nuclear power plants.

The new Part 1010 procedures allow licensees of power plants to fulfill their obligation under Section 13.6 of the Act to report unpermitted releases of radionuclides to the Agency and the Illinois Emergency Management Agency (IEMA). These procedures establish a requirement that within 24 hours after any unpermitted release of radionuclides into the groundwater, surface water, or soil, the licensee must evaluate the release to determine whether it needs to be reported and, if reporting is necessary, make the report to the Agency and IEMA within that same 24 hours. The new rules contain the proper procedure for reporting the releases, including the appropriate reporting phone numbers for the Agency and IEMA, as well as instructions on electronic reporting. The rules require a follow-up written report sent to the Agency and the IEMA within five days after reporting the release. This follow-up report must contain the information required for the initial report as well as supplemental information on the release utilizing the best data available.

Under these rules, a radionuclide is deemed to have been detected if an unpermitted release of liquids either: (1) results in tritium concentrations of 200 picocuries per liter (pCi/L) or more outside the licensee controlled area, or (2) contains tritium at quantities of 0.002 Curies (Ci) or more.

- 16) Information and questions regarding these Adopted Rules shall be directed to:

Marie Tipsord
Illinois Pollution Control Board

POLLUTION CONTROL BOARD

NOTICE OF ADOPTED RULES

100 W. Randolph 11-500
Chicago, IL 60601

312/814-4925

Copies of the Board's opinions and orders may be requested from the Clerk of the Board at the address listed in #8 above or by calling 312/814-3620. Please refer to the Docket number R07-20 in your request. The Board order is also available from the Board's Web site (www.ipcb.state.il.us)

The full text of the Adopted Rules begins on the next page:

POLLUTION CONTROL BOARD

NOTICE OF ADOPTED RULES

TITLE 35: ENVIRONMENTAL PROTECTION
SUBTITLE I: ATOMIC RADIATION
CHAPTER I: POLLUTION CONTROL BOARDPART 1010
PROCEDURES FOR REPORTING RELEASES OF
RADIONUCLIDES AT NUCLEAR POWER PLANTS

SUBPART A: GENERAL PROVISIONS

| Section | |
|----------|---------------|
| 1010.100 | Purpose |
| 1010.102 | Applicability |
| 1010.104 | Scope |
| 1010.106 | Definitions |
| 1010.108 | Severability |

SUBPART B: REPORTING

| | |
|----------|--------------------------|
| 1010.200 | Evaluation of Releases |
| 1010.202 | Reporting of Releases |
| 1010.204 | Follow-up Written Report |

AUTHORITY: Implementing and authorized by Sections 13.6 and 27 of the Environmental Protection Act [415 ILCS 5/13.6 and 27].

SOURCE: Adopted at 32 Ill. Reg. 7789, effective May 2, 2008.

SUBPART A: GENERAL PROVISIONS

Section 1010.100 Purpose

This Part prescribes standards for detecting and reporting unpermitted releases of radionuclides from nuclear power plants pursuant to Section 13.6 of the Illinois Environmental Protection Act [415 ILCS 5/13.6].

Section 1010.102 Applicability

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NOTICE OF ADOPTED RULES

This Part applies to licensees of nuclear power plants that are required under Section 13.6 of the Act to report an unpermitted release of a radionuclide.

Section 1010.104 Scope

This Part sets forth the procedures licensees of nuclear power plants must follow to satisfy their obligation under Section 13.6 of the Act to report unpermitted releases of radionuclides to the Agency and to IEMA. This Part addresses only the reporting of unpermitted releases of radionuclides required under Section 13.6 of the Act. The requirements of this Part are independent of, and do not replace or supersede, any other reporting requirements in State or federal law or regulation. This Part does not prevent or preclude licensees from reporting releases of radionuclides that are not required to be reported under Section 13.6 of the Act.

Section 1010.106 Definitions

Except as stated in this Section, or unless a different meaning of a word or term is clear from the context, the definition of words or terms in this Part shall be the same as that applied to the same words or terms in the Illinois Environmental Protection Act.

"Act" means the Illinois Environmental Protection Act [415 ILCS 5].

"Agency" means the Illinois Environmental Protection Agency.

"Curie" or "Ci" means the quantity of radioactive material producing 37 billion nuclear transformations per second.

"Groundwater" means underground water that occurs within the saturated zone and geologic materials where the fluid pressure in the pore space is equal to or greater than atmospheric pressure. [415 ILCS 5/3.64]

"IEMA" means the Illinois Emergency Management Agency.

"L" means liter.

"Licensee" means the holder of a license issued for a nuclear power plant under chapter I of title 10 of the Code of Federal Regulations.

"Licensee controlled area" means the land or property that is owned, leased, or otherwise controlled by the licensee.

POLLUTION CONTROL BOARD

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"Picocurie" or "pCi" means the quantity of radioactive material producing 2.22 nuclear transformations per minute. One pCi is one trillionth (10^{-12}) of one curie.

"Person" is any individual, partnership, co-partnership, firm, company, limited liability company, corporation, association, joint stock company, trust, estate, political subdivision, State agency, or any other legal entity, or their legal representative, agent, or assigns. [415 ILCS 5/3.315]

"Station generated liquids" means liquids used in, or as a part of, the power generation process at a nuclear power plant and that contain, or potentially could contain, radionuclides.

"Surface water" means all water that is open to the atmosphere and subject to surface runoff.

"Unpermitted release of a radionuclide" means any spilling, leaking, emitting, discharging, escaping, leaching, or disposing of a radionuclide into groundwater, surface water, or soil that is not permitted under State or federal law or regulation. [415 ILCS 5/13.6(c)]. "Unpermitted release of a radionuclide" does not include the discharge of a radionuclide from a point source at a designated process water or cooling water outfall identified in the nuclear power plant's National Pollutant Discharge Elimination System permit, provided the discharge is authorized in the nuclear power plant's United States Nuclear Regulatory Commission operating license.

Section 1010.108 Severability

If any provision in this Part or its application to any person or under any circumstances is adjudged invalid, such adjudication shall not affect the validity of this Part as a whole or of any portion not adjudged invalid.

SUBPART B: REPORTING

Section 1010.200 Evaluation of Releases

Within 24 hours after an unpermitted release of a radionuclide from a nuclear power plant into groundwater, surface water, or soil, the licensee must evaluate the release in accordance with this Section to determine whether it must be reported. The evaluation cannot take into account

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remedial actions taken in response to the release (i.e., the evaluation must be based on the volumes of station generated liquids and concentrations or quantities of radionuclides released, not on the volumes of station generated liquids and concentrations or quantities of radionuclides remaining after the initiation or completion of response actions). If the release is required to be reported, the licensee must report the release in accordance with Section 1010.202 of this Part.

- a) Licensees must report unpermitted releases of station generated liquids that result in tritium concentrations of 200 pCi/L or more outside of the licensee controlled area.
- b) Licensees must report unpermitted releases of station generated liquids that contain tritium at quantities of 0.002 Curies or more.

Section 1010.202 Reporting of Releases

- a) Reports required under Section 1010.200 must be given within 24 hours after the release to both the Agency and IEMA in accordance with the following:
 - 1) Reports to the Agency must be given by telephone and electronically. The Agency's telephone number for reporting environmental emergencies is 1-217-782-3637.
 - 2) Reports to IEMA must be given by telephone and electronically. IEMA's telephone number for reporting emergencies is 1-800-782-7860, or, if calling from outside Illinois, 1-217-782-7860.
 - 3) Electronic reports must be submitted on forms and in a format prescribed by the Agency, and must be submitted to addresses prescribed by the Agency and IEMA. The Agency shall consult with IEMA in developing the forms and format for electronic reports required under this Section.
- b) Reports required under Section 1010.200 must include, at a minimum, the following information using the best data available at the time of the report:
 - 1) The name and address of the nuclear power plant where the release occurred;

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- 2) The name, signature, and telephone number of the Principal Executive Officer for the nuclear power plant or the Principal Executive Officer's authorized agent;
 - 3) The specific location of the release;
 - 4) The time and duration of the release;
 - 5) An estimate of the volume and radionuclide concentrations (in pCi/L) of station generated liquids released, and an estimate of the flow rate if the release is ongoing;
 - 6) Identification of the radionuclides released and an estimate of the quantities released (in Curies);
 - 7) Whether the release was to groundwater, surface water, or soil, and a description of the area into which the release occurred (e.g., field, ditch, stream, or other description) and the size of the area affected;
 - 8) The actions taken to respond to, contain, and mitigate the release;
 - 9) The known and anticipated impacts to human health and the environment, including but not limited to groundwater and surface water resources, as a result of the release;
 - 10) The names, addresses, and telephone numbers of persons at the nuclear power plant who may be contacted for further information regarding the release; and
 - 11) The name and mailing address of the licensee of the nuclear power plant.
- c) The Agency must post copies of the electronic reports it receives under this Section on the Agency's website.

Section 1010.204 Follow-up Written Report

An owner or operator who reports a release under this Part must provide to the Agency and to IEMA a follow-up written report of the release within five business days after reporting the release.

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- a) The follow-up report must confirm and update the information provided by the licensee under Section 1010.202 utilizing the best data available and must also include the following information:
- 1) Copies of all lab analyses used to confirm the presence of, or conducted in response to, the release if lab analyses have been conducted;
 - 2) Plan view and, if available, geological cross-section maps showing, at a minimum, the location of the release, the locations of samples taken to confirm the release if samples have been taken, the locations of samples taken in response to the release if samples have been taken, the measured and modeled extents of the release if known, the groundwater flow direction if known, groundwater contours if known, the boundary of the licensee controlled area, and structures, roads, and other surface features;
 - 3) An estimate of the volume and radionuclide concentrations (in pCi/L) of station generated liquids released but not recovered;
 - 4) An estimate of the quantities (in Curies) of radionuclides released but not recovered;
 - 5) An updated description of activities taken in response to the release;
 - 6) If additional activities in response to the release are planned, a description of those activities; and
 - 7) The name and signature of the Principal Executive Officer for the nuclear power plant or the Principal Executive Officer's authorized agent.
- b) The follow-up report must be submitted electronically on forms and in a format prescribed by the Agency and must be submitted to addresses prescribed by the Agency and IEMA. Within five business days after submission of the electronic follow-up report, hard copies of the follow-up report must be submitted to the Agency and IEMA at the following addresses:

Illinois Environmental Protection Agency
Bureau of Water
Groundwater Section

POLLUTION CONTROL BOARD

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1021 North Grand Avenue East
P.O. Box 19276
Springfield, Il 62794-9276

Illinois Emergency Management Agency
Division of Nuclear Safety
Bureau of Environmental Safety
1035 Outer Park Drive
Springfield, Il 62704

The Agency shall consult with IEMA in developing the forms and format for reports required under this Section.

- c) The Agency must post copies of the follow-up reports it receives under this Section on the Agency's website.

TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

NOTICE OF ADOPTED RULES

- 1) Heading of the Part: Americans With Disabilities Act Grievance Procedure
- 2) Code Citation: 4 Ill. Adm. Code 1775
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 1775.10 | New |
| 1775.20 | New |
| 1775.30 | New |
| 1775.40 | New |
| 1775.50 | New |
| 1775.60 | New |
| 1775.70 | New |
- 4) Statutory Authority: Implementing and authorized by the Americans with Disabilities Act of 1990 (42 USC 12101 et seq.) and authorized by Article 16, Section 168 [40 ILCS 5/16-168] of the Illinois Pension Code
- 5) Effective Date of Rules: April 30, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Do these rules contain incorporations by reference? No
- 8) A copy of the adopted rules and any material incorporated by reference are on file in the Teachers' Retirement System's principal office and are available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: January 18, 2008; 32 Ill.Reg. 847
- 10) Has JCAR issued a Statement of Objection to these rules? No
- 11) Differences between proposal and final version: Various punctuation changes recommended by JCAR were made.
- 12) Have all the changes agreed upon by the agency and JCAR been as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will these rules replace any emergency rulemakings currently in effect? No
- 14) Are there any amendments pending on this Part? No

TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

NOTICE OF ADOPTED RULES

- 15) Summary and Purpose of Rules: In compliance with JCAR's direction to promulgate ADA grievance procedure rules, these rules set forth the process to resolve grievances asserted by qualified individuals with disabilities.
- 16) Information and questions regarding these adopted rules shall be directed to:

Cynthia M. Fain Gray, Assistant General Counsel
Teachers' Retirement System
2815 West Washington, P.O. Box 19253
Springfield, Illinois 62794-9253

217/753-0375

The full text of the Adopted Rules begins on the next page:

TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

NOTICE OF ADOPTED RULES

TITLE 4: DISCRIMINATION PROCEDURES
CHAPTER LXV: TEACHERS' RETIREMENT SYSTEMPART 1775
AMERICANS WITH DISABILITIES ACT GRIEVANCE PROCEDURE

| | |
|---------|------------------------------|
| Section | |
| 1775.10 | Purposes |
| 1775.20 | Definitions |
| 1775.30 | Procedure |
| 1775.40 | Designated Coordinator Level |
| 1775.50 | Final Level |
| 1775.60 | Accessibility |
| 1775.70 | Case-By-Case Resolution |

AUTHORITY: Implementing the Americans With Disabilities Act of 1990 (42 USC 12101 et seq.) and authorized by Section 16-168 of the Pension Code [40 ILCS 5/16-168].

SOURCE: Adopted at 32 Ill. Reg. 7799, effective April 30, 2008.

Section 1775.10 Purposes

- a) This grievance procedure is established pursuant to the Americans With Disabilities Act of 1990 (42 USC 12101 et seq.) (ADA) and specifically Section 35.107 of the Title II regulations, 28 CFR 35, requiring that a grievance procedure be established to resolve grievances asserted by qualified individuals with disabilities. Should any individual desire to review the ADA or its regulations to understand the rights, privileges and remedies afforded by it, please contact the Designated Coordinator.
- b) In general, the ADA requires that each program, service and activity offered by the Teachers' Retirement System (System), when viewed in its entirety, be readily accessible to and usable by qualified individuals with disabilities.
- c) It is the intention of the System to foster open communication with all individuals requesting readily accessible programs, services and activities. The System encourages supervisors of programs, services and activities to respond to requests for modifications before they become grievances.

TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

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Section 1775.20 Definitions

"Act" or "ADA" means the Americans With Disabilities Act of 1990 (42 USC 12101 et seq.).

"Complainant" is an individual with a disability who files a Grievance Form provided by the System under this procedure.

"Designated Coordinator" is the person appointed by the System who is responsible for the coordination of efforts of the System to comply with and carry out its responsibilities under Title II of the ADA, including investigation of grievances filed by complainants. The Designated Coordinator may be contacted at Teachers' Retirement System, ADA Coordinator, 2815 W. Washington St., Springfield IL 62702, 217/753-0311. (See 28 CFR 35.107.)

"Director" means the Executive Director of the System.

"Disabilities" shall have the same meaning as set forth in the Americans With Disabilities Act.

"Grievance" is any complaint under the ADA that is reduced to writing by an individual with a disability who meets the essential eligibility requirements for participation in or receipt of the benefits of a program, activity or service offered by the System and believes he or she has been excluded from participation in, or denied the benefits of, any program, service or activity of the System or has been subject to discrimination by the System. The ADA grievance procedures set forth in this Part do not supersede or provide an alternative to the System's administrative review appeal process set forth in 80 Ill. Adm. Code 1650.Subpart H.

"Grievance Form" is prescribed for the purpose of filing a grievance under this Part and includes information such as name, address, phone number, nature of the grievance, with specificity, including date of incident, time, place and witnesses if applicable.

"Qualified individual with a disability" means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility

TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

NOTICE OF ADOPTED RULES

requirements for the receipt of services or participation in programs or activities provided by the System.

Section 1775.30 Procedure

- a) Grievances must be submitted in accordance with procedures established in Sections 1775.40 and 1775.50 of this Part. It is mutually desirable and beneficial that grievances be satisfactorily resolved in a prompt manner. Time limits established in this procedure are in calendar days, unless otherwise stated, and may be extended by mutual agreement, in writing, by the complainant and the reviewer, at the Designated Coordinator and/or the Final Levels described in Sections 1775.40 and 1775.50.
- b) A complainant's failure to submit a grievance, or to submit or appeal it to the next level of procedure within the specified time limits, shall mean that the complainant has withdrawn the grievance or has accepted the last response from the System given in the grievance procedure.
- c) The System shall, upon being informed of individual's desire to file a formal grievance, instruct the individual how to receive a copy of this procedure and the Grievance Form.

Section 1775.40 Designated Coordinator Level

- a) If an individual desires to file a grievance, the individual shall promptly, but no later than 180 days after the alleged discrimination, submit the grievance to the Designated Coordinator in writing on the Grievance Form prescribed for that purpose. The Grievance Form must be completed in full in order to receive proper consideration by the Designated Coordinator.
- b) Upon request, assistance in completing the Grievance Form shall be provided by the System.
- c) The Designated Coordinator, or his/her representative, shall investigate the grievance and, if the grievance is found to be valid, shall make reasonable efforts to resolve it. The Designated Coordinator shall provide a written response to the complainant and Director within 15 business days after receipt of the Grievance Form.

TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

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Section 1775.50 Final Level

- a) If the grievance is not resolved at the Designated Coordinator Level to the satisfaction of the complainant, the complainant may submit a copy of the Grievance Form and Designated Coordinator's response to the Director for final review. The complainant shall submit these documents to the Director, together with a short written statement explaining the reasons for dissatisfaction with the Designated Coordinator's written response, within 15 business days after receipt by the complainant of the Designated Coordinator's response.
- b) Within 15 business days, the Director shall appoint a three-member panel to review the grievance at the Final Level. One member shall be designated chairman. The panel shall schedule a review of the grievance, which shall commence no later than 15 business days after the last member of the panel is appointed.
- c) Complainant shall be afforded an opportunity to appear before the panel. Complainant shall have a right to appoint a representative to appear on his or her behalf. The panel shall review the Designated Coordinator's written response and may conduct interviews and seek advice as it deems appropriate.
- d) Upon agreement of at least two of the panel members, but not later than 15 business days after the review described in subsection (b), the panel shall make recommendations in writing to the Director as to the proper resolution of the grievance. All recommendations shall include reasons for such recommendations and shall bear the signatures of the concurring panel members. A dissenting member of the panel may make a recommendation to the Director in writing and shall sign the recommendation.
- e) Within 15 business days after receipt of recommendations from a panel, the Director or designee shall approve, disapprove or modify the panel recommendations; shall render a decision on those recommendations in writing; shall state the basis for his or her decision; and shall cause a copy of the decision to be served on the parties. The Director's decision shall be final. If the Director disapproves or modifies the panel's recommendations, the Director may include written reasons for such disapproval or modification.
- f) The Grievance Form, the Designated Coordinator's response, the statement of the reasons for dissatisfaction, the recommendations of the panel, and the decision of

TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

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the Director shall be maintained in accordance with the State Records Act [5 ILCS 160] or as otherwise required by law.

Section 1775.60 Accessibility

The System shall ensure that all stages of the grievance procedure are readily accessible to and usable by individuals with disabilities.

Section 1775.70 Case-By-Case Resolution

Each grievance involves a unique set of factors that includes but is not limited to: the specific nature of the disability; the essential eligibility requirements, the benefits to be derived, and the nature of the service, program or activity at issue; the health and safety of others; and whether an accommodation would constitute a fundamental alteration to the program, service or activity or undue hardship on the System. Accordingly, termination of a grievance at any level, whether through the granting of relief or otherwise, shall not constitute a precedent on which any other complainants should rely.

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENT

- 1) Heading of the Part: Airport Hazard Zoning
- 2) Code Citation: 92 Ill. Adm. Code 16
- 3) Section Number: 16.APPENDIX A Adopted Action: Amend
- 4) Statutory Authority: Implementing and authorized by the Airport Zoning Act [620 ILCS 25]
- 5) Effective Date of Amendment: May 1, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 1880
- 10) Has JCAR issued a Statement of Objection to this amendment? No
- 11) Differences between proposal and final version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No agreements were necessary.
- 13) Will this rulemaking replace any emergency amendment currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendment: By this Notice, the Department has amended Section 16.Appendix A to add numerous publicly-owned airports to the Part. This Part prescribes requirements for administration and enforcement that restrict the height of structures, equipment, and vegetation and that regulate the use of property on or in the vicinity of publicly-owned airports. The following airports are now covered under this Part: Robinson Municipal Airport (RSV), Taylorville Municipal Airport (TAZ), Mid

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENT

America St. Louis Airport (BLV), Logan County Airport (AAA), Vandalia Municipal Airport (VLA), Waukegan Regional Airport (UGN), Southern Illinois Airport (MDH), St. Louis Downtown Airport (CPS), Macomb Municipal Airport (MQB), Chicago Executive Airport (PWK), Havana Regional Airport (9I0), Morris Municipal Airport (C09), Effingham County Memorial Airport (1H2), University of Illinois – Willard Airport (CMI), and Mt. Sterling Municipal Airport (I63).

- 16) Information and questions regarding this adopted amendment shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
#1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENT

TITLE 92: TRANSPORTATION
CHAPTER I: DEPARTMENT OF TRANSPORTATION
SUBCHAPTER b: AERONAUTICSPART 16
AIRPORT HAZARD ZONING

Section

| | |
|-------------------|---|
| 16.10 | Purpose and Scope |
| 16.20 | Applicability |
| 16.30 | Definitions |
| 16.35 | Public Hearings |
| 16.40 | Surfaces and Height Limitations |
| 16.50 | Horizontal Surface |
| 16.60 | Conical Surface |
| 16.70 | Primary Surface |
| 16.80 | Approach Surface |
| 16.90 | Transitional Surfaces |
| 16.100 | Circling Approach Surface |
| 16.110 | Instrument Approach Obstruction Clearance Surface |
| 16.120 | Heliport/Vertiport Surfaces |
| 16.130 | Use Restrictions |
| 16.140 | Pre-Existing, Non-Conforming Uses (Grandfather Clause) |
| 16.150 | Pre-Existing, Non-Conforming Structures, Uses, or Vegetation Abandoned or Destroyed |
| 16.160 | Notice of Construction or Alteration of Any Structure |
| 16.170 | Permits |
| 16.180 | Variances |
| 16.190 | Administrative and Judicial Review |
| 16.200 | Penalties |
| 16.210 | Conflicting Regulations |
| 16.220 | Severability |
| 16.APPENDIX A | Applicable Airports |
| 16.ILLUSTRATION A | Airports Imaginary Surfaces |
| 16.ILLUSTRATION B | Airports (Public- or Private-Use) Minimum Dimensional Standards |
| 16.ILLUSTRATION C | Obstruction Standards (\leq 6 Nautical Miles) |
| 16.ILLUSTRATION D | Obstruction Standards ($>$ 6 Nautical Miles) |
| 16.ILLUSTRATION E | Public- or Private-Use Heliport/Vertiport Minimum Dimensional Standards |

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENT

AUTHORITY: Implementing and authorized by the Airport Zoning Act [620 ILCS 25].

SOURCE: Adopted at 28 Ill. Reg. 2421, effective January 26, 2004; amended at 29 Ill. Reg. 12529, effective July 27, 2005; amended at 30 Ill. Reg. 14117, effective August 10, 2006; amended at 31 Ill. Reg. 3191, effective February 9, 2007; amended at 32 Ill. Reg. 7806, effective May 1, 2008.

DEPARTMENT OF TRANSPORTATION

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Section 16.APPENDIX A Applicable Airports

| Airport | City | County | ARP Latitude | ARP Longitude | Fed Std. | State Std. | Applicable Date |
|---------|---------------------|-------------|-----------------|------------------|-------------|---------------|--------------------|
| SPI | Springfield | Sangamon | 39-50.64 | 89-40.66 | X | | Jan. 26, 2004 |
| MLI | Moline | Rock Island | 41-26.91 | 90-30.45 | X | | July 29, 2005 |
| SQI | Sterling-Rock Falls | Whiteside | 41-44.57 | 89-40.58 | X | | July 29, 2005 |
| SLO | Salem | Marion | 38-38.57 | 88-57.85 | X | | July 29, 2005 |
| H96 | Benton | Franklin | 38-00.41 | 88-56.07 | X | | Sept. 15, 2006 |
| CIR | Cairo | Alexander | 37-03.87 | 89-13.18 | X | | Sept. 15, 2006 |
| CTK | Canton | Fulton | 40-34.15 | 90-04.49 | X | | Sept. 15, 2006 |
| DEC | Decatur | Macon | 39-50.08 | 88-51.94 | X | | Sept. 15, 2006 |
| DKB | DeKalb | DeKalb | 41-56.02 | 88-42.34 | X | | Sept. 15, 2006 |
| GBG | Galesburg | Knox | 40-56.28 | 90-25.87 | X | | Sept. 15, 2006 |
| HSB | Harrisburg | Saline | 37-48.69 | 88-32.95 | X | | Sept. 15, 2006 |
| IJX | Jacksonville | Morgan | 39-46.48 | 90-14.30 | X | | Sept. 15, 2006 |
| JOT | Joliet | Will | 41-31.08 | 88-10.52 | X | | Sept. 15, 2006 |
| EZI | Kewanee | Henry | 41-12.31 | 89-57.83 | X | | Sept. 15, 2006 |
| IGQ | Lansing | Cook | 41-32.09 | 87-31.77 | X | | Sept. 15, 2006 |
| MWA | Marion | Williamson | 37-45.30 | 89-00.67 | X | | Sept. 15, 2006 |
| MTO | Mattoon | Coles | 39-28.68 | 88-16.75 | X | | Sept. 15, 2006 |
| PRG | Paris | Edgar | 39-42.01 | 87-40.17 | X | | Sept. 15, 2006 |
| 3MY | Peoria | Peoria | 40-47.72 | 89-36.80 | X | | Sept. 15, 2006 |
| PIA | Peoria | Peoria | 40-39.86 | 89-41.60 | X | | Sept. 15, 2006 |
| VYS | Peru | LaSalle | 41-21.11 | 89-09.19 | X | | Sept. 15, 2006 |
| LOT | Romeoville | Will | 41-36.44 | 88-05.77 | X | | Sept. 15, 2006 |
| DPA | West Chicago | DuPage | 41-54.47 | 88-14.92 | X | | Sept. 15, 2006 |
| K06 | Beardstown | Cass | 39-58.40 | 90-24.22 | X | | Feb. 28, 2007 |
| OLY | Olney | Richland | 38-43.31 | 88-10.59 | X | | Feb. 28, 2007 |
| LWV | Lawrenceville | Lawrence | 38-45.86 | 87-36.33 | X | | Feb. 28, 2007 |
| CUL | Carmi | White | 38-05.38 | 88-07.38 | X | | Feb. 28, 2007 |
| C73 | Dixon | Lee | 41-50.02 | 89-26.77 | X | | Feb. 28, 2007 |
| ORD | Chicago | Cook | 41-58.72 | 87-54.29 | X | | Feb. 28, 2007 |

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENT

| <u>TAZ</u> | <u>Taylorville</u> | <u>Christian</u> | <u>39-31.95</u> | <u>89-19.84</u> | <u>X</u> | <u>May 1, 2008</u> | |
|----------------|--------------------------------------|------------------|-------------------------|--------------------------|---------------------|-----------------------|----------------------------|
| <u>Airport</u> | <u>City</u> | <u>County</u> | <u>ARP Latitude</u> | <u>ARP Longitude</u> | <u>Fed Std.</u> | <u>State Std.</u> | <u>Applicable Date</u> |
| <u>BLV</u> | <u>Belleville/Mascoutah</u> | <u>St. Clair</u> | <u>38-32.71</u> | <u>89-50.11</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>AAA</u> | <u>Lincoln</u> | <u>Logan</u> | <u>40-09.52</u> | <u>89-20.10</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>VLA</u> | <u>Vandalia</u> | <u>Fayette</u> | <u>38-59.49</u> | <u>89-09.97</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>UGN</u> | <u>Waukegan</u> | <u>Lake</u> | <u>42-25.33</u> | <u>87-52.07</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>MDH</u> | <u>Carbondale</u> | <u>Jackson</u> | <u>37-46.69</u> | <u>89-15.12</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>CPS</u> | <u>Cahokia/Sauget</u> | <u>St. Clair</u> | <u>38-34.24</u> | <u>90-09.37</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>MQB</u> | <u>Macomb</u> | <u>McDonough</u> | <u>40-31.21</u> | <u>90-39.14</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>PWK</u> | <u>Wheeling/Prospect Heights</u> | <u>Cook</u> | <u>42-06.85</u> | <u>87-54.09</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>9I0</u> | <u>Havana</u> | <u>Mason</u> | <u>40-13.32</u> | <u>90-01.37</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>C09</u> | <u>Morris</u> | <u>Grundy</u> | <u>41-25.53</u> | <u>88-25.12</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>1H2</u> | <u>Effingham</u> | <u>Effingham</u> | <u>39-04.23</u> | <u>88-32.01</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>CMI</u> | <u>Champaign/Savoy</u> | <u>Champaign</u> | <u>40-02.36</u> | <u>88-16.68</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>I63</u> | <u>Mt. Sterling</u> | <u>Brown</u> | <u>39-59.25</u> | <u>90-48.25</u> | <u>X</u> | | <u>May 1, 2008</u> |
| <u>RSV</u> | <u>Robinson</u> | <u>Crawford</u> | <u>39-00.96</u> | <u>87-38.99</u> | <u>X</u> | | <u>May 1, 2008</u> |

(Source: Amended at 32 Ill. Reg. 7806, effective May 1, 2008)

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Bi-State Parks Airport Hazard Zoning Regulations
- 2) Code Citation: 92 Ill. Adm. Code 22
- 3)

| <u>Section Numbers:</u> | <u>Adopted Action:</u> |
|-------------------------|------------------------|
| 22.10 | Repeal |
| 22.20 | Repeal |
| 22.30 | Repeal |
| 22.40 | Repeal |
| 22.50 | Repeal |
| 22.60 | Repeal |
| 22.70 | Repeal |
| 22.80 | Repeal |
| 22.90 | Repeal |
| 22.100 | Repeal |
| 22.110 | Repeal |
| 22.120 | Repeal |
| 22.130 | Repeal |
| 22.140 | Repeal |
| 22.150 | Repeal |
| 22.160 | Repeal |
- 4) Statutory Authority: Implementing and authorized by the Airport Zoning Act [620 ILCS 25]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this repealer contain an automatic repeal date? No
- 7) Does this repealer contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 1888
- 10) Has JCAR issued a Statement of Objection to this repealer? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the Illinois Register, has included the St. Louis Downtown Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Effingham County Memorial Airport Hazard Zoning Regulations
- 2) Code Citation: 92 Ill. Adm. Code 40
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 40.5 | Repeal |
| 40.10 | Repeal |
| 40.20 | Repeal |
| 40.30 | Repeal |
| 40.40 | Repeal |
| 40.50 | Repeal |
| 40.60 | Repeal |
| 40.70 | Repeal |
| 40.80 | Repeal |
| 40.90 | Repeal |
| 40.100 | Repeal |
| 40.110 | Repeal |
| 40.120 | Repeal |
| 40.130 | Repeal |
| 40.140 | Repeal |
| 40.150 | Repeal |
- 4) Statutory Authority: Implementing and authorized by the Airport Zoning Act [620 ILCS 25]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 1907
- 10) Has JCAR issued a Statement of Objection to this repealer? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Effingham County Memorial Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Havana Regional Airport Hazard Zoning Regulations
- 2) Code Citation: 92 Ill. Adm. Code 49
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 49.10 | Repeal |
| 49.20 | Repeal |
| 49.30 | Repeal |
| 49.40 | Repeal |
| 49.50 | Repeal |
| 49.60 | Repeal |
| 49.70 | Repeal |
| 49.80 | Repeal |
| 49.90 | Repeal |
| 49.100 | Repeal |
| 49.110 | Repeal |
| 49.120 | Repeal |
| 49.130 | Repeal |
| 49.140 | Repeal |
| 49.EXHIBIT A | Repeal |
- 4) Statutory Authority: Implementing and authorized by Section 17 of the Airport Zoning Act [620 ILCS 25/17]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this repealer contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 1926
- 10) Has JCAR issued a Statement of Objection to this repealer? No
- 11) Differences between Proposal and Final Version: None

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Havana Regional Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Logan County Airport Hazard Zoning Regulations
- 2) Code Citation: 92 Ill. Adm. Code 60
- 3)

| <u>Section Numbers:</u> | <u>Adopted Action:</u> |
|-------------------------|------------------------|
| 60.10 | Repeal |
| 60.20 | Repeal |
| 60.30 | Repeal |
| 60.40 | Repeal |
| 60.50 | Repeal |
| 60.60 | Repeal |
| 60.70 | Repeal |
| 60.80 | Repeal |
| 60.90 | Repeal |
| 60.100 | Repeal |
| 60.110 | Repeal |
| 60.120 | Repeal |
| 60.130 | Repeal |
| 60.140 | Repeal |
| 60.150 | Repeal |
| 60.160 | Repeal |
- 4) Statutory Authority: Implementing and authorized by the Airport Zoning Act [620 ILCS 25]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 1949
- 10) Has JCAR issued a Statement of Objection to this repealer? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Logan County Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Macomb Municipal Airport Hazard Zoning Regulations
- 2) Code Citation: 92 Ill. Adm. Code 62
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 62.5 | Repeal |
| 62.10 | Repeal |
| 62.20 | Repeal |
| 62.30 | Repeal |
| 62.40 | Repeal |
| 62.50 | Repeal |
| 62.60 | Repeal |
| 62.70 | Repeal |
| 62.80 | Repeal |
| 62.90 | Repeal |
| 62.100 | Repeal |
| 62.110 | Repeal |
| 62.120 | Repeal |
| 62.130 | Repeal |
| 62.140 | Repeal |
| 62.150 | Repeal |
- 4) Statutory Authority: Implementing and authorized by the Airport Zoning Act [620 ILCS 25]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 1969
- 10) Has JCAR issued a Statement of Objection to this repealer? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace an emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Macomb Municipal Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Morris Municipal Airport Hazard Zoning
- 2) Code Citation: 92 Ill. Adm. Code 67
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 67.10 | Repeal |
| 67.20 | Repeal |
| 67.30 | Repeal |
| 67.40 | Repeal |
| 67.50 | Repeal |
| 67.60 | Repeal |
| 67.70 | Repeal |
| 67.80 | Repeal |
| 67.90 | Repeal |
| 67.100 | Repeal |
| 67.110 | Repeal |
| 67.120 | Repeal |
| 67.130 | Repeal |
| 67.140 | Repeal |
| 67.EXHIBIT A | Repeal |
- 4) Statutory Authority: Implementing and authorized by Section 17 of the Airport Zoning Act [620 ILCS 25/17]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 1988
- 10) Has JCAR issued a Statement of Objection to this repealer? No
- 11) Differences between Proposal and Final Version: None

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Morris Municipal Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Scott Joint-Use Airport Hazard Zoning
- 2) Code Citation: 92 Ill. Adm. Code 77
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 77.10 | Repeal |
| 77.20 | Repeal |
| 77.30 | Repeal |
| 77.40 | Repeal |
| 77.50 | Repeal |
| 77.60 | Repeal |
| 77.70 | Repeal |
| 77.80 | Repeal |
| 77.90 | Repeal |
| 77.100 | Repeal |
| 77.110 | Repeal |
| 77.120 | Repeal |
| 77.130 | Repeal |
| 77.140 | Repeal |
| 77.EXHIBIT A | Repeal |
- 4) Statutory Authority: Implementing and authorized by Section 17 of the Airport Zoning Act [620 ILCS 25/17]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this repealer contain an automatic repeal date? No
- 7) Does this repealer contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any materials incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 2011
- 10) Has JCAR issued a Statement of Objection to this repealer? No
- 11) Differences between Proposal and Final Version: None

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Mid America St. Louis Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Southern Illinois Airport Hazard Zoning Regulations
- 2) Code Citation: 92 Ill. Adm. Code 80
- 3)

| <u>Section Numbers:</u> | <u>Adopted Action:</u> |
|-------------------------|------------------------|
| 80.5 | Repeal |
| 80.10 | Repeal |
| 80.20 | Repeal |
| 80.30 | Repeal |
| 80.40 | Repeal |
| 80.50 | Repeal |
| 80.60 | Repeal |
| 80.70 | Repeal |
| 80.80 | Repeal |
| 80.90 | Repeal |
| 80.100 | Repeal |
| 80.110 | Repeal |
| 80.120 | Repeal |
| 80.130 | Repeal |
| 80.140 | Repeal |
| 80.150 | Repeal |
- 4) Statutory Authority: Implementing and authorized by the Airport Zoning Act [620 ILCS 25]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this repealer contain an automatic repeal date? No
- 7) Does this repealer contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 2035
- 10) Has JCAR issued a Statement of Objection to this repealer? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Southern Illinois Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Taylorville Municipal Airport Hazard Zoning Regulations
- 2) Code Citation: 92 Ill. Adm. Code 86
- 3)

| <u>Section Numbers:</u> | <u>Adopted Action:</u> |
|-------------------------|------------------------|
| 86.10 | Repeal |
| 86.20 | Repeal |
| 86.30 | Repeal |
| 86.40 | Repeal |
| 86.50 | Repeal |
| 86.60 | Repeal |
| 86.70 | Repeal |
| 86.80 | Repeal |
| 86.90 | Repeal |
| 86.100 | Repeal |
| 86.110 | Repeal |
| 86.120 | Repeal |
| 86.130 | Repeal |
| 86.140 | Repeal |
| 86.150 | Repeal |
| 86.160 | Repeal |
- 4) Statutory Authority: Implementing and authorized by the Airport Zoning Act [620 ILCS 25]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this repealer contain an automatic repeal date? No
- 7) Does this repealer contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 2055
- 10) Has JCAR issued a Statement of Objection to this repealer? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Taylorville Municipal Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Vandalia Municipal Airport Hazard Zoning Regulations
- 2) Code Citation: 92 Ill. Adm. Code 88
- 3)

| <u>Section Numbers:</u> | <u>Adopted Action:</u> |
|-------------------------|------------------------|
| 88.5 | Repeal |
| 88.10 | Repeal |
| 88.20 | Repeal |
| 88.30 | Repeal |
| 88.40 | Repeal |
| 88.50 | Repeal |
| 88.60 | Repeal |
| 88.70 | Repeal |
| 88.80 | Repeal |
| 88.90 | Repeal |
| 88.100 | Repeal |
| 88.110 | Repeal |
| 88.120 | Repeal |
| 88.130 | Repeal |
| 88.140 | Repeal |
| 88.150 | Repeal |
- 4) Statutory Authority: Implementing and authorized by the Airport Zoning Act [620 ILCS 25]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this repealer contain an automatic repeal date? No
- 7) Does this repealer contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 2074
- 10) Has JCAR issued a Statement of Objection to this repealer? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Vandalia Municipal Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Waukegan Memorial Airport Zoning Regulations
- 2) Code Citation: 92 Ill. Adm. Code 92
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 92.5 | Repeal |
| 92.10 | Repeal |
| 92.20 | Repeal |
| 92.30 | Repeal |
| 92.40 | Repeal |
| 92.50 | Repeal |
| 92.60 | Repeal |
| 92.70 | Repeal |
| 92.80 | Repeal |
| 92.90 | Repeal |
| 92.100 | Repeal |
| 92.110 | Repeal |
| 92.120 | Repeal |
| 92.130 | Repeal |
| 92.140 | Repeal |
| 92.150 | Repeal |
| 92.160 | Repeal |
- 4) Statutory Authority: Implementing and authorized by the Airport Zoning Act [620 ILCS 25]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this repealer contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 2093
- 10) Has JCAR issued a Statement of Objection to this repealer? No

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 11) Differences between Proposal and Final Version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this repealer replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the Illinois Register, has included the Waukegan Regional Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 1) Heading of the Part: Pal-Waukeee Municipal Airport Hazard Zoning
- 2) Code Citation: 92 Ill. Adm. Code 96
- 3)

| <u>Section Numbers</u> : | <u>Adopted Action</u> : |
|--------------------------|-------------------------|
| 96.10 | Repeal |
| 96.20 | Repeal |
| 96.30 | Repeal |
| 96.40 | Repeal |
| 96.50 | Repeal |
| 96.60 | Repeal |
| 96.70 | Repeal |
| 96.80 | Repeal |
| 96.90 | Repeal |
| 96.100 | Repeal |
| 96.110 | Repeal |
| 96.120 | Repeal |
| 96.130 | Repeal |
| 96.140 | Repeal |
| 96.EXHIBIT A | Repeal |
- 4) Statutory Authority: Implementing and authorized by Section 17 of the Airport Zoning Act [620 ILCS 25/17]
- 5) Effective Date of Repealer: May 1, 2008
- 6) Does this repealer contain an automatic repeal date? No
- 7) Does this repealer contain incorporations by reference? No
- 8) A copy of the adopted repealer, including any material incorporated by reference, is on file in the agency's Division of Aeronautics and Office of Chief Counsel and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: February 8, 2008; 32 Ill. Reg. 2108
- 10) Has JCAR issued a Statement of Objection to this repealer? No
- 11) Differences between Proposal and Final Version: None

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED REPEALER

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No changes were necessary.
- 13) Will this rulemaking replace any emergency repealer currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Repealer: By this Notice, the Department has repealed this Part in its entirety and, elsewhere in this issue of the *Illinois Register*, has included the Pal-Waukee Municipal Airport under 92 Ill. Adm. Code 16 (Part 16), the Department's generic rule on the administration and enforcement of airport hazard zoning. Part 16 restricts the height of structures, equipment, and vegetation and regulates the use of property on or in the vicinity of publicly-owned airports.

It is preferable to have all airports requesting inclusion in the administration and enforcement of airport hazard zoning under one rule rather than duplicating the requirements in separate rules, which was the Department's practice several decades ago. Therefore, the Department has repealed this Part and added the airport to Part 16, which was also amended.

- 16) Information and questions regarding this Adopted Repealer shall be directed to:

Mr. Robert Hahn, Airspace Specialist
Illinois Department of Transportation
Division of Aeronautics
1 Langhorne Bond Drive
Abraham Lincoln Capital Airport
Springfield, Illinois 62707-8415

217/524-1580

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PUBLIC HEARING ON PROPOSED AMENDMENTS

- 1) Heading of the Part: Health Care Worker Background Check Code
- 2) Code Citation: 77 Ill. Adm. Code 955
- 3) Register Citation to Notice of Proposed amendments: 32 Ill. Reg. 4529; April 4, 2008
- 4) Date, Time and Location of Public Hearing:

10:00 AM
Thursday, May 29, 2008
525 W. Jefferson St.
4th Floor conference room
Springfield, Illinois
- 5) Other Pertinent Information: On April 4, 2008, the Department of Public Health proposed amendments to the Health Care Worker Background Check Code (77 Ill. Adm. Code 955) to implement Public Act 95-0120, enacted by the Illinois General Assembly and signed by the Governor on August 13, 2007. PA 95-0120 removed references to UCIA criminal history records checks from the Health Care Worker Background Check Act [225 ILCS 46] (the Act) and provided for electronic fingerprint-based criminal history records checks as a condition of employment with health care employers and active status on the Health Care Worker Registry. PA 95-0120 also made changes in provisions concerning definitions, exceptions, ineligibility for employment, waivers, application fees, health care employer files, and immunity from liability. Sections concerning duplicate background checks and non-fingerprint based and fingerprint based UCIA background checks are being repealed.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
MAY AGENDA

JOINT COMMITTEE ON ADMINISTRATIVE RULES

SCHEDULED MEETING:

STRATTON OFFICE BUILDING
ROOM C-1
SPRINGFIELD, ILLINOIS
9:00 A.M.
MAY 20, 2008

NOTICES: The scheduled date and time for the JCAR meeting are subject to change. Due to *Register* submittal deadlines, the Agenda below may be incomplete. Other items not contained in this published Agenda are likely to be considered by the Committee at the meeting and items from the list can be postponed to future meetings.

If members of the public wish to express their views with respect to a rulemaking, they should submit written comments to the Office of the Joint Committee on Administrative Rules at the following address:

*Joint Committee on Administrative Rules
700 Stratton Office Building
Springfield, Illinois 62706
Email: jcar@ilga.gov
Phone: 217/785-2254*

RULEMAKINGS CURRENTLY BEFORE JCAR

PROPOSED RULEMAKINGS

Central Management Services

1. Access to Information (2 Ill. Adm. Code 751)
-First Notice Published: 31 Ill. Reg. 13261 – 9/21/07
-Expiration of Second Notice: 5/21/08

Children and Family Services

2. Services Delivered by the Department of Children and Family Services (89 Ill. Adm. Code 302)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
MAY AGENDA

-First Notice Published: 31 Ill. Reg. 9665 – 7/13/07
-Expiration of Second Notice: 6/13/08

3. Unusual Incidents (89 Ill. Adm. Code 331)
-First Notice Published: 32 Ill. Reg. 1006 – 1/25/08
-Expiration of Second Notice: 6/13/08
4. Licensing Standards for Day Care Homes (89 Ill. Adm. Code 406)
-First Notice Published: 32 Ill. Reg. 8397 – 6/15/07
-Expiration of Second Notice: 6/13/08
5. Licensing Standards for Group Day Care Homes (89 Ill. Adm. Code 408)
-First Notice Published: 31 Ill. Reg. 8422 – 6/15/07
-Expiration of Second Notice: 6/13/08

Commerce and Economic Opportunity

6. Economic Development for a Growing Economy Program (EDGE) (14 Ill. Adm. Code 527)
-First Notice Published: 32 Ill. Reg. 2865 – 2/29/08
-Expiration of Second Notice: 6/4/08
7. High Speed Internet Services and Information Technology Program (14 Ill. Adm. Code 547)
-First Notice Published: 32 Ill. Reg. 3452 – 3/14/08
-Expiration of Second Notice: 6/14/08
8. Illinois Small Business Development Program (14 Ill. Adm. Code 570)
-First Notice Published: 32 Ill. Reg. 2874 – 2/29/08
-Expiration of Second Notice: 6/4/08

Council on Developmental Disabilities

9. Grants (Repealer) (59 Ill. Adm. Code 400)
-First Notice Published: 32 Ill. Reg. 2604 – 2/22/08
-Expiration of Second Notice: 6/7/08
10. State Plan, Awards and Administrative Requirements (59 Ill. Adm. Code 400)
-First Notice Published: 32 Ill. Reg. 2618 – 2/22/08
-Expiration of Second Notice: 6/7/08

JOINT COMMITTEE ON ADMINISTRATIVE RULES
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Education

11. The "Grow Your Own" Teacher Education Initiative (23 Ill. Adm. Code 60)
 - First Notice Published: 32 Ill. Reg. 1777 – 2/8/08
 - Expiration of Second Notice: 6/1/08
12. School Technology Program (23 Ill. Adm. Code 575)
 - First Notice Published: 32 Ill. Reg. 1789 – 2/8/08
 - Expiration of Second Notice: 6/1/08

Gaming Board

13. Riverboat Gambling (86 Ill. Adm. Code 3000)
 - First Notice Published: 32 Ill. Reg. 1512 – 2/8/08
 - Expiration of Second Notice: 6/13/08
14. Riverboat Gambling (86 Ill. Adm. Code 3000)
 - First Notice Published: 32 Ill. Reg. 1206 – 2/1/08
 - Expiration of Second Notice: 6/13/08

Green Governments Coordinating Council

15. Agency Sustainability Planning Tool (71 Ill. Adm. Code 2500)
 - First Notice Published: 32 Ill. Reg. 2876 – 2/29/08
 - Expiration of Second Notice: 6/14/08

Healthcare and Family Services

16. Medical Assistance Programs (89 Ill. Adm. Code 120)
 - First Notice Published: 32 Ill. Reg. 1530 – 2/8/08
 - Expiration of Second Notice: 6/28/08
17. Reimbursement for Nursing Costs for Geriatric Facilities (89 Ill. Adm. Code 147)
 - First Notice Published: 32 Ill. Reg. 300 – 1/11/08
 - Expiration of Second Notice: 6/11/08
18. Hospital Services (89 Ill. Adm. Code 148)
 - First Notice Published: 32 Ill. Reg. 303 – 1/11/08
 - Expiration of Second Notice: 6/4/08

JOINT COMMITTEE ON ADMINISTRATIVE RULES
MAY AGENDA

19. Hospital Reimbursement Changes (89 Ill. Adm. Code 152)
-First Notice Published: 32 Ill. Reg. 305 – 1/11/08
-Expiration of Second Notice: 6/4/08

Health Facilities Planning Board

20. Narrative and Planning Policies (77 Ill. Adm. Code 1100)
-First Notice Published: 32 Ill. Reg. 1039 – 1/25/08
-Expiration of Second Notice: 6/13/08
21. Processing, Classification Policies and Review Criteria (77 Ill. Adm. Code 1110)
-First Notice Published: 32 Ill. Reg. 1050 – 1/25/08
-Expiration of Second Notice: 6/13/08

Human Services

22. Related Program Provisions (89 Ill. Adm. Code 117)
-First Notice Published: 31 Ill. Reg. 14998 – 11/9/07
-Expiration of Second Notice: 6/11/08
23. Food Stamps (89 Ill. Adm. Code 121)
-First Notice Published: 31 Ill. Reg. 15005 – 11/9/07
-Expiration of Second Notice: 6/11/08
24. Food Stamps (89 Ill. Adm. Code 121)
-First Notice Published: 32 Ill. Reg. 2433 – 2/15/08
-Expiration of Second Notice: 6/14/08
25. Appeals and Hearings (89 Ill. Adm. Code 510)
-First Notice Published: 32 Ill. Reg. 1219 – 2/1/08
-Expiration of Second Notice: 6/13/08
26. Program Definitions (89 Ill. Adm. Code 521)
-First Notice Published: 32 Ill. Reg. 1226 – 2/1/08
-Expiration of Second Notice: 6/13/08
27. Criteria for the Evaluation of Programs of Services in Community Rehabilitation Agencies (89 Ill. Adm. Code 530)
-First Notice Published: 32 Ill. Reg. 1238 – 2/1/08

JOINT COMMITTEE ON ADMINISTRATIVE RULES
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-Expiration of Second Notice: 6/13/08

28. Application (89 Ill. Adm. Code 557)
 - First Notice Published: 32 Ill. Reg. 1243 – 2/1/08
 - Expiration of Second Notice: 6/13/08
29. Customer Financial Participation (89 Ill. Adm. Code 562)
 - First Notice Published: 32 Ill. Reg. 1247 – 2/1/08
 - Expiration of Second Notice: 6/13/08
30. Individualized Plan for Employment (IPE) (89 Ill. Adm. Code 572)
 - First Notice Published: 32 Ill. Reg. 1252 – 2/1/08
 - Expiration of Second Notice: 6/13/08
31. Services (89 Ill. Adm. Code 590)
 - First Notice Published: 32 Ill. Reg. 1258 – 2/1/08
 - Expiration of Second Notice: 6/13/08

Natural Resources

32. Camping on Department of Natural Resources Properties (17 Ill. Adm. Code 130)
 - First Notice Published: 32 Ill. Reg. 2653 – 2/22/08
 - Expiration of Second Notice: 5/25/08
33. Regulations for the Letting of Concessions, Farm Leases, Sale of Buildings and Facilities, and Demolitions (17 Ill. Adm. Code 150)
 - First Notice Published: 32 Ill. Reg. 2447 – 2/15/08
 - Expiration of Second Notice: 5/23/08
34. White-Tailed Deer Hunting by Use of Firearms (17 Ill. Adm. Code 650)
 - First Notice Published: 32 Ill. Reg. 2662 – 2/22/08
 - Expiration of Second Notice: 5/31/08
35. White-Tailed Deer Hunting by Use of Muzzleloading Rifles (17 Ill. Adm. Code 660)
 - First Notice Published: 32 Ill. Reg. 2687 – 2/22/08
 - Expiration of Second Notice: 5/28/08
36. White-Tailed Deer Hunting by Use of Bow and Arrow (17 Ill. Adm. Code 670)
 - First Notice Published: 32 Ill. Reg. 2669 – 2/22/08
 - Expiration of Second Notice: 5/31/08

JOINT COMMITTEE ON ADMINISTRATIVE RULES
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Public Health

37. Illinois Home Health, Home Services, and Home Nursing Agency Code (77 Ill. Adm. Code 245)
-First Notice Published: 31 Ill. Reg. 11168 – 8/3/07
-Expiration of Second Notice: 5/21/08
38. Grade A Pasteurized Milk and Milk Products (77 Ill. Adm. Code 775)
-First Notice Published: 31 Ill. Reg. 7384 – 5/25/07
-Expiration of Second Notice: 5/25/08

Revenue

39. Lottery (General) (11 Ill. Adm. Code 1770)
-First Notice Published: 32 Ill. Reg. 1071 – 1/25/08
-Expiration of Second Notice: 5/21/08

State Fire Marshal

40. Fire Truck Revolving Loan Program (41 Ill. Adm. Code 290)
-First Notice Published: 32 Ill. Reg. 2722 – 2/22/08
-Expiration of Second Notice: 5/31/08
41. Ambulance Revolving Loan Program (41 Ill. Adm. Code 292)
-First Notice Published: 32 Ill. Reg. 2727 – 2/22/08
-Expiration of Second Notice: 5/31/08

Student Assistance Commission

42. General Provisions (23 Ill. Adm. Code 2700)
-First Notice Published: 32 Ill. Reg. 1794 – 2/8/08
-Expiration of Second Notice: 6/4/08
43. Federal Family Education Loan Program (FFELP) (23 Ill. Adm. Code 2720)
-First Notice Published: 32 Ill. Reg. 1815 – 2/8/08
-Expiration of Second Notice: 6/4/08
44. Illinois National Guard (ING) Grant Program (23 Ill. Adm. Code 2730)
-First Notice Published: 32 Ill. Reg. 1830 – 2/8/08

JOINT COMMITTEE ON ADMINISTRATIVE RULES
MAY AGENDA

-Expiration of Second Notice: 6/4/08

45. Illinois Veteran Grant (IVG) Program (23 Ill. Adm. Code 2733)
 - First Notice Published: 32 Ill. Reg. 1838 – 2/8/08
 - Expiration of Second Notice: 6/4/08
46. Higher Education License Plate (HELP) Grant Program (23 Ill. Adm. Code 2737)
 - First Notice Published: 32 Ill. Reg. 1845 – 2/8/08
 - Expiration of Second Notice: 6/4/08
47. State Scholar Program (23 Ill. Adm. Code 2760)
 - First Notice Published: 32 Ill. Reg. 1850 – 2/8/08
 - Expiration of Second Notice: 6/4/08
48. Illinois Future Teacher Corps (IFTC) Program (23 Ill. Adm. Code 2764)
 - First Notice Published: 32 Ill. Reg. 1858 – 2/8/08
 - Expiration of Second Notice: 6/4/08
49. College Savings Bond Bonus Incentive Grant (BIG) Program (23 Ill. Adm. Code 2771)
 - First Notice Published: 32 Ill. Reg. 1866 – 2/8/08
 - Expiration of Second Notice: 6/4/08
50. Illinois Prepaid Tuition Program (23 Ill. Adm. Code 2775)
 - First Notice Published: 32 Ill. Reg. 1873 – 2/8/08
 - Expiration of Second Notice: 6/4/08

Transportation

51. Procedures for Transportation Workplace Drug and Alcohol Testing Programs (92 Ill. Adm. Code 340)
 - First Notice Published: 32 Ill. Reg. 2452 – 2/15/08
 - Expiration of Second Notice: 5/23/08
52. Special Training Requirements (92 Ill. Adm. Code 380)
 - First Notice Published: 32 Ill. Reg. 2456 – 2/15/08
 - Expiration of Second Notice: 5/23/08
53. Controlled Substances and Alcohol Use and Testing (92 Ill. Adm. Code 382)
 - First Notice Published: 32 Ill. Reg. 2465 – 2/15/08
 - Expiration of Second Notice: 5/23/08

JOINT COMMITTEE ON ADMINISTRATIVE RULES
MAY AGENDA

54. Commercial Driver's License Standards; Requirements and Penalties (92 Ill. Adm. Code 383)
 - First Notice Published: 32 Ill. Reg. 2469 – 2/15/08
 - Expiration of Second Notice: 5/23/08
55. Safety Fitness Procedures (92 Ill. Adm. Code 385)
 - First Notice Published: 32 Ill. Reg. 2474 – 2/15/08
 - Expiration of Second Notice: 5/23/08
56. Procedures and Enforcement (92 Ill. Adm. Code 386)
 - First Notice Published: 32 Ill. Reg. 2483 – 2/15/08
 - Expiration of Second Notice: 5/23/08
57. Minimum Levels of Financial Responsibility for Motor Carriers (92 Ill. Adm. Code 387)
 - First Notice Published: 32 Ill. Reg. 2494 – 2/15/08
 - Expiration of Second Notice: 5/23/08
58. Motor Carrier Safety Regulations: General (92 Ill. Adm. Code 390)
 - First Notice Published: 32 Ill. Reg. 2500 – 2/15/08
 - Expiration of Second Notice: 5/23/08
59. Qualification of Drivers (92 Ill. Adm. Code 391)
 - First Notice Published: 32 Ill. Reg. 2524 – 2/15/08
 - Expiration of Second Notice: 5/23/08
60. Driving of Commercial Motor Vehicles (92 Ill. Adm. Code 392)
 - First Notice Published: 32 Ill. Reg. 2530 – 2/15/08
 - Expiration of Second Notice: 5/23/08
61. Parts and Accessories Necessary for Safe Operations (92 Ill. Adm. Code 393)
 - First Notice Published: 32 Ill. Reg. 2535 – 2/15/08
 - Expiration of Second Notice: 5/29/08
62. Hours-of-Service of Drivers (92 Ill. Adm. Code 395)
 - First Notice Published: 32 Ill. Reg. 2540 – 2/15/08
 - Expiration of Second Notice: 5/23/08
63. Inspection, Repair and Maintenance (92 Ill. Adm. Code 396)
 - First Notice Published: 32 Ill. Reg. 2548 – 2/15/08

JOINT COMMITTEE ON ADMINISTRATIVE RULES
MAY AGENDA

-Expiration of Second Notice: 5/23/08

64. Transportation of Hazardous Materials; Driving and Parking (92 Ill. Adm. Code 397)
-First Notice Published: 32 Ill. Reg. 2553 – 2/15/08
-Expiration of Second Notice: 5/23/08

EMERGENCY RULEMAKINGS

Commerce Commission

65. Electric Interconnection of Distributed Generation Facilities (83 Ill. Adm. Code 466) (Emergency)
-Notice Published: 32 Ill. Reg. 6556 – 4/18/08

Human Services

66. Child Care (89 Ill. Adm. Code 50) (Emergency)
-Notice Published: 32 Ill. Reg. 6652 – 4/18/08

Secretary of State

67. Department of Personnel (Repealer) (80 Ill. Adm. Code 420) (Emergency)
-Notice Published: 32 Ill. Reg. 6659 – 4/18/08

PEREMPTORY RULEMAKINGS

Central Management Services

68. Pay Plan (80 Ill. Adm. Code 310) (Peremptory)
-Notice Published: 32 Ill. Reg. 6097 – 4/11/08
69. Pay Plan (80 Ill. Adm. Code 310) (Peremptory)
-Notice Published: 32 Ill. Reg. 7154 – 5/2/08

Healthcare and Family Services

70. Medical Assistance Programs (89 Ill. Adm. Code 120) (Peremptory)
-Notice Published: 32 Ill. Reg. 7212 – 5/2/08
71. Medical Payment (89 Ill. Adm. Code 140) (Peremptory)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
MAY AGENDA

-Notice Published: 32 Ill. Reg. 6743 – 4/18/08

AGENCY RESPONSES

Healthcare and Family Services

- 72. Medical Payment (89 Ill. Adm. Code 140; 31 Ill. Reg. 13570)
- 73. Hospital Services (89 Ill. Adm. Code 148; 32 Ill. Reg. 518) (Emergency)
- 74. Hospital Reimbursement Changes (89 Ill. Adm. Code 152; 32 Ill. Reg. 529) (Emergency)

Public Health

- 75. Smoke Free Illinois Code (77 Ill. Adm. Code 975; 31 Ill. Reg. 13672)

Secretary of State

- 76. Department of Personnel (80 Ill. Adm. Code 420; 32 Ill. Reg. 3013) (Emergency)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of April 29, 2008 through May 5, 2008 and have been scheduled for review by the Committee at its May 20, 2008 meeting. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rulemaking should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield IL 62706.

| <u>Second Notice Expires</u> | <u>Agency and Rule</u> | <u>Start Of First Notice</u> | <u>JCAR Meeting</u> |
|--------------------------------------|--|--------------------------------------|-------------------------|
| 6/13/08 | <u>Health Facilities Planning Board</u> , Narrative and Planning Policies (77 Ill. Adm. Code 1100) | 1/25/08 32 Ill. Reg. 1039 | 5/20/08 |
| 6/13/08 | <u>Health Facilities Planning Board</u> , Processing, Classification Policies and Review Criteria (77 Ill. Adm. Code 1110) | 1/25/08 32 Ill. Reg. 1050 | 5/20/08 |
| 6/13/08 | <u>Department of Human Services</u> , Appeals and Hearings (89 Ill. Adm. Code 510) | 2/1/08 32 Ill. Reg. 1219 | 5/20/08 |
| 6/13/08 | <u>Department of Human Services</u> , Program Definitions (89 Ill. Adm. Code 521) | 2/1/08 32 Ill. Reg. 1226 | 5/20/08 |
| 6/13/08 | <u>Department of Human Services</u> , Criteria for the Evaluation of Programs of Services in Community Rehabilitation Agencies (89 Ill. Adm. Code 530) | 2/1/08 32 Ill. Reg. 1238 | 5/20/08 |
| 6/13/08 | <u>Department of Human Services</u> , Application (89 Ill. Adm. Code 557) | 2/1/08 32 Ill. Reg. 1243 | 5/20/08 |
| 6/13/08 | <u>Department of Human Services</u> , Customer Financial Participation (89 Ill. Adm. Code 562) | 2/1/08 32 Ill. Reg. | 5/20/08 |

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

| | | | |
|---------|---|---------------------------------|---------|
| | | 1247 | |
| 6/13/08 | <u>Department of Human Services, Individualized Plan for Employment (IPE) (89 Ill. Adm. Code 572)</u> | 2/1/08 32 Ill. Reg. 1252 | 5/20/08 |
| 6/13/08 | <u>Department of Human Services, Services (89 Ill. Adm. Code 590)</u> | 2/1/08 32 Ill. Reg. 1258 | 5/20/08 |
| 6/13/08 | <u>Illinois Gaming Board, Riverboat Gambling (86 Ill. Adm. Code 3000)</u> | 2/8/08 32 Ill. Reg. 1512 | 5/20/08 |
| 6/13/08 | <u>Illinois Gaming Board, Riverboat Gambling (86 Ill. Adm. Code 3000)</u> | 2/1/08 32 Ill. Reg. 1206 | 5/20/08 |
| 6/13/08 | <u>Department of Children and Family Services, Services Delivered by the Department of Children and Family Services (89 Ill. Adm. Code 302)</u> | 7/13/07 31 Ill. Reg. 9665 | 5/20/08 |
| 6/13/08 | <u>Department of Children and Family Services, Unusual Incidents (89 Ill. Adm. Code 331)</u> | 1/25/08 32 Ill. Reg. 1006 | 5/20/08 |
| 6/13/08 | <u>Department of Children and Family Services, Licensing Standards for Day Care Homes (89 Ill. Adm. Code 406)</u> | 6/15/07 31 Ill. Reg. 8397 | 5/20/08 |
| 6/13/08 | <u>Department of Children and Family Services, Licensing Standards for Group Day Care Homes (89 Ill. Adm. Code 408)</u> | 6/15/07 31 Ill. Reg. 8422 | 5/20/08 |
| 6/14/08 | <u>Illinois Green Governments Coordinating Council, Agency Sustainability Planning Tool (71 Ill. Adm. Code 2500)</u> | 2/29/08 32 Ill. Reg. 2876 | 5/20/08 |

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

| | | | |
|---------|--|---------------------------------|---------|
| 6/14/08 | <u>Department of Human Services</u> , Food Stamps (89 Ill. Adm. Code 121) | 2/15/08 32 Ill. Reg. 2433 | 5/20/08 |
| 6/14/08 | <u>Department of Commerce and Economic Opportunity</u> , High Speed Internet Services and Information Technology Program (14 Ill. Adm. Code 547) | 3/14/08 32 Ill. Reg. 3452 | 5/20/08 |

DEPARTMENT OF LABOR

NOTICE OF PUBLIC INFORMATION

CONTRACTOR PROHIBITED FROM AN AWARD
OF A CONTRACT OR SUBCONTRACT
FOR PUBLIC WORKS PROJECTS

Pursuant to the findings in Re: Sunset Cartage, IDOL File No. 2008-PW-DA08-0118, the Director of the Department of Labor gives notice that Sunset Cartage, its members, officers, managers, agents, and all persons acting in Sunset Cartage's interest and/or on Sunset Cartage's behalf and any business entity, including, but not limited to, any firm, corporation, partnership or association in which Sunset Cartage, its members, officers, managers, agents, and all other persons acting in Sunset Cartage's interest and/or on Sunset Cartage's behalf have an interest, pecuniary or otherwise, are prohibited from being awarded any contract or subcontract for a public works project covered by the Prevailing Wage Act [820 ILCS 130/0.01-12 (2001)] commencing April 25, 2008 and continuing through April 25, 2010.

Copies of the Prevailing Wage Act are available on the internet at <http://www.legis.state.il.us/ilcs/ch820/ch820act130.htm>, and at the:

Illinois Department of Labor
Conciliation and Mediation Division
One West Old State Capital Plaza, Room 300
Springfield, Illinois 62701-1217

PROCLAMATIONS

**2008-129 (Revised)
Older Americans Month**

WHEREAS, the State of Illinois is home to more than 2 million citizens aged 60 years or older; and

WHEREAS, the older Americans of the State of Illinois are a vital part of our nation's demographic makeup; and

WHEREAS, older citizens are members of our community entitled to dignified, independent lives free from fears, myths, and misconceptions about aging; and

WHEREAS, each community in the United States must strive to recognize the contributions of our older citizens, understand and address their evolving needs, and support their caregivers; and

WHEREAS, our society is dependent upon intergenerational cooperation and support, and benefits from our collective efforts to serve older Americans and the people who love and care for them; and

WHEREAS, this year marks the 43rd anniversary of the passage of the Older Americans Act by the United States Congress, which ensures government aid and programs for older persons:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim May 2008 as **OLDER AMERICANS MONTH** in Illinois, and encourage all citizens to recognize the significant impact older Americans have made on the State of Illinois.

Issued by the Governor April 2, 2008

Filed by the Secretary of State May 5, 2008

2008-174**We Remember, We Care for Indigent Persons Day**

WHEREAS, the world of an indigent person is accompanied by many mental, emotional, psychological and physical stresses that can affect them for the rest of their lives. Depression runs rampant, living conditions are meager at best, and social isolation is common; and

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WHEREAS, the plight of the needy, homeless, and less fortunate has become everyone's problem, not just their own. For many years, this devastating existence has been overlooked; and

WHEREAS, the State of Illinois, along with private organizations, are making attempts to remedy these situations, creating programs that deal with the immediate and long term problems associated with the indigent population. These social service programs have been created as a way to help them help themselves by providing multidimensional assistance; and

WHEREAS, the Departments of Health and Family Services and Human Services lead the way in providing valuable assistance to qualified persons in the State of Illinois. My administration continues to support the social service organizations that improve the quality of life of this special population:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim May 21, 2008 as **WE REMEMBER, WE CARE FOR INDIGENT PERSONS DAY** in Illinois, and encourage all citizens to be mindful of the silent struggles many members of our state have to endure, including poverty, disability, and abandonment.

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Filed by the Secretary of State May 5, 2008

2008-175**Provider Appreciation Day**

WHEREAS, early childhood is the most critical developmental period for all children; and

WHEREAS, 2.8 million people earn a living by teaching and caring for young children or by working in jobs directly related to this field; and

WHEREAS, of the 21 million children under age six in America, 13 million are in child care at least part time. An additional 24 million school-age children are in some form of child care outside of school time; and

WHEREAS, seeing the need for a day to appreciate and recognize child care providers, a group of volunteers in New Jersey started Provider Appreciation Day in 1996; and

WHEREAS, by calling attention to the importance of high quality child care services for all children and families in our state, these provider groups hope to improve the quality and availability of such services:

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THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim May 9, 2008 as **PROVIDER APPRECIATION DAY** in Illinois and urge all citizens to join me in recognizing Illinois' child care providers for their commitment and dedication to our children.

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Filed by the Secretary of State May 5, 2008

2008-176**Emergency Medical Services Week**

WHEREAS, emergency medical services (EMS) embody the true concept of teamwork by recognizing the interdependent relationship among trauma centers, EMS system hospitals, ambulance providers, emergency and trauma physicians, emergency nurses, emergency medical technicians (EMTs) – basic, intermediate and paramedic – field nurses, emergency communication nurses, trauma nurse specialists, emergency dispatchers and first responders who are dedicated to saving lives; and

WHEREAS, in Illinois there are 63 EMS resource hospitals, 64 trauma centers, 16,940 first responders, 21,331 basic EMTs, 1,180 intermediate EMTs, and 12,131 paramedic EMTs, selflessly providing 24-hour service to the people of Illinois; and

WHEREAS, this year's national theme, "EMS – Your Life is Our Mission", underscores the immediate nature of the situations to which EMS personnel must respond; and

WHEREAS, access to quality emergency care dramatically improves the survival and recovery rate of those who experience sudden illness or injury; and

WHEREAS, approximately two-thirds of all emergency medical services providers are volunteers; and

WHEREAS, the members of emergency medical services teams, whether career or volunteer, engage in thousands of hours of specialized training and continuing education to enhance their lifesaving skills:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim May 18 – 24, 2008 as **EMERGENCY MEDICAL SERVICES WEEK** in Illinois, and encourage all citizens to recognize the dedication and lifesaving work that the men and women of emergency medical services teams provide to the communities of this state.

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2008-177**Emergency Medical Services for Children Day**

WHEREAS, Emergency Medical Services for Children (EMSC) recognizes that children have unique physiological responses to illness and injury; and

WHEREAS, EMSC supports a specialized approach to pediatric care; and

WHEREAS, EMSC endorses the high-level emergency care given by emergency medical services providers with pediatric emergency skills, who are prepared to respond to sick or injured children and restore them to an optimum level of health; and

WHEREAS, EMSC espouses the tenets and practices of family-centered and culturally competent care for children and their families; and

WHEREAS, EMSC assists in training with advanced technical equipment and services in preparation to save the life of a child; and

WHEREAS, EMSC works with physicians, nurses, social workers, psychologists, emergency medical technicians, paramedics, firefighters, educators, administrators and others to identify and address issues surrounding pediatric care; and

WHEREAS, EMSC assists in the development of training programs and guidelines for emergency care providers, so that children with special health care needs get timely, appropriate care; and

WHEREAS, in Illinois, there are 16,940 first responders, 20,331 basic EMTs, 1,180 intermediate EMTs and 12,131 paramedic EMTs dedicated to promoting preventive measures, pre-hospital care, outpatient and specialized services, and inpatient and rehabilitative care; and

WHEREAS, the State of Illinois proudly recognizes these dedicated men and women of EMSC for aiding and saving the lives of Illinois children:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim May 21, 2008 as **EMERGENCY MEDICAL SERVICES FOR CHILDREN DAY** in Illinois, and encourage all citizens to commend those that use their advanced training and talents to help children in times of crisis.

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2008-178**AmeriCorps Week**

WHEREAS, since its creation in 1994 the AmeriCorps national service program has proven to be a highly effective way to engage Americans of all ages and backgrounds in meeting a wide range of community needs and promoting the ethic of service and volunteering; and

WHEREAS, each year AmeriCorps, including AmeriCorps VISTA (Volunteers in Service to America) and AmeriCorps NCCC (National Civilian Conservation Corps), provides opportunities for 75,000 citizens across the nation, including over 2,000 in Illinois, to give back to our communities, our state, and our country; and

WHEREAS, AmeriCorps was designed to give a key role to states in deciding where resources should be directed to meet state and local needs through Governor-appointed state service commissions, including the Serve Illinois Commission on Volunteerism and Community Service; and

WHEREAS, AmeriCorps has invested more than \$5 billion dollars to support tens of thousands of nonprofit, community, educational, and faith-based community groups. Those grants have leveraged hundreds of millions of additional funds and in-kind donations from others sources; and

WHEREAS, since 1994 more than 540,000 men and women across the nation, including nearly 19,000 from Illinois, have taken the AmeriCorps pledge to "get things done for America" by becoming AmeriCorps members. Last year AmeriCorps members recruited and supervised more than 1.7 million community volunteers, demonstrating AmeriCorps' value as a powerful catalyst and force multiplier; and

WHEREAS, those AmeriCorps members have served a total of more than 705 million hours nationwide, including over 25 million served by residents from Illinois, helping to improve the lives of our state's most vulnerable citizens, strengthen our educational system, protect our environment, and contribute to our public safety, and;

WHEREAS, in return for their service AmeriCorps members have earned more than \$1.4 billion in Segal AmeriCorps Education Awards to use to further their own

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educational advancement – including more than \$52.2 million that has been awarded to residents of Illinois; and

WHEREAS, even after their terms of service end AmeriCorps members often remain engaged in our communities as volunteers, teachers, public servants, and nonprofit leaders; and

WHEREAS, AmeriCorps Week, designated as May 11-18 this year, is an opportune time for the people of Illinois to salute AmeriCorps members and alums for their powerful impact, thank all of AmeriCorps' community partners in Illinois who make the program possible, and bring more Americans into service. During this week the Serve Illinois Commission, in conjunction with the State's AmeriCorps programs and their LeaderCorps representatives, have collaborated to organize statewide service day events in celebration of AmeriCorps Week:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim May 11-18, 2008 as **AMERICORPS WEEK** in Illinois, and urge citizens to thank AmeriCorps members and alumni for their service and to find ways to give back to their communities.

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Filed by the Secretary of State May 5, 2008

2008-179**MDA Firefighter / Paramedic Appreciation Month**

WHEREAS, volunteerism embodies the true spirit of America and is exemplified by the men and women of our state's firefighters and paramedics; and

WHEREAS, when these heroes are not battling life-threatening situations, they are unselfishly contributing to their communities in other ways, including raising money for local charities and volunteering with agencies such as the Muscular Dystrophy Association (MDA); and

WHEREAS, the MDA combats 43 neuromuscular diseases that affect nearly one million Americans, including almost 3,000 families in Illinois; and

WHEREAS, the Illinois firefighters and paramedics, who have pledged their lives to saving the lives of others, have also pledged their efforts for over 53 years to help find cures for devastating diseases by supporting MDA's fight against neuromuscular diseases; and

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WHEREAS, in pursuit of this goal, the departments and districts of the Illinois firefighters and paramedics are conducting "Fill the Boot" fundraising drives; and

WHEREAS, the State of Illinois is proud to recognize Illinois firefighters and paramedics as they conduct fundraising projects in our state for the MDA:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim July 2008 as **MDA FIREFIGHTER / PARAMEDIC APPRECIATION MONTH** in Illinois, and encourage all citizens to acknowledge the ongoing contributions of these brave men and women.

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ILLINOIS ADMINISTRATIVE CODE

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