

# 2009

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# ILLINOIS

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# REGISTER

RULES  
OF GOVERNMENTAL  
AGENCIES



Volume 33, Issue 26  
June 26, 2009  
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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 preemptory 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.].

### ILLINOIS REGISTER PUBLICATION SCHEDULE FOR 2009

<b><u>Issue #</u></b>	<b><u>Rules Due Date</u></b>	<b><u>Date of Issue</u></b>
1	December 22, 2008	January 2, 2009
2	December 29, 2008	January 9, 2009
3	January 5, 2009	January 16, 2009
4	January 12, 2009	January 23, 2009
5	January 20, 2009	January 30, 2009
6	January 26, 2009	February 6, 2009
7	February 2, 2009	February 13, 2009
8	February 9, 2009	February 20, 2009
9	February 17, 2009	February 27, 2009
10	February 23, 2009	March 6, 2009
11	March 2, 2009	March 13, 2009
12	March 9, 2009	March 20, 2009
13	March 16, 2009	March 27, 2009
14	March 23, 2009	April 3, 2009
15	March 30, 2009	April 10, 2009
16	April 6, 2009	April 17, 2009
17	April 13, 2009	April 24, 2009
18	April 20, 2009	May 1, 2009
19	April 27, 2009	May 8, 2009
20	May 4, 2009	May 15, 2009
21	May 11, 2009	May 22, 2009
22	May 18, 2009	May 29, 2009

<u>Issue #</u>	<u>Rules Due Date</u>	<u>Date of Issue</u>
23	May 26, 2009	June 5, 2009
24	June 1, 2009	June 12, 2009
25	June 8, 2009	June 19, 2009
26	June 15, 2009	June 26, 2009
27	June 22, 2009	July 6, 2009
28	June 29, 2009	July 10, 2009
29	July 6, 2009	July 17, 2009
30	July 13, 2009	July 24, 2009
31	July 20, 2009	July 31, 2009
32	July 27, 2009	August 7, 2009
33	August 3, 2009	August 14, 2009
34	August 10, 2009	August 21, 2009
35	August 17, 2009	August 28, 2009
36	August 24, 2009	September 4, 2009
37	August 31, 2009	September 11, 2009
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44	October 19, 2009	October 30, 2009
45	October 26, 2009	November 6, 2009
46	November 2, 2009	November 13, 2009
47	November 9, 2009	November 20, 2009
48	November 16, 2009	November 30, 2009
49	November 23, 2009	December 4, 2009
50	November 30, 2009	December 11, 2009
51	December 7, 2009	December 18, 2009
52	December 14, 2009	December 28, 2009

**Editor's Note:** The Secretary of State Index Department is providing this opportunity to remind you that the next filing period for your Regulatory Agenda will occur from May 11 to July 1, 2009.

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Medical Assistance Programs
- 2) Code Citation: 89 Ill. Adm. Code 120
- 3) Section Number: 120.374                      Proposed Action:  
New Section
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Complete Description of the Subjects and Issues Involved: The U.S. Census Bureau recruits thousands of temporary employees once every 10 years and has asked all states to exempt income earned by temporary census workers from consideration when determining eligibility for Medicaid. Federal guidelines permit states to exempt earnings from temporary employment with the U.S. Census Bureau for medical eligibility under Titles XIX and XXI of the Social Security Act; Illinois did so for the 2000 census.
- 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? No
- 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>
120.335	Amendment	33 Ill. Reg. 5683; April 17, 2009
120.381	Amendment	33 Ill. Reg. 5683; April 17, 2009
120.310	Amendment	33 Ill. Reg. 5994; April 24, 2009
120.329	Repeals Peremptory	33 Ill. Reg. 6608; May 15, 2009
- 11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.
- 12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Tamara Tanzillo Hoffman  
Chief of Staff  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue E., 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/557-7157

The Department requests the submission of written comments within 30 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

These proposed amendments may have an impact on small businesses, small municipalities, and not-for-profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent agendas because: it was not anticipated by the Department when the most recent regulatory agendas were published.

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 120

MEDICAL ASSISTANCE PROGRAMS

SUBPART A: GENERAL PROVISIONS

Section

120.1 Incorporation by Reference

SUBPART B: ASSISTANCE STANDARDS

Section

- 120.10 Eligibility For Medical Assistance
- 120.11 MANG(P) Eligibility
- 120.12 Healthy Start – Medicaid Presumptive Eligibility Program For Pregnant Women
- 120.14 Presumptive Eligibility for Children
- 120.20 MANG(AABD) Income Standard
- 120.30 MANG(C) Income Standard
- 120.31 MANG(P) Income Standard
- 120.32 KidCare Parent Coverage Waiver Eligibility and Income Standard
- 120.40 Exceptions To Use Of MANG Income Standard
- 120.50 AMI Income Standard (Repealed)

SUBPART C: FINANCIAL ELIGIBILITY DETERMINATION

Section

- 120.60 Cases Other Than Long Term Care, Pregnant Women and Certain Children
- 120.61 Cases in Intermediate Care, Skilled Nursing Care and DMHDD – MANG(AABD) and All Other Licensed Medical Facilities
- 120.62 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings Under 89 Ill. Adm. Code 140.643
- 120.63 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings
- 120.64 MANG(P) Cases
- 120.65 Department of Mental Health and Developmental Disabilities (DMHDD)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

## Licensed Community – Integrated Living Arrangements

## SUBPART D: MEDICARE PREMIUMS

## Section

120.70	Supplementary Medical Insurance Benefits (SMIB) Buy-In Program
120.72	Eligibility for Medicare Cost Sharing as a Qualified Medicare Beneficiary (QMB)
120.73	Eligibility for Medicaid Payment of Medicare Part B Premiums as a Specified Low-Income Medicare Beneficiary (SLIB)
120.74	Qualified Medicare Beneficiary (QMB) Income Standard
120.75	Specified Low-Income Medicare Beneficiary (SLIB) Income Standards
120.76	Hospital Insurance Benefits (HIB)

## SUBPART E: RECIPIENT RESTRICTION PROGRAM

## Section

120.80	Recipient Restriction Program
--------	-------------------------------

## SUBPART F: MIGRANT MEDICAL PROGRAM

## Section

120.90	Migrant Medical Program (Repealed)
120.91	Income Standards (Repealed)

## SUBPART G: AID TO THE MEDICALLY INDIGENT

## Section

120.200	Elimination Of Aid To The Medically Indigent
120.208	Client Cooperation (Repealed)
120.210	Citizenship (Repealed)
120.211	Residence (Repealed)
120.212	Age (Repealed)
120.215	Relationship (Repealed)
120.216	Living Arrangement (Repealed)
120.217	Supplemental Payments (Repealed)
120.218	Institutional Status (Repealed)
120.224	Foster Care Program (Repealed)
120.225	Social Security Numbers (Repealed)
120.230	Unearned Income (Repealed)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

120.235	Exempt Unearned Income (Repealed)
120.236	Education Benefits (Repealed)
120.240	Unearned Income In-Kind (Repealed)
120.245	Earmarked Income (Repealed)
120.250	Lump Sum Payments and Income Tax Refunds (Repealed)
120.255	Protected Income (Repealed)
120.260	Earned Income (Repealed)
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120.262	Exempt Earned Income (Repealed)
120.270	Recognized Employment Expenses (Repealed)
120.271	Income From Work/Study/Training Program (Repealed)
120.272	Earned Income From Self-Employment (Repealed)
120.273	Earned Income From Roomer and Boarder (Repealed)
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120.276	Payments from the Illinois Department of Children and Family Services (Repealed)
120.280	Assets (Repealed)
120.281	Exempt Assets (Repealed)
120.282	Asset Disregards (Repealed)
120.283	Deferral of Consideration of Assets (Repealed)
120.284	Spend-down of Assets (AMI) (Repealed)
120.285	Property Transfers (Repealed)
120.290	Persons Who May Be Included in the Assistance Unit (Repealed)
120.295	Payment Levels for AMI (Repealed)

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120.311	Residence
120.312	Age
120.313	Blind
120.314	Disabled
120.315	Relationship
120.316	Living Arrangements
120.317	Supplemental Payments
120.318	Institutional Status

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 120.319 Assignment of Rights to Medical Support and Collection of Payment
- 120.320 Cooperation in Establishing Paternity and Obtaining Medical Support
- 120.321 Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support
- 120.322 Proof of Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support
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- 120.329 Compliance with Non-Economic Eligibility Requirements of Article IV (Suspended)
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- [120.374 Earned Income from Temporary Employment with the Census Bureau](#)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

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120.383	Deferral of Consideration of Assets
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AUTHORITY: Implementing Articles III, IV, V and VI and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and 12-13].

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

SOURCE: Filed effective December 30, 1977; preemptory amendment at 2 Ill. Reg. 17, p. 117, effective February 1, 1978; amended at 2 Ill. Reg. 31, p. 134, effective August 5, 1978; emergency amendment at 2 Ill. Reg. 37, p. 4, effective August 30, 1978, for a maximum of 150 days; preemptory amendment at 2 Ill. Reg. 46, p. 44, effective November 1, 1978; preemptory amendment at 2 Ill. Reg. 46, p. 56, effective November 1, 1978; emergency amendment at 3 Ill. Reg. 16, p. 41, effective April 9, 1979, for a maximum of 150 days; emergency amendment at 3 Ill. Reg. 28, p. 182, effective July 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 33, p. 415, effective August 18, 1979; amended at 3 Ill. Reg. 38, p. 243, effective September 21, 1979; preemptory amendment at 3 Ill. Reg. 38, p. 321, effective September 7, 1979; amended at 3 Ill. Reg. 40, p. 140, effective October 6, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; preemptory amendment at 4 Ill. Reg. 9, p. 259, effective February 22, 1980; amended at 4 Ill. Reg. 10, p. 258, effective February 25, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; amended at 4 Ill. Reg. 27, p. 387, effective June 24, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 37, p. 800, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 27, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1134, effective January 26, 1981; preemptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; amended at 5 Ill. Reg. 7104, effective June 23, 1981; amended at 5 Ill. Reg. 8041, effective July 27, 1981; amended at 5 Ill. Reg. 8052, effective July 24, 1981; preemptory amendment at 5 Ill. Reg. 8106, effective August 1, 1981; preemptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; preemptory amendment at 5 Ill. Reg. 10079, effective October 1, 1981; preemptory amendment at 5 Ill. Reg. 10095, effective October 1, 1981; preemptory amendment at 5 Ill. Reg. 10113, effective October 1, 1981; preemptory amendment at 5 Ill. Reg. 10124, effective October 1, 1981; preemptory amendment at 5 Ill. Reg. 10131, effective October 1, 1981; amended at 5 Ill. Reg. 10730, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 10760, effective October 1, 1981; amended at 5 Ill. Reg. 10767, effective October 1, 1981; preemptory amendment at 5 Ill. Reg. 11647, effective October 16, 1981; preemptory amendment at 6 Ill. Reg. 611, effective January 1, 1982; amended at 6 Ill. Reg. 1216, effective January 14, 1982; emergency amendment at 6 Ill. Reg. 2447, effective March 1, 1982, for a maximum of 150 days; preemptory amendment at 6 Ill. Reg. 2452, effective February 11, 1982; preemptory amendment at 6 Ill. Reg. 6475, effective May 18, 1982; preemptory amendment at 6 Ill. Reg. 6912, effective May 20, 1982; emergency amendment at 6 Ill. Reg. 7299, effective June 2, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 8115, effective July 1, 1982; amended at 6 Ill. Reg. 8142, effective July 1, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg.

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

10970, effective August 26, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12293, effective October 1, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 394, effective January 1, 1983; codified at 7 Ill. Reg. 6082; amended at 7 Ill. Reg. 8256, effective July 1, 1983; amended at 7 Ill. Reg. 8264, effective July 5, 1983; amended (by adding Section being codified with no substantive change) at 7 Ill. Reg. 14747; amended (by adding Sections being codified with no substantive change) at 7 Ill. Reg. 16108; amended at 8 Ill. Reg. 5253, effective April 9, 1984; amended at 8 Ill. Reg. 6770, effective April 27, 1984; amended at 8 Ill. Reg. 13328, effective July 16, 1984; amended (by adding Sections being codified with no substantive change) at 8 Ill. Reg. 17897; amended at 8 Ill. Reg. 18903, effective September 26, 1984; peremptory amendment at 8 Ill. Reg. 20706, effective October 3, 1984; amended at 8 Ill. Reg. 25053, effective December 12, 1984; emergency amendment at 9 Ill. Reg. 830, effective January 3, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 4515, effective March 25, 1985; amended at 9 Ill. Reg. 5346, effective April 11, 1985; amended at 9 Ill. Reg. 7153, effective May 6, 1985; amended at 9 Ill. Reg. 11346, effective July 8, 1985; amended at 9 Ill. Reg. 12298, effective July 25, 1985; amended at 9 Ill. Reg. 12823, effective August 9, 1985; amended at 9 Ill. Reg. 15903, effective October 4, 1985; amended at 9 Ill. Reg. 16300, effective October 10, 1985; amended at 9 Ill. Reg. 16906, effective October 18, 1985; amended at 10 Ill. Reg. 1192, effective January 10, 1986; amended at 10 Ill. Reg. 3033, effective January 23, 1986; amended at 10 Ill. Reg. 4907, effective March 7, 1986; amended at 10 Ill. Reg. 6966, effective April 16, 1986; amended at 10 Ill. Reg. 10688, effective June 3, 1986; amended at 10 Ill. Reg. 12672, effective July 14, 1986; amended at 10 Ill. Reg. 15649, effective September 19, 1986; amended at 11 Ill. Reg. 3992, effective February 23, 1987; amended at 11 Ill. Reg. 7652, effective April 15, 1987; amended at 11 Ill. Reg. 8735, effective April 20, 1987; emergency amendment at 11 Ill. Reg. 12458, effective July 10, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 14034, effective August 14, 1987; amended at 11 Ill. Reg. 14763, effective August 26, 1987; amended at 11 Ill. Reg. 20142, effective January 1, 1988; amended at 11 Ill. Reg. 20898, effective December 14, 1987; amended at 12 Ill. Reg. 904, effective January 1, 1988; amended at 12 Ill. Reg. 3516, effective January 22, 1988; amended at 12 Ill. Reg. 6234, effective March 22, 1988; amended at 12 Ill. Reg. 8672, effective May 13, 1988; amended at 12 Ill. Reg. 9132, effective May 20, 1988; amended at 12 Ill. Reg. 11483, effective June 30, 1988; emergency amendment at 12 Ill. Reg. 11632, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 11839, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12835, effective July 22, 1988; emergency amendment at 12 Ill. Reg. 13243, effective July 29, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 17867, effective October 30, 1988; amended at 12 Ill. Reg. 19704, effective November 15, 1988; amended at 12 Ill. Reg. 20188, effective November 23, 1988; amended at 13 Ill. Reg. 116, effective January 1, 1989; amended at 13 Ill. Reg. 2081, effective February 3, 1989; amended at 13 Ill. Reg. 3908, effective March 10, 1989; emergency amendment at 13 Ill. Reg. 11929,

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

effective June 27, 1989, for a maximum of 150 days; emergency expired November 25, 1989; emergency amendment at 13 Ill. Reg. 12137, effective July 1, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 15404, effective October 6, 1989; emergency amendment at 13 Ill. Reg. 16586, effective October 2, 1989, for a maximum of 150 days; emergency expired March 1, 1990; amended at 13 Ill. Reg. 17483, effective October 31, 1989; amended at 13 Ill. Reg. 17838, effective November 8, 1989; amended at 13 Ill. Reg. 18872, effective November 17, 1989; amended at 14 Ill. Reg. 760, effective January 1, 1990; emergency amendment at 14 Ill. Reg. 1494, effective January 2, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 4233, effective March 5, 1990; emergency amendment at 14 Ill. Reg. 5839, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 6372, effective April 16, 1990; amended at 14 Ill. Reg. 7637, effective May 10, 1990; amended at 14 Ill. Reg. 10396, effective June 20, 1990; amended at 14 Ill. Reg. 13227, effective August 6, 1990; amended at 14 Ill. Reg. 14814, effective September 3, 1990; amended at 14 Ill. Reg. 17004, effective September 30, 1990; emergency amendment at 15 Ill. Reg. 348, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 5302, effective April 1, 1991; amended at 15 Ill. Reg. 10101, effective June 24, 1991; amended at 15 Ill. Reg. 11973, effective August 12, 1991; amended at 15 Ill. Reg. 12747, effective August 16, 1991; amended at 15 Ill. Reg. 14105, effective September 11, 1991; amended at 15 Ill. Reg. 14240, effective September 23, 1991; amended at 16 Ill. Reg. 139, effective December 24, 1991; amended at 16 Ill. Reg. 1862, effective January 20, 1992; amended at 16 Ill. Reg. 10034, effective June 15, 1992; amended at 16 Ill. Reg. 11582, effective July 15, 1992; amended at 16 Ill. Reg. 17290, effective November 3, 1992; amended at 17 Ill. Reg. 1102, effective January 15, 1993; amended at 17 Ill. Reg. 6827, effective April 21, 1993; amended at 17 Ill. Reg. 10402, effective June 28, 1993; amended at 18 Ill. Reg. 2051, effective January 21, 1994; amended at 18 Ill. Reg. 5934, effective April 1, 1994; amended at 18 Ill. Reg. 8718, effective June 1, 1994; amended at 18 Ill. Reg. 11231, effective July 1, 1994; amended at 19 Ill. Reg. 2905, effective February 27, 1995; emergency amendment at 19 Ill. Reg. 9280, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 11931, effective August 11, 1995; amended at 19 Ill. Reg. 15079, effective October 17, 1995; amended at 20 Ill. Reg. 5068, effective March 20, 1996; amended at 20 Ill. Reg. 15993, effective December 9, 1996; emergency amendment at 21 Ill. Reg. 692, effective January 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 7423, effective May 31, 1997; amended at 21 Ill. Reg. 7748, effective June 9, 1997; amended at 21 Ill. Reg. 11555, effective August 1, 1997; amended at 21 Ill. Reg. 13638, effective October 1, 1997; emergency amendment at 22 Ill. Reg. 1576, effective January 5, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 7003, effective April 1, 1998; amended at 22 Ill. Reg. 8503, effective May 1, 1998; amended at 22 Ill. Reg. 16291, effective August 28, 1998; emergency amendment at 22 Ill. Reg. 16640, effective September 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19875, effective October 30, 1998; amended at 23 Ill. Reg. 2381, effective January 22, 1999; amended at 23 Ill. Reg. 11301, effective August 27, 1999; amended at 24 Ill. Reg. 7361, effective May 1, 2000;

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emergency amendment at 24 Ill. Reg. 10425, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15075, effective October 1, 2000; amended at 24 Ill. Reg. 18309, effective December 1, 2000; amended at 25 Ill. Reg. 8783, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 10533, effective August 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 16098, effective December 1, 2001; amended at 26 Ill. Reg. 409, effective December 28, 2001; emergency amendment at 26 Ill. Reg. 8583, effective June 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 9843, effective June 26, 2002; emergency amendment at 26 Ill. Reg. 11029, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 15051, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16288, effective October 25, 2002; amended at 27 Ill. Reg. 4708, effective February 25, 2003; emergency amendment at 27 Ill. Reg. 10793, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18609, effective November 26, 2003; amended at 28 Ill. Reg. 4701, effective March 3, 2004; amended at 28 Ill. Reg. 6139, effective April 1, 2004; emergency amendment at 28 Ill. Reg. 6610, effective April 19, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 7152, effective May 3, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11149, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12921, effective September 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13621, effective September 28, 2004; amended at 28 Ill. Reg. 13760, effective October 1, 2004; amended at 28 Ill. Reg. 14541, effective November 1, 2004; amended at 29 Ill. Reg. 820, effective January 1, 2005; amended at 29 Ill. Reg. 10195, effective June 30, 2005; amended at 29 Ill. Reg. 14939, effective September 30, 2005; emergency amendment at 30 Ill. Reg. 521, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 10314, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 15029, effective September 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 2629, effective January 28, 2007; emergency amendment at 31 Ill. Reg. 7323, effective May 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11667, effective August 1, 2007; amended at 31 Ill. Reg. 12756, effective August 27, 2007; emergency amendment at 31 Ill. Reg. 15854, effective November 7, 2007, for a maximum of 150 days; emergency rule suspended at 31 Ill. Reg. 16060, effective November 13, 2007; emergency rule repealed, effective May 10, 2008; peremptory amendment at 32 Ill. Reg. 7212, effective April 21, 2008; peremptory amendment suspended at 32 Ill. Reg. 8450, effective May 21, 2008; peremptory amendment repealed under Section 5-125 of the Illinois Administrative Procedure Act, effective November 16, 2008; amended at 32 Ill. Reg. 17428, effective November 1, 2008; peremptory amendment at 32 Ill. Reg. 18889, effective November 18, 2008; peremptory amendment suspended at 32 Ill. Reg. 18906, effective November 19, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 33 Ill. Reg. 6551, effective April 28, 2009; peremptory rule repealed by emergency rulemaking at 33 Ill. Reg. 6712, effective April 28, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 1681, effective February 1, 2009; amended at 33 Ill. Reg. 2289, effective March 1, 2009;

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emergency amendment at 33 Ill. Reg. 5802, effective April 2, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

SUBPART H: MEDICAL ASSISTANCE – NO GRANT

**Section 120.374 Earned Income from Temporary Employment with the Census Bureau**

Earned income from temporary employment with the U.S. Census Bureau related to decennial census activities is exempt.

(Source: Added at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)



## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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- 12) Time, Place, and Manner in which interested persons may comment on this proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Tamara Tanzillo Hoffman  
Chief of Staff  
Illinois Department of Healthcare and Family Services  
201 South Grand Avenue E., 3rd Floor  
Springfield IL 62763-0002

217/557-7157

The Department requests the submission of written comments within 30 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

These proposed amendments may have an impact on small businesses, small municipalities, and not-for-profit corporations as defined in Sections 1-75, 1-80 and 1-85 of the Illinois Administrative Procedure Act [5 ILCS 100/1-75, 1-80, 1-85]. These entities may submit comments in writing to the Department at the above address in accordance with the regulatory flexibility provisions in Section 5-30 of the Illinois Administrative Procedure Act [5 ILCS 100/5-30]. These entities shall indicate their status as small businesses, small municipalities, or not-for-profit corporations as part of any written comments they submit to the Department.

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent regulatory agendas because: it was not anticipated by the Department when the most recent regulatory agendas were published.

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DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENT

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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

TITLE 89: SOCIAL SERVICES  
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES  
SUBCHAPTER b: ASSISTANCE PROGRAMSPART 128  
VETERANS' HEALTH INSURANCE PROGRAM

## SUBPART A: GENERAL PROVISIONS

Section	General Description
128.100	General Description
128.110	Definitions

## SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section	General Description
128.200	Eligibility
128.210	Eligibility Exclusions and Terminations
128.220	Application Process
128.230	Determination of Monthly Countable Income
128.240	Eligibility Determination and Enrollment Process
128.250	Appeals
128.260	Renewals of Eligibility
128.300	Covered Services
128.310	Service Exclusions
128.320	Co-payments and Cost Sharing
128.330	Premium Requirements
128.340	Non-payment of Premium
128.350	Provider Reimbursement

AUTHORITY: The Veterans' Health Insurance Program Act [330 ILCS 125].

SOURCE: Emergency rule adopted at 30 Ill. Reg. 15044, effective September 1, 2006, for a maximum of 150 days; adopted at 31 Ill. Reg. 2643, effective January 28, 2007; amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

## SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

**Section 128.230 Determination of Monthly Countable Income**

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- a) The earned and unearned income of the following persons shall be counted when determining eligibility, except as specified in subsections (b) and (c) of this Section.
- 1) Income of the veteran;
  - 2) Income of the veteran's spouse;
  - 3) Unearned income of a dependent child under the age of 18 years who is included in the income standard as set forth at 89 Ill. Adm. Code 120.20 because it is to the advantage of the veteran.
- b) Monthly unearned income shall be counted as described at 89 Ill. Adm. Code 120.330 through 120.345 and Sections 120.350, 120.355, 120.371 and 120.376. However, 89 Ill. Adm. Code 120.335(a) shall not apply.
- c) Monthly earned income shall be considered as described at 89 Ill. Adm. Code 120.360, 120.361; [and](#) 120.371 [through](#), ~~120.372, 120.373 and~~ 120.375.

(Source: Amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## HEALTH FACILITIES PLANNING BOARD

## NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Narrative and Planning Policies
- 2) Code Citation: 77 Ill. Adm. Code 1100
- 3)
 

<u>Section Numbers</u> :	<u>Proposed Action</u> :
1100.220	Amend
1100.440	Amend
1100.510	Amend
1100.520	Amend
1100.630	Amend
1100.670	Amend
1100.810	New
1100.APPENDIX A	Repeal
- 4) Statutory Authority: 20 ILCS 3960/12, Illinois Health Facilities Planning Act
- 5) A Complete Description of the Subjects and Issues Involved:
  - a. Definitions:  
 Definitions from Part 1110 – "Processing, Classification Policies and Review Criteria" have been relocated to Section 1100.220 – "Definitions" to consolidate all "Subpart A" definitions into one location.  
  
 Two (2) new definitions were added: "Quality of Care" and "Rapid Population Growth Rate", in response to requests received from public comment related to the Part 1110 amendments which became effective earlier this year.
  - b. Requirements for Authorized Hospital Beds:  
 If physically available beds or patient care units are not in compliance with Hospital Licensing Requirements, an action plan of correction must be in place. The original rule states that the correction plan must be approved by IDPH, but at this point in time, Licensure is not prepared to review correction plans. Section 1100.440(a)(1)(A) deletes language concerning the approval of correction plans by IDPH.  
  
 Section 1100.440(a)(2)(D) changes the language concerning the number of reserve beds a hospital may have, as follows: "The number of reserve beds shall not exceed 10% of the sum of physically available beds and transitional beds within each category of service. Hospitals with a total bed count of less than 50

## HEALTH FACILITIES PLANNING BOARD

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beds may report up to a total of five reserve beds."

- c. **In-Center Hemodialysis Category of Service:**  
The need determination formula has been changed back to the version in place prior to the 3/18/08 rule revisions (changes mandated by amendments to the Act). The proposed revision is a five-year need determination which applies to the "Planning Area Need" requirements in the category of service review criteria found in Part 1110.

A new Section has been added to provide a 10-year need assessment for long-range planning purposes and to fulfill the requirements of the Act.

- d. **Long-Term Medical Care for Children:**  
At present, "Long-Term Medical Care for Children" (LTMCC) is classified as one of the "Specialized Long-Term Care Categories of Service". Two (2) facilities in Illinois are in this classification: Shriners Hospitals for Children and LaRabida Children's Hospital. It is proposed to re-classify these facilities as hospitals. In Section 1100.670 - "Specialized Long-Term Care Categories of Service", language referencing LTMCC is deleted.

- e. **Long Term Acute Care Hospital Category of Service:**  
A new Section (1100.810) is proposed to provide basic planning parameters for "Long-Term Acute Care Hospital Category of Service", including:

Planning Areas  
Age Groups  
Occupancy Target  
Authorized Hospital Bed Capacity  
Need Determination

- f. **Section 1100.APPENDIX A - Applicable Codes and Standards Utilized in 77 Ill. Adm. Code: Chapter II, Subchapter a:**  
It is proposed that this Section be repealed.

- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking:

Mental Health and Developmental Disabilities Code [405 ILCS 5]

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Hospital Licensing Act [210 ILCS 85]

Nursing Home Care Act [210 ILCS 45/1- 129]

Glossary of Terms Commonly Used in Health Care, 2004 Edition, Illinois Hospital Association (IHA)

Ambulatory Surgical Treatment Center Act [210 ILCS 5]

"Emergency Severity Index Version 4: Implementation Handbook" published by the Agency for Healthcare Research and Quality, Rockville MD (Gilboy N, Tanabe P, Travers DA, Rosenau AM, Eitel DR; AHRQ Publication No. 05-0046-2; May 2005).

Emergency Medical Services (EMS) Systems Act [210 ILCS 50/32.5]

Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300)

Shortage Designation Branch in the Health Resources and Services Administration (HRSA) Bureau of Health Professions National Center for Health Workforce.

Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons

Alternative Health Care Delivery Act [210 ILCS 3/35]

2004 WHO Centre for Health Development Ageing and Health Technical Report Volume 5 "A Glossary of terms for community health care and Services for older persons"

"Directory of Residency Training Programs" developed by the American Medical Association, 535 Dearborn, Chicago, Illinois 60610 and the National Organ Procurement and Transplantation Network.

MapQuest – [www.mapquest.com](http://www.mapquest.com)

- 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? No

## HEALTH FACILITIES PLANNING BOARD

## NOTICE OF PROPOSED AMENDMENTS

- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking:

Public Hearing  
July 9, 2009  
10:00am-12:00  
100 W. Randolph Street  
Conference Room 031, 9<sup>th</sup> Floor  
Chicago, IL

Interested persons may present their comments concerning this rulemaking within 45 days after the publication of this issue of the Illinois Register to:

Claire Burman  
Coordinator, Rules Development  
IHFPB  
222 South Michigan Avenue – 7<sup>th</sup> Floor  
Chicago, IL 60603  
Claire.Burman@illinois.gov

312/814-2565

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: None
- B) Reporting, bookkeeping or other procedures required for compliance: None
- C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: January 2009

HEALTH FACILITIES PLANNING BOARD

NOTICE OF PROPOSED AMENDMENTS

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

## HEALTH FACILITIES PLANNING BOARD

## NOTICE OF PROPOSED AMENDMENTS

TITLE 77: PUBLIC HEALTH  
CHAPTER II: HEALTH FACILITIES PLANNING BOARD  
SUBCHAPTER a: ILLINOIS HEALTH CARE FACILITIES PLANPART 1100  
NARRATIVE AND PLANNING POLICIES

## SUBPART A: GENERAL NARRATIVE

Section	
1100.10	Introduction
1100.20	Authority
1100.30	Purpose
1100.40	Health Maintenance Organizations (Repealed)
1100.50	Subchapter Organization
1100.60	Mandatory Reporting of Data
1100.70	Data Appendices
1100.75	Annual Bed Report
1100.80	Institutional Master Plan Hospitals (Repealed)
1100.90	Public Hearings

## SUBPART B: DEFINITIONS

Section	
1100.210	Introduction
1100.220	Definitions

## SUBPART C: PLANNING POLICIES

Section	
1100.310	Need Assessment
1100.320	Staffing
1100.330	Professional Education
1100.340	Public Testimony
1100.350	Multi-Institutional Systems
1100.360	Modern Facilities
1100.370	Occupancy/Utilization Standards
1100.380	Systems Planning
1100.390	Quality

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1100.400	Location
1100.410	Needed Facilities
1100.420	Discontinuation
1100.430	Coordination with Other State Agencies
1100.440	Requirements for Authorized Hospital Beds

## SUBPART D: NEED ASSESSMENT

## Section

1100.510	Introduction, Formula Components, Planning Area Development Policies, and Normal Travel Time Determinations
1100.520	Medical-Surgical/Pediatric Categories of Service
1100.530	Obstetric Care Category of Service
1100.540	Intensive Care Category of Service
1100.550	Comprehensive Physical Rehabilitation Category of Service
1100.560	Acute Mental Illness Treatment Category of Service
1100.570	Substance Abuse/Addiction Treatment Category of Service (Repealed)
1100.580	Neonatal Intensive Care Category of Service
1100.590	Burn Treatment Category of Service (Repealed)
1100.600	Therapeutic Radiology Equipment (Repealed)
1100.610	Open Heart Surgery Category of Service
1100.620	Cardiac Catheterization Services
1100.630	In-Center Hemodialysis Category of Service
1100.640	Non-Hospital Based Ambulatory Surgery
1100.650	Computer Systems (Repealed)
1100.660	General Long-Term Nursing Care Category of Service
1100.661	General Long-Term Care-Sheltered Care Category of Service (Repealed)
1100.670	Specialized Long-Term Care Categories of Service
1100.680	Intraoperative Magnetic Resonance Imaging Category of Service (Repealed)
1100.690	High Linear Energy Transfer (L.E.T.) (Repealed)
1100.700	Positron Emission Tomographic Scanning (P.E.T.) (Repealed)
1100.710	Extracorporeal Shock Wave Lithotripsy (Repealed)
1100.720	Selected Organ Transplantation
1100.730	Kidney Transplantation
1100.740	Subacute Care Hospital Model
1100.750	Postsurgical Recovery Care Center Alternative Health Care Model
1100.760	Children's Respite Care Center Alternative Health Care Model
1100.770	Community-Based Residential Rehabilitation Center Alternative Health Care Model

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1100.800 Freestanding Emergency Center Medical Services Category of Service  
| [1100.810](#) [Long-Term Acute Care Hospital Category of Service](#)

1100.APPENDIX A Applicable Codes and Standards Utilized in 77 Ill. Adm. Code: Chapter  
| II, Subchapter a ([Repealed](#))

AUTHORITY: Implementing and authorized by the Illinois Health Facilities Planning Act [20 ILCS 3960].

SOURCE: Fourth Edition adopted at 3 Ill. Reg. 30, p. 194, effective July 28, 1979; amended at 4 Ill. Reg. 4, p. 129, effective January 11, 1980; amended at 5 Ill. Reg. 4895, effective April 22, 1981; amended at 5 Ill. Reg. 10297, effective September 30, 1981; amended at 6 Ill. Reg. 3079, effective March 8, 1982; emergency amendments at 6 Ill. Reg. 6895, effective May 20, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 11574, effective September 9, 1982; Fifth Edition adopted at 7 Ill. Reg. 5441, effective April 15, 1983; amended at 8 Ill. Reg. 1633, effective January 31, 1984; codified at 8 Ill. Reg. 15476; amended at 9 Ill. Reg. 3344, effective March 6, 1985; amended at 11 Ill. Reg. 7311, effective April 1, 1987; amended at 12 Ill. Reg. 16079, effective September 21, 1988; amended at 13 Ill. Reg. 16055, effective September 29, 1989; amended at 16 Ill. Reg. 16074, effective October 2, 1992; amended at 18 Ill. Reg. 2986, effective February 10, 1994; amended at 18 Ill. Reg. 8448, effective July 1, 1994; emergency amendment at 19 Ill. Reg. 1941, effective January 31, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 2985, effective March 1, 1995; amended at 19 Ill. Reg. 10143, effective June 30, 1995; recodified from the Department of Public Health to the Health Facilities Planning Board at 20 Ill. Reg. 2594; amended at 20 Ill. Reg. 14778, effective November 15, 1996; amended at 21 Ill. Reg. 6220, effective May 30, 1997; expedited correction at 21 Ill. Reg. 17201, effective May 30, 1997; amended at 23 Ill. Reg. 2960, effective March 15, 1999; amended at 24 Ill. Reg. 6070, effective April 7, 2000; amended at 25 Ill. Reg. 10796, effective August 24, 2001; amended at 27 Ill. Reg. 2904, effective February 21, 2003; amended at 31 Ill. Reg. 15255, effective November 1, 2007; amended at 32 Ill. Reg. 4743, effective March 18, 2008; amended at 32 Ill. Reg. 12321, effective July 18, 2008; expedited correction at 33 Ill. Reg. 4040, effective July 18, 2008; amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

## SUBPART B: DEFINITIONS

**Section 1100.220 Definitions**

"Act" means the Illinois Health Facilities Planning Act [20 ILCS 3960].

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"Acute Dialysis" means dialysis given on an intensive care, inpatient basis to patients suffering from (presumably reversible) acute renal failure, or to patients with chronic renal failure with serious complications.

"Acute Mental Illness" means a crisis state or an acute phase of one or more specific psychiatric disorders in which a person displays one or more specific psychiatric symptoms of such severity as to prohibit effective functioning in any community setting. Persons who are acutely mentally ill may be admitted to an acute mental illness facility or unit under the provisions of the Mental Health and Developmental Disabilities Code [405 ILCS 5], which determines the specific requirements for admission by age and type of admission.

"Acute Mental Illness Facility" or "Acute Mental Illness Unit" means a facility or a distinct unit in a facility that provides a program of acute mental illness treatment service (as defined in this Section); that is designed, equipped, organized and operated to deliver inpatient and supportive acute mental illness treatment services; and that is licensed by the Department of Public Health under the Hospital Licensing Act [210 ILCS 85] or is a facility operated or maintained by the State or a State agency.

"Acute Mental Illness Treatment Service" means a category of service that provides a program of care for those persons suffering from acute mental illness. These services are provided in a highly structured setting in a distinct psychiatric unit of a general hospital, in a private psychiatric hospital, or in a State-operated facility to individuals who are severely mentally ill and in a state of acute crisis, in an effort to stabilize the individual and either effect his or her quick placement in a less restrictive setting or reach a determination that extended treatment is needed. Acute mental illness is typified by an average length of stay of 45 days or less for adults and 60 days or less for children and adolescents.

"Admissions" means the number of patients accepted for inpatient service during a 12-month period; the newborn are not included.

"Adult Catheterization" means the cardiac catheterization of patients 15 years of age and older.

"Adverse Action" means a disciplinary action taken by Illinois Department of Public Health, Centers for Medicare and Medicaid Services, or any other State or federal agency against a person or entity that owns and/or operates a licensed or

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Medicare or Medicaid certified healthcare facility in the State of Illinois. These actions include, but are not limited to, all Type A violations. A "Type A" violation means a violation of the Nursing Home Care Act or 77 Ill. Adm. Code 300, 330, 340, 350 or 390 that creates a condition or occurrence relating to the operation and maintenance of a facility presenting a substantial probability that death or serious mental or physical harm to a resident will result therefrom. [210 ILCS 45/1-129]

"Ambulatory Care" means all types of health care services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services that do not require an overnight stay. (Source: Glossary of Terms Commonly Used in Health Care, 2004 Edition, Illinois Hospital Association (IHA))

"Ambulatory Surgical Treatment Center" means any institution, place or building required to be licensed pursuant to the Ambulatory Surgical Treatment Center Act [210 ILCS 5].

"Applicable Codes" and/or "Current Recognized Standards" means the current official codes of governmental bodies applicable under law or regulation to Illinois health facilities and/or standards of health facility design, construction and equipment promulgated on a regular or permanent basis by an authority, public or private. A listing of the applicable codes utilized in the application review process may be found in Appendix A of this Part.

"Authorized Hospital Bed Capacity" means the number of beds recognized for planning purposes at a hospital facility, as determined by HFPPB. The operational status of authorized hospital beds is identified as physically available, reserve, or transitional, as follows:

"Physically Available Beds" means beds that are physically set up, meet hospital licensure requirements, and are available for use. These are beds maintained in the hospital for the use of inpatients and that furnish accommodations with supporting services (such as food, laundry, and housekeeping). These beds may or may not be staffed, but are physically available.

## HEALTH FACILITIES PLANNING BOARD

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"Reserve Beds" means beds that are not set up for inpatients, but could be made physically available for inpatient use within 72 hours.

"Transitional Beds" means beds for which a Certificate of Need (CON) has been issued, but that are not yet physically available, and beds that are temporarily unavailable due to modernization projects that do not require a CON.

"Authorized Long-Term Care Bed Capacity" means the number of beds by category of service, recognized and licensed by IDPH for long-term care.

"Average Daily Census" or "ADC" means over a 12-month period the average number of inpatients receiving service on any given day.

"Average Length of Stay" or "ALOS" means over a 12-month period the average duration of inpatient stay expressed in days as determined by dividing total inpatient days by total admissions.

"Base Year" means the calendar year, as determined by IDPH, that serves as the starting point or benchmark for the historical utilization and population projections.

"Board Certified or Board Eligible Physician" means a physician who has satisfactorily completed an examination (or is "eligible" to take such examination) in a medical specialty and has taken all of the specific training requirements for certification by a specialty board. For purposes of this definition, "medical specialty" shall mean a specific area of medical practice by health care professionals.

"Cardiac Catheterization Category of Service" means, for the purposes of this Subpart, the performance of catheterization procedures that, due to safety and quality considerations, are preferably performed within a cardiac catheterization laboratory or special procedure room. Procedures that do not require the use of such specialized settings, such as pericardiocentesis, myocardial biopsy, cardiac pacemaker insertion or replacement, right heart catheterization with a flow-directed catheter (e.g., Swan-Ganz catheter), intra-aortic balloon pump assistance with intra-aortic balloon catheter placement, certain types of electrophysiology, arterial pressure or blood gas monitoring, fluoroscopy, and cardiac ultrasound, are not recognized as procedures that, under this Subchapter, would in and of

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themselves qualify a facility as having a cardiac catheterization category of service.

"Cardiac Surgeon" means a physician board eligible or board certified by the American Board of Thoracic Surgery.

"Cardiac Surgery Room" means a physically identifiable room adequately staffed and equipped for the performance of open and closed heart surgery and extracorporeal bypass.

"Cardiological Team" means the designated specialists and support personnel who consistently work together in the performance of open heart surgery.

"Cardiovascular Surgical Procedures" means any surgical procedure dealing with the heart, coronary arteries and surgery of the great vessels.

"Cardiovascular Surgical Services" means the programs, equipment and staff dealing with the surgery of the heart, coronary arteries and great vessels.

"Category of Service" means a grouping by generic class of various types or levels of support functions, equipment, care or treatment provided to patient/residents. Examples include but are not limited to medical-surgical, pediatrics, cardiac catheterization, etc. A category of service may include subcategories or levels of care that identify a particular degree or type of care within the category of service.

"Chronic Renal Dialysis" means a category of service in which dialysis is performed on a regular long-term basis in patients with chronic irreversible renal failure. The maintenance and preparation of patients for kidney transplantation (including the immediate post-operative period and in case of organ rejection) or other acute conditions within a hospital does not constitute a chronic renal dialysis category of service.

"Clinical Encounter Time" means an instance of direct provider/practitioner to patient interaction, between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating or treating the patient's condition, or both. The clinical encounter definition excludes practitioner actions in the absence of a patient, such as practitioner to practitioner interaction and practitioner to records interaction.

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"Closed Heart Surgery" means any cardiovascular surgical procedures that do not include the use of a heart/lung pump.

"Combined Maternity and Gynecological Unit" means an entire facility or a distinct part of a facility that provides both a program of maternity care (as defined in this Section) and a program of obstetric gynecological care (as defined in this Section), and that is designed, equipped, organized and operated in accordance with the requirements of the Hospital Licensing Act [210 ILCS 85].

"Community-Based Residential Rehabilitation" means services that include, but are not limited to, case management, training and assistance with activities of daily living, nursing consultation, traditional therapies (physical, occupational, speech), functional interventions in the residence and community (job placement, shopping, banking, recreation), counseling, self-management strategies, productive activities, and multiple opportunities for skill acquisition and practice throughout the day. [210 ILCS 3/35]

"Community-Based Residential Rehabilitation Center" means a designated site that provides rehabilitation or support, or both, for persons who have experienced severe brain injury, who are medically stable, and who no longer require acute rehabilitative care or intense medical or nursing services. The average length of stay in a community-based residential rehabilitation center shall not exceed 4 months. [210 ILCS 3/35]

"Comprehensive Physical Rehabilitation" means a category of service provided in a comprehensive physical rehabilitation facility providing the coordinated interdisciplinary team approach to physical disability under a physician licensed to practice medicine in all its branches who directs a plan of management of one or more of the classes of chronic or acute disabling disease or injury. Comprehensive physical rehabilitation services can be provided only by a comprehensive physical rehabilitation facility.

"Comprehensive Physical Rehabilitation Facility" means a distinct bed unit of a hospital or a special referral hospital that provides a program of comprehensive physical rehabilitation; that is designed, equipped, organized and operated to deliver inpatient rehabilitation services; and that is licensed by the Department of Public Health under the Hospital Licensing Act or is a facility operated or

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maintained by the State or a State agency. Types of comprehensive physical rehabilitation facilities include:

Freestanding comprehensive physical rehabilitation facility means a specialty hospital dedicated to the provision of comprehensive rehabilitation; and

Hospital-based comprehensive physical rehabilitation facility means a distinct unit, located in a hospital, dedicated to the provision of comprehensive physical rehabilitation.

"Dedicated Cardiac Catheterization Laboratory" means a distinct laboratory that is staffed, equipped and operated solely for the provision of cardiac catheterization.

"Designated Pediatric Beds" means beds within the facility that are primarily used for pediatric patients and are not a component part of a distinct pediatric unit as defined in this Section.

"Dialysis" means a process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semi-permeable membrane. [210 ILCS 62/5] The two types of dialysis that are recognized in classical practice are hemodialysis and peritoneal dialysis.

"Dialysis Technician" means an individual who is not a registered nurse or physician and who provides dialysis care under the supervision of a registered nurse or physician. [210 ILCS 62/5]

"Discontinuation" means to cease operation of an entire health care facility or to cease operation of a category of service and is further defined in 77 Ill. Adm. Code 1130.

"Distinct Unit" means a physically distinct area comprising all beds served by a nursing station in which a particular category of service is provided and utilizing a nursing staff assigned exclusively to the distinct area.

"DRG" means diagnostic related groups utilized in the Medicare program for health care reimbursement.

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"Emergency Medical Services System" or "EMS System" means *an organization of hospitals, vehicle service providers and personnel approved by IDPH in a specific geographic area, which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a BLS, ILS, and/or ALS level pursuant to a System program plan submitted to and approved by IDPH, and pursuant to the EMS Region Plan adopted for the EMS Region in which the System is located.* [210 ILCS 50/3.20]

"Emergent Care" means medical or surgical procedures and care provided to those patients treated in an emergency department (ED) of a hospital or freestanding emergency center who have traumatic conditions or illnesses with an acuity level that is classified as level one or level two based upon the Emergency Severity Index (ESI) as defined in the "Emergency Severity Index Version 4: Implementation Handbook" published by the Agency for Healthcare Research and Quality, Rockville MD (Gilboy N, Tanabe P, Travers DA, Rosenau AM, Eitel DR; AHRQ Publication No. 05-0046-2; May 2005, no later amendments or editions included).

"End Stage Renal Disease" or "ESRD" means that stage of renal impairment that appears irreversible and permanent and that requires a regular course of dialysis or kidney transplantation to maintain life. [210 ILCS 62/5]

"End Stage Renal Disease Facility" means a freestanding facility or a unit within an existing health care facility that furnishes in-center hemodialysis treatment and other routine dialysis services to end stage renal disease patients. These types of services may include self-dialysis, training in self-dialysis, dialysis performed by trained professional staff, and chronic maintenance dialysis, including peritoneal dialysis.

"Executive Secretary" or "Secretary" means the chief executive officer of ~~HFPB~~the State Board, responsible to the Chairman and, through the Chairman, responsible to the State Board for the execution of its policies and procedures.

"Extracorporeal Circulation (Bypass)" means, for the purpose of open heart surgery category of service, the circulation of blood outside the body, as through a heart/lung apparatus for carbon dioxide-oxygen exchange.

"Fertility Rate" means determinations by IDPH of population fertility that is based upon resident birth data for an area.

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"Freestanding Emergency Center" or "FEC" means a facility subject to licensure under Section 32.5 of the Emergency Medical Services (EMS) Systems Act [210 ILCS 50/32.5] that provides emergency medical and related services.

"Freestanding Emergency Center Medical Services" or "FECMS" means a category of service pertaining to the provision of emergency medical and related services provided in a freestanding emergency center.

"General Long-Term Care" means a classification of categories of service that provide inpatient levels of care primarily for convalescent or chronic disease adult patients/residents who do not require specialized long-term care services. The General Long-Term Care Classification includes the nursing category of service, which provides inpatient treatment for convalescent or chronic disease patients/residents and includes the skilled nursing level of care and/or the intermediate nursing level of care (both as defined in IDPH's Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Adm. Code 300)).

"HFPB" or "State Board" means the Health Facilities Planning Board established by the Act.

"Health Professional Shortage Areas" means urban or rural areas, population groups, or medical or other public facilities that may have shortages of primary medical care, dental or mental health providers, as determined by HHS' Shortage Designation Branch in the Health Resources and Services Administration (HRSA) Bureau of Health Professions National Center for Health Workforce.

"Health Service Area" or "HSA" means the following geographic areas:

HSA I – Illinois Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, and Winnebago

HSA II – Illinois Counties of Bureau, Fulton, Henderson, Knox, LaSalle, Marshall, McDonough, Peoria, Putnam, Stark, Tazewell, Warren, and Woodford

HSA III – Illinois Counties of Adams, Brown, Calhoun, Cass, Christian, Greene, Hancock, Jersey, Logan, Macoupin, Mason, Menard, Montgomery, Morgan, Pike, Sangamon, Schuyler, and Scott

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HSA IV – Illinois Counties of Champaign, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Ford, Iroquois, Livingston, Macon, McLean, Moultrie, Piatt, Shelby, and Vermilion

HSA V – Illinois Counties of Alexander, Bond, Clay, Crawford, Edwards, Effingham, Fayette, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jasper, Jefferson, Johnson, Lawrence, Marion, Massac, Perry, Pope, Pulaski, Randolph, Richland, Saline, Union, Wabash, Washington, Wayne, White, and Williamson

HSA VI – City of Chicago

HSA VII – DuPage County and Suburban Cook County

HSA VIII – Illinois Counties of Kane, Lake, and McHenry

HSA IX – Illinois Counties of Grundy, Kankakee, Kendall, and Will

HSA X – Illinois Counties of Henry, Mercer, and Rock Island

HSA XI – Illinois Counties of Clinton, Madison, Monroe, and St. Clair

"Hematocrit" means a measure of the packed cell volume of red blood cells expressed as a percentage of total blood volume.

"Hemodialysis" means a type of dialysis that involves the use of artificial kidney through which blood is circulated on one side of a semi-permeable membrane while the other side is bathed by a salt dialysis solution. The accumulated toxic products diffuse out of the blood into the dialysate bath solution. The concentration and total amount of water and salt in the body fluid are adjusted by appropriate alterations in composition of the dialysate fluid.

"Home Hemodialysis" means a type of dialysis that is done at home by the patient and a partner. Both are trained in the dialysis facility until the patient and partner become proficient to dialyze at home. The dialysis is usually three times per week.

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"Home-Assisted Hemodialysis" means done in a home and/or long term care setting through a staff-assisted program. The patient is not trained to do dialysis himself/herself.

"Hospital" means a facility, institution, place or building licensed pursuant to or operated in accordance with the Hospital Licensing Act [210 ILCS 45] or a State-operated facility that is utilized for the prevention, diagnosis and treatment of physical and mental illness. For purposes of this Subchapter, two basic types of hospitals are recognized:

General Hospital – a facility that offers an integrated variety of categories of service and that offers and performs scheduled surgical procedures on an inpatient basis.

Special or Specialized Hospital – a facility that offers, primarily, a special or particular category of service.

*"Illinois Department of Public Health" or "Agency" or "IDPH" means the Department of Public Health of the State of Illinois. [20 ILCS 3960/3]*

"In-Center Hemodialysis" means a category of service that is provided in an end stage renal disease facility licensed by the State of Illinois and/or certified by the Centers for Medicare and Medicaid Services.

"In-Center Hemodialysis Treatment" means a regimen of hemodialysis received by a patient usually three times a week, averaging four hours.

"Independent Travel Time Studies" means studies developed and submitted to refine or supplement the determination of Normal Travel Time. Independent Travel Time studies will be considered by HFPB only if conducted utilizing the criteria specified in this Part.

"Index of Medically Underserved" or "IMU" means shortage designation criteria applied to determine Medically Underserved Area or Medically Underserved Population designation. The four variables of the IMU are ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over.

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"Intensive Care Service" means a category of service providing the coordinated delivery of treatment to the critically ill patient or to patients requiring continuous care due to special diagnostic considerations requiring extensive monitoring of vital signs through mechanical means and through direct nursing supervision. This service is given at the direction of a physician on behalf of patients by physicians, dentists, nurses, and other professional and technical personnel. The intensive care category of service includes the following subcategories: medical ICU, surgical ICU, coronary care, pediatric ICU, and combinations of such ICUs. This category of service does not include intermediate intensive or coronary care and special care units that are included in the medical-surgical category of service.

"Intensive Care Unit" or "ICU" means a distinct part of a facility that provides a program of intensive care service; that is designed, equipped, organized and operated to deliver optimal medical care for the critically ill or for patients with special diagnostic conditions requiring specialized equipment, procedures and staff; and that is under the direct visual supervision of a qualified professional nurses' staff. Prior to February 15, 2003, the repeal of 77 Ill. Adm. Code 1110.1010, 1110.1020 and 1110.1030, the beds and corresponding utilization for the burn treatment category of service were included in the intensive care category of service.

"Key Room" means a term used in space planning to designate the primary functional component of a department used to develop a space program or estimate of square feet for that department. Examples of key rooms include, but are not limited to, examination rooms for ambulatory care, operating rooms for surgical suites, treatment stations for dialysis, imaging rooms for radiology.

"Kidney Transplantation Center" means a hospital that directly furnishes transplantation and other medical and surgical specialty services required for the care of the kidney transplant patient, including inpatient dialysis furnished directly or under arrangement.

"Kidney Transplantation Service" means a category of service that involves the surgical replacement of a nonfunctioning human kidney with a donor kidney in order to restore renal function to the patient.

"Maternity Care" means a subcategory of obstetric service related to the medical care of the patient prior to and during the act of giving birth either to a living child

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or to a dead fetus and to the continuing medical care of both patient and newborn infant under the direction of a physician, on behalf of the patient, by physicians, nurses, and other professional and technical personnel.

"Maternity Facility" or "Maternity Unit" means an entire facility or a distinct part of a facility that provides a program of maternity and newborn care and that is designed, equipped, organized, and operated in accordance with the requirements of the Hospital Licensing Act.

"Medically Underserved Areas" means a whole county or a group of contiguous counties, or a group of county or civil divisions, or a group of urban census tracts in which residents have a shortage of personal health services, as determined by HHS' Shortage Designation Branch in the Health Resources and Services Administration (HRSA) Bureau of Health Professions National Center for Health Workforce.

"Medically Underserved Populations" means groups of persons who face economic, cultural or linguistic barriers to health care, as determined by HHS' Shortage Designation Branch in the Health Resources and Services Administration (HRSA) Bureau of Health Professions National Center for Health Workforce.

"Medical-Surgical Service" means a category of service pertaining to the medical-surgical inpatient care performed at the direction of a physician, on behalf of the patient, by physicians, dentists, nurses and other professional and technical personnel. For purposes of 77 Ill. Adm. Code Subchapter a (Illinois Health Care Facilities Plan), this category of service may include medical-surgical and their respective sub-specialties of service. The medical-surgical category of service specifically does not include the following other separate categories of service and their subcategories:

Obstetric Service;

Pediatric Service;

Intensive Care Service;

Comprehensive Physical Rehabilitation Service;

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Acute and Chronic Mental Illness Treatment Service;

Neonatal Intensive Care Service;

General Long-Term Care Service;

Specialized Long-Term Care Service;

Long-Term Acute Care Service.

"Medical-Surgical Unit" means an assemblage of inpatient beds and related facilities in which medical-surgical services are provided to a defined and limited class of patients according to their particular medical care needs.

"Modernization" means modification of an existing health care facility by means of building, alteration, reconstruction, remodeling, replacement and/or necessary expansion, the erection of new buildings, or the acquisition, alteration or replacement of equipment. Modification does not include a substantial change in either the bed count or scope of the facility.

"Neonatal Intensive Care" means a level of care providing constant and close medical coordination, multi-disciplinary consultation and supervision to those neonates with serious and life threatening developmental or acquired medical and surgical problems that require highly specialized treatment and highly trained nursing personnel.

"Neonatal Intensive Care Service" means a category of service providing treatment of the infant for problems identified in the neonatal period that warrant intensive care. An intensive neonatal care service must include a related obstetric service for care of the high-risk mother (except when the facility is dedicated to the care of children).

"Neonatal Intensive Care Unit" means a distinct part of a facility that provides a program of intensive neonatal care and that is designed, equipped and operated to deliver medical and surgical care to high-risk infants.

"Neonatologist" means a physician who is certified by the American Board of Pediatrics Subboard of Neonatal-Perinatal Medicine or a licensed osteopathic

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physician with equivalent training and experience and certified by the American Osteopathic Board of Pediatricians.

"Newborn Nursery Level I" means hospitals that are designated under 77 Ill. Adm. Code 640 to provide care to normal and low-risk pregnant women and newborns, but do not operate Neonatal Intensive Care Units or Special Care Nurseries.

"Newborn Nursery Level II" means hospitals that are designated under 77 Ill. Adm. Code 640 to provide care to women and newborns at moderate risk and do not operate Neonatal Intensive Care Units or Special Care Nurseries.

"Newborn Nursery Level II with Extended Neonatal Capabilities" means hospitals that are designated under 77 Ill. Adm. Code 640 to provide care to women and newborns at moderate risk and do operate Special Care Nurseries.

"Newborn Nursery Level III" means hospitals that are designated under 77 Ill. Adm. Code 640 to provide care for perinatal patients requiring increasingly complex care, and do operate Neonatal Intensive Care Units.

"Non-Hospital Based Ambulatory Surgery" means a category of service relating to surgery that is performed at ambulatory surgical treatment centers on patients that arrive and are discharged the same day. Ambulatory surgery as the provision of surgical services may require anesthesia or a period of post-operative observation or both on a patient whose inpatient stay is not anticipated as being medically necessary.

"Non-emergent Care" means medical or surgical procedures and care provided to those patients treated in an emergency department (ED) of a hospital or freestanding emergency center who have conditions or illnesses that are not classified as level one or level two based upon the Emergency Severity Index.

"Normal Travel Time" means the time necessary to traverse a route by an individual vehicle driving at posted speed limits between any two points of interest. Normal Travel Time is to be considered by HFPB only as calculated utilizing methodologies specified in this Part. Normal Travel Time for proposed projects shall be established by using the facility's location as the base point and utilizing time factors specified in the applicable rules.

HFPBSTATE BOARD NOTE: Normal Travel Time as used in this Part is a

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conceptual model approximating a reasonable time of travel between two points. It is intended to exclude a "worst" or "best" case situation such as travel during rush hours, midnight hours, or by emergency vehicle.

"Observation Days" means the number of days of service provided to outpatients for the purpose of determining whether a patient requires admission as an inpatient or other treatment. The observation period shall not exceed 48 hours.

"Obstetric Gynecological Care" means a subcategory of obstetric service in which medical care is provided to clean gynecological, surgical or medical cases that are admitted to a postpartum section of an obstetric unit in accordance with the requirements of the Hospital Licensing Act.

"Obstetric Service" means a category of service pertaining to the medical or surgical care of maternity and newborn patients or medical or surgical cases that may be admitted to a postpartum unit

"Occupancy Rate" means a measure of inpatient health facility use, determined by dividing average daily census by the number of authorized beds~~facility's bed capacity~~. It measures the average percentage of a facility's beds occupied and may be institution-wide or specific for one department or service.

"Occupancy Target" means a utilization level established by IDPH for a facility or service reflecting adequate access as well as operational efficiency.

"Open Heart Surgery" means a category of service that utilizes any form of cardiac surgery that requires the use of extracorporeal circulation and oxygenation. The use of a pump during the procedure distinguishes "open heart" from "closed heart" surgery.

"Operating Room (Class B)" or "Surgical Procedure Room (Class B)" means a setting designed and equipped for major or minor surgical procedures performed in conjunction with oral, parenteral or intravenous sedation or under analgesic or dissociative drugs. (Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

"Operating Room (Class C)" means a setting designed and equipped for major surgical procedures that require general or regional block anesthesia and support

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of vital bodily functions. (Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

"Out-of-Home Respite Care" means care provided in a facility setting to a clinically stable individual whose medical condition does not require major diagnostic procedures or therapeutic interventions and who normally receives care in a home environment for the purposes of providing a respite to the caregiver from the responsibilities of providing the care.

"Patient Care Unit" means the grouping of beds to provide an inpatient category of service. Units are physically identifiable areas that are staffed to provide all care required for particular service.

"Patient Days" means the total number of days of service provided to inpatients ~~of a facility~~ over a 12-month period, usually expressed as annual patient days measured. This figure includes observation days if the observation patient occupies a bed that is included in ~~IDPH's the State Agency's~~ Inventory of Health Care Facilities and Services and Need Determinations.

"Patient Migration" means the total number of patients who reside in a given planning area but receive services at health care facilities located in another planning area for a given year. Patient migration is determined by utilizing the latest available patient origin data concerning admissions to health care facilities by various categories of service for a given year. The term in-migration refers to the number of patients who are not residents of a planning area that enter the area to receive services, while the term out-migration refers to the number of planning area residents who leave the planning area to obtain services elsewhere.

"Pediatric Catheterization" means the cardiac catheterization of patients zero to 14 years in age.

"Pediatric Facility" or "Distinct Pediatric Unit" means an entire facility or a distinct unit of a facility, where the nurses' station services only that unit, that provides a program of pediatric service and is designed, equipped, organized and operated to render medical-surgical care to the zero to 14 age population.

"Pediatric Service" means a category of service for the delivery of treatment pertaining to the non-intensive medical-surgical care of a pediatric patient (zero to

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14 years in age) performed at the direction of a physician on behalf of the patient by physicians, dentists, nurses and other professional and technical personnel.

"Perinatal Center" means a referral facility intended to care for the high-risk patient before, during or after labor and delivery that is characterized by sophistication and availability of personnel, equipment, laboratory, transportation techniques, consultation, and other support services. A perinatal center shall be a university or university-affiliated facility responsible for the administration and implementation of the Department of Human Services' regionalized perinatal health care program, including continuing education for health professions.

"Peritoneal Dialysis" means a type of dialysis in which the dialysate fluid is infused slowly into the peritoneum, causing dialysis of water and waste products to occur through the peritoneal sac, which acts as a semi-permeable membrane. The fluid and waste, after accumulating for a period of time (one hour), is drained from the abdomen and the process is repeated.

"Planning Area" means a defined geographic area within the State established by HFPBthe State Board as a basis for the collection, organization, and analysis of information to determine health care resources and needs and to serve as a basis for planning.

"Population Estimates" means the latest available numbers of residents of a geographic area based upon birth and death records and other inputs, as determined by IDPH. These numbers may be further broken down by age and sex cohorts.

"Population Projections" means the numbers of residents of a geographic area projected for one or more future time periods, as determined by IDPH and based upon State of Illinois population projections, as available. These numbers are for defined geographic areas and may be further broken down by age and sex cohorts.

"Post-Anesthesia Recovery Phase I" means the phase in surgical recovery that focuses on providing a transition from a totally anesthetized state to one requiring less acute interventions. Recovery occurs in the post-anesthesia care unit (PACU). The purpose of this phase is for patients to regain physiological homeostasis and receive appropriate nursing intervention as needed.

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"Post-Anesthesia Recovery Phase II" means the phase in surgical recovery that focuses on preparing the patient for self care, care by family members, or care in an extended care environment. The patient is discharged to phase II recovery when intensive nursing care no longer is needed. In the phase II area, sometimes referred to as the step-down or discharge area, the patient becomes more alert and functional.

"Postsurgical Recovery Care Center" means a designated site which provides postsurgical recovery care for generally healthy patients undergoing surgical procedures that require overnight nursing care, pain control, or observation that would otherwise be provided in an inpatient setting. Such a center may be either freestanding or a defined unit of an ambulatory surgical treatment center or hospital. The maximum length of stay for patients in a postsurgical recovery care center is not to exceed 72 hours. (Section 35 of the Alternative Health Care Delivery Act [210 ILCS 3/35])

"Postsurgical Recovery Care Center Alternative Health Care Model" means a category of service for the provision of postsurgical recovery care within a postsurgical recovery care center.

"Pre-Dialysis" means that the initiation of hemodialysis therapy is anticipated within 12 months.

"Pump Procedures" means the utilization of a heart/lung pump in surgery to perform the work of the heart and lungs. Included in these procedures are myocardial revascularization, aortic and mitral valve replacement, ventricular aneurysm repairs, pulmonary valvuloplasty, and all other procedures utilizing a cardiac pump.

"Quality of Care", for purposes of 77 Ill. Adm. Code 1110.230, the degree to which delivered health services meet established professional standards and are judged to be of value to the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other outcomes, given the existing state of medical science and art. (WHO Centre for Health Development, Ageing and Health Technical Report Volume 5 "A Glossary of Terms for Community Health Care and Services for Older Persons" (2004))

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"Rapid Population Growth Rate" means an average of the three most recent annual growth rates of a defined geographic area's population, that has exceeded the average of three to seven immediately preceding annual growth rates by at least 100%.

"Renal Dialysis Facility" means a freestanding facility, or a unit within an existing health care facility, that furnishes routine chronic dialysis services to chronic renal disease patients. Routine services are self-dialysis, training in self-dialysis, dialysis performed by trained professional staff, and chronic maintenance dialysis, including peritoneal dialysis.

"Resource Hospital" means the hospital that is responsible for an Emergency Medical Services (EMS) System in a specific geographic region. Responsibilities include education for EMS personnel and recommendations for their re-licensure, and development of standard medical protocols for the EMS system for which it takes the lead. Resource hospitals deal with pre-hospital and Emergency Department issues only, unlike the Trauma Center. The Resource Hospital functions with the Associate and Participating Hospitals within the specific EMS system. There are 62 EMS systems within 11 EMS Regions in Illinois.

"Selected Organ Transplantation Center" means a hospital that provides staffing and other adult or pediatric medical and surgical specialty services required for the care of a transplant patient.

"Selected Organ Transplantation Service" means a category of service relating to the surgical transplantation of any of the following human organs: heart, lung, heart-lung, liver, pancreas or intestine. It does not include bone marrow or cornea transplants.

"Self-Care Dialysis" or "Self-Dialysis" means maintenance dialysis performed by a trained patient in a special facility with or without the assistance of a family member or other helper.

"Self-Care Dialysis Training" means a program that trains patients or their helpers, or both, to perform self-care dialysis in the in-center setting.

"Short-Term Transitional Care" means, for the purpose of Children's Respite Care Center Alternative Health Care Model, care provided to an individual on an

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interim basis to allow for the training of the home caregiver or to allow the relocation of the patient from one care environment to another.

"Site" means the location of an existing or proposed facility. An existing facility site is determined by street address. In a proposed facility the legal property description or the street address can be used to identify the site.

*"State Board" means the Health Facilities Planning Board established by the Act. [20 ILCS 3960/3]*

"Special Procedures Laboratory with a Cardiac Catheterization Service" means a special procedures or angiography laboratory that has the equipment, staff and support services required to provide cardiac catheterization and in which catheterizations are routinely performed. The laboratory is also utilized for other procedures, such as angiography, not directly related to cardiac catheterization.

"Specialized Long-Term Care" means a classification consisting of categories of service that provide inpatient care primarily for children (ages zero through 21) or inpatient care for adults who require specialized treatment and care because of mental or developmental disabilities. The Specialized Long-Term Care Classification includes the following categories of services:

Chronic Mental Illness (MI) – levels of care provided to severely mentally ill clients in a structured setting in a psychiatric unit of a general hospital, in a private psychiatric hospital, or in a State-operated facility primarily in order to facilitate the improvement of their functioning level, to prevent further deterioration of their functioning level, or, in some instances, to maintain their current level of functioning.

Long-Term Care for the Developmentally Disabled (Adult) (DD-Adult) – levels of care for developmentally disabled adults as defined in the Illinois Mental Health and Developmental Disabilities Code [405 ILCS 5] (including those facilities licensed as Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)) that provide an integrated, individually tailored program of services for developmentally disabled adults and that provide an active, aggressive and organized program of services directed toward achieving measurable behavioral and learning objectives.

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Long-Term Care for the Developmentally Disabled (Children) (DD-Children) – levels of care for developmentally disabled children limited to those residents ages zero through 21 years and whose condition meets the definition of developmental disabilities in the Illinois Mental Health and Developmental Disabilities Code.

"Subacute Care" means the provision of *medical specialty care for patients who need a greater intensity or complexity of care than generally provided in a skilled nursing facility but who no longer require acute hospital care. Subacute care includes physician supervision, registered nursing and physiological monitoring on a continual basis.* (Section 35 of the Alternative Health Care Delivery Act [210 ILCS 3/35])

"Subacute Care Hospital" means a designated site that provides medical specialty care for patients who need a greater intensity or complexity of care than generally provided in a skilled nursing facility but who no longer require acute hospital care. The average length of stay for patients treated in subacute care hospitals shall not be less than 20 days; for individual patients, the expected length of stay at the time of admission shall not be less than 10 days. A subacute care hospital is either a freestanding building or a distinct physical and operational entity within a hospital or nursing home building. A subacute care hospital shall only consist of beds currently existing in licensed hospitals or skilled nursing facilities. (Section 35 of the Alternative Health Care Delivery Act)

"Subacute Care Hospital Model" means a category of service for the provision of subacute care.

"Surgical Referral Site" means an ambulatory surgical treatment center or hospital in which surgery will be performed and the surgical patient then transferred to the recovery care center.

"Teaching Institution" means, for the purpose of selected organ transplantation category of service, a hospital having a major relationship with a medical school as defined and listed in the current Directory of Residency Training Programs developed by the American Medical Association, 535 Dearborn, Chicago, Illinois 60610 and the National Organ Procurement and Transplantation Network.

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"Transplant Hospital" means a hospital that furnishes organ transplants and other medical and surgical specialty services required for the care of transplant patients. A transplant hospital may have one or more types of organ transplant programs operating within the same hospital.

~~"Unit" means the grouping of beds to provide a category of service. Units are physically identifiable areas that are staffed to provide all care required for particular service.~~

"Urea" means the chief product of urine and the final product of protein metabolism in the body.

"Urea Reduction Ratio" or "URR" means the amount of blood cleared of urea during dialysis. It is reflected by the ratio of the measured level of urea before dialysis and urea remaining after dialysis. The larger the URR, the greater the amount of urea removed during the dialysis treatment.

"Use Rate" means the ratio of inpatient days per 1,000 population over a 12-month period (Inpatient Days/Population in Thousands = Use Rate). For need assessment purposes, HFPB may establish minimum or maximum use rates in order to promote the development of additional resources or to limit unnecessary duplication of services and beds in a planning area.

"Utilization Standards" means an operational target for facilities or services that may demonstrate operational efficiencies, minimum proficiency or other performance parameters. Utilization standards and their purposes are established by category of service. Utilization may be expressed by various ratios, such as facility or bed service occupancy rates or hours of use for types of equipment, operating rooms, dialysis stations, etc.

~~"Utilization" means patterns or rates of use of a single service or type of service or piece of equipment, within a given facility or also in combinations of facilities. Utilization may be expressed by various ratios such as facility or bed service occupancy rates or hours of use for types of equipment, operating rooms, dialysis stations, etc.~~

(Source: Amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## SUBPART C: PLANNING POLICIES

## HEALTH FACILITIES PLANNING BOARD

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**Section 1100.440 Requirements for Authorized Hospital Beds**

- a) Authorized hospital beds are to be classified as one of the following:
  - 1) Physically Available Beds
    - A) Patient rooms and patient care units (PCUs) shall be compliant with applicable licensure codes and standards for hospital facilities, pursuant to the Hospital Licensing Requirements (77 Ill. Adm. Code 250) as determined by IDPH. If a patient room or a PCU is not compliant with the Hospital Licensure Requirements, an action plan of correction shall be in place, including a schedule for completion, ~~approved by IDPH~~. The action plan shall be in the process of being implemented on schedule for the PCU and beds to be considered authorized and recorded as part of the inventory.
    - B) The approved number of beds is to be recorded in the Inventory of Health Care Facilities.
  - 2) Reserve Beds
    - A) Patient rooms and PCUs must be compliant with applicable licensure codes and standards for hospital facilities, as determined by IDPH. If a patient room or a PCU is not compliant with licensure codes and standards for hospital facilities, there must be an action plan of correction in place, including a schedule for completion, ~~approved by IDPH~~. The action plan shall be in the process of being implemented on schedule for the PCU and beds to be considered authorized and recorded as part of the inventory. (See 77 Ill. Adm. Code 250.)
    - B) Patient rooms and PCUs shall be able to be set up and physically available for inpatient care within 72 hours, including equipment, furnishings and non-time-sensitive supplies.
    - C) Patient room and PCU equipment, furnishings and supplies designated for reserve beds shall be maintained either on the

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hospital's campus or in a storage facility that is owned or operated by the hospital.

- D) The number of reserve beds shall not exceed 10% of the sum of physically available beds and transitional beds within each category of service. [Hospitals with a total bed count of less than 50 beds may report up to a total of five reserve beds.](#)
  - E) The approved number of beds is to be recorded in the Inventory of Health Care Facilities.
- 3) Transitional Beds
- A) For transitional beds that are part of an approved CON project, the CON project is to be compliant with CON requirements.
  - B) For transitional beds that are not part of a CON project, the individually identified beds can be designated transitional for no more than one reporting period.
  - C) The approved number of beds is to be recorded in the Inventory of Health Care Facilities.
- b) The sum of physically available, reserve, and transitional beds for each category of service shall not exceed the authorized bed capacity for that service.

(Source: Amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## SUBPART D: NEED ASSESSMENT

**Section 1100.510 Introduction, Formula Components, Planning Area Development Policies, and Normal Travel Time Determinations**

- a) Introduction  
This Subpart details the policies and methodologies utilized to assess the need for beds and services. The calculations and numeric results, as well as the related data elements that pertain to the methodologies detailed in this Subpart, are contained in the Inventory of Health Care Facilities.

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## b) Formula Components

Formulas utilized by HFPB in projecting the need for beds and services can be categorized as demand based or incidence based need formulas. Each of these formula types represents a different conceptual outlook and incorporates different data elements as formula variables.

- 1) Demand Based Formula. Demand equations utilize the concept that what has occurred in the past will occur in the future. The formulas utilize inpatient days of care and population projections as the key data variables. The first formula step is to establish a utilization to population ratio (use rate). This ratio basically says that within a population an average number of inpatient days of care will be generated. This rate is then applied to the population projection for the same area. This states that if the rate of use is constant, a future population can be expected to generate an identifiable number of inpatient days. These projected days are then converted to a daily census (projected days – 365) and multiplied by an occupancy target. The projected day figure can be equated to 100% occupancy of service for which need is projected. An occupancy factor adjustment is applied to insure that sufficient beds exist to handle days when inpatient admissions are exceptionally high. This type of formula may also be adjusted by the application of minimum and maximum use rates in planning areas that lack facilities or certain types of beds or where a high concentration of beds and services has caused unnecessary duplication. These rates are controls and serve to inflate (minimum use rate) or deflate (maximum use rate) the projected bed need. These rates are established when historical patterns of use are influenced by a maldistribution of services. By adding to or subtracting from the number of needed beds, development of new beds and facilities can be influenced to add beds to underserved areas and to restrict bed growth in areas of high bed to population ratios.
- 2) Incidence Based Formula. This type of formula utilizes the incidence level of a disease or a condition within a population to predict need. Utilizing national or State rates, the formula predicts the number of planning area residents who will need hospitalization based on the number of people who live in the planning area. Utilizing a standard estimate of how long a patient will be hospitalized, admissions are converted into patient days. As in the demand formulas, days are then converted to an average daily census and an occupancy factor adjustment is applied to obtain area bed need.

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- c) Planning Area Development Policies  
HFPB recognizes the need to establish planning areas for the purpose of assessing and determining the need for health care facilities, beds, and services. In establishing planning areas the following principles and factors apply:
- 1) For purposes of delineating planning area boundaries and for purposes of calculating population estimates, the smallest geographical areas to be utilized shall be community areas for the city of Chicago and townships for all other areas in the State outside of Chicago.
  - 2) Source of patient information shall be the primary basis for the allocation of geographic areas (e.g., townships, community areas, counties) into planning areas. As a general principle, 50% or more of residents receiving care from facilities or resources located within the planning area should reside within the planning area.  
  
~~HFPBSTATE BOARD~~ NOTE: Source of patient information may only be available on a zip code basis. In such cases, the relationship between zip code boundaries and community area or township boundaries will be approximated for use in establishing planning area boundaries.
  - 3) Planning area boundaries should be established taking into consideration the number and type of existing health care facilities and services located within the area, shared and overlapping market areas between or among facilities, and patterns of patient referral to area health care facilities. Planning areas may vary in size in order to ~~ensure~~insure access within a reasonable travel time.
  - 4) The primary market area for health care facilities located within a planning area should serve a substantial number of residents of the planning area. A primary market area means the geographic location in which 50% or more of a facility's patients/residents reside. HFPB recognizes that certain health care facilities (e.g., tertiary and specialty facilities) may have primary market areas that are not entirely contained within the planning area in which the facility is located.
  - 5) Planning area boundaries can also be influenced by the following factors:

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- A) natural geographic boundaries;
  - B) political boundaries that affect the patterns of services;
  - C) transportation patterns and systems;
  - D) time and distance required to access service by area residents;
  - E) affiliations between health care facilities and other health care entities that affect patterns of service;
  - F) trade and economic market patterns that influence the financing of health care services;
  - G) the lack of existing health resources or services in an area;
  - H) referral patterns to obtain tertiary services;
  - I) the impact of reimbursement or managed care programs;
  - J) socio-economic factors such as but not limited to population density, income level, or age characteristics.
- 6) Planning area boundaries may vary by category of service. HFPB recognizes that certain services (e.g., neonatal ICU, comprehensive physical rehabilitation, selected organ transplantation, cardiac surgery, etc.) may require a large population base in order to assure the provision of quality care and to be cost effective.
- 7) Planning areas for the acute care categories of services of medical-surgical/pediatrics, obstetrics and intensive care must contain a minimum population of 40,000. This population base would be sufficient to support a 100 bed hospital based upon a facility target occupancy of 80% and an inpatient day use rate of 725 days per 1,000 population.
- 8) Planning areas for general long-term service must contain a minimum population of 10,000. This population base would be sufficient to support 100 nursing care beds based upon a rate of 9 beds per 1,000 population (projected 1997 statewide need divided by projected 1997 State

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population) with a target occupancy of 90%.

- 9) HFPB recognizes that some long-term care facilities may have a primary market area that is not contained within the planning area in which the facility is located. Placement in long-term care facilities may be influenced by such factors as, but not limited to: location of next of kin or relatives; seeking services of a specialized nature such as treatment for various diseases or disabilities; or seeking services related to religious, ethnic, or fraternal needs. Because of the significant degree of mobility that is exercised in seeking long term care services, HFPB shall not allocate portions of a facility's beds and services to more than one planning area.
- d) Normal Travel Time Determinations  
Normal Travel Time for proposed projects shall be the time determined by MapQuest, Inc. (MapQuest – [www.mapquest.com](http://www.mapquest.com)) multiplied by an adjustment factor that is based upon the location of the applicant facility.
  - 1) For applicant facilities located in the City of Chicago, Normal Travel Time shall be calculated as MapQuest times 1.25.
  - 2) For applicant facilities located in the Chicago Metropolitan region, including counties of Cook (excluding Chicago), DuPage, Will, Kendall, Kane, McHenry, Lake and Aux Sable Township of Grundy County, plus the counties of Winnebago, Peoria, Sangamon and Champaign, Normal Travel Time shall be calculated as MapQuest times 1.15.
  - 3) For applicant facilities located in any other area of the State, Normal Travel Time shall be calculated as MapQuest times 1.0.
- e) Independent Travel Time Studies may be prepared and submitted in addition to the above to refine or supplement the determination of Normal Travel Time, provided that they are conducted as follows:
  - 1) The study is conducted by an engineering firm pre-qualified in traffic studies by the Illinois Department of Transportation (IDOT) or prepared by a ~~professional engineer~~[Professional Engineer](#) also certified by the Institute of Transportation Engineers (ITE) as a Professional Traffic Operations Engineer (PTOE).

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- 2) A Travel Time shall consist of a minimum of three round trips for each defined survey route.
- 3) No more than one third of the round trips shall start or conclude during a rush hour period, i.e.:

Morning Peak Period: 6:30 AM-9:30 AM

Evening Peak Period: 3:30 PM-6:30 PM

- 4) The routes used for determination of Normal Travel Time shall be reasonably direct.
- 5) Average travel time for a one-way trip will be considered.
- 6) All travel routes and calculations of Normal Travel Time are to be documented and sealed by the responsible [professional engineer](#)~~Professional Engineer~~.

~~HFPBSTATE BOARD~~ NOTE: Calculations produced by MapQuest, Inc. have been used as a basis for the above methodologies. MapQuest assumes vehicular travel at posted speed limits, with some adjustment for number of intersections and turns. The adjustment factors in subsection (d) are intended to reflect additional factors related to density of population.

(Source: Amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 1100.520 Medical-Surgical Care and Pediatric Care**

- a) Planning Areas  
There are 40 medical-surgical and pediatric care planning areas that have been delineated by HFPB contained within six regions established for the State of Illinois.
  - 1) Region A (comprised of HSAs 6, 7, 8 and 9)
    - A) Planning Area A-1: City of Chicago Community Areas of Uptown, Lincoln Square, North Center, Lakeview, Lincoln Park, Near North Side, Edison Park, Norwood Park, Jefferson Park, Forest

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Glen, North Park, Albany Park, Portage Park, Irving Park, Dunning, Montclare, Belmont Cragin, Hermosa, Avondale, Logan Square, O'Hare and Edgewater.

- B) Planning Area A-2: City of Chicago Community Areas of Humboldt Park, West Town, Austin, West Garfield Park, East Garfield Park, Near West Side, North Lawndale, South Lawndale, Lower West Side, Loop, Armour Square, McKinley Park and Bridgeport.
- C) Planning Area A-3: City of Chicago Community Areas of Douglas, Oakland, Fuller Park, Grand Boulevard, Kenwood, Near South Side, Washington Park, Hyde Park, Woodlawn, South Shore, Chatham, Avalon Park, South Chicago, Burnside, Calumet Heights, Roseland, Pullman, South Deering, East Side, Garfield Ridge, Archer Heights, Brighton Park, New City, West Elsdon, Gage Park, Clearing, West Lawn, West Englewood, Englewood, Chicago Lawn and Greater Grand Crossing.
- D) Planning Area A-4: City of Chicago Community Areas of West Pullman, Riverdale, Hegewisch, Ashburn, Auburn Gresham, Beverly, Washington Heights, Mount Greenwood, and Morgan Park; Cook County Townships of Lemont, Stickney, Worth, Lyons, Palos, Calumet, Thornton, Bremen, Orland, Rich and Bloom.
- E) Planning Area A-5: DuPage County.
- F) Planning Area A-6: Cook County Townships of River Forest, Oak Park, Cicero, Berwyn, Riverside, Proviso, Leyden and Norwood Park.
- G) Planning Area A-7: Cook County Townships of Maine, Elk Grove, Schaumburg, Palatine and Wheeling.
- H) Planning Area A-8: City of Chicago Community Areas of Rogers Park and West Ridge; Cook County Townships of Northfield, New Trier, Niles and Evanston.

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- I) Planning Area A-9: Lake County.
  - J) Planning Area A-10: McHenry County.
  - K) Planning Area A-11: Cook County Townships of Barrington and Hanover; Kane County Townships of Hampshire, Rutland, Dundee, Burlington, Plato, Elgin, Virgil, Campton and St. Charles.
  - L) Planning Area A-12: Kendall County; Kane County Townships of Kaneville, Black Berry, Aurora, Big Rock, Sugar Grove, Batavia and Geneva.
  - M) Planning Area A-13: Grundy and Will Counties.
  - N) Planning Area A-14: Kankakee County.
- 2) Region B (comprised of HSA 1)
- A) Planning Area B-1: Boone and Winnebago Counties; DeKalb County Townships of Franklin, Kingston, and Genoa; Ogle County Townships of Monroe, White Rock, Lynnville, Scott, Marion, Byron, Rockvale, Leaf River and Mount Morris.
  - B) Planning Area B-2: Jo Daviess and Stephenson Counties; Ogle County Townships of Forrester, Maryland, Lincoln, and Brookville; Carroll County Townships of Washington, Savanna, Woodland, Mount Carroll, Freedom, Salem, Cherry Grove-Shannon and Rock Creek-Lima.
  - C) Planning Area B-3: Whiteside County; Lee County Townships of Palmyra, Nelson, Harmon, Hamilton, Dixon, South Dixon, Marion, East Grove, Nachusa, China, Amboy, May, Ashton, Bradford, Lee Center, and Sublette; Carroll County Townships of York, Fairhaven, Wysox, and Elkhorn Grove; Ogle County Townships of Eagle Point, Buffalo, Pine Creek, Woosung, Grand Detour, Oregon, Nashua, Taylor, Pine Rock and Lafayette.
  - D) Planning Area B-4: Lee County Townships of Reynolds, Alto, Viola, Willow Creek, Brooklyn, and Wyoming; DeKalb County

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Townships of Paw Paw, Victor, Somonauk, Sandwich, Shabbona, Clinton, Squaw Grove, Milan, Afton, Pierce, Malta, DeKalb, Cortland, Mayfield, South Grove and Sycamore; Ogle County Townships of Flagg and Dement.

- 3) Region C (comprised of HSAs 2 and 10)
  - A) Planning Area C-1: Woodford, Peoria, Tazwell, and Marshall Counties; Stark County Townships of Goshen, Toulon, Penn, West Jersey, Valley and Essex.
  - B) Planning Area C-2: LaSalle, Bureau, and Putnam Counties; Stark County Townships of Elmira and Osceola.
  - C) Planning Area C-3: Henderson, Warren and Knox Counties.
  - D) Planning Area C-4: McDonough and Fulton Counties.
  - E) Planning Area C-5: Rock Island, Henry and Mercer Counties.
- 4) Region D (comprised of HSA 4)
  - A) Planning Area D-1: Champaign, Douglas, and Piatt Counties; Ford County Townships of Lyman, Sullivant, Peach Orchard, Wall, Drummer, Dix, Patton, and Button; Iroquois County Townships of Loda, Pigeon Grove and Artesia.
  - B) Planning Area D-2: Livingston and McLean Counties; Ford County Townships of Rogers, Mona, Pella and Brenton.
  - C) Planning Area D-3: Vermilion County; Iroquois County Townships of Milks Grove, Chebanse, Papineau, Beaverville, Ashkum, Martinton, Beaver, Danforth, Douglas, Iroquois, Crescent, Middleport, Belmont, Concord, Sheldon, Ash Grove, Milford, Stockland, Fountain Creek, Lovejoy, Prairie Green, Onarga and Ridgeland.
  - D) Planning Area D-4: DeWitt, Macon, Moultrie and Shelby Counties.

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- E) Planning Area D-5: Coles, Cumberland, Clark and Edgar Counties.
- 5) Region E (comprised of HSA 3)
- A) Planning Area E-1: Logan, Menard, Mason, Sangamon, Christian and Cass Counties; Brown County Townships of Ripley, Cooperstown, and Versailles; Schuyler County Townships of Littleton, Oakland, Buena Vista, Rushville, Browning, Hickory, Woodstock, Bainbridge and Frederick.
- B) Planning Area E-2: Macoupin and Montgomery Counties.
- C) Planning Area E-3: Greene, Jersey and Calhoun Counties.
- D) Planning Area E-4: Pike, Scott and Morgan Counties.
- E) Planning Area E-5: Adams and Hancock Counties; Schuyler County Townships of Birmingham, Brooklyn, Camden, and Huntsville; Brown County Townships of Pea Ridge, Missouri, Lee, Mount Sterling, Buckhorn and Elkhorn.
- 6) Region F (comprised of HSAs 5 and 11)
- A) Planning Area F-1: Madison and St. Clair Counties; Monroe County Precincts 2, 3, 4, 5, 7, 10, 11, 14, 16, 17, 18, 19, 21, and 22; Clinton County Townships of Sugar Creek, Looking Glass, Germantown, Breese, St. Rose, Wheatfield, Wade, Sante Fe, Lake, Irishtown, Carlyle and Clement.
- B) Planning Area F-2: Bond, Fayette, and Effingham Counties; Clay County Townships of Blair, Bible Grove, and Larkinsburg; Jasper County Townships of Grove, North Muddy, South Muddy, Smallwood, Wade and Crooked Creek.
- C) Planning Area F-3: Crawford, Lawrence, Richland, Wabash, and Edwards Counties; Jasper County Townships of Hunt City, Willow Hill, Ste. Marie, Fox, and Grandville; Clay County Townships of

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Louisville, Songer, Xenia, Oskaloosa, Hoosier, Harter, Stanford, Pixley, and Clay City; Wayne County Townships of Orchard, Keith, Garden Hill, Berry, Bedford, Lamard, Indian Prairie, Zif, Elm River, Jasper, Mount Erie, Massilion, Leech, Barnhill and Grover.

- D) Planning Area F-4: Marion, Jefferson, and Washington Counties; Wayne County Townships of Big Mound, Orel, Hickory Hill, Arrington and Four Mile; Clinton County Townships of East Fork, Meridian and Brookside.
- E) Planning Area F-5: Hamilton, White, Gallatin, Hardin, and Saline Counties; Pope County Townships of Eddyville #6 and Golconda #2.
- F) Planning Area F-6: Franklin, Williamson, Johnson, and Massac Counties; Pope County Townships of Jefferson #4, Webster #5, Golconda #1 and Golconda #3.
- G) Planning Area F-7: Randolph, Perry, Jackson, Union, Alexander, and Pulaski Counties; Monroe County Precincts 1, 6, 8, 9, 12, 13, 15, 20 and 23.
- b) Age Groups
- 1) For medical-surgical care, ages 15 and over.
  - 2) For pediatric care, ages 0-14.
- c) Occupancy Targets:
- 1) Occupancy Targets for "Modernization".
 

A)	Medical-Surgical	1-25 beds	60%
		26-99 beds	75%
		100-199 beds	85%
		200+ beds	88%
B)	Pediatrics	1-30 beds	65%

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		31+ beds	75%
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## 2) Occupancy Targets for "Addition of Beds".

A)	Medical-Surgical	1-99 beds	80%
		100-199 beds	85%
		200+ beds	90%

B)	Pediatrics	1-99 MS beds	80%
		100-199 MS beds	85%
		200+ MS beds	90%

## d) Bed Capacity

- 1) Medical-surgical bed capacity is the total number of medical-surgical beds for a facility as determined by HFPB pursuant to this Part.
- 2) Pediatric bed capacity is the total number of pediatric beds for a facility as determined by HFPB pursuant to this Part.

## e) Need Determination

In assessing the number of beds required to serve the residents of a planning area, HFPB shall establish a base year and utilize the following methodology to determine the projected number of medical-surgical and pediatric beds needed in a planning area:

- 1) Divide the three year average of experienced medical-surgical and pediatric patient days (i.e., the average of the base year's and the two prior years' patient days) for each of ~~five~~<sup>three</sup> age groups (0-14, 15-44, 45-64, 65-74, and 75+~~15-64~~ and ~~65+~~) by the base year population estimate for each age group, resulting in age specific base use rates;
- 2) Multiply each age specific base use rate by the population projection, 10 years from the base year, to obtain each age group's projected patient days;
- 3) Add the projected days of the age groups to obtain total projected patient days;

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- 4) Increase or decrease the projected patient days by a migration patient days factor to obtain total projected patient days. The migration patient days factor is determined as follows:
  - A) Subtract the number of medical-surgical and pediatric in-migration admissions (i.e., non-planning area residents who were admitted to planning area facilities) from the number of out-migration admissions (i.e., planning area residents who were admitted to facilities located outside of the planning area) to obtain either a positive or negative net patient migration number;
  - B) Multiply the net patient migration number by the State's base year average length of stay for the combined medical-surgical and pediatric admissions to obtain net migration patient days for the planning area;
  - C) Multiply the net migration patient days number by .50 (50% statutory adjustment factor) to obtain the migration patient days factor;
- 5) Divide the total projected patient days by the number of days in the projected year to obtain the planning area's projected average daily census (ADC);
- 6) Divide the ADC by .80 (80% occupancy factor) if the ADC is below 100; by .85 (85% occupancy factor) if the ADC is 100 through 199; and by .90 (90% occupancy factor) if the ADC is 200 or over, to obtain the projected planning area bed need;
- 7) Subtract the number of existing beds in the planning area from the projected planning area bed need to determine the projected number of surplus (excess) beds or the projected bed deficit or additional beds needed in the area.

(Source: Amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 1100.630 In-Center Hemodialysis Category of Service**

- a) Planning Areas

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Planning areas for the in-center hemodialysis category of service are Health Service Areas.

- b) Age Groups  
For in-center hemodialysis, all ages.
- c) Utilization Target  
Facilities providing in-center hemodialysis should operate their dialysis stations at or above an average annual utilization rate of 80%, assuming three patient shifts per day per renal dialysis station operating six days a week.
- d) Need Determination  
[The five-year need determination is a short-term assessment that applies to the planning area need requirements in the 77 Ill. Adm. Code 1110 category of service review criteria.](#) The in-center hemodialysis or end stage renal disease (ESRD) station need is a ~~five year~~[10-year](#) projection from the base year. The need for additional treatment stations can be projected utilizing the following methodology:
  - 1) Establish a minimum institutional dialysis rate by dividing the total number of institutional dialysis patients in the base year by the State base year population estimate in thousands and multiply the result by .6 (60%).
  - 2) Determine each planning area's experienced institutional dialysis rate by dividing the number of patients receiving dialysis in the base year by the planning area population projection in thousands for the base year.
  - 3) Multiply each planning area's population projection in thousands by the greater of the minimum institutional dialysis rate or the experienced institutional dialysis rate for the planning area to determine the estimated number of institutional dialysis patients.
  - 4) Multiply the planning area's projected number of institutional dialysis patients by a factor of 1.33 (~~510~~[510](#) year increase in prevalence) to determine the projected number of institutional dialysis patients in the planning area for the projected year.
  - 5) Multiply the projected number of annual institutional dialysis patients by 156 ([3 treatments/week x 52 weeks](#)) to determine the projected number of

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institutional procedures.

- 6) Divide the projected number of annual institutional procedures by 749 (3 shifts/day x 6 days/week x 52 weeks/year x .80 utilization target)<sup>936</sup> to determine the projected number of stations needed for the projected year.
- 7) Subtract the number of existing stations from the projected number of needed stations to determine the excess (surplus) or additional (deficit) number of stations needed.

e) 10-Year Need Determination

The 10-year need determination for in-center hemodialysis or end stage renal disease (ESRD) stations involves a 10-year projection from the base year. This formula is used for long-term planning purposes. The need for additional treatment stations can be projected utilizing the following methodology:

- 1) Establish a minimum institutional dialysis rate by dividing the total number of institutional dialysis patients in the base year by the State base year population estimate in thousands and multiply the result by .6 (60%).
- 2) Determine each planning area's experienced institutional dialysis rate by dividing the number of patients receiving dialysis in the base year by the planning area population projection in thousands for the base year.
- 3) Multiply each planning area's population projection in thousands by the greater of the minimum institutional dialysis rate or the experienced institutional dialysis rate for the planning area to determine the estimated number of institutional dialysis patients.
- 4) Multiply the projected number of annual institutional dialysis patients by 156 (3 treatments/week x 52 weeks) to determine the projected number of institutional procedures.
- 5) Divide the projected number of annual institutional procedures by 749 (3 shifts/day x six days/week x 52 weeks/year x .80 utilization target) to determine the projected number of stations needed for the projected year.

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- 6) Subtract the number of existing stations from the projected number of needed stations to determine the excess (surplus) or additional (deficit) number of stations needed.

(Source: Amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 1100.670 Specialized Long-Term Care Categories of Service**

## a) Categories of Service:

- 1) ~~The~~ Chronic Mental Illness (MIM-I); ~~Category of Service,~~
- 2) ~~The~~ Long-Term Care for the Developmentally Disabled (Adult) (DD-Adult); ~~and Category of Service,~~
- 3) ~~The~~ Long-Term Care for the Developmentally Disabled (Children) (DD-Children); ~~Category of Service, and~~
- 4) ~~Long-Term Medical Care for Children.~~

## b) Planning Areas:

- 1) The State of Illinois is utilized for the MI category of service; ~~Chronic Mental Illness and Long-Term Medical Care for Children Categories of Service;~~
- 2) Health Service Areas are utilized for the DD-Children category of service; ~~Developmentally Disabled Children Category of Service.~~
- 3) For DD-Adult category of service; ~~Developmentally Disabled Adults Category of Service:~~

HSA I, HSA II, HSA III, HSA IV, HSA V, HSA X, HSA XI, and the combined HSA's VI, VII, VIII and IX.

## c) Occupancy Targets:

- 1) Modernization 80%; Additional Beds 90% for the MI category of service; ~~Chronic Mental Illness and Long-Term Medical Care for children~~

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~~Categories of Service~~; and

- 2) Modernization 80%; Additional Beds 93% for the ~~DD-Adult and DD-Children categories of service~~~~Developmentally Disabled Children and Adult Categories of Service~~.
- d) Bed Capacity: For facilities licensed pursuant to the Nursing Home Care Act (~~Ill. Rev. Stat. 1991, ch. 111½, par. 4151-101 et seq.~~) [210 ILCS 45], the bed capacity is the licensed bed capacity for the service. ~~In State-operated facilities the bed capacity is the reported functional capacity. For facilities licensed pursuant to the Hospital Licensing Act, the bed capacity is the lesser of measured bed capacity or functional bed capacity per patient room.~~
- e) Bed Need Determination for the Specialized Categories of Service:
  - 1) No formula bed need for the ~~MI and DD-Children categories of service~~~~Chronic Mental Illness, Long Term care for the developmentally disabled (children), and long term Medical Care for Children~~ Categories of Service has been developed. It is the responsibility of the applicant to document the need for the service by complying with all applicable ~~review criteria~~~~Review Criteria~~ contained in 77 Ill. Adm. Code 1110, Subpart S.
  - 2) Bed need for the ~~DD-Adult category of service~~~~Long Term Care for the Developmentally Disabled (adult) Category of Service~~ is calculated in two parts:
    - A) For facilities licensed as ICF/DD 16-bed or fewer, total bed need and the number of additional beds needed are determined by dividing the planning area's projected adult developmentally disabled population by 21.4 to determine the total number of beds needed for developmentally disabled adult residents in the planning area. The number of additional beds needed or excess beds is determined by subtracting the number of existing beds in ICF/DD 16-bed or fewer facilities from the total number of beds needed for developmentally disabled adult residents in the planning area.
    - B) For facilities with more than 16 beds, no bed need formula has been established.

## HEALTH FACILITIES PLANNING BOARD

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(Source: Amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

**Section 1100.810 Long-Term Acute Care Hospital Category of Service**

a) Planning Areas

HSA 1

HSAs 2 and 10

HSAs 3 and 4

HSAs 5 and 11

HSAs 6, 7, 8 and 9

b) Age Groups

For Long-Term Acute Care Hospital (LTACH) services, all ages.

c) Occupancy Target

Facilities that provide LTACH beds should operate those beds at or above an annual minimum occupancy rate of 85%.

d) Authorized Hospital Bed Capacity

1) Any beds in existence prior to the enactment of this Section that were used as LTACH beds have been reclassified from medical-surgical or ICU beds to LTACH beds.

2) Beds in LTACHs certified by CMMS shall be reclassified by HFPB in its inventory.

e) Need Determination

The following methodology is utilized to determine the projected number of LTACH beds needed in a planning area:

1) Divide the patient days for LTACH category of service for the base year by the population for the base year to determine the planning area's experienced use rate.

2) If the experienced use rate is less than 60% of the State's base year use rate, adjust the planning area's use rate to 60% of the State's base year use rate to establish a minimum use rate.

## HEALTH FACILITIES PLANNING BOARD

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- 3) Multiply the experienced or minimum use rate by the projected population to obtain projected patient days.
- 4) Divide total projected patient days by days in year to obtain projected average daily census.
- 5) Divide the projected average daily census by the occupancy target for the service to obtain the bed need.
- 6) Calculate the number of beds that should be added in each area by subtracting the number of beds in existing facilities from the number of beds needed.

(Source: Added at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

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**Section 1100.APPENDIX A Applicable Codes and Standards Utilized in 77 Ill. Adm. Code: Chapter II, Subchapter a (Repealed)**

The following listing of codes and standards is compiled from the current editions of rules and regulations utilized by the Agency for purposes of licensure, certification and accreditation. Should these standards be amended and specific code references added, altered or deleted, the references stated in such regulations shall take precedence over this listing. In addition to these standards and codes, all building codes, ordinances and regulations which are enforced by City, County, or other local jurisdictions in which the facility is, or will be located must be observed.

~~STATE OF ILLINOIS CODES AND STANDARDS~~

<u>Codes or Standards:</u>	<u>Agency:</u>
(A) Illinois State Plumbing Code (1976)	Department of Public Health, Environmental Health Protection
(B) Accessibility Standards for the Handicapped (June, 1978)	Capital Development Board
(C) Rules and Regulations for Fire Prevention and Safety (September, 1973)	Office of the State Fire Marshal, Division of Fire Prevention
(D) Rules and Regulations for Food Service Sanitation (1975)	Department of Public Health, Environmental Health Protection
(E) Boiler Safety Act and Boiler Rules and Regulations (1978) (Ill. Rev. Stat. 1981, ch. 111 ½, par. 3201 et seq.)	Office of the State Fire Marshal, Boiler and Pressure Vessel Safety
(F) State of Illinois Safety Glazing Materials Act, 1971 (Ill. Rev. Stat. 1981, ch. 111 ½, par. 3101 et seq.)	State of Illinois, Department of Labor

~~OTHER CODES AND REFERENCES~~

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<u>Codes or Standards:</u>	<u>Agency:</u>
(A) <del>National Fire Protection Association (NFPA) 101 Life Safety Code 1976 Edition (New Health Care Occupancies—Residential—Custodial Care); NFPA 101 Life Safety Code 1967 Edition (Life Safety Code for all Existing Structures); and all appropriate references including, but not limited to:</del> <del>(1) NFPA 10—1975, Standard for Portable Extinguishers.</del> <del>(2) NFPA 10—1978, Standard for Portable Extinguishers.</del> <del>(3) NFPA 13—1976, Installation of Sprinkler Systems.</del> <del>(4) NFPA 13A—1976, Care and Maintenance of Sprinkler Systems.</del> <del>(5) NFPA 56F—1974, Standard for Non-Flammable Medical Gas Systems.</del> <del>(6) NFPA 70—1975, National Electrical Code.</del> <del>(7) NFPA 70—1978, National Electrical Code.</del> <del>(8) NFPA 70—1981, National Electrical Code.</del> <del>(9) NFPA 72—1975, Local Protective Systems.</del> <del>(10) NFPA 90A—1976, Air Conditioning and Ventilating Systems.</del> <del>(11) NFPA 90A—1978, Air Conditioning and Ventilating Systems.</del> <del>(12) NFPA 96—1976, Vapor Removal from Cooking Equipment.</del> <del>(13) NFPA 220—1975, Standard Types of Building Construction.</del> <del>(14) NFPA 220—1979, Standard Types of Building Construction.</del> <del>(15) NFPA 253—1978, Flooring Radiant Heat Energy Test.</del> <del>(16) NFPA 225—1972, Test of Surface Burning Characteristics of Building Materials.</del>	National Fire Protection Association

## HEALTH FACILITIES PLANNING BOARD

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- (17) ~~NFPA 255—1979, Test of Surface Burning Characteristics of Building Materials.~~  
(18) ~~NFPA 258—1976, Measuring Smoke Generated by Solid Material.~~

National Fire Protection  
Association

(B) ~~Underwriters' Laboratory, Inc. (UL):~~

- (1) ~~Fire Resistance Index (All Editions)~~  
(2) ~~Building Material Directory (All Editions)~~  
(3) ~~Standard No. 181—1974, Factory Made Air Duct Materials and Air Duct Conductors.~~

Underwriters' Laboratories,  
Inc.

(C) ~~American Society for Testing and Materials (ASTM):~~

- (1) ~~Standard No. E-84—1977A, Method of Test for Surface Burning Characteristics of Building Materials (as currently revised in NFPA 255—1979)~~  
(2) ~~Standard No. E-90—1975, Recommended Practice for Laboratory Measurement of Airborne Sound Transmission Loss of Building Partitions.~~

American Society for Testing  
and Materials

(D) ~~American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE):~~

- (1) ~~Handbook of Fundamentals, 1975 and 1977 Editions.~~  
(2) ~~Standard No. 52—68, Methods of Testing Air Cleaning Devices Used in General Ventilation for Removing Particulate Matter, 1968.~~  
(3) ~~Standard No. 52—76, Methods of Testing~~

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	<del>Air Cleaning Devices Used in General Ventilation for Removing Particulate Matter, 1977.</del>	<del>American Society of Heating, Refrigerating and Air-Conditioning Engineers.</del>
(E)	<del>Uniform Building Code (1976 Edition)</del>	<del>International Conference of Building Contractors</del>
(F)	<del>National Standard Plumbing Code (1976 Edition)</del>	<del>National Association of Plumbing Heating—Cooling Contractors</del>
(G)	<del>American Standards Specifications for Making Buildings and Facilities Accessible to, and Usable by, the Physically Handicapped, 1968 (Revised, 1971)</del>	<del>American National Standards Institute</del>
(H)	<del>American National Safety Code for Elevators, Dumbwaiters, Escalators, and Moving Stairs, Standard No. A17.1-1971</del>	<del>American National Standards Institute</del>
(I)	<del>Pamphlet P-2.1-1967, Standard for Medical-Surgical Vacuum Systems in Hospitals</del>	<del>Compressed Gas Association</del>
(J)	<del>Public Health Service Publication No. 934, Food Service Sanitation Manual</del>	<del>Superintendent of Documents, U.S. Government Printing Office</del>
(K)	<del>HUD FT/TS-24, A Guide to Air Borne, Impact and Structure Borne Noise Control in Multi-Family Dwellings</del>	<del>Superintendent of Documents, U.S. Government Printing Office</del>
(L)	<del>National Bureau of Standards (NBS) Technical Note 708—Appendix II, Test Method for Measuring the Smoke Generation Characteristics of Solid Materials</del>	<del>National Bureau of Standards</del>

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- (M) ~~DOP Penetration Test Method MIL-STD No. 282, Filter Units, Protective Clothing, Gas Mask Components and Related Products: Performance Test Methods~~ ~~Navel Publications and Form Ctr. (5801 Tabor Avenue, Philadelphia, PA 19120)~~
- (N) ~~National Council on Radiation Protection (NCRP):~~
- (1) ~~Report No. 33, Medical X-Ray and Gamma Ray Protection for Energies Up to 10 MEV Equipment Design and Use.~~
- (2) ~~Report No. 34, Medical X-Ray and Gamma Ray Protection for Energies 10 MEV Structural Shielding Design and Evaluation.~~
- ~~National Council on Radiation Protection~~

(Source: Repealed at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)



## POLLUTION CONTROL BOARD

## NOTICE OF PROPOSED AMENDMENT

applicable SIP so that the provisions of the NO<sub>x</sub>, SIP Call Trading Program do not apply to affected EGUs.

IEPA's proposal requesting the Board to amend the Illinois rules is the first step to revision of the SIP. If the Board adopts a final rule in this rulemaking, IEPA will submit the rule to USEPA for approval and inclusion in the SIP.

EGUs currently must comply with two sets of rules for the 2009 ozone season and beyond: the Illinois Clean Air Interstate Rule (CAIR) requirements at Part 225 and the Illinois NO<sub>x</sub> Trading Program at Part 217. To address and remove the duplication, this rulemaking proposes to sunset the provisions of the NO<sub>x</sub> Trading Program, by adding a new Section 217.751 to sunset the rules beginning with the 2009 ozone control season.

- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: The Agency stated that it relied on the following documents in preparing its proposal to the Board:
- a. Illinois Environmental Protection Act (415 ILCS 5.)
  - b. The Clean Air Act, as amended in 1990 (42 USC 7401 et seq.);
  - c. Rule to Reduce Interstate Transport of Fine Particulate Matter and Ozone (Clean Air Interstate Rule); Revisions to Acid Rain Program; Revisions to the NO<sub>x</sub> SIP Call; Final Rule, 70 *Fed. Reg.* 25162 (May 12, 2005);
  - d. Approval and Promulgation of Air Quality Implementation Plans; Illinois; Oxides of Nitrogen Regulations, 66 *Fed. Reg.* 56454 (November 8, 2001)
  - e. Approval of Implementation Plans of Illinois; Clean Air Interstate Rule, 72 *Fed. Reg.* 58528 (October 16, 2007);
  - f. North Carolina v. USEPA, 531 F.3d 896 (C.A.D.C. Cir. 2008); and
  - g. North Carolina v. USEPA, 550 F.3d 1176 (C.A.D.C. Cir. 2008).
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No

## POLLUTION CONTROL BOARD

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- 9) Does this rulemaking contain incorporations by reference? No
- 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>
217.3863	Amend	32 Ill. Reg. 17075; Oct. 31, 2008
217.388	Amend	32 Ill. Reg. 17075; Oct. 31, 2008
217.390	Amend	32 Ill. Reg. 17075; Oct. 31, 2008
217.392	Amend	32 Ill. Reg. 17075; Oct. 31, 2008
217.394	Amend	32 Ill. Reg. 17075; Oct. 31, 2008
217.396	Amend	32 Ill. Reg. 17075; Oct. 31, 2008
217.100	Amended	33 Ill. Reg. 6921; May 22, 2009
217.104	Amended	33 Ill. Reg. 6921; May 22, 2009
217.121	Repealed	33 Ill. Reg. 6921; May 22, 2009
217.141	Amended	33 Ill. Reg. 6921; May 22, 2009
217.150	New Section	33 Ill. Reg. 6921; May 22, 2009
217.152	New Section	33 Ill. Reg. 6921; May 22, 2009
217.154	New Section	33 Ill. Reg. 6921; May 22, 2009
217.155	New Section	33 Ill. Reg. 6921; May 22, 2009
217.156	New Section	33 Ill. Reg. 6921; May 22, 2009
217.157	New Section	33 Ill. Reg. 6921; May 22, 2009
217.158	New Section	33 Ill. Reg. 6921; May 22, 2009
217.160	New Section	33 Ill. Reg. 6921; May 22, 2009
217.162	New Section	33 Ill. Reg. 6921; May 22, 2009
217.164	New Section	33 Ill. Reg. 6921; May 22, 2009
217.165	New Section	33 Ill. Reg. 6921; May 22, 2009
217.166	New Section	33 Ill. Reg. 6921; May 22, 2009
217.180	New Section	33 Ill. Reg. 6921; May 22, 2009
217.182	New Section	33 Ill. Reg. 6921; May 22, 2009
217.184	New Section	33 Ill. Reg. 6921; May 22, 2009
217.185	New Section	33 Ill. Reg. 6921; May 22, 2009
217.186	New Section	33 Ill. Reg. 6921; May 22, 2009
217.200	New Section	33 Ill. Reg. 6921; May 22, 2009
217.202	New Section	33 Ill. Reg. 6921; May 22, 2009
217.204	New Section	33 Ill. Reg. 6921; May 22, 2009
217.220	New Section	33 Ill. Reg. 6921; May 22, 2009
217.222	New Section	33 Ill. Reg. 6921; May 22, 2009
217.240	New Section	33 Ill. Reg. 6921; May 22, 2009
217.242	New Section	33 Ill. Reg. 6921; May 22, 2009

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217.244	New Section	33 Ill. Reg. 6921; May 22, 2009
217.340	New Section	33 Ill. Reg. 6921; May 22, 2009
217.342	New Section	33 Ill. Reg. 6921; May 22, 2009
217.344	New Section	33 Ill. Reg. 6921; May 22, 2009
217.345	New Section	33 Ill. Reg. 6921; May 22, 2009
217.APPENDIX H	New Section	33 Ill. Reg. 6921; May 22, 2009

- 11) Statement of Statewide Policy Objectives: 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: The Board will accept written public comment on this proposal for 45 days after the date of publication in the *Illinois Register*. Comments should reference Docket R09-20 and be addressed to:

John Therriault  
 Clerk's Office  
 Illinois Pollution Control Board  
 100 W. Randolph St., Suite 11-500  
 Chicago, IL 60601

The Board will also accept sworn testimony and oral public comment at the hearings scheduled as followed:

Thursday, June 18, 2008, 1:00 p.m.

Thursday, July 23, 2009 1:00 p.m.

JAMES R. THOMPSON CENTER  
 Room 11-512  
 100 W. Randolph-Room 11-512  
 Chicago, IL 60601

IEPA OFFICE BUILDING  
 Room 1244N, First Floor  
 1021 N. Grand Avenue East  
 Springfield, IL 62794

Procedural details concerning the order of hearings and requirements concerning pre-filing of testimony are detailed in a May 13, 2009 hearing officer order.

Interested persons may request copies of the Board's opinion and orders and hearing officer orders in Docket R09-20 by calling the Clerk's office at 312-814-3620, or download from the Board's Web site at [www.ipcb.state.il.us](http://www.ipcb.state.il.us).

## POLLUTION CONTROL BOARD

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For more information, contact Kathleen Crowley at 312/814-6929 or email at crowlek@ipcb.state.il.us.

- 13) Initial Regulatory Flexibility Analysis:
  - A) Types of small businesses, small municipalities and not for profit corporations affected: Any of the 229 electrical generating units that are subject to the NO<sub>x</sub> Trading Program and that identify themselves as small businesses, small municipalities, or not-for-profit corporations
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of Professional skills necessary for compliance: None.
- 14) Regulatory Agenda on which this rulemaking was summarized: July 2006 (30 Ill. Reg. 11906-08). This rulemaking was not included in either of the two most recent regulatory agendas because: the need for the rulemaking is the result of recent federal court decisions concerning USEPA rules. This caused uncertainty associated with the CAIR Trading program that was adopted by both USEPA and Illinois to replace the one that is the subject of this proposal. This is explained in item 5), above.
- 15) Does this amendment require the review of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code [30 ILCS 500/5-25]? No

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

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENT

TITLE 35: ENVIRONMENTAL PROTECTION  
SUBTITLE B: AIR POLLUTION  
CHAPTER I: POLLUTION CONTROL BOARD  
SUBCHAPTER c: EMISSION STANDARDS AND LIMITATIONS  
FOR STATIONARY SOURCES

PART 217  
NITROGEN OXIDES EMISSIONS

SUBPART A: GENERAL PROVISIONS

- Section
- 217.100 Scope and Organization
- 217.101 Measurement Methods
- 217.102 Abbreviations and Units
- 217.103 Definitions
- 217.104 Incorporations by Reference

SUBPART B: NEW FUEL COMBUSTION EMISSION SOURCES

- Section
- 217.121 New Emission Sources

SUBPART C: EXISTING FUEL COMBUSTION EMISSION SOURCES

- Section
- 217.141 Existing Emission Sources in Major Metropolitan Areas

SUBPART K: PROCESS EMISSION SOURCES

- Section
- 217.301 Industrial Processes

SUBPART O: CHEMICAL MANUFACTURE

- Section
- 217.381 Nitric Acid Manufacturing Processes

SUBPART Q: STATIONARY RECIPROCATING

## POLLUTION CONTROL BOARD

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## INTERNAL COMBUSTION ENGINES AND TURBINES

## Section

217.386	Applicability
217.388	Control and Maintenance Requirements
217.390	Emissions Averaging Plans
217.392	Compliance
217.394	Testing and Monitoring
217.396	Recordkeeping and Reporting

## SUBPART T: CEMENT KILNS

## Section

217.400	Applicability
217.402	Control Requirements
217.404	Testing
217.406	Monitoring
217.408	Reporting
217.410	Recordkeeping

SUBPART U: NO<sub>x</sub> CONTROL AND TRADING PROGRAM FOR  
SPECIFIED NO<sub>x</sub> GENERATING UNITS

## Section

217.450	Purpose
217.452	Severability
217.454	Applicability
217.456	Compliance Requirements
217.458	Permitting Requirements
217.460	Subpart U NO <sub>x</sub> Trading Budget
217.462	Methodology for Obtaining NO <sub>x</sub> Allocations
217.464	Methodology for Determining NO <sub>x</sub> Allowances from the New Source Set-Aside
217.466	NO <sub>x</sub> Allocations Procedure for Subpart U Budget Units
217.468	New Source Set-Asides for "New" Budget Units
217.470	Early Reduction Credits (ERCs) for Budget Units
217.472	Low-Emitter Requirements
217.474	Opt-In Units
217.476	Opt-In Process
217.478	Opt-In Budget Units: Withdrawal from NO <sub>x</sub> Trading Program
217.480	Opt-In Units: Change in Regulatory Status

## POLLUTION CONTROL BOARD

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217.482 Allowance Allocations to Opt-In Budget Units

## SUBPART V: ELECTRIC POWER GENERATION

## Section

217.521 Lake of Egypt Power Plant  
217.700 Purpose  
217.702 Severability  
217.704 Applicability  
217.706 Emission Limitations  
217.708 NO<sub>x</sub> Averaging  
217.710 Monitoring  
217.712 Reporting and Recordkeeping

SUBPART W: NO<sub>x</sub> TRADING PROGRAM FOR  
ELECTRICAL GENERATING UNITS

## Section

217.750 Purpose  
| [217.751 Sunset Provisions](#)  
217.752 Severability  
217.754 Applicability  
217.756 Compliance Requirements  
217.758 Permitting Requirements  
217.760 NO<sub>x</sub> Trading Budget  
217.762 Methodology for Calculating NO<sub>x</sub> Allocations for Budget Electrical Generating  
Units (EGUs)  
217.764 NO<sub>x</sub> Allocations for Budget EGUs  
217.768 New Source Set-Asides for "New" Budget EGUs  
217.770 Early Reduction Credits for Budget EGUs  
217.774 Opt-In Units  
217.776 Opt-In Process  
217.778 Budget Opt-In Units: Withdrawal from NO<sub>x</sub> Trading Program  
217.780 Opt-In Units: Change in Regulatory Status  
217.782 Allowance Allocations to Budget Opt-In Units

SUBPART X: VOLUNTARY NO<sub>x</sub> EMISSIONS REDUCTION PROGRAM

## Section

## POLLUTION CONTROL BOARD

## NOTICE OF PROPOSED AMENDMENT

217.800	Purpose
217.805	Emission Unit Eligibility
217.810	Participation Requirements
217.815	NO <sub>x</sub> Emission Reductions and the Subpart X NO <sub>x</sub> Trading Budget
217.820	Baseline Emissions Determination
217.825	Calculation of Creditable NO <sub>x</sub> Emission Reductions
217.830	Limitations on NO <sub>x</sub> Emission Reductions
217.835	NO <sub>x</sub> Emission Reduction Proposal
217.840	Agency Action
217.845	Emissions Determination Methods
217.850	Emissions Monitoring
217.855	Reporting
217.860	Recordkeeping
217.865	Enforcement
217.APPENDIX A	Rule into Section Table
217.APPENDIX B	Section into Rule Table
217.APPENDIX C	Compliance Dates
217.APPENDIX D	Non-Electrical Generating Units
217.APPENDIX E	Large Non-Electrical Generating Units
217.APPENDIX F	Allowances for Electrical Generating Units
217.APPENDIX G	Existing Reciprocating Internal Combustion Engines Affected by the NO <sub>x</sub> SIP Call

AUTHORITY: Implementing Sections 9.9 and 10 and authorized by Sections 27 and 28.5 of the Environmental Protection Act [415 ILCS 5/9.9, 10, 27 and 28.5 (2004)].

SOURCE: Adopted as Chapter 2: Air Pollution, Rule 207: Nitrogen Oxides Emissions, R71-23, 4 PCB 191, April 13, 1972, filed and effective April 14, 1972; amended at 2 Ill. Reg. 17, p. 101, effective April 13, 1978; codified at 7 Ill. Reg. 13609; amended in R01-9 at 25 Ill. Reg. 128, effective December 26, 2000; amended in R01-11 at 25 Ill. Reg. 4597, effective March 15, 2001; amended in R01-16 and R01-17 at 25 Ill. Reg. 5914, effective April 17, 2001; amended in R07-18 at 31 Ill. Reg. 14271, effective September 25, 2007; amended in R09-20 at 33 Ill. Reg. \_\_\_\_, effective \_\_\_\_\_.

SUBPART W: NO<sub>x</sub> TRADING PROGRAM FOR  
ELECTRICAL GENERATING UNITS

[Section 217.751 Sunset Provisions](#)

POLLUTION CONTROL BOARD

NOTICE OF PROPOSED AMENDMENT

The provisions of this Subpart W shall not apply for any control period in 2009 or thereafter. Noncompliance with the provisions of this Subpart that occurred prior to 2009 is subject to the applicable provisions of this Subpart.

(Source: Added at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## SECRETARY OF STATE

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Issuance of Licenses
- 2) Code Citation: 92 Ill. Adm. Code 1030
- 3) Section Number: 1030.92                      Proposed Action: Amendment
- 4) Statutory Authority: 625 ILCS 5/2-104; 625 ILCS 5/6-113
- 5) A Complete Description of the Subjects and Issues Involved: This rulemaking is being amended to authorize a person, holding a "L" or "M" classification, to operate a motorcycle or motor driven cycle with rear wheel extensions, while maintaining a single front wheel.
- 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? No
- 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>
1030.14	New Section	33 Ill. Reg. 6243, May 1, 2009
1030.97	Amendment	33 Ill. Reg. 4559, March 27, 2009
- 11) Statement of Statewide Policy Objectives: The rulemaking will not create or enlarge a State mandate.
- 12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Text of the prepared amendments is posted on the Secretary of State's website, [www.sos.il.us/departments/index/home](http://www.sos.il.us/departments/index/home) as part of the *Illinois Register*. Interested persons may present their comments concerning this proposed rulemaking in writing within 45 days after publication of this Notice to:

Arlene J. Pulley

## SECRETARY OF STATE

## NOTICE OF PROPOSED AMENDMENT

Office of the Secretary of State  
Driver Services Department  
2701 South Dirksen Parkway  
Springfield, Illinois 62723

217/557-4462

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: None
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of Professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent agendas because: the need for this rulemaking was not anticipated at the time the agendas were prepared.

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

## SECRETARY OF STATE

## NOTICE OF PROPOSED AMENDMENT

TITLE 92: TRANSPORTATION  
CHAPTER II: SECRETARY OF STATEPART 1030  
ISSUANCE OF LICENSES

Section	
1030.1	Definitions
1030.10	What Persons Shall Not be Licensed or Granted Permits
1030.11	Procedure for Obtaining a Driver's License/Temporary Visitor's Driver's License
1030.13	Denial of License or Permit
1030.15	Cite for Re-testing
1030.16	Physical and Mental Evaluation
1030.17	Errors in Issuance of Driver's License/Cancellation
1030.18	Medical Criteria Affecting Driver Performance
1030.20	Classification of Drivers – References (Repealed)
1030.30	Classification Standards
1030.40	Fifth Wheel Equipped Trucks
1030.50	Bus Driver's Authority, Religious Organization and Senior Citizen Transportation
1030.55	Commuter Van Driver Operating a For-Profit Ridesharing Arrangement
1030.60	Third-Party Certification Program
1030.63	Religious Exemption for Social Security Numbers
1030.65	Instruction Permits
1030.70	Driver's License Testing/Vision Screening
1030.75	Driver's License Testing/Vision Screening With Vision Aid Arrangements Other Than Standard Eye Glasses or Contact Lenses
1030.80	Driver's License Testing/Written Test
1030.81	Endorsements
1030.82	Charter Bus Driver Endorsement Requirements
1030.83	Hazardous Material Endorsement
1030.84	Vehicle Inspection
1030.85	Driver's License Testing/Road Test
1030.86	Multiple Attempts – Written and/or Road Tests
1030.88	Exemption of Facility Administered Road Test
1030.89	Temporary Driver's Licenses and Temporary Instruction Permits
1030.90	Requirement for Photograph and Signature of Licensee on Driver's License
1030.91	Disabled Person Identification Card
1030.92	Restrictions
1030.93	Restricted Local Licenses

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- 1030.94 Duplicate or Corrected Driver's License or Instruction Permit
- 1030.95 Consular Licenses (Repealed)
- 1030.96 Seasonal Restricted Commercial Driver's License
- 1030.97 Invalidation of a Driver's License, Permit and/or Driving Privilege
- 1030.98 School Bus Commercial Driver's License or Instruction Permit
- 1030.100 Anatomical Gift Donor (Repealed)
- 1030.110 Emergency Medical Information Card
- 1030.115 Change-of-Address
- 1030.120 Issuance of a Probationary License
- 1030.130 Grounds for Cancellation of a Probationary License
- 1030.140 Use of Captured Images
- 1030.APPENDIX A Questions Asked of a Driver's License Applicant
- 1030.APPENDIX B Acceptable Identification Documents

AUTHORITY: Implementing Article I of the Illinois Driver Licensing Law of the Illinois Vehicle Code [625 ILCS 5/Ch. 6, Art. I] and authorized by Section 2-104(b) of the Illinois Vehicle Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/2-104(b)].

SOURCE: Filed March 30, 1971; amended at 3 Ill. Reg. 7, p. 13, effective April 2, 1979; amended at 4 Ill. Reg. 27, p. 422, effective June 23, 1980; amended at 6 Ill. Reg. 2400, effective February 10, 1982; codified at 6 Ill. Reg. 12674; amended at 9 Ill. Reg. 2716, effective February 20, 1985; amended at 10 Ill. Reg. 303, effective December 24, 1985; amended at 10 Ill. Reg. 18182, effective October 14, 1986; amended at 11 Ill. Reg. 9331, effective April 28, 1987; amended at 11 Ill. Reg. 18292, effective October 23, 1987; amended at 12 Ill. Reg. 3027, effective January 14, 1988; amended at 12 Ill. Reg. 13221, effective August 1, 1988; amended at 12 Ill. Reg. 16915, effective October 1, 1988; amended at 12 Ill. Reg. 19777, effective November 15, 1988; amended at 13 Ill. Reg. 5192, effective April 1, 1989; amended at 13 Ill. Reg. 7808, effective June 1, 1989; amended at 13 Ill. Reg. 12880, effective July 19, 1989; amended at 13 Ill. Reg. 12978, effective July 19, 1989; amended at 13 Ill. Reg. 13898, effective August 22, 1989; amended at 13 Ill. Reg. 15112, effective September 8, 1989; amended at 13 Ill. Reg. 17095, effective October 18, 1989; amended at 14 Ill. Reg. 4570, effective March 8, 1990; amended at 14 Ill. Reg. 4908, effective March 9, 1990; amended at 14 Ill. Reg. 5183, effective March 21, 1990; amended at 14 Ill. Reg. 8707, effective May 16, 1990; amended at 14 Ill. Reg. 9246, effective May 16, 1990; amended at 14 Ill. Reg. 9498, effective May 17, 1990; amended at 14 Ill. Reg. 10111, effective June 11, 1990; amended at 14 Ill. Reg. 10510, effective June 18, 1990; amended at 14 Ill. Reg. 12077, effective July 5, 1990; amended at 14 Ill. Reg. 15487, effective September 10, 1990; amended at 15 Ill. Reg. 15783, effective October 18, 1991; amended at 16 Ill. Reg. 2182, effective January 24, 1992; emergency amendment at 16 Ill. Reg. 12228, effective July 16, 1992, for a maximum of 150 days; emergency expired on December

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13, 1992; amended at 16 Ill. Reg. 18087, effective November 17, 1992; emergency amendment at 17 Ill. Reg. 1219, effective January 13, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 2025, effective February 1, 1993; amended at 17 Ill. Reg. 7065, effective May 3, 1993; amended at 17 Ill. Reg. 8275, effective May 24, 1993; amended at 17 Ill. Reg. 8522, effective May 27, 1993; amended at 17 Ill. Reg. 19315, effective October 22, 1993; amended at 18 Ill. Reg. 1591, effective January 14, 1994; amended at 18 Ill. Reg. 7478, effective May 2, 1994; amended at 18 Ill. Reg. 16457, effective October 24, 1994; amended at 19 Ill. Reg. 10159, effective June 29, 1995; amended at 20 Ill. Reg. 3891, effective February 14, 1996; emergency amendment at 20 Ill. Reg. 8358, effective June 4, 1996, for a maximum of 150 days; emergency amendment repealed in response to an objection of the Joint Committee on Administrative Rules at 20 Ill. Reg. 14279; amended at 21 Ill. Reg. 6588, effective May 19, 1997; amended at 21 Ill. Reg. 10992, effective July 29, 1997; amended at 22 Ill. Reg. 1466, effective January 1, 1998; emergency amendment at 23 Ill. Reg. 9552, effective August 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 13947, effective November 8, 1999; amended at 24 Ill. Reg. 1259, effective January 7, 2000; emergency amendment at 24 Ill. Reg. 1686, effective January 13, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 6955, effective April 24, 2000; emergency amendment at 24 Ill. Reg. 13044, effective August 10, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 18400, effective December 4, 2000; amended at 25 Ill. Reg. 959, effective January 5, 2001; amended at 25 Ill. Reg. 7742, effective June 5, 2001; amended at 25 Ill. Reg. 12646, effective September 24, 2001; emergency amendment at 25 Ill. Reg. 12658, effective September 24, 2001, for a maximum of 150 days; emergency expired February 20, 2002; amended at 26 Ill. Reg. 9961, effective June 24, 2002; amended at 27 Ill. Reg. 855, effective January 3, 2003; emergency amendment at 27 Ill. Reg. 7340, effective April 14, 2003, for a maximum of 150 days; emergency expired September 10, 2003; emergency amendment at 27 Ill. Reg. 16968, effective October 17, 2003, for a maximum of 150 days; emergency expired March 14, 2004; emergency amendment at 28 Ill. Reg. 384, effective January 1, 2004, for a maximum of 150 days; emergency expired May 29, 2004; amended at 28 Ill. Reg. 8895, effective June 14, 2004; amended at 28 Ill. Reg. 10776, effective July 13, 2004; amended at 29 Ill. Reg. 920, effective January 1, 2005; emergency amendment at 29 Ill. Reg. 2469, effective January 31, 2005, for a maximum of 150 days; emergency expired June 29, 2005; amended at 29 Ill. Reg. 9488, effective June 17, 2005; amended at 29 Ill. Reg. 12519, effective July 28, 2005; amended at 29 Ill. Reg. 13237, effective August 11, 2005; amended at 29 Ill. Reg. 13580, effective August 16, 2005; amended at 30 Ill. Reg. 910, effective January 6, 2006; amended at 30 Ill. Reg. 5621, effective March 7, 2006; amended at 30 Ill. Reg. 11365, effective June 15, 2006; emergency amendment at 30 Ill. Reg. 11409, effective June 19, 2006, for a maximum of 150 days; emergency expired November 15, 2006; amended at 31 Ill. Reg. 4782, effective March 12, 2007; amended at 31 Ill. Reg. 5096, effective March 15, 2007; amended at 31 Ill. Reg. 5864, effective March 29, 2007; amended at 31 Ill. Reg. 6370, effective April 12, 2007; amended at 31 Ill. Reg. 7643, effective May 16, 2007; amended at 31 Ill. Reg. 11342, effective July 18, 2007;

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amended at 31 Ill. Reg. 14547, effective October 9, 2007; amended at 31 Ill. Reg. 14849, effective October 22, 2007; amended at 31 Ill. Reg. 16543, effective November 27, 2007; amended at 31 Ill. Reg. 16843, effective January 1, 2008; emergency amendment at 32 Ill. Reg. 208, effective January 2, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 6544, effective April 4, 2008; amended at 33 Ill. Reg. 2391, effective January 21, 2009; amended at 33 Ill. Reg. 8489, effective June 5, 2009; amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

**Section 1030.92 Restrictions**

- a) A driver services facility representative shall have the authority to determine license restrictions. No restriction shall be added until the driving test is given unless the restriction is due to a vision or hearing defect.
- b) If a change in a person's physical and/or visual condition is discovered by a facility representative, the representative has the authority to add, delete or change the restrictions.
- c) A Type B restriction requires corrective eye lenses. This restriction is added when a person needs corrective eye lenses to meet visual acuity standards as provided in Section 1030.70. This restriction includes eye glasses and contact lenses in one or both eyes, pursuant to Section 1030.75.
- d) A Type C restriction requires the driver to use one or more mechanical aids (e.g., hand operated brake, gearshift extension, shoulder harness, or foot operated steering wheel) to assist with the proper and safe operation of the vehicle.
- e) A Type D restriction requires the driver to use one or more prosthetic aids (e.g., artificial legs, artificial hands, hook on right or left arm, or brace on each leg) while operating a motor vehicle.
- f) A Type E restriction requires automatic transmission. An automatic transmission restriction is added when a driver is unable to operate a standard shift vehicle due to the minimal use of one or both arms and/or legs.
- g) A Type F restriction requires left and right outside rearview mirrors when a driver is hearing impaired, has a monocular visual acuity reading of 20/100 or worse in either eye, requires a right outside rearview mirror because of problems turning the head while backing, cannot meet the peripheral vision requirements of Section 1030.70(a), and/or takes the road test in a right hand-driven vehicle with the

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steering wheel on the right side. A driver may be restricted to both left and right rearview mirrors if minimum peripheral standards are met by the use of only one eye in accordance with Sections 1030.70 and 1030.75.

- h) A Type G restriction requires the driver to drive only in the daylight. This restriction is added when a driver has binocular visual acuity that does not meet the 20/40 minimum in accordance with Section 1030.70(a), but is not worse than 20/70. People who want to drive utilizing a non-standard lens arrangement pursuant to Section 1030.75 are restricted to daylight driving only.
- i) A Type J restriction with appropriate numerical indicators includes other restrictions not listed in this Section. These Type J restrictions and numerical indicators are as follows:
- 1) J01 Driver has been issued an Illinois Medical Restriction Card, which must be carried in addition to a valid Illinois driver's license/permit.
  - 2) J02 Driver authorized to operate a religious organization bus within classification, as provided in IVC Section 6-106.2.
  - 3) J03 Driver authorized to operate a religious organization bus or van within Class D only. The driver took the religious organization bus test in a Class D vehicle, but may hold a Class A, B or C license.
  - 4) J04 Driver authorized to operate a religious organization bus or van within Class C or a lesser classification vehicle only. The driver took the religious organization bus test in a Class C vehicle, but may hold a Class A or B license.
  - 5) J05 Driver authorized to operate a senior citizen transportation vehicle within classification. The driver operates a vehicle that is utilized solely for the purpose of providing transportation for senior citizens, as provided in IVC Section 6-106.3.
  - 6) J06 Driver authorized to operate a senior citizen transportation vehicle within Class D only. The driver took the senior citizen transportation vehicle test in a Class D vehicle, but may hold a

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Class A, B or C license.

- 7) J07 Driver authorized to operate a senior citizen transportation vehicle within written Class C vehicle, or a lesser classification vehicle only. The driver took the senior citizen transportation vehicle test in a Class C vehicle, but may hold a Class A or B license.
- 8) J08 Driver authorized to operate a commuter van in a for-profit ridesharing arrangement within classification, as provided in IVC Section 6-106.4.
- 9) J09 Driver who is 16 or 17 years of age authorized to operate either Class L motor-driven cycles or Class M motorcycles, as provided in IVC Section 6-103(2).
- 10) J10 Driver restricted to the operation of a vehicle with a GVWR of 16,000 pounds or less.
- 11) J11 Indicates the driver took the road test on a three-wheel motorcycle (Class M) or three-wheel motor-driven cycle (Class L) and is restricted to a three-wheel cycle of the proper class.
- 12) J12 Driver authorized to operate Class B or lesser classification vehicle for the passenger endorsement.
- 13) J13 Driver authorized to operate Class C classification vehicle for the passenger endorsement.
- 14) J14 Restricted to the use of a non-standard lens arrangement pursuant to Section 1030.75 when operating a motor vehicle. (Lens arrangement may be designed for monocular or binocular vision.)
- 15) J15 Special Restrictions – An applicant may have special restrictions applied specifically to the vehicle the applicant is operating at the time a road test is being administered by a facility examiner. These special restrictions may apply only when the applicant is operating that particular motor vehicle. This J15 restriction only applies to variations of C, D or E restrictions. To remove a special restriction

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or to operate another motor vehicle would require the applicant to be administered another road test in the new vehicle.

- 16) J16 Pedalcycle Only – Authorizes an applicant holding a Class L license to operate a pedacycle only.
- [17](#)) [J17](#) [Authorizes a person holding a Class L or M license to operate a motorcycle or motor driven cycle with rear wheel extensions while maintaining a single front wheel.](#)
- [1847](#)) J33 Driver authorized to operate a Class D vehicle using a non-standard lens arrangement, pursuant to Section 1030.75, during nighttime hours.
- [1948](#)) J48 Allows a person to use commercial privileges only for driving school buses to transport students for school-related activities.
- [2049](#)) J50 Farm waived non-CDL (Class A only) – Allows farmers or a member of the farmer's family who is 21 years of age or older and has completed all of the applicable exams (core, combination, air brake, and all three parts of the road test) to drive a farm waived non-CDL (Class A only) vehicle. Those eligible may operate the truck/tractor semi-trailer to transport farm products, equipment or supplies to or from a farm, if used within 150 air miles of the farm, and not used in the operations of a common or contract carrier.
- [2120](#)) J71 No photo or signature – out of state at renewal – license issued to driver who is temporarily absent from State of Illinois at expiration date of his/her driver's license.
- [2224](#)) J72 No photo or signature – out of country at renewal – license issued to driver who is temporarily residing outside the United States of America at the expiration date of his/her driver's license.
- [2322](#)) J73 No photo or signature – military or military dependent – license issued at the expiration of the driver's license of the licensee, spouse and dependent children who are living with the licensee while on active duty serving in the Armed Forces of the United States outside the State of Illinois.

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- |        [2423](#)) J74 Military deferral card issued at the expiration of the driver's license to extend the expiration while in the military of the licensee, spouse and dependent children who are living with the licensee while on active duty serving in the Armed Forces of the United States outside the State of Illinois.
- |        [2524](#)) J75 No photo or signature – administrative approval license to driver who having his/her photograph taken is against his/her religious convictions or has a serious facial disfigurement.
- |        [2625](#)) J88 Deaf/Hard of Hearing – requires alternative forms of communication.
- |        [2726](#)) J99 This restriction appears on the license if more than two J restrictions are placed on the driver.
- j) A Type K restriction indicates the driver is authorized to operate a commercial motor vehicle intrastate only.
- k) A Type L restriction indicates that the person is not authorized to operate vehicles equipped with air brakes.
- l) An applicant who wants to appeal a type of restriction that has been added to a driver's license, depending on the type of restriction, shall:
- 1) For Type B, C, D, E, F, G, J01, or any other medical restriction that has been added to the driver's license pursuant to the restrictions contained in subsection (i), follow the manner prescribed by this Part.
  - 2) For any other types of restrictions that have been added to the driver's license pursuant to this Section, appeal to the Department of Administrative Hearings pursuant to IVC Section 2-118.
  - 3) Further review of all restrictions shall be conducted by the courts pursuant to the Administrative Review Law [735 ILCS 5/Art. III].

(Source: Amended at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## DEPARTMENT OF STATE POLICE

## NOTICE OF PROPOSED RULES

- 1) Heading of the Part: Bait Car Procedures
- 2) Code Citation: 20 Ill. Adm. Code 1297
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
1297.10	New Section
1297.20	New Section
1297.30	New Section
1297.40	New Section
- 4) Statutory Authority: Implementing Section 14-3(n) of the Criminal Code [720 ILCS 5/14-3(n)] and authorized by Section 2605-15 of the Civil Administrative Code of Illinois [20 ILCS 2605/2605-15]
- 5) A Complete Description of the Subjects and Issues Involved: The rulemaking will implement Section 14-3(n) of the Criminal Code [720 ILCS 5/14-3(n)] that provides for an exemption to Illinois eavesdropping statute for bait cars. The rulemaking will delineate regulations concerning the use of devices in the recording of transmissions from a microphone placed by a person under the authority of a law enforcement agency inside a bait car surveillance vehicle and to adopt measures regarding the retention of any such recorded evidence.
- 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? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking will not require a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Within 45 days after the publication of this Notice, any interested person

## DEPARTMENT OF STATE POLICE

## NOTICE OF PROPOSED RULES

may submit comments, data, views or argument regarding the proposed amendments. The submissions must be in writing and directed to:

Mr. John M. Hosteny  
Interim Chief Legal Counsel  
Illinois State Police  
801 South 7<sup>th</sup> Street, Suite 1000-S  
Post Office Box 19461  
Springfield, Illinois 62794-9461

Telephone: 217/782-7658

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: Small municipalities may be affected
  - B) Reporting, bookkeeping or other procedures required for compliance: None
  - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda which this rulemaking was summarized: January 2009

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

## DEPARTMENT OF STATE POLICE

## NOTICE OF PROPOSED RULES

TITLE 20: CORRECTIONS, CRIMINAL JUSTICE, AND LAW ENFORCEMENT  
CHAPTER II: DEPARTMENT OF STATE POLICEPART 1297  
BAIT CAR PROCEDURES

## SUBPART A: PROMULGATION

Section	
1297.10	Purpose
1297.20	Definitions

## SUBPART B: OPERATIONS

1297.30	Interception and Recording Standards
1297.40	Specifications for Equipment

AUTHORITY: Implementing Section 14-3(n) of the Criminal Code [720 ILCS 5/14-3(n)] and authorized by Section 2605-15 of the Civil Administrative Code of Illinois [20 ILCS 2605/2605-15].

SOURCE: Adopted at 33 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_.

## SUBPART A: PROMULGATION

**Section 1297.10 Purpose**

The purpose of this Part is to delineate regulations concerning the use of devices in the recording of transmissions from a microphone placed by a person under the authority of a law enforcement agency inside a bait car surveillance vehicle and to adopt measures regarding the retention of any such recorded evidence. These regulations shall apply exclusively to bait cars as defined in Section 14-1(f) of the Code.

**Section 1297.20 Definitions**

Unless specified otherwise, all terms shall have the meaning set forth in Section 14-1 of the Criminal Code. For purpose of this Part, the following additional definitions apply:

## DEPARTMENT OF STATE POLICE

## NOTICE OF PROPOSED RULES

"Article 14" means Article 14 of the Criminal Code [720 ILCS 5/Art. 14] (Eavesdropping).

"Code" or "Criminal Code" means the Criminal Code of 1961 [720 ILCS 5].

"Inside a bait car" means inside of the vehicle.

"Inventoried" means retained under the policies and procedures of the investigating law enforcement agency conducting the interception or recording; or, if no policy or procedure exists, the policies and procedures established by the office of the sheriff of the county in which the interception or recording occurred.

## SUBPART B: OPERATIONS

**Section 1297.30 Interception and Recording Standards**

- a) Any and all recordings made pursuant to this Section shall be protected from editing or other alteration. The first recording from each device used shall be designated as the "original" for inventory and reporting purposes.
- b) Any and all original recordings shall be inventoried in accordance with the guidelines of the appropriate law enforcement agency.

**Section 1297.40 Specifications for Equipment**

- a) Based on the operating specifications of the recording equipment, all recorded conversations will be saved to virgin blank media and protected from future additions, editing or alterations.
- b) The materials and equipment used for recording conversations pursuant to Section 14-3(n) of the Code shall be of a type and quality sufficient to satisfy the requirements of Article 14 and ensure adequate collection and preservation of evidence.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Minimum Standards for Individual and Group Medicare Supplement Insurance
- 2) Code Citation: 50 Ill. Adm. Code 2008
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
2008.30	Amendment
2008.35	Repeal
2008.40	Amendment
2008.60	Amendment
2008.64	New Section
2008.67	New Section
2008.70	Amendment
2008.71	Amendment
2008.72	Amendment
2008.107	New Section
2008.APPENDIX B	Amendment
2008.APPENDIX C	Amendment
2008.APPENDIX D	Amendment
2008.APPENDIX E	Amendment
2008.APPENDIX F	Amendment
2008.APPENDIX G	Amendment
2008.APPENDIX H	Amendment
2008.APPENDIX I	Amendment
2008.APPENDIX J	Amendment
2008.APPENDIX K	Amendment
2008.APPENDIX L	Amendment
2008.APPENDIX M	Amendment
2008.APPENDIX N	Amendment
2008.APPENDIX W	New Section
2008.APPENDIX AA	New Section
2008.APPENDIX BB	New Section
2008.APPENDIX CC	New Section
2008.APPENDIX DD	New Section
2008.APPENDIX EE	New Section
2008.APPENDIX FF	New Section
2008.APPENDIX GG	New Section
2008.APPENDIX HH	New Section
2008.APPENDIX II	New Section

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

2008.APPENDIX JJ

New Section

- 4) Statutory Authority: Implementing Sections 363 and 363a and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/363, 363a and 401]
- 5) Effective Date of Rulemaking: June 10, 2009
- 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: 33 Ill. Reg. 2876; February 13, 2009
- 10) Has JCAR issued a Statement of Objection to this Rulemaking? No
- 11) Differences between proposal and final version:
  - a) For consistency throughout these amendments, change "co-insurance" to "coinsurance".
  - b) In the Table of Contents and the Section Headings for 2008.64 and 2008.67, add "with an Effective Date for Coverage" following "Delivery".
  - c) In the Table of Contents for 2008.71 and 2008.72, after "and", add "with an Effective Date for Coverage".
  - d) In Section 2008.30(c), on the second line, after "(MIPPA", add "(PL 110-275)".
  - e) In Section 2008.30(c), on the fifth line, after "Act", add "(42 USC 1395ss(o))".
  - f) In Section 2008.40, in the definition of "1990 Standardized Medicare", on the third line, after "and", add "with an effective date for coverage".
  - g) In Section 2008.40, in the definition of "2010 Standardized Medicare", on the last line, after "and", add "with an effective date for coverage".

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

- h) In Section 2008.40, in the definition of "Medicare", after "Aged", add "and Disabled" and after "amended" add "(42 USC 1801-1898)".
- i) In Section 2008.64 and Section 2008.67, on the second line, after "State", add "with an effective date for coverage on or after". On the sixth line, after "issued", add "with an effective date for coverage on or after".
- j) In Section 2008.64(a)(7), sixth line, after "Act", add "(42 USC 1901-1941)".
- k) In Section 2008.64(a)(7)(B), fifth line, after "Act", add "(42 USC 426(b))". In the seventh line, after "Act", add "42 USC 1395y(b)(1)(A)(v)".
- l) In Section 2008.71, on the third line, following "and", add "with an effective date for coverage".
- m) In Section 2008.71(a)(7)(A), on the fifth line, after "Act", add "(42 USC 1901-1941)".
- n) In Section 2008.71(a)(7)(C), on the fifth line, after "Act", add "(42 USC 426(b))" and in line 8, after "Act", add "42 USC 1395y(b)(1)(A)(v)".
- o) In Section 2008.107 (d) in the fifth line, after "and", change "section" back to "Section".
- p) In Section 2008.APPENDIX B, under "Complete Answers Are Very Important, paragraph 3, line 4, strike "L" and add "N" in lieu thereof.
- q) In Section 2008.APPENDIX W, page 4, delete "C, D, E, F, H, I, M, N, X and Y" and add "AA through JJ" in lieu thereof.
- r) In Section 2008.APPENDIX CC, add the following row to the bottom of this table:

Remainder of Medicare Approved Amounts	80%	20%	\$0
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DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

s) In Section 2008.APPENDIX EE, delete all proposed text. JCAR inadvertently duplicated Appendix EE twice. Line 2392 – 2439 is the first Appendix EE starts with lines 2392-2439.

t) In Section 2008.APPENDIX II, change the dollar amount from \$10 to \$0 as highlighted in blue below:

<u>HOME HEALTH CARE MEDICARE APPROVED SERVICES</u> <u>—Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>—Durable medical equipment</u> <u>First \$[131] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

u) In Section 2008.APPENDIX II, change the days indicated from "670" to "60" as highlighted in blue below:

<u>FOREIGN TRAVEL— NOT COVERED BY MEDICARE</u> <u>Medically necessary emergency care services beginning during the first <u>60</u> days of each trip outside the USA</u>	<u>\$0</u> <u>\$0</u>	<u>\$0</u> <u>80% to a lifetime maxi-mum benefit of \$50,000</u>	<u>\$250</u> <u>20% and amounts over the \$50,000 lifetime maximum</u>
<u>First \$250 each calendar year</u> <u>Remainder of Charges</u>			

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

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of rulemaking: These amendments have incorporated required federal changes from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Genetic Information nondiscrimination Act of 2008. As dictated by federal law, the changes relating to the Genetic Information Nondiscrimination Act needed to be in place by June 1, 2009, and are herewith adopted. The MIPPA changes cannot be adopted prior to June 1, 2010. As a result, this effective date has been written into the appropriate rule provisions by design.
- 16) Information and questions regarding this adopted rulemaking shall be directed to:

William McAndrew, Deputy Director  
Consumer Market Division  
Department of Financial and Professional Regulation  
Division of Insurance  
320 West Washington Street  
Springfield, Illinois 62767-0001

217/782-4395

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

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

## TITLE 50: INSURANCE

## CHAPTER I: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

## PART 2008

MINIMUM STANDARDS FOR INDIVIDUAL  
AND GROUP MEDICARE SUPPLEMENT INSURANCE

## SUBPART A: GENERAL PROVISIONS

## Section

2008.10	Authority
2008.20	Purpose
2008.30	Applicability and Scope
2008.35	Effective Date ( <a href="#">Repealed</a> )
2008.40	Definitions

## SUBPART B: COVERAGE, POLICY &amp; BENEFIT PROVISIONS

2008.45	Creditable Coverage
2008.50	Policy Definitions and Terms
2008.60	Policy Provisions
2008.61	Benefit Conversion Requirements During Transition (Repealed)
<a href="#">2008.64</a>	<a href="#">Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after June 1, 2010</a>
<a href="#">2008.67</a>	<a href="#">Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after June 1, 2010</a>
2008.70	Minimum Benefit Standards for <a href="#">Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to February 11, 1992</a> <del>the Effective Date of this Part</del>
2008.71	Benefit Standards for <a href="#">1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery after or Delivered on or After February 11, 1992 and with an Effective Date for Coverage Prior to June 1, 2010</a> <del>the Effective Date of this Part</del>
2008.72	Standard Medicare Supplement Benefit Plans <a href="#">for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or after February 11, 1992 and with an Effective Date for Coverage Prior to June 1, 2010</a>

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2008.120 Effective Date (Repealed)

2008.APPENDIX A Policy Checklist

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2008.APPENDIX J	Plan H ( <a href="#">not available after May 31, 2010</a> )
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2008.APPENDIX O	Notice of Medicare Changes (Renumbered)
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2008.APPENDIX Q	Disclosure Statements (Renumbered)
2008.APPENDIX R	Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage
2008.APPENDIX S	Medicare Supplement Refund Calculation Format
2008.APPENDIX T	Notice of Medicare Changes
2008.APPENDIX U	Medicare Supplement Policies Report
2008.APPENDIX V	Disclosure Statements
<a href="#">2008.APPENDIX W</a>	<a href="#">Outline of Medicare Supplement Coverage – Cover Page for Medicare Supplement Plans Sold on or after June 1, 2010</a>
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<a href="#">2008.APPENDIX JJ</a>	<a href="#">Plan N (for plans issued on or after June 1, 2010)</a>

AUTHORITY: Implementing Sections 363 and 363a and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/363, 363a and 401].

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SOURCE: Adopted at 6 Ill. Reg. 7115, effective June 1, 1982 and January 1, 1983; codified at 7 Ill. Reg. 3474; emergency amendment at 13 Ill. Reg. 586, effective January 1, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 8520, effective May 23, 1989; amended at 14 Ill. Reg. 19243, effective November 27, 1990; amended at 16 Ill. Reg. 2766, effective February 11, 1992; corrected at 16 Ill. Reg. 3590; amended at 16 Ill. Reg. 15452, effective September 29, 1992; emergency amendment at 16 Ill. Reg. 19226, effective December 1, 1992, for a maximum of 150 days; emergency expired April 29, 1993; amended at 17 Ill. Reg. 11469, effective July 9, 1993; amended at 20 Ill. Reg. 6393, effective April 28, 1996; amended at 23 Ill. Reg. 3704, effective March 10, 1999; amended at 23 Ill. Reg. 14700, effective January 1, 2000; amended at 24 Ill. Reg. 19151, effective January 1, 2001; amended at 25 Ill. Reg. 7886, effective June 18, 2001; amended at 26 Ill. Reg. 5130, effective March 25, 2002; amended at 29 Ill. Reg. 14188, effective September 8, 2005; amended at 33 Ill. Reg. 8904, effective June 10, 2009.

## SUBPART A: GENERAL PROVISIONS

**Section 2008.30 Applicability and Scope**

- a) Except as otherwise specifically provided in Sections 2008.70, 2008.75, 2008.76, 2008.80, 2008.81, 2008.90 and 2008.103 of this Part, this Part shall apply to:
  - 1) All Medicare supplement policies delivered or issued for delivery in this State on or after June 1, 1982, and
  - 2) All certificates issued under group Medicare supplement policies, which policies or contracts have been delivered or issued for delivery in this State.
- b) This Part shall not apply to:
  - 1) "*Accident Only*" or "*Specified Disease*" types of policies (Section 363(1)(b) of the Illinois Insurance Code (the Code)), or
  - 2) Policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons, which policies or plans are not marketed or purported or held to be Medicare supplement policies or benefit plans (Section 363(1)(b) of the Code), or
  - 3) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor

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organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

- c) [Under section 104\(c\) of the Medicare Improvements for Patients and Providers Act of 2008 \(MIPPA\) \(PL 110-275\), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage Plans \(established under Medicare Part C\) must comply with the Medicare supplement requirements of section 1882\(o\) of the Social Security Act \(42 USC 1395ss\(o\)\).](#)

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

**Section 2008.35 Effective Date [\(Repealed\)](#)**

~~The 2005 amendments to this Part are effective on September 8, 2005. Insurers are permitted to continue using current forms, or to make changes to current forms if offering Plan K or L, as appropriate through 2005. Insurers may offer any authorized plan upon approval by the Director.~~

(Source: Repealed at 33 Ill. Reg. 8904, effective June 10, 2009)

**Section 2008.40 Definitions**

For the purposes of this Part:

["1990 Standardized Medicare supplement benefit plan", "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after February 11, 1992 and with an effective date for coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date that are not replaced by the issuer at the request of the insured.](#)

["2010 Standardized Medicare supplement benefit plan", "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.](#)

Applicant means:

*in the case of an individual Medicare supplement policy, the person who*

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*seeks to contract for insurance benefits; and*

*in the case of a group Medicare supplement policy, the proposed certificateholder (Section 363(2)(a) of the Code).*

Bankruptcy means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in this State.

Certificate means *any certificate delivered or issued for delivery in this State under a group Medicare supplement policy (Section 363(2)(b) of the Code).*

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

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

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

Department means the Illinois Department of Financial and Professional Regulation.

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

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

Employee Welfare Benefit Plan means a plan, fund or program of employee benefits as defined in 29 USC 1002 (Employee Retirement Income Security Act).

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

Issuer includes insurance companies, fraternal benefit societies, health care service plans, and any other entity delivering or issuing for delivery in this State

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Medicare supplement policies or certificates.

Medicare means the Health Insurance for the Aged [and Disabled](#) Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended ([42 USC 1801-1898](#)).

Medicare Advantage Plan means a plan of coverage for health benefits under Medicare Part C as defined in Section 1395w-28(b)(1) of the Social Security Act (42 USC 1395w-28(b)(1)), and includes:

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

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

Medicare Advantage private fee-for-service plans.

Medicare Supplement Policy means a group or individual policy of (accident and sickness) insurance or a subscriber contract (of hospital and medical service associations) other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 USC 1395 et seq.) or an issued policy under a demonstration project specified in 42 USC Section 1395ss(g)(1) which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare (Section 363(2)(c) of the Code).

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

["Pre-Standardized Medicare supplement benefit plan", "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to February 11, 1992.](#)

Secretary means the Secretary of the United States Department of Health and Human Services.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

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## SUBPART B: COVERAGE, POLICY &amp; BENEFIT PROVISIONS

**Section 2008.60 Policy Provisions**

- a) Except for permitted preexisting condition clauses as described in Section 2008.70(a)(1), ~~and~~ Section 2008.71(a)(1), and Section 2008.64(a)(1) of this Part, no policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.
- b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.
- c) No Medicare supplement policy or certificate in force in the State shall contain benefits which duplicate benefits provided by Medicare.
- d) Subject to Sections 2008.70(a)(4), (5) and (7) and 2008.71(a)(4) and (5):
  - 1) A Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.
  - 2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.
  - 3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs will not be renewed after the policyholder enrolls in Medicare Part D unless:
    - A) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and
    - B) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D

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enrollment, accounting for any claims paid, if applicable.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

**Section 2008.64 Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after June 1, 2010**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this State as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage on or after June 1, 2010 remain subject to the requirements of Section 2008.70 for Pre-Standardized Plans or Section 2008.71 for 1990 Plans.

- a) General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.
- 1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
  - 2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
  - 3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

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- 4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
- 5) Each Medicare supplement policy shall be guaranteed renewable.
  - A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.
  - B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
  - C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subsection (a)(5)(E), the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder:
    - i) Provides for continuation of the benefits contained in the group policy; or
    - ii) Provides for benefits that otherwise meet the requirements of this subsection.
  - D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall
    - i) Offer the certificateholder the conversion opportunity described in subsection (a)(5)(C); or
    - ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.
  - E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer

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coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

- 6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- 7) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period in which the policyholder or certificateholder has applied for, and is determined to be entitled to medical assistance under Title XIX of the Social Security Act (42 USC 1901-1941), but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance. In no case shall the suspension exceed 24 months..
  - A) If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated, effective as of the date of termination of entitlement, if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.
  - B) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act (42 USC 426(b)) and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of the Social Security Act (42 USC 1395y(b)(1)(A)(v)). If suspension occurs and if the policyholder or certificate holder loses

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coverage under the group health plan, the policy shall be automatically reinstated, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan..

C) Reinstatement of coverages as described in subsections (a)(7)(A) and (B):

i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

b) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61<sup>st</sup> day through the 90<sup>th</sup> day in any Medicare benefit period;

2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

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- 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
  - 4) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
  - 5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;
  - 6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
- c) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 2008.67 of this Part.
- 1) Medicare Part A Deductible: Coverage for 100% of the Medicare Part A inpatient hospital deductible amount per benefit period.
  - 2) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.
  - 3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
  - 4) Medicare Part B Deductible: Coverage for 100% of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

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- 5) One Hundred Percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- 6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

**Section 2008.67 Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or after June 1, 2010**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage June 1, 2010 remain subject to the requirements of Section 2008.70 for Pre-Standardized Plans or Section 2008.71 for 1990 Plans.

- a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Section 2008.64(b) of this Part.
- b) If an issuer makes available any of the additional benefits described in Section 2008.64(c), or offers standardized benefit Plans K or L as described in subsections (f)(8) and (9) of this Section, then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subsection (a),

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a policy form or certificate form containing either standardized benefit Plan C as described in subsection (f)(3) or standardized benefit Plan F as described in subsection (f)(5).

- c) No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this State, except as may be permitted in subsection (g) and in Section 2008.73 of this Part.
- d) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in Sections 2008.40 and 2008.50 of this Part. Each benefit shall be structured in accordance with the format provided in Section 2008.64(b) and (c) of this Part; or, in the case of plans K or L, in subsection (f)(8) or (f)(9) and list the benefits in the order shown. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.
- e) In addition to the benefit plan designations required in subsection (d) of this Section, an issuer may use other designations to the extent permitted by law.
- f) Make-up of 2010 Standardized Benefit Plans:

  - 1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Section 2008.64(b) of this Part.
  - 2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible as defined in Section 2008.64(c)(1) of this Part.
  - 3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(1), (3), (4), and (6) of this Part, respectively.
  - 4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in Section 2008.64(b) of

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this Part), plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Section 2008.64(c)(1), (3), and (6) of this Part, respectively.

- 5) Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible, the skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(1), (3), (4), (5), and (6), respectively.
- 6) Standardized Medicare supplement Plan F With High Deductible shall include only the following: 100% of covered expenses following the payment of the annual deductible set forth in subsection (f)(6)(B).
  - A) The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(1), (3), (4), (5), and (6) of this Part, respectively.
  - B) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by (regular) Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.
- 7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically

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necessary emergency care in a foreign country as defined in Section 2008.64(c)(1), (3), (5), and (6), respectively.

- 8) Standardized Medicare supplement Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:
- A) Part A Hospital Coinsurance 61<sup>st</sup> through 90<sup>th</sup> days: Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61<sup>st</sup> through the 90<sup>th</sup> day in any Medicare benefit period;
  - B) Part A Hospital Coinsurance, 91<sup>st</sup> through 150<sup>th</sup> days: Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91<sup>st</sup> through the 150<sup>th</sup> day in any Medicare benefit period;
  - C) Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
  - D) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subsection (f)(8)(J);
  - E) Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subsection (f)(8)(J);
  - F) Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subsection (f)(8)(J);

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- G) Blood: Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subsection (f)(8)(J);
- H) Part B Cost Sharing: Except for coverage provided in subsection (f)(8)(I), coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subsection (f)(8)(J);
- I) Part B Preventive Services: Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
- J) Cost Sharing After Out-of-Pocket Limits: Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.
- 9) Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:
- A) The benefits described in subsections (f)(8)(A), (B), (C) and (I);
- B) The benefit described in subsections (f)(8)(D), (E), (F), (G) and (H), but substituting 75% for 50%; and
- C) The benefit described in subsection (f)(8)(J), but substituting \$2000 for \$4000.

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- 10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 50% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(2), (3) and (6) of this Part, respectively.
- 11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(1), (3) and (6) of this Part, respectively, with copayments in the following amounts:
- A) the lesser of \$20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and
- B) the lesser of \$50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.
- g) New or Innovative Benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

**Section 2008.70 Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to February 11, 1992**

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**Effective Date of this Part**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State prior to June 1, 1982. No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

## a) General Standards.

The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.

- 1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
- 2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
- 3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, ~~copayment, or coinsurance amounts, amount and copayment percentage factors.~~ Premiums may be modified to correspond with such changes.
- 4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:
  - A) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium, or

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- B) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.
- 5) An insurer shall:
- A) Except as authorized by the Director, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.
  - B) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (a)(5)(D), the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:
    - i) an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and
    - ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 2008.71(b) of this Part.
  - C) If a membership in a group is terminated, the issuer shall:
    - i) offer the certificateholder such conversion opportunities as are described in subsection (a)(5)(B); or
    - ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.
  - D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have

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been covered under the group policy being replaced.

- 6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
  - 7) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection (a).
- b) Minimum Benefit Standards.
- 1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61<sup>st</sup> day through the 90<sup>th</sup> day in any Medicare benefit period;
  - 2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;
  - 3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;
  - 4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;
  - 5) Coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

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- 6) Coverage for the coinsurance amount or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (\$100);
- 7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) (42 CFR 409.87(a) 1988, no subsequent dates or editions) unless replaced in accordance with federal regulations (42 CFR 409.87(b) 1988, no subsequent dates or editions) or already paid for under Part A, subject to the Medicare deductible amount.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

**Section 2008.71 Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery after or Delivered on or After February 11, 1992 and Prior to June 1, 2010 ~~the Effective Date of this Part~~**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State on or after February 11, 1992 and with an effective date for coverage prior to June 1, 2010 ~~the effective date of this Part~~. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy or certificate unless it complies with these benefit standards.

- a) General Standards  
The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.
  - 1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
  - 2) A Medicare supplement policy or certificate shall not indemnify against

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losses resulting from sickness on a different basis than losses resulting from accidents.

- 3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, ~~copayment, or coinsurance amounts, amount and copayment percentage factors.~~ Premiums may be modified to correspond with such changes.
- 4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
- 5) Each Medicare supplement policy shall be guaranteed renewable and:
  - A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual;
  - B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;
  - C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under [subsection Section 2008.71\(a\)\(5\)\(E\)](#), the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):
    - i) Provides for continuation of the benefits contained in the group policy, or
    - ii) Provides for such benefits as otherwise meet the requirements of this subsection;
  - D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

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- i) Offer the certificateholder the conversion opportunity described in [subsection Section 2008.71\(a\)\(5\)\(C\)](#), or
    - ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy;
  - E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
  - F) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection (a)(5).
- 6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- 7) A Medicare supplement policy or certificate shall provide:
- A) That benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act ([42 USC 1901-1941](#)), but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.

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- B) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstated (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.
- C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under [sectionSection 226\(b\) of the Social Security Act \(42 USC 426\(b\)\)](#) and is covered under a group health plan as defined in [sectionSection 1862\(b\)\(1\)\(A\)\(v\) of the Social Security Act \(42 USC 1395y\(b\)\(1\)\(A\)\(v\)\)](#). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of such coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of such loss.
- D) Reinstitution of such coverages as described in subsections (a)(7)(B) and (C):
- i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
  - ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

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- iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

- 8) If, after June 1, 2010, an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan (as described in Section 2008.72 of this Part) to a 2010 Standardized plan (as described in Section 2008.67 of this Part), the offer and subsequent exchange shall comply with the following requirements:
  - A) An issuer need not provide justification to the Director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the Director.
  - B) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.
  - C) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than 6 months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.
  - D) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

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- b) Standards for Basic ("Core") Benefits Common to Benefit Plans A-J  
Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.
- 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61<sup>st</sup> day through the 90<sup>th</sup> day in any Medicare benefit period;
  - 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
  - 3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
  - 4) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
  - 5) Coverage for the coinsurance amount (or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount) of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
- c) Standards for Additional Benefits  
The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 2008.72 of this Part.

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- 1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
- 2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.
- 3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- 4) Eighty Percent of the Medicare Part B Excess Charges: Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or State law, and the Medicare-approved Part B charge.
- 5) One Hundred Percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or State law, and the Medicare-approved Part B charge.
- 6) Basic Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- 7) Extended Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- 8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care

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would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or illness of sudden and unexpected onset.

- 9) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:
- A) An annual clinical preventive medical history and physical examination that may include tests and services from subsection (c)(9)(B) and patient education to address preventive health care measures; ~~and~~
  - B) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;
  - C) Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.
- 10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.
- A) For purposes of this benefit, the following definitions shall apply:
    - i) "Activities of daily living" include but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
    - ii) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse

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provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

- iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.
- iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

## B) Coverage Requirements and Limitations

- i) At-home recovery services provided must be primarily services which assist in activities of daily living.
- ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.
- iii) Coverage is limited to:  
No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

The actual charges for each visit up to a maximum reimbursement of \$40 per visit.

\$1,600 per calendar year.

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7 visits in any one week.

Care furnished on a visiting basis in the insured's home.

Services provided by a care provider as defined in this Section.

At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than 8 weeks after the service date of the last Medicare approved home health care visit.

- C) Coverage is excluded for:
  - i) Home care visits paid for by Medicare or other government programs; and
  - ii) Care provided by family members, unpaid volunteers or providers who are not care providers.
  
- d) Standards for Plans K and L
  - 1) Standardized Medicare supplement benefit Plan "K" shall consist of the following:
    - A) Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61<sup>st</sup> through the 90<sup>th</sup> day in any Medicare benefit period;
    - B) Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91<sup>st</sup> through the 150<sup>th</sup> day in any Medicare benefit period;
    - C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the

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applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

- D) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subsection (d)(1)(J);
- E) Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21<sup>st</sup> day through the 100<sup>th</sup> day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subsection (d)(1)(J);
- F) Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subsection (d)(1)(J);
- G) Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subsection (d)(1)(J);
- H) Except for coverage provided in subsection (d)(1)(J), coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subsection (d)(1)(J);
- I) Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
- J) Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under

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Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

- 2) Standardized Medicare supplement benefit Plan "L" shall consist of the following:
  - A) The benefits described in subsections (d)(1)(A), (B), (C) and (J);
  - B) The benefits described in subsections (d)(1)(D), (E), (F), (G) and (H), but substituting 75% for 50%; and
  - C) The benefit described in subsection (d)(1)(J), but substituting \$2000 for \$4000.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

**Section 2008.72 Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or after February 11, 1992 and Prior to June 1, 2010**

- a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in Section 2008.71 of this Part.
- b) No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this State, except as may be permitted in subsection (g) and Section 2008.73 of this Part.
- c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in subsection (e) of this Section and conform to the definitions in Section 2008.40 of this Part. Each benefit shall be structured in accordance with the format provided in Section 2008.71(b) and (c) and list the benefits in the order shown in Appendix B of this Part. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.
- d) An issuer may use, in addition to the benefit plan designations required in subsection (c) of this Section, other designations to the extent permitted by law.

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- e) Make-up of benefit plans:
- 1) Standardized Medicare supplement benefit Plan "A" shall be limited to the Basic ("Core") Benefits Common to all Benefit Plans, as defined in Section 2008.71(b) of this Part.
  - 2) Standardized Medicare supplement benefit Plan "B" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible as defined in Section 2008.71(c)(1) of this Part.
  - 3) Standardized Medicare supplement benefit Plan "C" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Section 2008.71(c)(1), (2), (3) and (8) of this Part respectively.
  - 4) Standardized Medicare supplement benefit Plan "D" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (8) and (10) of this Part respectively.
  - 5) Standardized Medicare supplement benefit Plan "E" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Section 2008.71(c)(1), (2), (8) and (9) of this Part respectively.
  - 6) Standardized Medicare supplement benefit Plan "F" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, 100% of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 2008.71(c)(1), (2), (3), (5) and (8) of this Part respectively.

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- 7) Standardized Medicare supplement benefit high deductible Plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan "F" deductible. The covered expenses include the Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A deductible, Skilled Nursing Facility Care, the Medicare Part B deductible, 100% of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 2008.71(c)(1), (2), (3), (5) and (8) respectively. The annual high deductible Plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12 month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.
- 8) Standardized Medicare supplement benefit Plan "G" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80% of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (4), (8) and (10) of this Part respectively.
- 9) Standardized Medicare supplement benefit Plan "H" shall consist of only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Section 2008.71(c)(1), (2), (6) and (8) of this Part respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- 10) Standardized Medicare supplement benefit Plan "I" shall consist of only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100% of the Medicare Part B Excess Charges, Basic Prescription Drug

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Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (5), (6), (8) and (10) of this Part respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

- 11) Standardized Medicare supplement benefit Plan "J" shall consist of only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100% of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (3), (5), (7), (8), (9) and (10) of this Part respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.
  - 12) Standardized Medicare supplement benefit high deductible Plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible Plan "J" deductible. The covered expenses include the Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medicare Part B deductible, 100% of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (8) and (10) respectively. The annual high deductible Plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan "J" policy, and shall be in addition to any other specific benefit deductible. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12 month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.
- f) Make-up of two Medicare supplement plans mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

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- 1) Standardized Medicare supplement benefit Plan "K" shall consist of only those benefits described in Section 2008.71(d)(1).
- 2) Standardized Medicare supplement benefit Plan "L" shall consist of only those benefits described in Section 2008.71(d)(2).
- g) New or Innovative Benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

## SUBPART F: REPORTING &amp; PROHIBITIONS

**Section 2008.107 Prohibition Against Use of Genetic Information and Requests for Genetic Testing**

This Section applies to all policies with policy years beginning on or after May 21, 2009.

- a) An issuer of a Medicare supplement policy or certificate:
  - 1) shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and
  - 2) shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.
- b) Nothing in subsection (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

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- 1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or
- 2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).
- c) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of the individual to undergo a genetic test.
- d) Subsection (c) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Part C of Title XI (42 USC 1320d-1320d-8) and Section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 USC 1320d-2), as may be revised from time to time) and consistent with subsection (a).
- e) For purposes of carrying out subsection (d), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.
- f) Notwithstanding subsection (c), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:
  - 1) The request is made pursuant to research that complies with 45 CFR 46 (2005) or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.
  - 2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:
    - A) compliance with the request is voluntary; and

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- B) non-compliance will have no effect on enrollment status or premium or contribution amounts.
- 3) No genetic information collected or acquired under this subsection (f) shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.
- 4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection (f), including a description of the activities conducted.
- 5) The issuer complies with other conditions the Secretary may by regulation require for activities conducted under this subsection (f).
- g) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.
- h) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to the individual's enrollment under the policy in connection with the enrollment.
- i) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase shall not be considered a violation of subsection (h) if the request, requirement, or purchase is not in violation of subsection (g).
- j) For the purposes of this Section only:
- 1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of the issuer.
- 2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.
- 3) "Genetic information" means, with respect to any individual, information about the individual's genetic tests, the genetic tests of family members of

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the individual, and the manifestation of a disease or disorder in family members of the individual. The term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by the pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

- 4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.
- 5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.
- 6) "Underwriting purposes" means,
  - A) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;
  - B) the computation of premium or contribution amounts under the policy;
  - C) the application of any pre-existing condition exclusion under the policy; and
  - D) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

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(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

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**Section 2008.APPENDIX B Outline of Medicare Supplement Coverage – Cover Page [for Medicare Supplement Plans Sold Prior to June 1, 2010](#)**

[COMPANY NAME]

Outline of Medicare Supplement Coverage – Cover Page: 1 of 2  
Benefit Plans \_\_\_\_\_ [insert letters of plans being offered]

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in Illinois.

See Outlines of Coverage sections for details about all plans.

**BASIC BENEFITS FOR PLANS A-J:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services.

Blood: First 3 pints of blood each year.

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility <del>Coinsurance</del> <del>Co-Insurance</del>	Skilled Nursing Facility <del>Coinsurance</del> <del>Co-Insurance</del>	Skilled Nursing Facility <del>Coinsurance</del> <del>Co-Insurance</del>
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care NOT Covered by Medicare

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<b>F</b>	<b>F*</b>	<b>G</b>	<b>H</b>	<b>I</b>	<b>J</b>	<b>J*</b>
Basic Benefits						
Skilled Nursing Facility <del>Coinsurance</del> <del>Insurance</del>						
Part A Deductible						
Part B Deductible					Part B Deductible	
Part B Excess (100%)	Part B Excess (80%)			Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
Foreign Travel Emergency						
	At-Home Recovery			At-Home Recovery	At-Home Recovery	At-Home Recovery
					Preventive Care NOT Covered by Medicare	

Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year [\$ \_\_\_\_] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are [\$ \_\_\_\_]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

## NOTE:

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear above. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

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[COMPANY NAME]

## Outline of Medicare Supplement Coverage – Cover Page 2

Basic Benefits for Plans K and L include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels.

<b>J</b>	<b>K**</b>	<b>L**</b>
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first 3 pints of blood 50% Part B Coinsurance, except 100% coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare benefits end 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first 3 pints of blood 75% Part B Coinsurance, except 100% coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT Covered by Medicare		
	[\$ ] Out of Pocket Annual Limit***	[\$ ] Out of Pocket Annual Limit***

\*\* Plans K and L provide for different cost-sharing for items and services than Plans A-J.

Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "excess charges". You will be responsible for paying excess charges.

\*\*\*The out-of-pocket annual limit will increase each year for inflation.

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See Outlines of Coverage for details and exceptions.

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**PREMIUM INFORMATION [Boldface Type]**

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

**DISCLOSURES [Boldface Type]**

Use this outline to compare benefits and premiums among policies.

[This outline shows benefits and premiums of policies sold for effective dates prior to June 1, 2010.](#)

## READ YOUR POLICY VERY CAREFULLY

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

**RIGHT TO RETURN POLICY [Boldface Type]**

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

**POLICY REPLACEMENT [Boldface Type]**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

**NOTICE [Boldface Type]**

This policy may not fully cover all of your medical costs.

(for producers:)

Neither (insert company's name) nor its agents are connected with Medicare.

(for direct response:)

(insert company's name) is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local

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Social Security office or consult "Medicare & You" for more details.

**COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified on the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in Appendices C through [N](#) of this Part. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this Appendix. An issuer may use additional benefit plan designations on these charts pursuant to Section 2008.72(d) of this Part.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Director.]

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

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**Section 2008.APPENDIX C Plan A (for plans issued prior to June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	\$0	[\$_____] (Part A Deductible)
61st thru 90th day	All but [\$_____] a day	[\$_____] a day	\$0
91st day and after;			
- While using 60 lifetime reserve days	All but [\$_____] a day	[\$_____] a day	\$0
- Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
-Beyond the Additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$_____] a day	\$0	Up to [\$_____] a day
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

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<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited <del>coinsurance</del> <del>insurance</del> for out-patient drugs and inpatient respite care	\$0	Balance
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**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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**(Plan A Continued)****MEDICARE (PART B) – Medical Services-Per Calendar Year**

\*Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	[\$100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved Amounts*	\$0	\$0	[\$100] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b>			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			

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First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

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**Section 2008.APPENDIX D Plan B (for plans issued prior to June 1, 2010)****MEDICARE (PART A) – Hospital Services-Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but [\$_____] a day	[\$_____] a day	\$0
91 <sup>st</sup> day and after;			
- While using 60 lifetime reserve days	All but [\$_____] a day	[\$_____] a day	\$0
- Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
-Beyond the Additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but [\$_____] a day	\$0	Up to [\$_____] a day
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			

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First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited <del>coinsurance</del> <del>insurance</del> for out-patient drugs and inpatient respite care	\$0	Balance

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**(Plan B Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\*Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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<b>CLINICAL LABORATORY SERVICES</b>			
TEST FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b>			
MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

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**Section 2008.APPENDIX E Plan C (for plans issued prior to June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$ _____]	[\$ _____] (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but [\$ _____] a day	[\$ _____] a day	\$0
91 <sup>st</sup> day and after;			
- While using 60 lifetime reserve days	All but [\$ _____] a day	[\$ _____] a day	\$0
- Once lifetime reserve day are used:			
- Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
- Beyond the Additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but [\$ _____] a day	Up to [\$ _____] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited <del>coinsurance</del> <del>insurance</del> for out-patient drugs and inpatient respite care	\$0	Balance

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**(Plan C Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\*Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[100] of Medicare Approved Amounts*	\$0	\$[100] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved Amounts	\$0	\$[100] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES-TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[100] of Medicare Approved Amounts*	100%	\$0	\$0
Remainder of Medicare Approved Amounts	80%	\$[100] (Part B Deductible) 20%	\$0

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**(Plan C Continued)****OTHER BENEFITS – Not Covered By Medicare**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL-NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX F Plan D (for plans issued prior to June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$ _____]	[\$ _____] (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but [\$ _____] a day	[\$ _____] a day	\$0
91 <sup>st</sup> day and after;			
- While using 60 lifetime reserve days	All but [\$ _____] a day	[\$ _____] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
- Beyond the Additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but [\$ _____] a day	Up to [\$ _____] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited <del>coinsurance</del> <del>ee-insurance</del> for out-patient drugs and inpatient respite care	\$0	Balance
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**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**(Plan D Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\*Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[100] of Medicare Approved Amounts*	100%	\$0	\$0
	\$0	\$0	\$[100] (Part B Deductible)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT HOME RECOVERY SERVICES- NOT COVERED BY MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS – Not Covered by Medicare**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX G Plan E (not available after May 31, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$ _____ ]	[\$ _____ ] (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but [\$ _____ ] a day	[\$ _____ ] a day	\$0
91 <sup>st</sup> day and after;			
- While using 60 lifetime reserve days	All but [\$ _____ ] a day	[\$ _____ ] a day	\$0
- Once lifetime reserve day are used:			
- Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
- Beyond the Additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but [\$ _____ ] a day	Up to [\$ _____ ] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited <del>coinsurance</del> <del>insurance</del> for out-patient drugs and inpatient respite care	\$0	Balance

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**(Plan E Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\* Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 generally 80%	\$0 generally 20%	\$[100] (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$[100] of Medicare Approved Amounts Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[100] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	\$0	\$0

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

- Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	[\$100] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**(Plan E Continued)****OTHER BENEFITS – Not Covered By Medicare**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL-NOT COVERED BY MEDICARE</b>  Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of Charges	  \$0 \$0	  \$0 80% to a lifetime maximum benefit of \$50,000	  \$250 20% and amounts over the \$50,000 lifetime maximum
<b>**PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE</b>  Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	  \$0 \$0	  \$120 \$0	  \$0 All costs

\*\* Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX H Plan F or High Deductible Plan F (for plans issued prior to June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

- \* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- [\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$\_\_\_\_\_] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are [\$\_\_\_\_\_] . Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$__] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$__] DEDUCTIBLE**] YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but [\$_____] a day	[\$_____] a day	\$0
91 <sup>st</sup> day and after;			
- While using 60 lifetime reserve days	All but [\$_____] a day	[\$_____] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0***
- Beyond the Additional 365 days	\$0	\$0	All costs

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<p><b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21<sup>st</sup> thru 100<sup>th</sup> day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but [\$_____] a day \$0</p>	<p>\$0 Up to [\$_____] a day \$0</p>	<p>\$0 \$0 All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited <del>coinsurance</del> <del>ee</del> <del>insurance</del> for out-patient drugs and in-patient respite care</p>	<p>\$0</p>	<p>Balance</p>

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**(Plan F or High Deductible Plan F Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\*Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[\*\*This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$\_\_\_] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$\_\_\_]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible].

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$___] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$___] DEDUCTIBLE**] YOU PAY
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$[100] of Medicare Approved Amounts*	\$0	\$[100] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b>			
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved Amounts*	\$0	\$[100] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES-TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$___] DEDUCTIBLE**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$___] DEDUCTIBLE**] YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	[\$100] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – Not Covered By Medicare**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY THE [\$___] DEDUCTIBLE**] PLAN PAYS</b>	<b>[IN ADDITION TO THE [\$___] DEDUCTIBLE**] YOU PAY</b>
<b>FOREIGN TRAVEL-NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX I Plan G (for plans issued prior to June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but [\$_____] a day	[\$_____] a day	\$0
91 <sup>st</sup> day and after;			
- While using 60 lifetime reserve days	All but [\$_____] a day	[\$_____] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
- Beyond the Additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but [\$_____] a day	Up to [\$_____] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited <a href="#">coinsurance</a> <del>co-insurance</del> for out-patient drugs and inpatient respite care	\$0	Balance

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**(Plan G Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\*Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0  generally 80%  \$0	\$0  generally 20%  80%	\$[100] (Part B Deductible) \$0  20%
<b>BLOOD</b> First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[100] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies - Durable medical equipment First \$[100] of Medicare Approved Amounts*	100%  \$0	\$0  \$0	\$0  \$[100] (Part B Deductible)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT-HOME RECOVERY SERVICES- NOT COVERD BY MEDICARE</b> Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX J Plan H (not available after May 31, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but [\$_____] a day	[\$_____] a day	\$0
91 <sup>st</sup> day and after;			
-While using 60 lifetime reserve days	All but [\$_____] a day	[\$_____] a day	\$0
-Once lifetime reserve days are used:			
-Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
-Beyond the Additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but [\$_____] a day	Up to [\$_____] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			

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First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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## NOTICE OF ADOPTED AMENDMENTS

**(Plan H Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\* Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b> such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0  generally 80%  \$0	\$0  generally 20%  0%	\$[100] (Part B Deductible) \$0  All costs
<b>BLOOD</b> First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[100] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			

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- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – Not Covered By Medicare**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

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## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX K Plan I (not available after May 31, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$ _____]	[\$ _____] (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but [\$ _____] a day	[\$ _____] a day	\$0
91 <sup>st</sup> day and after;			
- While using 60 lifetime reserve days	All but [\$ _____] a day	[\$ _____] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**
- Beyond the Additional 365 days	\$0	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> thru 100 <sup>th</sup> day	All but [\$ _____] a day	Up to [\$ _____] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b>			

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First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited <del>coinsurance</del> <del>insurance</del> for out-patient drugs and inpatient respite care	\$0	Balance

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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## NOTICE OF ADOPTED AMENDMENTS

**(Plan I Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\* Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0 generally 80% \$0	\$0 generally 20% 100%	\$[100] (Part B Deductible) \$0 \$0
<b>BLOOD</b> First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[100] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	\$0	\$0

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- Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	[\$100] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT-HOME RECOVERY SERVICES- NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

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## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX L Plan J or High Deductible Plan J (not available after May 31, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

- \* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[\*\* This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [\$\_\_\_\_\_] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [\$\_\_\_\_\_] . Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$_____] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$_____] DEDUCTIBLE**] YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but [\$_____] a day	[\$_____] a day	\$0
91 <sup>st</sup> day and after; - While using 60 lifetime reserve days - Once lifetime reserve days are used:	All but [\$_____] a day	[\$_____] a day	\$0
- Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0***
- Beyond the Additional 365 days	\$0	\$0	All costs

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<p><b>SKILLED NURSING FACILITY CARE*</b>          You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21<sup>st</sup> thru 100<sup>th</sup> day</p> <p>101<sup>st</sup> day and after</p>	<p>All approved amounts</p> <p>All but [\$ _____] a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to [\$ _____] a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b></p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b></p> <p>Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited <del>coinsurance</del> <del>insurance</del> for out-patient drugs and in-patient respite care</p>	<p>\$0</p>	<p>Balance</p>

\*\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid."

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**(Plan J or High Deductible Plan J Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\* Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[\*\*This high deductible plan pays the same benefits as Plan J after one has paid a calendar year [\$ \_\_\_] deductible. Benefits from the high deductible Plan J will not begin until out-of-pocket expenses are [\$ \_\_\_]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate outpatient prescription drug deductible or the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$ ___] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$ ___] DEDUCTIBLE**] YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts <b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0  generally 80%  \$0	\$[100] (Part B Deductible) generally 20%  100%	\$0  \$0  \$0
<b>BLOOD</b> First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[100] (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

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**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$___] DEDUCTIBLE**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$___] DEDUCTIBLE**] YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment			
First \$[100] of Medicare Approved Amounts*	\$0	\$[100] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>AT-HOME RECOVERY SERVICES-NOT COVERED BY MEDICARE</b>			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
- Benefit for each visit	\$0	Actual charges to \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY [\$___] DEDUCTIBLE**] PLAN PAYS</b>	<b>[IN ADDITION TO [\$___] DEDUCTIBLE**] YOU PAY</b>
<b>FOREIGN TRAVEL-NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip			

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outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
<b>***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE</b>			
Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All costs

\*\*\* Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

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## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX M Plan K ([for plans issued prior to June 1, 2010](#))**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

- \* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD**

- \*\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[ ]	\$[ ] (50% of Part A deductible)	\$[ ] (50% of Part A deductible)♦
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[ ] a day	\$[ ] a day	\$0
91 <sup>st</sup> day and after:			
- While using 60 lifetime reserve days	All but \$[ ] a day	\$[ ] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- Beyond the additional 365 days	\$0	\$0	All costs

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<p><b>SKILLED NURSING FACILITY CARE**</b>          You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days          21<sup>st</sup> thru 100<sup>th</sup> day          101<sup>st</sup> day and after</p>	<p>All approved amounts          All but \$[ ] a day          \$0</p>	<p>\$0          Up to \$[ ] a day          \$0</p>	<p>\$0          Up to \$[ ] a day ♦          All costs</p>
<p><b>BLOOD</b>          First 3 pints          Additional amounts</p>	<p>\$0          100%</p>	<p>50%          \$0</p>	<p>50%♦          \$0</p>
<p><b>HOSPICE CARE</b>          Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care</p>	<p>50% of coinsurance or copayments</p>	<p>50% of coinsurance or copayments♦</p>

**\*\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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## PLAN K

**MEDICARE (PART B) – MEDICAL SERVICES-PER CALENDAR YEAR**

\*\*\*\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[100] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0  Generally 75% or more of Medicare approved amounts  Generally 80%	\$0  Remainder of Medicare approved amounts  Generally 10%	\$[100] (Part B deductible)****♦  All costs above Medicare approved amounts  Generally 10% ♦
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$ ])*
<b>BLOOD</b> First 3 pints Next \$[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$[100] (Part B deductible)**** ♦ Generally 10% ♦
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[ ] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be**

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**responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN K****PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment first \$[100] of Medicare Approved Amounts*****	\$0	\$0	\$[100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	10%	10% ♦

\*\*\*\*\* Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

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**Section 2008.APPENDIX N Plan L (for plans issued prior to June 1, 2010)**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

- \* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD**

- \*\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOSPITALIZATION**</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$[ ]	\$[ ] (75% of Part A deductible)	\$[ ] (25% of Part A deductible)♦
61 <sup>st</sup> thru 90 <sup>th</sup> day	All but \$[ ] a day	\$[ ] a day	\$0
91 <sup>st</sup> day and after:			
- While using 60 lifetime reserve days	All but \$[ ] a day	\$[ ] a day	\$0
- Once lifetime reserve days are used:			
- Additional 365 days	\$0	100% of Medicare eligible expenses	\$0***
- Beyond the additional 365 days	\$0	\$0	All costs

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## NOTICE OF ADOPTED AMENDMENTS

<p><b>SKILLED NURSING FACILITY CARE**</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</p> <p>First 20 days 21<sup>st</sup> thru 100<sup>th</sup> day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but \$[ ] a day \$0</p>	<p>\$0 Up to \$[ ] a day \$0</p>	<p>\$0 Up to \$[ ] a day♦ All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>75% \$0</p>	<p>25% ♦ \$0</p>
<p><b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care</p>	<p>75% of coinsurance or copayments</p>	<p>25% of coinsurance or copayments ♦</p>

**\*\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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## PLAN L

**MEDICARE (PART B) – MEDICAL SERVICES-PER CALENDAR YEAR**

\*\*\*\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$[100] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0  Generally 75% or more of Medicare approved amounts  Generally 80%	\$0  Remainder of Medicare approved amounts  Generally 15%	\$[100] (Part B deductible)**** ♦  All costs above Medicare approved amounts  Generally 5% ♦
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$_____])*
<b>BLOOD</b> First 3 pints Next \$[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% ♦ \$[100] (Part B deductible) ♦ Generally 5% ♦
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[ ] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be**

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**responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**PLAN L****PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
- Medically necessary skilled care services and medical supplies	100%	\$0	\$0
- Durable medical equipment 1st \$[100] of Medicare Approved Amounts*****	\$0	\$0	[\$100] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	80%	15%	5% ♦

\*\*\*\*\* Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(Source: Amended at 33 Ill. Reg. 8904, effective June 10, 2009)

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**Section 2008.APPENDIX W Outline of Medicare Supplement Coverage – Cover Page for Medicare Supplement Plans Sold on or after June 1, 2010**

**Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

**Basic Benefits:**

- Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- Blood** – First three pints of blood each year.
- Hospice** – Part A coinsurance.

<b><u>A</u></b>	<b><u>B</u></b>	<b><u>C</u></b>	<b><u>D</u></b>	<b><u>F</u></b>	<b><u>F*</u></b>	<b><u>G</u></b>	<b><u>K</u></b>	<b><u>L</u></b>	<b><u>M</u></b>	<b><u>N</u></b>
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER			
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance

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	<a href="#">Part A Deductible</a>	<a href="#">Part A Deductible</a>	<a href="#">Part A Deductible</a>	<a href="#">Part A Deductible</a>	<a href="#">Part A Deductible</a>	<a href="#">50% Part A Deductible</a>	<a href="#">75% Part A Deductible</a>	<a href="#">50% Part A Deductible</a>	<a href="#">Part A Deductible</a>
		<a href="#">Part B Deductible</a>		<a href="#">Part B Deductible</a>					
				<a href="#">Part B Excess (100%)</a>	<a href="#">Part B Excess (100%)</a>				
		<a href="#">Foreign Travel Emergency</a>			<a href="#">Foreign Travel Emergency</a>	<a href="#">Foreign Travel Emergency</a>			
						<a href="#">Out-of-pocket limit \$[4140]; paid at 100% after limit reached</a>	<a href="#">Out-of-pocket limit \$[2070]; paid at 100% after limit reached</a>		

\* [Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \\$\[1860\] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \\$\[1860\]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.](#)

**[PREMIUM INFORMATION \[Boldface Type\]](#)**

[We \[insert issuer's name\] can only raise your premium if we raise the premium for all policies like yours in this State. \[If the premium is based on the increasing age of the insured, include information specifying when premiums will change.\]](#)

**[DISCLOSURES \[Boldface Type\]](#)**

[Use this outline to compare benefits and premiums among policies.](#)

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J will no longer be available for sale after May 31, 2010.](#)

**[READ YOUR POLICY VERY CAREFULLY \[Boldface Type\]](#)**

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This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

**RIGHT TO RETURN POLICY [Boldface Type]**

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

**POLICY REPLACEMENT [Boldface Type]**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

**NOTICE [Boldface Type]**

This policy may not fully cover all of your medical costs.

[for producers:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult Medicare and You for more details.

**COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

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[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in Appendices AA through JJ of this Part. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this Part. An issuer may use additional benefit plan designations on these charts pursuant to Section 2008.67(e) of this Part.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Director.]

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX AA Plan A (for plans issued on or after June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

- \*—A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>HOSPITALIZATION*</u></b> <u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____ ]</u>	<u>\$0</u>	<u>[\$ _____ ] (Part A Deductible)</u>
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but [\$ _____ ] a day</u>	<u>[\$ _____ ] a day</u>	<u>\$0</u>
<u>91<sup>st</sup> day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but [\$ _____ ] a day</u>	<u>[\$ _____ ] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve days are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare Eligible Expenses</u>	<u>\$0**</u>
<u>– Beyond the Additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE*</u></b> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>

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<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but [\$_____] a day</u>	<u>\$0</u>	<u>Up to [\$_____] a day</u>
<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b>			
<u>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</u>	<u>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**(Plan A Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

- \*\_\_\_\_\_Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</u></b>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>[\$100] (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>generally 80%</u>	<u>generally 20%</u>	<u>\$0</u>
<b><u>Part B Excess Charges</u></b> <u>(Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>

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<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
<u>Next \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<b><u>CLINICAL LABORATORY SERVICES</u></b>			
<b><u>TESTS FOR DIAGNOSTIC SERVICES</u></b>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>PARTS A &amp; B</u></b>			
<b><u>SERVICES</u></b>	<b><u>MEDICARE PAYS</u></b>	<b><u>PLAN PAYS</u></b>	<b><u>YOU PAY</u></b>
<b><u>HOME HEALTH CARE</u></b>			
<u>MEDICARE APPROVED SERVICES</u>			
– <u>Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
– <u>Durable medical equipment</u>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$100 (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

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## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX BB Plan B (for plans issued on or after June 1, 2010)****MEDICARE (PART A) – Hospital Services-Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

- \*———A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>HOSPITALIZATION*</u></b>			
<u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$_____]</u>	<u>[\$_____] (Part A Deductible)</u>	<u>\$0</u>
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but [\$_____] a day</u>	<u>[\$_____] a day</u>	<u>\$0</u>
<u>91<sup>st</sup> day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but [\$_____] a day</u>	<u>[\$_____] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve days are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare Eligible Expenses</u>	<u>\$0**</u>
<u>– Beyond the Additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE*</u></b>			
<u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>

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<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but [\$ _____ ] day</u>	<u>\$0</u>	<u>Up to [\$ _____ ] a day</u>
<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b>			
<u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**(Plan B Continued)**

**MEDICARE (PART B) – Medical Services – Per Calendar Year**

- \*—Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b><u>SERVICES</u></b>	<b><u>MEDICARE PAYS</u></b>	<b><u>PLAN PAYS</u></b>	<b><u>YOU PAY</u></b>
<b><u>MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</u></b>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>

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<u>Remainder of Medicare Approved Amounts</u>	<u>generally 80%</u>	<u>generally 20%</u>	<u>\$0</u>
<u>Part B Excess Charges (Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
First 3 pints	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
Next \$[100] of Medicare Approved Amounts*	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>
Remainder of Medicare Approved Amounts	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<b><u>CLINICAL LABORATORY SERVICES</u></b>			
<u>TEST FOR DIAGNOSTIC SERVICES</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

**PARTS A & B**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>HOME HEALTH CARE</u></b>			
<u>MEDICARE APPROVED SERVICES</u>			
– <u>Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
– <u>Durable medical equipment</u>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

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**Section 2008.APPENDIX CC Plan C (for plans issued on or after June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

- \*———A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>HOSPITALIZATION*</u></b>			
<u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____ ]</u>	<u>[\$ _____ ] (Part A Deductible)</u>	<u>\$0</u>
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but [\$ _____ ] a day</u>	<u>[\$ _____ ] a day</u>	<u>\$0</u>
<u>91<sup>st</sup> day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but [\$ _____ ] a day</u>	<u>[\$ _____ ] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve day are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare Eligible Expenses</u>	<u>\$0**</u>
<u>– Beyond the Additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE*</u></b>			
<u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			

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<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but [\$ _____ ] a day</u>	<u>Up to [\$ _____ ] a day</u>	<u>\$0</u>
<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b>			
<u>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</u>	<u>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**(Plan C Continued)**

**MEDICARE (PART B) – Medical Services – Per Calendar Year**

- \* \_\_\_\_\_ Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<u><b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b></u>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>	<u>\$0</u>

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<u>Remainder of Medicare Approved Amounts</u>	<u>generally 80%</u>	<u>generally 20%</u>	<u>\$0</u>
<b><u>Part B Excess Charges</u></b> <u>(Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
<u>Next \$[100] of Medicare Approved Amounts</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>	<u>\$0</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<b><u>CLINICAL LABORATORY SERVICES -- TESTS FOR DIAGNOSTIC SERVICES</u></b>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

**PARTS A & B**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>HOME HEALTH CARE</u></b>			
<u>MEDICARE APPROVED SERVICES</u>			
<u>– Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>– Durable medical equipment</u>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>	<u>\$0</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

**(Plan C Continued)****OTHER BENEFITS – Not Covered By Medicare**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u></b>			
<u>medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</u>			
<u>First \$250 each calendar year</u>	<u>\$0</u>	<u>\$0</u>	<u>\$250</u>

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<a href="#">Remainder of Charges</a>	<a href="#">\$0</a>	<a href="#">80% to a lifetime maximum benefit of \$50,000</a>	<a href="#">20% and amounts over the \$50,000 lifetime maximum</a>
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(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX DD Plan D (for plans issued on or after June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<b><u>SERVICES</u></b>	<b><u>MEDICARE PAYS</u></b>	<b><u>PLAN PAYS</u></b>	<b><u>YOU PAY</u></b>
<b><u>HOSPITALIZATION*</u></b>			
<u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____ ]</u>	<u>[\$ _____ ] (Part A Deductible)</u>	<u>\$0</u>
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but [\$ _____ ] a day</u>	<u>[\$ _____ ] a day</u>	<u>\$0</u>
<u>91<sup>st</sup> day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but [\$ _____ ] a day</u>	<u>[\$ _____ ] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve days are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare Eligible Expenses</u>	<u>\$0**</u>
<u>– Beyond the Additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE*</u></b>			
<u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but [\$ _____ ] a day</u>	<u>Up to [\$ _____ ] a day</u>	<u>\$0</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b>			
<u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**(Plan D Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

\* Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

<b><u>SERVICES</u></b>	<b><u>MEDICARE PAYS</u></b>	<b><u>PLAN PAYS</u></b>	<b><u>YOU PAY</u></b>
<b><u>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</u></b>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>generally 80%</u>	<u>generally 20%</u>	<u>\$0</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>Part B Excess Charges</u> (Above Medicare Approved Amounts)	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
<u>Next \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<b><u>CLINICAL LABORATORY SERVICES</u></b>			
<u>TESTS FOR DIAGNOSTIC SERVICES</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

**PARTS A & B**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>HOME HEALTH CARE</u></b>			
<u>MEDICARE APPROVED SERVICES</u>			
<u>– Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>– Durable medical equipment</u>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

**OTHER BENEFITS – Not Covered by Medicare**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u></b>			
<u>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</u>			
<u>First \$250 each calendar year</u>	<u>\$0</u>	<u>\$0</u>	<u>\$250</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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<a href="#">Remainder of Charges</a>	<a href="#">\$0</a>	<a href="#">80% to a lifetime maximum benefit of \$50,000</a>	<a href="#">20% and amounts over the \$50,000 lifetime maximum</a>
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(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX EE Plan F or High Deductible Plan F (for plans issued on or after June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$ \_\_\_\_\_] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are [\$ \_\_\_\_\_]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>[AFTER YOU PAY \$_____ DEDUCTIBLE**] PLAN PAYS</u>	<u>[IN ADDITION TO \$_____ DEDUCTIBLE**] YOU PAY</u>
<u>HOSPITALIZATION*</u> <u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____]</u>	<u>[\$ _____] (Part A Deductible)</u>	<u>\$0</u>
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but [\$ _____] a day</u>	<u>[\$ _____] a day</u>	<u>\$0</u>
<u>91<sup>st</sup> day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but [\$ _____] a day</u>	<u>[\$ _____] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve days are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare Eligible Expenses</u>	<u>\$0***</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>- Beyond the Additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE*</u></b> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but [\$ _____ ] a day</u>	<u>Up to [\$ _____ ] a day</u>	<u>\$0</u>
<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b> <u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/coinsurance for out-patient drugs and in- patient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

**\*\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**(Plan F or High Deductible Plan F Continued)**

**MEDICARE (PART B) – Medical Services – Per Calendar Year**

\* Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**[\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$ ] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$ ]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>[AFTER YOU PAY [\$ ] DEDUCTIBLE**] PLAN PAYS</u>	<u>[IN ADDITION TO [\$ ] DEDUCTIBLE**] YOU PAY</u>
<u>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</u>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>[\$100] (Part B Deductible)</u>	<u>\$0</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>generally 80%</u>	<u>generally 20%</u>	<u>\$0</u>
<u>Part B Excess Charges</u> (Above Medicare Approved Amounts)	<u>\$0</u>	<u>100%</u>	<u>\$0</u>
<u>BLOOD</u>			
<u>First 3 pints</u>	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
<u>Next \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>[\$100] (Part B Deductible)</u>	<u>\$0</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<u>CLINICAL LABORATORY SERVICES</u>			
<u>TESTS FOR DIAGNOSTIC SERVICES</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

**PARTS A & B**

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>[AFTER YOU PAY [ \$ ] DEDUCTIBLE**] PLAN PAYS</u>	<u>[IN ADDITION TO [ \$ ] DEDUCTIBLE**] YOU PAY</u>
<b><u>HOME HEALTH CARE</u></b>			
<b><u>MEDICARE APPROVED SERVICES</u></b>			
<u>– Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>– Durable medical equipment</u>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>[\$100] (Part B Deductible)</u>	<u>\$0</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

**OTHER BENEFITS – Not Covered By Medicare**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>[AFTER YOU PAY THE [ \$ ] DEDUCTIBLE**] PLAN PAYS</u>	<u>[IN ADDITION TO THE [ \$ ] DEDUCTIBLE**] YOU PAY</u>
<b><u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u></b>			
<u>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</u>			
<u>First \$250 each calendar year</u>	<u>\$0</u>	<u>\$0</u>	<u>\$250</u>
<u>Remainder of Charges</u>	<u>\$0</u>	<u>80% to a lifetime maximum benefit of \$50,000</u>	<u>20% and amounts over the \$50,000 lifetime maximum</u>

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX FF Plan G (for plans issued on or after June 1, 2010)****MEDICARE (PART A) – Hospital Services – Per Benefit Period**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<b><u>SERVICES</u></b>	<b><u>MEDICARE PAYS</u></b>	<b><u>PLAN PAYS</u></b>	<b><u>YOU PAY</u></b>
<b><u>HOSPITALIZATION*</u></b>			
<u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____ ]</u>	<u>[\$ _____ ] (Part A Deductible)</u>	<u>\$0</u>
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but [\$ _____ ] a day</u>	<u>[\$ _____ ] a day</u>	<u>\$0</u>
<u>91<sup>st</sup> day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but [\$ _____ ] a day</u>	<u>[\$ _____ ] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve days are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare Eligible Expenses</u>	<u>\$0**</u>
<u>– Beyond the Additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE*</u></b>			
<u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but [\$ _____ ] a day</u>	<u>Up to [\$ _____ ] a day</u>	<u>\$0</u>
<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b>			
<u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**(Plan G Continued)****MEDICARE (PART B) – Medical Services – Per Calendar Year**

**\* Once you have been billed \$[100] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.**

<b><u>SERVICES</u></b>	<b><u>MEDICARE PAYS</u></b>	<b><u>PLAN PAYS</u></b>	<b><u>YOU PAY</u></b>
<b><u>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</u></b>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>Remainder of Medicare Approved Amounts</u>	<u>generally 80%</u>	<u>generally 20%</u>	<u>\$0</u>
<b><u>Part B Excess Charges</u></b> (Above Medicare Approved Amounts)	<u>\$0</u>	<u>100%</u>	<u>\$0</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
<u>Next \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<b><u>CLINICAL LABORATORY SERVICES</u></b>			
<u>TESTS FOR DIAGNOSTIC SERVICES</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

**PARTS A & B**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>HOME HEALTH CARE</u></b>			
<u>MEDICARE APPROVED SERVICES</u>			
<u>– Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>– Durable medical equipment</u>			
<u>First \$[100] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u></b>			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</u>			
<u>First \$250 each calendar year</u>	<u>\$0</u>	<u>\$0</u>	<u>\$250</u>
<u>Remainder of Charges</u>	<u>\$0</u>	<u>80% to a lifetime maximum benefit of \$50,000</u>	<u>20% and amounts over the \$50,000 lifetime maximum</u>

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX GG Plan K (for plans issued on or after June 1, 2010)**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<b><u>HOSPITALIZATION**</u></b> <u>Semiprivate room and board,</u> <u>general nursing and miscellaneous</u> <u>services and supplies</u>			
<u>First 60 days</u>	<u>All but \$[ ]</u>	<u>\$[ ] (50% of Part A deductible)</u>	<u>\$[ ] (50% of Part A deductible)♦</u>
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but \$[ ] a day</u>	<u>\$[ ] a day</u>	<u>\$0</u>
<u>91<sup>st</sup> day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but \$[ ] a day</u>	<u>\$[ ] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve days are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare eligible expenses</u>	<u>\$0***</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>- Beyond the additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE**</u></b> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but \$[ ] a day</u>	<u>Up to \$[ ] a day</u>	<u>Up to \$[ ] a day ♦</u>
<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>50%</u>	<u>50%♦</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b> <u>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</u>	<u>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</u>	<u>50% of copayment/coinsurance</u>	<u>50% of Medicare copayment/coinsurance♦</u>

**\*\*\*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN K****MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

**\*\*\*\*** Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<u><b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</b></u>  <u>First \$[100] of Medicare Approved Amounts****</u>  <u>Preventive Benefits for Medicare covered services</u>  <u>Remainder of Medicare Approved Amounts</u>	<u>\$0</u>  <u>Generally 75% or more of Medicare approved amounts</u>  <u>Generally 80%</u>	<u>\$0</u>  <u>Remainder of Medicare approved amounts</u>  <u>Generally 10%</u>	<u>\$[100] (Part B deductible)****♦</u>  <u>All costs above Medicare approved amounts</u>  <u>Generally 10% ♦</u>
<u><b>Part B Excess Charges (Above Medicare Approved Amounts)</b></u>	<u>\$0</u>	<u>\$0</u>	<u>All costs (and they do not count toward annual out-of-pocket limit of [\$__])*</u>
<u><b>BLOOD</b></u>  <u>First 3 pints</u>  <u>Next \$[100] of Medicare Approved Amounts****</u>  <u>Remainder of Medicare Approved Amounts</u>	<u>\$0</u>  <u>\$0</u>  <u>Generally 80%</u>	<u>50%</u>  <u>\$0</u>  <u>Generally 10%</u>	<u>50% ♦</u>  <u>\$[100] (Part B deductible)**** ♦</u>  <u>Generally 10% ♦</u>
<u><b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b></u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[\_\_] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**PARTS A & B**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<b><u>HOME HEALTH CARE MEDICARE APPROVED SERVICES</u></b>			
<u>– Medically necessary skilled care services and medical supplies</u>	100%	\$0	\$0
<u>– Durable medical equipment</u>			
<u>    First \$[100] of Medicare Approved Amounts*****</u>	\$0	\$0	\$[100] (Part B deductible) ♦
<u>    Remainder of Medicare Approved Amounts</u>	80%	10%	10% ♦

\*\*\*\*\* Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX HH Plan L (for plans issued on or after June 1, 2010)**

Companies must add the current fixed dollar amount authorized by Medicare where the brackets appear below. The dollar amount is updated periodically by Medicare and companies must reflect these changes to their outlines of coverage in a timely manner.

\* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$[ ] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

**MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\*\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<b><u>HOSPITALIZATION**</u></b> <u>Semiprivate room and board,</u> <u>general nursing and miscellaneous</u> <u>services and supplies</u>			
<u>First 60 days</u>	<u>All but \$[ ]</u>	<u>\$[ ] (75% of Part A deductible)</u>	<u>\$[ ] (25% of Part A deductible)♦</u>
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but \$[ ] a day</u>	<u>\$[ ] a day</u>	<u>\$0</u>
<u>91<sup>st</sup> day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but \$[ ] a day</u>	<u>\$[ ] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve days are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare eligible expenses</u>	<u>\$0***</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>- Beyond the additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE**</u></b> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but \$[ ] a day</u>	<u>Up to \$[ ] a day</u>	<u>Up to \$[ ] a day♦</u>
<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>75%</u>	<u>25% ♦</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b> <u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</u>	<u>75% of copayment/coinsurance</u>	<u>25% of copayment/coinsurance♦</u>

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN L****MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*\*\*\* Once you have been billed \$[100] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<u>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</u>  <u>First \$[100] of Medicare Approved Amounts****</u>  <u>Preventive Benefits for Medicare covered services</u>  <u>Remainder of Medicare Approved Amounts</u>	<u>\$0</u>  <u>Generally 75% or more of Medicare approved amounts</u>  <u>Generally 80%</u>	<u>\$0</u>  <u>Remainder of Medicare approved amounts</u>  <u>Generally 15%</u>	<u>\$[100] (Part B deductible)**** ♦</u>  <u>All costs above Medicare approved amounts</u>  <u>Generally 5% ♦</u>
<u>Part B Excess Charges (Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs (and they do not count toward annual out-of-pocket limit of [\$ _____])*</u>
<u>BLOOD</u> <u>First 3 pints</u>  <u>Next \$[100] of Medicare Approved Amounts****</u>  <u>Remainder of Medicare Approved Amounts</u>	<u>\$0</u>  <u>\$0</u>  <u>Generally 80%</u>	<u>75%</u>  <u>\$0</u>  <u>Generally 15%</u>	<u>25% ♦</u>  <u>\$[100] (Part B deductible) ♦</u>  <u>Generally 5% ♦</u>
<u>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

\* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[ ] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

PLAN LPARTS A & B

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<u>HOME HEALTH CARE MEDICARE APPROVED SERVICES</u>			
– <u>Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
– <u>Durable medical equipment</u>			
<u>1<sup>st</sup> \$[100] of Medicare Approved Amounts*****</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B deductible) ♦</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>15%</u>	<u>5% ♦</u>

\*\*\*\*\* Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX II Plan M (for plans issued on or after June 1, 2010)****PLAN M****MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<b><u>HOSPITALIZATION*</u></b> <u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but \$[992]</u>	<u>\$[496] (50% of Part A deductible)</u>	<u>\$[496] (50% of Part A deductible)</u>
<u>91<sup>st</sup> day and after:</u>	<u>All but \$[248] a day</u>	<u>\$[248] a day</u>	<u>\$0</u>
<u>– While using 60 lifetime reserve days</u>	<u>All but \$[496] a day</u>	<u>\$[496] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve days are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare eligible expenses</u>	<u>\$0**</u>
<u>– Beyond the additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE*</u></b> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but \$[124] a day</u>	<u>Up to \$[124] a day</u>	<u>\$0</u>
<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b> You must meet Medicare's requirements, including a doctor's certification of terminal illness	<u>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</u>	<u>Medicare copayment/ coinsurance</u>	<u>\$0</u>

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN M**

**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</u></b>			
<u>1<sup>st</sup> \$[131] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>Remainder of Medicare Approved Amounts</u>	<u>Generally 80%</u>	<u>Generally 20%</u>	<u>\$0</u>
<b><u>Part B Excess Charges</u></b> <u>(Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
<u>Next \$[131] of Medicare Approved Amounts</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<b><u>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</u></b>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

**PARTS A & B**

<b><u>HOME HEALTH CARE MEDICARE APPROVED SERVICES</u></b>			
<u>– Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>– Durable medical equipment</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>1<sup>st</sup> \$[131] of Medicare Approved Amounts*</u>			
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u><b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b></u>			
<u>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</u>			
<u>First \$250 each calendar year</u>	<u>\$0</u>	<u>\$0</u>	<u>\$250</u>
<u>Remainder of Charges</u>	<u>\$0</u>	<u>80% to a lifetime maximum benefit of \$50,000</u>	<u>20% and amounts over the \$50,000 lifetime maximum</u>

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX JJ Plan N (for plans issued on or after June 1, 2010)****PLAN N****MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<b><u>HOSPITALIZATION*</u></b> <u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but \$[992]</u>	<u>\$[992](Part A deductible)</u>	<u>\$0</u>
<u>61<sup>st</sup> thru 90<sup>th</sup> day</u>	<u>All but \$[248] a day</u>	<u>\$[248] a day</u>	<u>\$0</u>
<u>91<sup>st</sup> day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but \$[496] a day</u>		
<u>– Once lifetime reserve days are used:</u>		<u>\$[496] a day</u>	<u>\$0</u>
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare eligible expenses</u>	
<u>– Beyond the additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>SKILLED NURSING FACILITY CARE*</u></b> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

<u>21<sup>st</sup> thru 100<sup>th</sup> day</u>	<u>All but \$[124] a day</u>	<u>Up to \$[124] a day</u>	<u>\$0</u>
<u>101<sup>st</sup> day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional Amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b>			
<u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

**\*\* NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN N**

**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b><u>SERVICES</u></b>	<b><u>MEDICARE PAYS</u></b>	<b><u>PLAN PAYS</u></b>	<b><u>YOU PAY</u></b>
<b><u>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</u></b>			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>1<sup>st</sup> \$[131] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>Generally 80%</u>	<u>Balance, other than up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</u>	<u>Up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</u>
<b><u>Part B Excess Charges</u></b> <u>(Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
<u>First 3 pints</u>	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
<u>Next \$[131] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<b><u>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</u></b>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

**PARTS A & B**

<b><u>HOME HEALTH CARE MEDICARE APPROVED SERVICES</u></b>			
<u>– Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>– Durable medical equipment</u>			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<u>1<sup>st</sup> \$[131] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b><u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u></b>			
<u>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</u>			
<u>First \$250 each calendar year</u>	<u>\$0</u>	<u>\$0</u>	<u>\$250</u>
<u>Remainder of Charges</u>	<u>\$0</u>	<u>80% to a lifetime maximum benefit of \$50,000</u>	<u>20% and amount over the \$50,000 lifetime maximum</u>

(Source: Added at 33 Ill. Reg. 8904, effective June 10, 2009)

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Medical Payment
- 2) Code Citation: 89 Ill. Adm. Code 140
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
140.414	Amendment
140.422	Repeal
140.427	Repeal
140.443	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Amendments: June 15, 2009
- 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 Proposal Published in Illinois Register: December 1, 2008; 32 Ill. Reg. 18121
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences Between Proposal and Final Version:

In Section 140.414(a)(2)(A), changed "all federal and State laws and regulations regarding prescriptions for controlled substances" to "Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23)".

In Section 140.414(a)(2)(B), changed "federal and State laws and regulations" to "Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23)".

In Section 140.443(a), changed "federal and State laws and regulations" to "Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23)".

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF ADOPTED AMENDMENTS

In Section 140.443(b)(3), before "verified", added "or the prescriber's agent".

- 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 rulemakings currently in effect? No
- 14) Are there any other amendments pending on this Part? Yes

<u>Section Numbers:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
140.454	Amendment	July 18, 2008; 32 Ill. Reg. 10782
140.455	Amendment	July 18, 2008; 32 Ill. Reg. 10782
140.413	Amendment	August 22, 2008; 32 Ill. Reg. 13761
140.435	Amendment	August 22, 2008; 32 Ill. Reg. 13761
140.436	Amendment	August 22, 2008; 32 Ill. Reg. 13761
140.14	Amendment	August 29, 2008; 32 Ill. Reg. 14003
140.16	Amendment	August 29, 2008; 32 Ill. Reg. 14003
140.44	Amendment	August 29, 2008; 32 Ill. Reg. 14003
140.3	Amendment	January 30, 2009; 33 Ill. Reg. 1617
140.403	New Section	January 30, 2009; 33 Ill. Reg. 1617
140.400	Amendment	March 27, 2009; 33 Ill. Reg. 4468
140.425	Amendment	April 10, 2009; 33 Ill. Reg. 5178

- 15) Summary and Purpose of Amendments: The amendments comply with federal requirements that all non-electronic prescriptions be written on tamper-resistant prescription pads in order to be eligible for reimbursement under Medicaid.
- 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 E., 3<sup>rd</sup> 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

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## 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

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- 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
- 140.19 Application to Participate or for Reinstatement Subsequent to Termination,

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	Suspension or Barring
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140.21	Reimbursement for QMB Eligible Medical Assistance Recipients and QMB Eligible Only Recipients and Individuals Who Are Entitled to Medicare Part A or Part B and Are Eligible for Some Form of Medicaid Benefits
140.22	Magnetic Tape Billings (Repealed)
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140.82	Developmentally Disabled Care Provider Fund
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- 140.101 Transplants (Recodified)
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- 140.110 Disproportionate Share Hospital Adjustments (Recodified)
- 140.116 Payment for Inpatient Services for GA (Recodified)
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- 140.200 Payment for Hospital Services During Fiscal Year 1982 (Recodified)
- 140.201 Payment for Hospital Services After June 30, 1982 (Repealed)
- 140.202 Payment for Hospital Services During Fiscal Year 1983 (Recodified)
- 140.203 Limits on Length of Stay by Diagnosis (Recodified)
- 140.300 Payment for Pre-operative Days and Services Which Can Be Performed in an Outpatient Setting (Recodified)
- 140.350 Copayments (Recodified)
- 140.360 Payment Methodology (Recodified)
- 140.361 Non-Participating Hospitals (Recodified)
- 140.362 Pre July 1, 1989 Services (Recodified)
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- 140.369 Groupings (Recodified)
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- 140.376 Utilization, Case-Mix and Discretionary Funds (Repealed)
- 140.390 Subacute Alcoholism and Substance Abuse Services (Recodified)
- 140.391 Definitions (Recodified)
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## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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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.

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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; 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.

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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. 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

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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; 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.

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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. 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,

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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 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,

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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, 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

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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. 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; peremptory amendment suspended at 32 Ill. Reg. 8449, effective May 21, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 32 Ill. Reg. 18323, effective November 12, 2008; peremptory amendment repealed by emergency rulemaking at 32 Ill. Reg. 18422, effective November 12, 2008, for a maximum of 150 days; emergency expired April 10, 2009; peremptory amendment repealed at 33 Ill. Reg. 6667, effective April 29, 2009; amended at 32 Ill. Reg. 7727, effective May 5, 2008; emergency amendment at 32 Ill. Reg. 10480, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 32 Ill. Reg. 17133, effective October 15, 2008; amended at 33 Ill. Reg. 209, effective December 29, 2008; amended at 33 Ill. Reg. 9048, effective June 15, 2009.

## SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

**Section 140.414 Requirements for Prescriptions and Dispensing of Pharmacy Items –  
PrescribersPhysicians**

For the purpose of this Section, "prescriber" shall mean any person who, within the scope of his or her professional licensing requirements, may prescribe or dispense drugs.

- a) Prescriptions

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- 1) A ~~prescriber~~physician may prescribe any pharmacy item, not otherwise excluded, ~~that~~which, in the ~~prescriber's~~physician's professional judgment, is essential for the diagnosis or accepted treatment of a recipient's present symptoms. The Department may require prior approval of any drug except as outlined in Section 140.442(a)(9). The Department shall require prior approval for the prescription of any items not excluded and not listed, or in excess of the quantities listed, in its Drug Manual (Section 140.72).
- 2) ~~A prescriber~~The physician shall:
  - A) Use ~~a tamper-resistant~~his own prescription form, as defined at Section 140.443(b)(2), for non-electronic prescriptions. Non-electronic prescriptions are defined at Section 140.443(b)(1). In addition, the prescriber shall ensure the prescription form is compliant with all federal and State laws and regulations regarding prescriptions for controlled substances~~(or the official form required by law for the prescription of controlled substances)~~; and
  - B) Enter on the form all data elements required under federal and State laws and regulations, as well as one of the following data elements identifying the prescriber~~the following information at a minimum~~:
    - i) Drug Enforcement Administration (DEA) Number; or
    - ii) National Provider Identifier (NPI); or
    - iii) Medical Assistance Program Provider Number; or
    - iv) Illinois State License Number.

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- iv) ~~Form and strength or potency of drug (or size of non-drug items);~~
  - v) ~~Quantity;~~
  - vi) ~~Directions for use;~~
  - vii) ~~Refill directions;~~
  - viii) ~~Legible signature in ink; and~~
  - ix) ~~Drug Enforcement Administration (DEA) Number or Social Security Number (for physicians who do not have a DEA number)~~
- 3) The ~~prescriber~~Physician shall not charge for writing a prescription, ~~and shall not write prescriptions for injectables which are given in the physician's office.~~
- 4) Items ~~that~~which shall not be prescribed are listed in Section 140.441. ~~Sections 140.440 through 140.450 as pharmaceutical services which are not covered by the Department:~~
- A) ~~Anorectic drugs or combinations including such drugs;~~
  - B) ~~Biologicals and drugs available without charge from the Illinois Department of Public Health or other agencies;~~
  - C) ~~Any vaccine, drug, or serum which is provided primarily for preventive purposes; e.g. influenza vaccine;~~
  - D) ~~Vitamin B12 or liver extract except for patients with macrocytic anemia, e.g. pernicious anemia, the diagnosis of which is established on the basis of hemotological studies;~~
  - E) ~~Injectable drugs, when equally effective oral preparations are available;~~
  - F) ~~Items such as dental products, hair products, facial tissues, infant~~

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~~disposable diapers, sanitary pads, tampons, soap or other personal hygiene products, articles of clothing or cosmetics of any type, proprietary food supplements or substitutes, sugar or salt substitutes, or household products; and~~

- ~~G) Infant formula, except for infant requiring a non-milk base product because of an allergic reaction to the usual infant products; and~~
- ~~H) Drugs that are classified by the Food and Drug Administration as ineffective or unsafe in a final order.~~

## b) Dispensed Items

- 1) A participating ~~prescriber~~physician may dispense pharmacy items subject to the Department's coverage policies. The prescriber listed in the Drug Manual (Section 140.72). ~~They physician~~ shall not charge for any samples dispensed or anesthesia agents administered for office surgical procedures.
- 2) The Department shall pay for items dispensed in an emergency or when not readily available from a pharmacy at the rate of the cost to the ~~prescriber~~physician for the item, plus 20% of the cost when itemized. The Department will pay a maximum of \$1.00 for unitemized items.

(Source: Amended at 33 Ill. Reg. 9048, effective June 15, 2009)

**Section 140.422 Requirements for Prescriptions and Dispensing Items of Pharmacy Items – Dentists (Repealed)**a) Prescriptions

- 1) ~~A dentist may prescribe within the scope of the practice of dentistry, any pharmacy item not otherwise excluded, which in the dentist's professional judgment, is essential for the diagnosis or accepted treatment of a recipient's presenting symptoms. The Department shall require prior approval for the prescription of any items not excluded and not listed, or in excess of the quantities listed, in its Drug Manual. Approval will be given if the item or quantity is determined appropriate for the condition to be~~

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~~treated in the judgment of a consulting dentist of the Department. Drugs shall be added to or removed from the Drug Manual (Section 140.72) on the basis of the Department's evaluation of changes in the listing of drugs recommended by the Committee on Drugs and Therapeutics of the Illinois State Medical Society. The Department evaluation shall include an assessment of the therapeutic value and cost impact. (See Sections 140.440 through 140.450 for covered pharmacy items).~~

- 2) ~~The dentist shall:~~
  - A) ~~Use his own prescription form (or the official form required by law for the prescription of controlled substances); and~~
  - B) ~~Enter on the form the following information at a minimum:~~
    - i) ~~Recipient's name;~~
    - ii) ~~Date;~~
    - iii) ~~Name of pharmacy item prescribed;~~
    - iv) ~~Form and strength or potency of drug (or size of non-drug item);~~
    - v) ~~Quantity;~~
    - vi) ~~Directions for use;~~
    - vii) ~~Refill directions;~~
    - viii) ~~Legible signature in ink, and~~
    - ix) ~~Drug Enforcement Administration (DEA) Number or Social Security Number (for dentists who do not have DEA Number).~~
- 3) ~~The dentist shall not charge for writing a prescription and shall not write prescriptions for injectables which are given in the dentist's office.~~

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- b) ~~Dispensed Items~~  
~~A dentist may dispense pharmacy items listed in the Drug Manual (Section 140.72). The dentist shall not charge for any samples dispensed or local anesthesia agents administered for office surgical procedures. The Department shall pay for items dispensed in an emergency or when not readily available from a pharmacy at the rate of the cost to the dentist for the item, plus 20% of the cost, when itemized. The Department will pay a maximum of \$1.00 for unitemized items.~~

(Source: Repealed at 33 Ill. Reg. 9048, effective June 15, 2009)

**Section 140.427 Requirements for Prescriptions and Dispensing ~~of~~ Pharmacy Items – Podiatry (Repealed)**

- a) ~~Prescriptions~~
- 1) ~~A podiatrist may prescribe within the scope of the practice of podiatry, any pharmacy item not otherwise excluded, which in the podiatrist's professional judgement, is essential for the diagnosis or accepted treatment of a recipient's presenting symptoms. The Department shall require prior approval for the prescription of any items not excluded and not listed, or in excess of the quantities listed, in the Department Drug Manual (Section 140.72). (See Sections 140.440 through 140.450 for covered pharmacy items).~~
- 2) ~~The podiatrist shall:~~
- A) ~~Use his own prescription form (or the official form required by law for the prescription of controlled substances); and~~
- B) ~~Enter on the for the following information at a minimum:~~
- i) ~~Recipient's name,~~
- ii) ~~Date,~~
- iii) ~~Name of pharmacy item prescribed,~~
- iv) ~~Form and strength or potency of drug (or size of non-drug~~

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- ~~item);~~
- ~~v) Quantity;~~
  - ~~vi) Directions for use;~~
  - ~~vii) Refill directions;~~
  - ~~viii) Legible signature in ink, and~~
  - ~~ix) Drug Enforcement Administration (DEA) Number or Social Security Number (for podiatrists who do not have DEA Number).~~
- 3) ~~The podiatrist shall not charge for writing a prescription and shall not write prescriptions for injectables which are given in the podiatrist's office.~~
- b) ~~Dispensed Items~~  
~~Dispensed items A podiatrist may dispense pharmacy items listed in the Drug Manual (Section 140.72). The podiatrist shall not charge for any samples dispensed or local anesthesia agents administered for office surgical procedures. The Department shall pay for items dispensed in an emergency or when not readily available from a pharmacy at the rate of the cost to the podiatrist for the item, plus 20% of the cost, when itemized. When not itemized, payment shall be made in the amount of \$1.00.~~

(Source: Repealed at 33 Ill. Reg. 9048, effective June 15, 2009)

**Section 140.443 Filling of Prescriptions**

- a) ~~The prescription form (or the official form required by law for the prescribing of controlled substances) must contain the following information required under Section 3(e) of the Pharmacy Practice Act of 1987 [225 ILCS 85/3(e)], 68 Ill. Adm. Code 1330 and 42 USC 1936(i)(23) and also contain the prescriber's at a minimum:~~
- 1) Drug Enforcement Administration (DEA) Number; or
  - 2) National Provider Identifier (NPI); or

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- 3) Medical Assistance Program Provider Number; or
  - 4) Illinois State License Number.
  - 1) Recipient's name;
  - 2) Date;
  - 3) Name of pharmacy item being prescribed;
  - 4) Form and strength or potency of drug (or size of non-drug item);
  - 5) Quantity;
  - 6) Directions for use;
  - 7) Refill directions;
  - 8) Legible signature of practitioner in ink; and
  - 9) Drug Enforcement Administration (DEA) Number or the Social Security Number (for those practitioners who do not have a DEA Number).
- b) To the extent required by federal law, effective with new prescriptions executed on or after April 1, 2008, for clients covered under Title XIX of the Social Security Act, a non-electronic prescription must be written on a tamper-resistant prescription pad to be eligible for reimbursement. This requirement applies to all prescriptions regardless of whether the Department is the primary payor.
- 1) Non-electronic prescriptions are prescriptions that are not transmitted from the prescriber to the pharmacy via telephone, telefax, electronic prescribing (e-prescribing) mechanism, or other means of electronic transmission.
  - 2) Effective April 1, 2008, a prescription form is considered tamper-resistant when it contains any of the following characteristics and, effective October 1, 2008, to be considered tamper-resistant, a prescription form must contain all of the following characteristics:

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- A) one or more industry-recognized features designed to prevent unauthorized copying of a completed or blank form;
  - B) one or more industry-recognized features to prevent the erasure or modification of information written on the prescription by the prescriber;
  - C) one or more industry-recognized features designed to prevent the use of counterfeit prescription forms.
- 3) If a patient presents at a pharmacy with a prescription written on a prescription pad that is not tamper-resistant, and the pharmacist contacts the prescriber via telephone, telefax, or other electronic communication device, and the prescriber or the prescriber's agent verifies the validity of the prescription, the prescription is then considered "electronic" and, therefore, exempt from the requirement that the prescription be written on a tamper-resistant pad. In such cases, the pharmacist shall note on the original prescription that the prescriber was contacted and the prescriber or the prescriber's agent verified the validity of the prescription.
- 4) If a patient presents at a pharmacy with a non-electronic prescription written on a pad that is not tamper-resistant, and the pharmacist is unable to contact the prescriber or the prescriber's agent to verify the validity of the prescription, and the pharmacist, in using his or her professional judgment, determines that not filling the prescription poses a health risk to the patient, the pharmacist may fill the prescription and the Department will reimburse for the prescription, provided that the patient is eligible for coverage of the drug and provided that the drug is covered by the Department. The pharmacist must obtain from the prescriber or the

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prescriber's agent a verbal, faxed, electronic or compliant written

prescription within 72 hours after the date on which the prescription was

filled.

- ~~c)~~b) Pharmacies shall not accept blank, presigned prescription forms.
- ~~d)~~e) If a drug is available by generic name and the identical drug is prescribed by trade name, payment will be based on cost of the generic product unless prior authorization has been obtained for reimbursement based upon the innovator product, or unless the Department determines that the innovator product, reimbursed at the brand name pricing methodology, is more cost-effective than the generic equivalent.
- ~~e)~~d) The Department shall not pay for dispensed items in excess of the maximum quantity established by the Department, unless prior approval has been granted to dispense an amount in excess of the maximum. The Department shall pay for no more than one month's supply of the item dispensed.
- ~~f)~~e) The Department shall pay for refills only if the prescribing practitioner authorized refills on the original prescription in accordance with State law.
- ~~g)~~f) Pharmacies may use a unit dose system in the dispensing of drugs when such a system is in compliance with all applicable State and Federal laws. The total quantity dispensed on one prescription cannot exceed the quantity prescribed or the maximum allowable quantity.

(Source: Amended at 33 Ill. Reg. 9048, effective June 15, 2009)

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- 1) Heading of the Part: Child Support Enforcement
- 2) Code Citation: 89 Ill. Adm. Code 160
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
160.60	Amendment
160.65	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Effective Date of Amendments: June 15, 2009
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Do 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 Proposal Published in Illinois Register: February 13, 2009; 33 Ill. Reg. 3030
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences Between Proposal and Final Version:

In Section 160.60(a)(1), changed "Child support worker" to "CSS" and "appropriate Division of Child" to "Child Support Specialist", and deleted "Support Enforcement personnel".

In Sections 160.60(c)(1), 160.60(d)(2) 3 times, 160.60(d)(3)(A), 160.60(d)(3)(B) twice, 160.60(d)(3)(C), and 160.60(d)(3)(D), changed "appropriate child support worker" to "CSS".

In Section 160.60(d)(A), changed "child support worker" to "CSS".

In Sections 160.65(a)(6), 160.65(f)(1) twice, 160.65(f)(2), 160.65(f)(3), 160.65(f)(4) twice, 160.65(g), 160.65(h)(1), 160.65(h)(1)(A), 160.65(h)(1)(B), 160.65(h)(1)(B)(i), and 160.65(h)(1)(B)(ii), changed "appropriate child support worker" to "CSS".

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- 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? No
- 14) Are there any other amendments pending on this Part? Yes

<u>Section Number:</u>	<u>Proposed Action:</u>	<u>Illinois Register Citation:</u>
160.70	Amendment	May 8, 2009; 33 Ill. Reg. 6377

- 15) Summary and Purpose of Amendments: These amendments make a technical change to reflect a the modification in definition of "family support specialist" (FSS) to "child support specialist" (CSS).
- 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, 3<sup>rd</sup> Floor  
Springfield IL 62763-0002

217/557-7157

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

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TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER f: COLLECTIONS

PART 160

CHILD SUPPORT ENFORCEMENT

SUBPART A: GENERAL PROVISIONS

Section

- 160.1 Incorporation by Reference
- 160.5 Definitions
- 160.10 Child Support Enforcement Program
- 160.12 Administrative Accountability Process
- 160.15 Fees for IV-D Non-TANF Cases
- 160.20 Assignment of Rights to Support
- 160.25 Recoupment

SUBPART B: COOPERATION WITH CHILD SUPPORT ENFORCEMENT

Section

- 160.30 Cooperation With Support Enforcement Program
- 160.35 Good Cause for Failure to Cooperate with Support Enforcement
- 160.40 Proof of Good Cause For Failure to Cooperate With Support Enforcement
- 160.45 Suspension of Child Support Enforcement Upon a Claim of Good Cause

SUBPART C: ESTABLISHMENT AND MODIFICATION OF  
CHILD SUPPORT ORDERS

Section

- 160.60 Establishment of Support Obligations
- 160.61 Uncontested and Contested Administrative Paternity and Support Establishment
- 160.62 Cooperation with Paternity Establishment and Continued Eligibility  
Demonstration Program (Repealed)
- 160.64 Compromise of Assigned Obligations
- 160.65 Modification of Support Obligations

SUBPART D: ENFORCEMENT OF CHILD SUPPORT ORDERS

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Section	
160.70	Enforcement of Support Orders
160.71	Credit for Payments Made Directly to the Title IV-D Client
160.75	Withholding of Income to Secure Payment of Support
160.77	Certifying Past-Due Support Information or Failure to Comply with a Subpoena or Warrant to State Licensing Agencies
160.80	Amnesty – 20% Charge (Repealed)
160.85	Diligent Efforts to Serve Process
160.88	State Case Registry
160.89	Interest

## SUBPART E: EARMARKING CHILD SUPPORT PAYMENTS

Section	
160.90	Earmarking Child Support Payments

## SUBPART F: DISTRIBUTION OF SUPPORT COLLECTIONS

Section	
160.95	State Disbursement Unit
160.100	Distribution of Child Support for TANF Recipients
160.110	Distribution of Child Support for Former AFDC or TANF Recipients Who Continue to Receive Child Support Enforcement Services
160.120	Distribution of Child Support Collected While the Client Was an AFDC or TANF Recipient, But Not Yet Distributed at the Time the AFDC or TANF Case Is Cancelled
160.130	Distribution of Intercepted Federal Income Tax Refunds
160.132	Distribution of Child Support for Non-TANF Clients
160.134	Distribution of Child Support For Interstate Cases
160.136	Distribution of Support Collected in IV-E Foster Care Maintenance Cases
160.138	Distribution of Child Support for Medical Assistance No Grant Cases

## SUBPART G: STATEMENT OF CHILD SUPPORT ACCOUNT ACTIVITY

Section	
160.140	Quarterly Notice of Child Support Account Activity

## SUBPART H: DEPARTMENT REVIEW OF DISTRIBUTION OF CHILD SUPPORT

Section

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- 160.150 Department Review of Distribution of Child Support for TANF Recipients  
160.160 Department Review of Distribution of Child Support for Former AFDC or TANF Recipients

AUTHORITY: Implementing and authorized by Sections 4-1.7, Art. X, 12-4.3, and 12-13 of the Illinois Public Aid Code [305 ILCS 5/4-1.7, Art. X, 12-4.3 and 12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 112.78 through 112.86 and 112.88 at 10 Ill. Reg. 11928; amended at 10 Ill. Reg. 19990, effective November 14, 1986; emergency amendment at 11 Ill. Reg. 4800, effective March 5, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9129, effective April 30, 1987; amended at 11 Ill. Reg. 15208, effective August 31, 1987; emergency amendment at 11 Ill. Reg. 1563, effective December 31, 1987, for a maximum of 150 days; amended at 12 Ill. Reg. 9065, effective May 16, 1988; amended at 12 Ill. Reg. 18185, effective November 4, 1988; emergency amendment at 12 Ill. Reg. 20835, effective December 2, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 22278, effective January 1, 1989; amended at 13 Ill. Reg. 4268, effective March 21, 1989; amended at 13 Ill. Reg. 7761, effective May 22, 1989; amended at 13 Ill. Reg. 14385, effective September 1, 1989; amended at 13 Ill. Reg. 16768, effective October 12, 1989; amended at 14 Ill. Reg. 18759, effective November 9, 1990; amended at 15 Ill. Reg. 1034, effective January 21, 1991; amended at 16 Ill. Reg. 1852, effective January 20, 1992; amended at 16 Ill. Reg. 9997, effective June 15, 1992; amended at 17 Ill. Reg. 2272, effective February 11, 1993; amended at 17 Ill. Reg. 18844, effective October 18, 1993; amended at 18 Ill. Reg. 697, effective January 10, 1994; amended at 18 Ill. Reg. 12052, effective July 25, 1994; amended at 18 Ill. Reg. 15083, effective September 23, 1994; amended at 18 Ill. Reg. 17886, effective November 30, 1994; amended at 19 Ill. Reg. 1314, effective January 30, 1995; amended at 19 Ill. Reg. 8298, effective June 15, 1995; amended at 19 Ill. Reg. 12675, effective August 31, 1995; emergency amendment at 19 Ill. Reg. 15492, effective October 30, 1995, for a maximum of 150 days; amended at 20 Ill. Reg. 1195, effective January 5, 1996; amended at 20 Ill. Reg. 5659, effective March 28, 1996; emergency amendment at 20 Ill. Reg. 14002, effective October 15, 1996, for a maximum of 150 days; amended at 21 Ill. Reg. 1189, effective January 10, 1997; amended at 21 Ill. Reg. 3922, effective March 13, 1997; emergency amendment at 21 Ill. Reg. 8594, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9220, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 12197, effective August 22, 1997; amended at 21 Ill. Reg. 16050, effective November 26, 1997; amended at 22 Ill. Reg. 14895, effective August 1, 1998; emergency amendment at 22 Ill. Reg. 17046, effective September 10, 1998, for a maximum of 150 days; amended at 23 Ill. Reg. 2313, effective January 22, 1999; emergency amendment at 23 Ill. Reg. 11715, effective September 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12737, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 14560, effective December 1, 1999; amended at 24 Ill. Reg. 2380,

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effective January 27, 2000; amended at 24 Ill. Reg. 3808, effective February 25, 2000; emergency amendment at 26 Ill. Reg. 11092, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17822, effective November 27, 2002; amended at 27 Ill. Reg. 4732, effective February 25, 2003; amended at 27 Ill. Reg. 7842, effective May 1, 2003; emergency amendment at 27 Ill. Reg. 12139, effective July 11, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18891, effective November 26, 2003; amended at 28 Ill. Reg. 4712, effective March 1, 2004; emergency amendment at 28 Ill. Reg. 10225, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 15591, effective November 24, 2004; emergency amendment at 29 Ill. Reg. 2743, effective February 7, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 10211, effective June 30, 2005; amended at 29 Ill. Reg. 14995, effective September 30, 2005; emergency amendment at 30 Ill. Reg. 5426, effective March 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 8897, effective May 1, 2006; amended at 30 Ill. Reg. 13393, effective July 28, 2006; amended at 31 Ill. Reg. 12771, effective August 27, 2007; emergency amendment at 32 Ill. Reg. 543, effective January 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 6511, effective March 31, 2008; amended at 32 Ill. Reg. 16805, effective October 6, 2008; amended at 33 Ill. Reg. 591, effective January 5, 2009; amended at 33 Ill. Reg. 9077, effective June 15, 2009.

SUBPART C: ESTABLISHMENT AND MODIFICATION OF  
CHILD SUPPORT ORDERS**Section 160.60 Establishment of Support Obligations**

## a) Definitions

- 1) "~~CSS~~"~~FSS~~" means any ~~Child Support Specialist~~~~Family Support Specialist~~ performing assigned duties, his ~~or her~~ supervisory staff and any other person assigned responsibility by the Director of the Department.
- 2) "Service" or "Served" means notice given:
  - A) by personal service, certified mail (with or without return receipt requested) or restricted delivery,
  - B) *by a person who is licensed or registered as a private detective under the Private Detective, Private Alarm, Private Security, and Locksmith Act of 2004 [225 ILCS 447] or by a registered employee of a private detective agency certified under that Act, or*

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- C) *in counties with a population of less than 2,000,000* [305 ILCS 5/10-4], by any method provided by law for service of summons. (See Sections 2-202, 2-203 and 2-206 of the Code of Civil Procedure [735 ILCS 5/2-202, 2-203 and 2-206].)
- 3) "Support Statutes" means the following:
- A) Article X of the Illinois Public Aid Code [305 ILCS 5/Art. X];
  - B) The Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5];
  - C) The Non-Support Punishment Act [750 ILCS 16];
  - D) The Uniform Interstate Family Support Act [750 ILCS 22];
  - E) The Illinois Parentage Act of 1984 [750 ILCS 45]; and
  - F) Any other statute in another state that provides for child support.
- 4) "Retroactive support" means support for a period prior to the date a court or administrative support order is entered.
- 5) "Child's needs" means:
- A) the custodial parent's statement of the associated costs, including, but not limited to, providing a child with: food, shelter, clothing, schooling, recreation, transportation and medical care; or
  - B) the State's current minimum hourly wage multiplied by 40 hours per work week, multiplied by 4.3 weeks per month, multiplied by the applicable child support guideline percentage contained in subsection (c)(1) of this Section.
- b) Responsible Relative Contact
- 1) Timing and Purpose of Contact
    - A) The Department shall contact and interview responsible relatives in

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Title IV-D cases to establish support obligations, following the IV-D client interview.

- B) The purpose of contact and interview shall be to obtain relevant facts, including income information (for example, paycheck stubs, income tax returns) necessary to determine the financial ability of such relatives for use in obtaining stipulated, consent and other court orders for support and in entering administrative support orders, pursuant to the support statutes.
- 2) At least ten working days in advance of the interview, the Department shall notify each responsible relative contacted of his support obligation, by ordinary mail, which notice shall contain the following:
- A) the Title IV-D case name and identification number;
  - B) the names and birthdates of the persons for whom support is sought or other information identifying such persons, such as a prior court number;
  - C) that the responsible relative has a legal obligation to support the named persons;
  - D) the date, time, place and purpose of the interview and that the responsible relative may be represented by counsel; and
  - E) that the responsible relative should bring specified information regarding his income and resources to the interview.
- 3) The Department shall notify each Title IV-D client of the date, time and place of the responsible relative interview and that the client may attend if he or she chooses.
- c) Determination of Financial Ability
- 1) In cases handled under subsection (d) of this Section, the [CSSFamily Support Specialist](#) shall determine the amount of child support and enter an administrative support order on the following basis:

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Number of Children	Percent of Responsible Relative's Net Income
1	20%
2	28%
3	32%
4	40%
5	45%
6 or more	50%

- A) "Net Income" is the total of all income from all sources, minus the following deductions:
- i) Federal income tax (properly calculated withholding or estimated payments);
  - ii) State income tax (properly calculated withholding or estimated payments);
  - iii) Social Security (FICA payments);
  - iv) Mandatory retirement contributions required by law or as a condition of employment;
  - v) Union dues;
  - vi) Dependent and individual health/hospitalization insurance premiums;
  - vii) Prior obligations of support or maintenance actually paid pursuant to a court order or administrative support order;
  - viii) Expenditures for repayment of debts that represent reasonable and necessary expenses for the production of income;
  - ix) Medical expenditures necessary to preserve life or health; and
  - x) Reasonable expenditures for the benefit of the child and the

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other parent, exclusive of gifts.

- B) The deductions in subsections (c)(1)(A)(viii), (ix) and (x) of this Section shall be allowed only for the period that such payments are due. The Department shall enter administrative support orders that contain provisions for an automatic increase in the support obligation upon termination of such payment period.
- 2) In de novo hearings provided for in subsection (d)(5)(H) of this Section and 89 Ill. Adm. Code 104.102, the Department's hearing officer shall determine the minimum amount of child support as follows:

Number of Children	Percent of Responsible Relative's Net Income
1	20%
2	28%
3	32%
4	40%
5	45%
6 or more	50%

- A) "Net Income" is the total of all income from all sources, minus the following deductions:
- i) Federal income tax (properly calculated withholding or estimated payments);
  - ii) State income tax (properly calculated withholding or estimated payments);
  - iii) Social Security (FICA payments);
  - iv) Mandatory retirement contributions required by law or as a condition of employment;
  - v) Union dues;
  - vi) Dependent and individual health/hospitalization insurance premiums;

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- vii) Prior obligations of support or maintenance actually paid pursuant to a court order or administrative support order;
  - viii) Expenditures for repayment of debts that represent reasonable and necessary expenses for the production of income;
  - ix) Medical expenditures necessary to preserve life or health; and
  - x) Reasonable expenditures for the benefit of the child and the other parent, exclusive of gifts.
- B) The deductions in subsections (c)(2)(A)(viii), (ix) and (x) of this Section shall be allowed only for the period that such payments are due. The Department shall enter administrative support orders that contain provisions for an automatic increase in the support obligation upon termination of such payment period.
- C) The above guidelines shall be applied in each case unless the Department finds that application of the guidelines would be inappropriate after considering the best interests of the child in light of evidence including but not limited to one or more of the following relevant factors:
- i) the financial resources and needs of the child;
  - ii) the financial resources and needs of the custodial parent;
  - iii) the standard of living the child would have enjoyed had the marriage not been dissolved, the separation not occurred or the parties married;
  - iv) the physical and emotional condition of the child, and his educational needs; and
  - v) the financial resources and needs of the non-custodial parent.

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- D) Each order requiring support that deviates from the guidelines shall state the amount of support that would have been required under the guidelines. The reason or reasons for the variance from the guidelines shall be included in the order.
- 3) In cases referred for judicial action under subsection (e) of this Section, the Department's legal representative shall ask the court to determine the amount of child support due in accord with Section 505 and medical support in accordance with Section 505.2 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505].
- 4) All orders for support shall include a provision for the health care coverage of the child. In all cases where health insurance coverage is not being furnished by the responsible relative to a child to be covered by a support order, the Department shall enter administrative, or request the court to enter, support orders requiring the relative to provide such coverage when a child can be added to an existing insurance policy at reasonable cost or indicating what alternative arrangement for health insurance coverage is being provided. Net income shall be reduced by the cost thereof in determining the minimum amount of support to be ordered.
- 5) In cases where the net income of the responsible relative cannot be determined because of default or any other reason, the Department shall order or request the court to order the responsible relative to pay retroactive support for the prior period in the amount of the child's needs as defined by subsection (a)(5)(A) or (B) of this Section when the IV-D client requests that such an order for retroactive support be entered or requested.
- 6) The final order in all cases shall state the support level in dollar amounts.
- 7) If there is no net income because of the unemployment of a responsible relative who resides in Illinois and is not receiving General Assistance in the City of Chicago and has children receiving cash assistance in Illinois, the Department, when proceeding under subsection (d) of this Section, shall order, or, when proceeding under subsection (e) of this Section, shall request the court to order the relative to report for participation in job search, training or work programs established for such relatives. In TANF

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cases, the Department shall order, when proceeding under subsection (d) of this Section, or, when proceeding under subsection (e) of this Section, shall request the court to order payment of past-due support pursuant to a plan and, if the responsible relative is unemployed, subject to a payment plan and not incapacitated, that the responsible relative participate in job search, training and work programs established under Section 9-6 and Article IXA of the Illinois Public Aid Code [305 ILCS 5/9-6 and Art. IXA].

- 8) The Department shall enter administrative support orders, or request the court to enter support orders, that include a provision requiring the responsible relative to notify the Department, within seven days:
  - A) of any new address of the responsible relative;
  - B) of the name and address of any new employer or source of income of the responsible relative;
  - C) of any change in the responsible relative's Social Security Number;
  - D) whether the responsible relative has access to health insurance coverage through the employer or other group coverage; and
  - E) if so, the policy name and number and the names of persons covered under the policy.
- 9) The Department shall enter administrative support orders, or request the court to enter support orders, that include a date on which the current support obligation terminates. The termination date shall be no earlier than the date on which the child covered by the order will attain the age of majority or is otherwise emancipated. The order for support shall state that the termination date does not apply to any arrearage that may remain unpaid on that date. The provision of a termination date in the order shall not prevent the order from being modified.
- 10) The Department shall enter administrative support orders, or request the court to enter support orders, that include a statement that if there is an unpaid arrearage or delinquency equal to at least one month's support obligation on the termination date stated in the order for support or, if

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there is no termination date stated in the order, on the date the child attains the age of majority or is otherwise emancipated, then the periodic amount required to be paid for current support of that child immediately prior to that date shall automatically continue to be an obligation, not as current support but as periodic payment toward satisfaction of the unpaid arrearage or delinquency.

- 11) At the request of the IV-D client, the Department shall enter administrative support orders, or request the court to enter support orders, that include provisions for retroactive support, as follows:
  - A) In cases handled under subsection (d) of this Section, the Department shall order the period of retroactive support to begin with the later of two years prior to the date of entry of the administrative support order or the date of the married parties' separation (or the date of birth of the child for whom support is ordered, if the child was born out of wedlock).
  - B) In de novo hearings provided for in subsection (d)(5)(H) of this Section and 89 Ill. Adm. Code 104.102, the Department's hearing officer shall order the period of retroactive support to begin with the later of two years prior to the date of entry of the administrative support order or the date of the married parties separation (or the date of birth of the child for whom support is ordered, if the child was born out of wedlock), unless, in cases where the child was born out of wedlock, the hearing officer, after having examined the factors set forth in Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14] and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505] decides that another date is more appropriate.
  - C) In cases referred for judicial action under subsection (e) of this Section, the Department's legal representative shall ask the court to determine the date retroactive support is to commence in accord with Article X of the Illinois Public Aid Code [305 ILCS 5/Art. X], Sections 510 and 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/510 and 505], and Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14].

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## d) Administrative Process

## 1) Use of Administrative Process

A) Unless otherwise directed by the Department, the [CSSFSS](#) shall establish support obligations of responsible relatives through the administrative process set forth in this subsection (d), in Title IV-D cases, wherein the court has not acquired jurisdiction previously, in matters involving:

- i) presumed paternity as set forth in Section 5 of the Illinois Parentage Act of 1984 [750 ILCS 45/5] and support is sought from one or both parents;
- ii) alleged paternity and support is sought from the mother;
- iii) an administrative paternity order entered under Section 160.61 and support is sought from the man determined to be the child's father, or from the mother, or both;
- iv) an establishment of parentage in accordance with Section 6 of the Illinois Parentage Act of 1984 [750 ILCS 45/6]; and
- v) an establishment of parentage under the laws of another state, and support is sought from the child's father, or from the mother, or both.

B) In addition to those items specified in subsection (b)(2) of this Section, the notice of support obligation shall inform the responsible relative of the following:

- i) that the responsible relative may be required to pay retroactive support as well as current support; and
- ii) that in its initial determination of child support under subsection (c) of this Section, the Department will only consider factors listed in subsections (c)(1)(A)(i) through (x) of this Section; and

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- iii) that the Department will enter an administrative support order based only on those factors listed in subsections (c)(1)(A)(i) through (x) of this Section; and
- iv) that in order for the Department to consider other factors listed in subsection (c)(2)(C) of this Section, Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14], and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505], either the responsible relative or the client must request a de novo hearing within 30 days after mailing or delivery of the administrative support order; and
- v) that both the client and the responsible relative have a right to request a de novo hearing within 30 days after the mailing or delivery of an administrative support order, at which time a Department hearing officer may consider other factors listed in subsection (c)(2)(C) of this Section, Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14], and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505]; and
- vi) that unless the client and/or the responsible relative requests a de novo hearing within 30 days after the order's mailing or delivery, the administrative support order will become a final enforceable order of the Department; and
- vii) that upon failure of the responsible relative to appear for the interview or to provide necessary information to determine net income, an administrative support order may be entered by default or the Department may seek court determination of financial ability based upon the guidelines.

- | 2) The [CSSFSS](#) shall determine the ability of each responsible relative to provide support in accordance with subsection (c) of this Section when such relative appears in response to the notice of support obligation and provides necessary information to determine net income. An administrative support order shall be entered which shall incorporate the

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resulting support amount therein. When requested by the IV-D client, the [CSSFSS](#) shall also determine (and incorporate in the administrative support order) the amount of retroactive support the responsible relative shall be required to pay by applying the relative's current net income (unless the relative provides necessary information to determine net income for the prior period) to the support guidelines in accordance with subsection (c) of this Section. The [CSSFSS](#) shall reduce the total amount of retroactive support determined by the amount of cash contributions made by the responsible relative to the IV-D client for the benefit of the child during the retroactive period as specified in the IV-D client's affidavit of direct contribution. In no event shall credit be given in excess of the total amount of the retroactive support determined.

## 3) Failure to Appear

- A) In instances in which the responsible relative fails to appear in response to the notice of support obligation or fails to provide necessary information to determine net income, the [CSSFSS](#) shall enter an administrative support order by default, except as provided in subsection (d)(3)(D) of this Section. The terms of the order shall be based upon the needs of the child for whom support is sought, as defined by subsection (a)(5) of this Section. No default order shall be entered when a responsible relative fails to appear at the interview unless the relative shall have been served as provided by law with a notice of support obligation.
- B) The [CSSFSS](#) may issue a subpoena to a responsible relative who fails to appear for interview, or who appears and furnishes income information, when the [CSSFSS](#) has information from the Title IV-D client, the relative's employer or any other reliable source indicating that:
- i) financial ability, as determined from the guidelines contained in subsection (c) of this Section, exceeds the amount indicated in case of default, as indicated in subsection (d)(3)(A) of this Section; or
  - ii) income exceeds that reported by the relative.

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- C) The [CSSFSS](#) will not issue a subpoena under subsection (d)(3)(B) of this Section where the information from the Title IV-D client, the responsible relative's employer or other source concerning the relative's financial ability is verified through documentation such as payroll records, paycheck stubs or income tax returns.
- D) In instances in which the relative fails or refuses to accept or fully respond to a Department subpoena issued to him pursuant to subsection (d)(3)(B) of this Section, the [CSSFSS](#) may enter a temporary administrative support order by default, in accordance with subsection (d)(3)(A) of this Section, and may then, after investigation and determination of the responsible relative's financial ability to support, utilizing existing State and federal sources (for example, Illinois Department of Employment Security), client statements, employer statements, or the use of the Department's subpoena powers, enter a support order in accord with subsection (c)(1) of this Section.
- 4) The Department shall register, enforce or modify an order entered by a court or administrative body of another state, and make determinations of controlling order where appropriate, in accordance with the provisions of the Uniform Interstate Family Support Act [750 ILCS 22].
- 5) An administrative support order shall include the following:
- A) the Title IV-D case name and identification number;
  - B) the names and birthdates of the persons for whom support is ordered;
  - C) the beginning date, amount and frequency of support;
  - D) any provision for health insurance coverage ordered under subsection (c)(4) of this Section;
  - E) a provision for retroactive support ordered under subsection (c)(11), including the total retroactive support obligation and the beginning date, amount (that shall not be less than 20 percent of the current support amount) and frequency of payments to be made

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until the retroactive support obligation is paid in full;

- F) the amount of any arrearage that has accrued under a prior support order and the beginning date, amount (that shall not be less than 20 percent of the support order) and frequency of payments to be made until the arrearage is paid in full;
- G) a provision requiring that support payments be made to the State Disbursement Unit;
- H) a statement informing the client and the responsible relative that they have 30 days from the date of mailing of the administrative support order in which to petition the Department for a release from or modification of the order and receive a hearing in accordance with 89 Ill. Adm. Code 104.102 and subsection (c)(2) of this Section, except that for orders entered as a result of a decision after a de novo hearing, the statement shall inform the client and the responsible relative that the order is a final administrative decision of the Department and that review is available only in accord with provisions of the Administrative Review Law [735 ILCS 5/Art III];
- I) except where the order was entered as a result of a decision after a de novo hearing, a statement that the order was based upon the factors listed in subsection (c)(1)(A) of this Section and that in order to have the Department consider other factors listed in subsection (c)(2)(C) of this Section, Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14] and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505], either the responsible relative or the client must request a de novo hearing within 30 days after mailing or delivery of the administrative support order; and
- J) in each administrative support order entered or modified on or after January 1, 2002, a statement that a support obligation required under the order, or any portion of a support obligation required under the order, that becomes due and remains unpaid for 30 days or more shall accrue simple interest at the rate of nine percent per annum.

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- 6) Every administrative support order entered on or after July 1, 1997, shall include income withholding provisions based upon and containing the same information as prescribed in Section 160.75. The Department shall also prepare and serve income withholding notices after entry of an administrative support order and effect income withholding in the same manner as prescribed in Section 160.75.
  - 7) The Department shall provide to each client and each responsible relative a copy of each administrative support order entered, no later than 14 days after entry of such order, by:
    - A) delivery at the conclusion of an interview where financial ability to support was determined. An acknowledgment of receipt signed by the client or relative or a written statement identifying the place, date and method of delivery signed by the Department's representative shall be sufficient for purposes of notice to that person.
    - B) regular mail to the party not receiving personal delivery where the relative fails or refuses to accept delivery, where either party does not attend the interview, or the orders are entered by default.
  - 8) In any case where the administrative support process has been initiated for the custodial parent and the non-marital child, and the custodial parent and the non-marital child move outside the original county, the administrative support case shall remain in the original county unless a transfer to the other county in which the custodial parent and the non-marital child reside is requested by either party or the Department and the hearing officer assigned to the original county finds that a change of venue would be equitable and not unduly hamper the administrative support process.
  - 9) In any case in which an administrative support order is entered to establish and enforce an arrearage only, and the responsible relative's current support obligation has been terminated, the administrative support order shall require the responsible relative to pay a periodic amount equal to the terminated current support amount until the arrearage is paid in full.
- e) Judicial Process

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- 1) The Department shall refer Title IV-D cases for court action to establish support obligations of responsible relatives, pursuant to the support statutes (see subsection (a)(3) of this Section) in matters requiring the determination of parentage (except when paternity is to be determined administratively under Section 160.61), when the court has acquired jurisdiction previously and in instances described in subsection (d)(3)(D) of this Section, and as otherwise determined by the Department.
- 2) The Department shall prepare and transmit pleadings and obtain or affix appropriate signature thereto, which pleadings shall include, but not be limited to, petitions to:
  - A) intervene;
  - B) modify;
  - C) change payment path;
  - D) establish an order for support;
  - E) establish retroactive support when the IV-D client requests it;
  - F) establish past-due support;
  - G) establish parentage;
  - H) obtain a rule to show cause;
  - I) enforce judicial and administrative support orders; and
  - J) combinations of the above.
- 3) Department legal representatives shall request that judicial orders for support require payments to be made to the State Disbursement Unit in accordance with Section 10-10.4 of the Illinois Public Aid Code [305 ILCS 5/10-10.4], Section 507.1 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/507.1], Section 320 of the Uniform Interstate Family Support Act [750 ILCS 22/320], Section 21.1 of the Illinois

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Parentage Act of 1984 [750 ILCS 45/21.1] and Section 25 of the Non-Support Punishment Act [750 ILCS 16/25].

- f) Petitions for Release from Administrative Support Orders – Extraordinary Remedies
- 1) Notwithstanding the statements required by subsections (d)(5)(H) and (d)(5)(I) of this Section, more than 30 days after the entry of an administrative support order under subsection (d) of this Section, a party aggrieved by entry of an administrative support order may petition the Department for release from the order on the same grounds as are provided for relief from judgments under Section 2-1401 of the Code of Civil Procedure.
  - 2) Petitions under this subsection (f) must:
    - A) cite a meritorious defense to entry of the order;
    - B) cite the exercise of due diligence in presenting that defense to the Department;
    - C) be filed no later than two years following the entry of the administrative support order, except that times listed below shall be excluded in computing the two years:
      - i) time during which the person seeking relief is under legal disability;
      - ii) time during which the person seeking relief is under duress;
      - iii) time during which the ground for relief is concealed from the person seeking relief;
    - D) be supported by affidavit or other appropriate showing as to matters not supported by the record.
  - 3) Notice of the filing of the petition must be given and a copy of the petition must be served on the other parent, caretaker or responsible relative by certified mail, return receipt requested, or by any manner provided by law

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for service of process. The filing of a petition under this subsection (f) does not affect the validity of the administrative support order.

(Source: Amended at 33 Ill. Reg. 9077, effective June 15, 2009)

**Section 160.65 Modification of Support Obligations**

## a) Definitions

- 1) "Order for support" means any court or administrative order establishing the level of child support due to a child from the responsible relative.
- 2) "Income Withholding Notice" means the notice served on a payor, pursuant to entry of a court or administrative order for support, that directs the payor to withhold a part of a responsible relative's income for payment of child support.
- 3) "Assignment of support" has the meaning set forth in Section 160.5.
- 4) "Assignment of medical support" has the meaning set forth in Section 160.5.
- 5) "Health insurance" means health insurance or health plan coverage for the dependent child for whom support is sought.
- 6) "Review" means the [CSSFSS](#) comparison of the responsible relative's current financial ability to the existing order for support, as described in subsection (f) of this Section.
- 7) "Quantitative Standard for Review" means the current financial ability of the responsible relative, as determined through modification review, is at least 20 percent above or below the existing order for support and the change is an amount equal to at least \$10 a month.

## b) Review and Modification of Support Orders

- 1) The Department, beginning October 13, 1993, shall review child support orders in Title IV-D cases at 36 month intervals after establishment, modification or the last review, whichever was the last to occur, unless:

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- A) In a case in which there is an assignment of support or an assignment of medical support, the Department determines, in accordance with subsection (b)(3) of this Section, that a review would not be in the best interests of the child and neither parent has requested a review; or
  - B) In a case in which there is no assignment of support or assignment of medical support, neither parent has requested a review; or
  - C) In a case in which there is an assignment of medical support but no assignment of support, the order for support requires health insurance for the child covered by the order and neither parent has requested a review.
- 2) Prior to the expiration of the 36 month period:
- A) The Department, in a case in which there is an assignment of support or an assignment of medical support, shall review the order if:
    - i) an order for withholding has been served on the responsible relative's payor, and payments have been received by the Department within the 90 days prior to selection for review; and
    - ii) the order for support does not require the responsible relative to provide health insurance for the child covered by the order; and
    - iii) the Department has not determined that a review would not be in the best interests of the child.
  - B) The Department, in a case in which there is no assignment of support or assignment of medical support, shall review orders as set forth in subsection (b)(2)(A) of this Section, but only with the consent of the client.
  - C) The Department may review any order for support, unless it has

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determined that a review would not be in the best interests of the child, whenever a change in financial circumstances of the responsible relative becomes known through representations of the relative or of the client or from independent sources, and such change would materially affect ability to support.

- 3) The Department shall determine that a review of an order for support would not be in the best interests of the child if there has been a finding of good cause, and it has been determined that support enforcement may not proceed without risk of harm to the child or caretaker relative.
- c) Notice of the Right to Request a Review
- 1) In each Title IV-D case the Department shall provide notice not less than once every three years to each parent subject to an order for support in the case. The notice may be included in the order and shall inform the parent of the right to request a review of the order, where to request a review and the information ~~that~~<sup>which</sup> must accompany a request.
  - 2) The Department shall use the broadcast or print media at least twice a calendar year to publicize the right to request a review as part of the child support enforcement program, and include notice of this right as part of the information on IV-D services contained in its brochures, pamphlets and other printed materials describing the program.
- d) Notice of Review
- 1) The Department shall notify the client and responsible relative that a review will be conducted at least 30 days before commencement of the review.
  - 2) The notice of review shall:
    - A) Require completion of a form financial affidavit and return of the affidavit to the Department within 15 calendar days after the date the client or relative received the notice; and
    - B) State that if, as a result of the review, action is taken to modify the order for support, the Department will order or request the court to

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order the responsible relative to provide health insurance. However, in cases where the client is not receiving medical assistance, the notice shall state that health insurance may be ordered or requested only with the client's consent, as provided in Section 160.60(c)(7).

- e) Information Gathering and Employer Contact
- 1) The Department shall capture all available responsible relative financial information from existing federal and State sources (for example, Illinois Department of Employment Security) through electronic data searches on all IV-D cases.
  - 2) The Department may send a notice to the responsible relative's employer, in accordance with Section 10-3.1 of the Illinois Public Aid Code [305 ILCS 5/10-3.1]. The notice shall:
    - A) require the disclosure of responsible relative employment information, including but not limited to:
      - i) the period of employment;
      - ii) the frequency of wage payments;
      - iii) gross wages, net pay and all deductions taken in reaching net pay;
      - iv) the number of dependent exemptions claimed by the responsible relative; and
      - v) health insurance coverage available to the responsible relative through the employer.
    - B) require employer compliance within 15 calendar days after the employer's receipt of the notice.
  - 3) If the responsible relative fails to return a completed financial affidavit within 15 calendar days after receipt of the notice of review, and the relative's employer is unknown, the Department may use available means

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for obtaining the relative's financial information, e.g., service of a subpoena upon the responsible relative.

## f) Review of the Order for Support

- 1) The [CSSFSS](#) shall review any financial information concerning the responsible relative. Where the responsible relative's information is not verified through an employer, wage stubs or income tax returns, the [CSSFSS](#) shall seek other verification, e.g., subpoena of the responsible relative's income tax return.
- 2) The [CSSFSS](#) shall determine the responsible relative's current financial ability in accordance with the guidelines contained in Section 160.60(c).
- 3) The [CSSFSS](#) shall compare the responsible relative's current financial ability to the amount of the existing order for support and determine if the Quantitative Standard for Review has been met.
- 4) The [CSSFSS](#) shall determine if health insurance is being provided for the child under the order for support or whether the child's health care needs are being met through other means. In no event shall the [CSSFSS](#) consider a child's eligibility for, or receipt of, medical assistance to meet the need to provide for the child's health care needs.

## g) Notice of Review Results

The Department shall inform the client and responsible relative of the results of the review and provide a copy of the [CSSFSS](#) calculation comparing the responsible relative's current financial ability to the amount of the existing order within 14 days after the review results are determined. The client and responsible relative will be advised whether or not the Department will take action to modify the existing order for support and of the right to contest the determination.

- 1) When the review indicates the Quantitative Standard for Review has not been met, the client and responsible relative, in both judicial and administrative cases, are advised as follows:
  - A) The Department will not take action to modify the order for support.

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- B) The Department will only take action to modify the order to require health insurance for the child covered by the order.
  - C) Either parent may request a redetermination within 30 calendar days after the date of the notice by:
    - i) signing and returning the request for a redetermination to the Department; and
    - ii) providing financial documentation or information concerning the child's health care needs not furnished previously, which will substantiate the request.
- 2) When the review indicates the Quantitative Standard for Review has been met, the client and responsible relative will be advised that:
- A) The Department will take action to modify the existing order for support in accordance with the review results.
  - B) In cases involving the judicial process, each parent will be informed 30 calendar days in advance of the hearing date and will have the opportunity to contest the review results at that time.
  - C) In cases where an administrative order for support is entered in accordance with subsection (h) of this Section:
    - i) The client and responsible relative will be advised that he or she has until 30 calendar days after the date of mailing of the administrative order for support in which to petition the Department for a release from or modification of the order and receive a hearing in accordance with 89 Ill. Adm. Code 104.102. The client will be further advised that he or she may provide financial documentation or information concerning the child's health care needs not furnished previously that will substantiate the requested relief.
    - ii) Where both the client and the responsible relative request a hearing, the two requests shall be merged and shall be disposed of simultaneously by the hearing proceeding. The

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parties shall be advised of the right to present evidence at the hearing, including the client's right to provide financial documentation or information concerning the child's health care needs not furnished previously that will substantiate the requested relief.

- iii) Where the responsible relative requests a hearing and the client does not, the client shall again be advised of the right to present evidence at the hearing.
- iv) Where the client requests a hearing and the responsible relative does not, the responsible relative shall again be advised of the right to present evidence at the hearing.

- 3) For purposes of calculating the 30 calendar day period in which to petition the Department for release from or modification of the administrative order for support or to request redetermination of the review results, the day immediately subsequent to the mailing of the order or determination shall be considered the first day and the day such request is received by the Department shall be considered as the last day.

#### h) Further Actions Taken by the Department

- 1) The Department shall take the following action when the [CSSFSS](#) has determined in accordance with subsection (f) of this Section that the Quantitative Standard for Review has been met or when the Quantitative Standard for Review has not been met, but there is a determination that the order for support needs to be modified to require provision of health insurance:

- A) In a case involving an order for support entered by the court, the [CSSFSS](#) shall:
  - i) prepare a petition to modify, and obtain or affix appropriate signature thereto;
  - ii) refer the case for legal action to modify the order for support pursuant to Section 510 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/510]; and

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- iii) provide the client and responsible relative with the notice described in subsection (g)(2)(B) of this Section.
- B) In a case involving an administrative order for support established under Section 160.60(d), or modified under this Section, the [CSSFSS](#) shall enter an administrative order for support incorporating the results of the review and containing the information specified in Section 160.60(d)(5). Any order for health insurance shall be entered in accordance with Section 160.60(c)(7).
- i) The [CSSFSS](#) shall effect income withholding in accordance with Section 160.60(d)(6).
  - ii) The [CSSFSS](#) shall provide to the client and responsible relative copies of the administrative order for support together with the notice described in subsection (g)(2)(C) of this Section.
- 2) Upon receipt of a petition for a release from or modification of an administrative order for support as described in subsection (g)(2)(C) of this Section within 30 calendar days after the date of mailing of such order, the Department will provide a hearing in accordance with 89 Ill. Adm. Code 104.102. The 30 calendar day period shall be calculated in accordance with subsection (g)(3) of this Section.
- 3) Upon receipt of a request for a redetermination as set forth in subsection (g)(1) of this Section within 30 calendar days after the date of mailing of the notice, the Department shall conduct such redetermination. The 30 calendar day period shall be calculated in accordance with subsection (g)(3) of this Section.
- i) Timeframes for Review and Modification
- 1) In any case in which there is an assignment of support or an assignment of medical support, the Department shall determine within 15 calendar days after October 13, 1993, or the date the order is 36 months old, whichever is later, whether a review should be conducted as provided in subsection

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(b)(1) of this Section.

- 2) Subsequent determinations about whether to review an order for support in a case in which there is an assignment of support or an assignment of medical support shall be made by the Department in accordance with subsection (b)(1) of this Section, at 36 month intervals based upon:
  - A) the date the order for support was modified; or
  - B) the date an order was entered determining that the order for support would not be modified; or
  - C) the date the period expired for requesting redetermination of the Department's review decision not to seek modification of the order for support.
- 3) Within 15 calendar days after receipt of a request for a review, the Department shall determine whether a review should be conducted in accordance with subsection (b)(1) of this Section.
- 4) Within 180 calendar days after determining that a review should be conducted or locating the non-requesting parent, whichever occurs later, the Department shall:
  - A) send the notice of review in accordance with subsection (d) of this Section;
  - B) conduct a review of the order in accordance with subsection (f) of this Section;
  - C) send the notice of review results in accordance with subsection (g) of this Section; and
  - D) conclude any action to modify the order for support.
- j) Interstate Review and Modification
  - 1) Initiating Cases

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- A) In any case in which there is an assignment of support or an assignment of medical support, the Department shall determine, within 15 calendar days after October 13, 1993, or the date the order for support is 36 months old, whichever date occurs later, whether a review should be conducted, as required under subsection (b)(1) of this Section, and whether the review should be conducted by the Department or another state.
- B) Subsequent determinations about whether to conduct a review shall be made in accordance with subsection (b)(1) of this Section, at 36 month intervals based upon:
- i) the date the order for support was modified; or
  - ii) the date an order was entered determining that the order for support would not be modified; or
  - iii) the date the period expired for requesting redetermination of a review decision not to seek modification of the order for support.
- C) Within 15 calendar days after receipt of a request for a review, the Department shall determine whether a review should be conducted, as required under subsection (b)(1) of this Section, and whether the review should be conducted by the Department or another state.
- D) Prior to the expiration of the 36 month period, the Department:
- i) shall review or request another state to review an order for support under the circumstances set forth in subsections (b)(2)(A) and (B) of this Section; and
  - ii) may review or request another state to review an order for support as provided in subsection (b)(2)(C) of this Section.
- E) The Department shall determine in which state a review should be conducted after considering all relevant factors, including but not limited to:

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- i) the location of existing orders;
  - ii) the present residence of each party; and
  - iii) whether a particular state has jurisdiction over the parties.
- F) In any case coming under the provisions of subsections (j)(1)(A), (B) and (C) of this Section, in which the Department has determined to request a review of an order for support in another state, the Department shall:
- i) send a request for review to that state within 20 calendar days after receipt of sufficient information to conduct the review and provide that state with sufficient information on the requestor of review to act on the request; and
  - ii) send to the parent in Illinois a copy of any notice issued by the responding state in connection with the review and modification of the order, within five working days after receipt of such notice by the Department.
- 2) Responding Cases
- A) Within 15 calendar days after receipt of a request for a review of an order for support in Illinois as the responding state, the Department shall determine whether a review should be conducted in accordance with subsection (b)(1) of this Section.
  - B) Within 180 calendar days after determining that a review should be conducted or locating the non-requesting parent, whichever occurs later, the Department shall take the actions specified in subsection (i)(4) of this Section.

(Source: Amended at 33 Ill. Reg. 9077, effective June 15, 2009)

## ILLINOIS EMERGENCY MANAGEMENT AGENCY

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- 1) Heading of the Part: Compensation of Local Governments for Emergency Planning and Participation in Nuclear Emergency Response Exercises
- 2) Code Citation: 32 Ill. Adm. Code 501
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
501.10	Amendment
501.20	Amendment
501.30	Amendment
501.40	Amendment
501.50	Amendment
501.60	Amendment
501.70	Amendment
501.80	Amendment
501.90	Amendment
501.APPENDIX A	Repealed
- 4) Statutory Authority: Implementing and authorized by the Illinois Nuclear Safety Preparedness Act [420 ILCS 5/4]
- 5) Effective Date of Amendments: June 11, 2009
- 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 material incorporated by reference, is on file at the Agency's headquarters located at 1035 Outer Park Drive, Springfield, Illinois and is available for public inspection
- 9) Notice of Proposal Published in the Illinois Register: 33 Ill. Reg. 1; January 2, 2009
- 10) Has JCAR issued a Statement of Objection to these Amendments? No
- 11) Differences between proposal and final version:  
In 501.10(a) – Deleted "incidents" and restored "accidents"

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In 501.20 – Added a definition of "Claim": ""Claim" means the forms used by grantees to document expenditures.".

In 501.20 – In the definition of "Volunteer", added "grantee" before "resolution".

In 501.50 – Added a new 2<sup>nd</sup> sentence: "Examples of specialty items include, but are not limited to, radios, computers, furniture or conference and training course fees.".

In 501.60(a) – changed the last sentence to read "Failure to meet the grant application submittal deadline may result in denial of the application if funds are no longer available due to allocation to other grants.".

In 501.90(c)(1)(C) – Changed "local government functions" to "local government emergency preparedness functions".

In 501.90(c)(3)(B) – Added a new 2<sup>nd</sup> sentence: "Current rates can be found in the FEMA Schedule of Equipment Rates.".

- 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 rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendments: IEMA is authorized to make grants available to local governmental entities for costs associated with the implementation of the Illinois Nuclear Safety Preparedness Act [420 ILCS 5/4]. The Agency is proposing these amendments to reflect the merger between IEMA and the former IDNS, clarify permissible uses of grant funds, clarify deadlines for grant applications and claims, and eliminate unnecessary grant agreement language.
- 16) Information and questions regarding these adopted amendments shall be directed to:

Louise Michels  
Staff Attorney  
Illinois Emergency Management Agency  
1035 Outer Park Drive  
Springfield, Illinois 62704

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ILLINOIS EMERGENCY MANAGEMENT AGENCY

NOTICE OF ADOPTED AMENDMENTS

217/785-9876

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

## ILLINOIS EMERGENCY MANAGEMENT AGENCY

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## TITLE 32: ENERGY

## CHAPTER II: ILLINOIS EMERGENCY MANAGEMENT AGENCY

## SUBCHAPTER c: NUCLEAR FACILITY SAFETY

## PART 501

## COMPENSATION OF LOCAL GOVERNMENTS FOR EMERGENCY PLANNING AND PARTICIPATION IN NUCLEAR EMERGENCY RESPONSE EXERCISES

## Section

501.10	Purpose and Scope
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501.60	Procedures for Awarding Future <del>Block</del> Grants
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501.80	<del>Claims</del> , Audit, Expenditure Record Requirements and <del>Block</del> Grant Fund Recovery Procedures
501.90	<del>Standards for the</del> Determination of Permissible Uses of <del>Block</del> Grant Funds
501.APPENDIX A	Wording of the Block Grant Agreement ( <del>Repealed</del> )

AUTHORITY: Implementing and authorized by Section 4 of the Illinois Nuclear Safety Preparedness Act [420 ILCS 5/4].

SOURCE: Emergency rule adopted at 5 Ill. Reg. 14862, effective November 22, 1982, for a maximum of 150 days; adopted at 7 Ill. Reg. 5877, effective April 23, 1983; codified at 8 Ill. Reg. 1599; amended at 9 Ill. Reg. 2283, effective January 30, 1985; amended at 14 Ill. Reg. 16923, effective October 2, 1990; emergency rule adopted at 20 Ill. Reg. 8341, effective June 4, 1996, for a maximum of 150 days; Part repealed, new Part adopted at 20 Ill. Reg. 14805, effective October 29, 1996; recodified from the Department of Nuclear Safety to the Illinois Emergency Management Agency at 27 Ill. Reg. 13641; amended at 33 Ill. Reg. 9110, effective June 11, 2009.

**Section 501.10 Purpose and Scope**

The purpose of ~~this Part~~ is to establish the policies and procedures necessary to compensate ~~grantees~~~~local governments~~ for costs associated with implementation of Section 4 of the Illinois Nuclear Safety Preparedness Act (the Act) [420 ILCS 5]. The policies and procedures contained

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in this Part are intended to further the following objectives:

- a) to encourage ~~grantees to prepare local government participation in preparing and implementing plans~~ to deal with the effects of nuclear accidents;
- b) to reduce the encumbrance of public funds obligated by ~~grantees local governments~~ in implementation of the Act by establishment of a ~~block grant~~ system of compensation, whereby grant monies are paid to the ~~grantee local government~~ in advance of actual expenditures, ~~when possible~~; and
- c) to provide guidance to ~~grantees local governments~~ and ~~Agency Department~~ staff in determining necessary activities and expenses payable pursuant to the Act.

(Source: Amended at 33 Ill. Reg. 9110, effective June 11, 2009)

**Section 501.20 Definitions**

"Agency" means the Illinois Emergency Management Agency.

"Authorized Expenses" means the actual expenditures of public funds by a ~~grantee local government~~ attributable to implementation of the Act as determined necessary by ~~the Director of the Illinois Emergency Management Agency Department of Nuclear Safety (Department)~~.

"Claim" means the forms used by grantee to document expenditures.

~~"Director" means the Director of the Department of Nuclear Safety or his designee.~~

"Drill" means the test or trial of a particular emergency preparedness system, function or operation, such as communications.

"Employee" means an individual actually paid wages or allowances by a ~~grantee local government~~ for work performed on a full-time, part-time or intermittent basis.

"Exercise" means the testing of emergency response plans for nuclear facilities, including, but not limited to, the biennial testing and evaluation of off-site radiological emergency response plans and preparedness in support of nuclear

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generating stations, as required by the U.S. Nuclear Regulatory Commission, 10 CFR 50, ~~appendix~~Appendix E, current as of January 1, 1996.

"Grantee" means a local governmental entity ~~receiving to which~~ a grant ~~is made~~.

"Local Government" means a political subdivision below the State Government level, such as a county, municipality, township, village or district, with authority to expend public funds.

"Volunteer" means an individual paid an allowance, set forth by grantee resolution, for work performed on an intermittent basis.

(Source: Amended at 33 Ill. Reg. 9110, effective June 11, 2009)

**Section 501.30 Incorporations by Reference**

All rules, standards and guidelines of agencies of the United States or nationally recognized organizations or associations that are incorporated by reference in this Part are incorporated as of the date specified in the reference and do not include any later amendments or editions. Copies of these rules, standards and guidelines that have been incorporated by reference are available for public inspection at the ~~Illinois Emergency Management Agency~~Department of Nuclear Safety, 1035 Outer Park Drive, Springfield, Illinois.

(Source: Amended at 33 Ill. Reg. 9110, effective June 11, 2009)

**Section 501.40 Policies and Procedures**

- a) The ~~Agency~~Department shall ~~provide compensation to grantees~~compensate local governments from fees collected pursuant to Section 4 of the Act.
- b) The ~~Agency~~Director shall provide ~~block~~ grants to ~~grantees~~local governments for expenses relating to implementation of emergency ~~preparedness~~planning and response activities conducted ~~by the Department~~ to deal with the possibility of nuclear accidents at nuclear power stations.
- c) All grants made under this Part providing for payment of funds in advance of anticipated expenditures shall be made in accordance with a grant agreement to be executed by both the ~~Agency~~Director of the Department and the head of the local governmental entity to whom the grant is awarded.

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- d) The Illinois Emergency Management Agency, Bureau of Disaster Assistance and Preparedness, Division of Planning and Analysis (DPA), Office of Nuclear Facility Safety, shall be responsible for implementation ~~of this Part~~ and shall be the point of contact for grantees/local governments relative to the provisions contained in this Part ~~herein~~.

(Source: Amended at 33 Ill. Reg. 9110, effective June 11, 2009)

**Section 501.50 Determination~~Establishment~~ of Grant Awards~~Initial Block Grants~~**

~~The initial amount of the block grants shall be based on the following criteria:~~

- a) The base amount of each grant, excluding special requirement and request amounts, shall be based on the grantee's recurring costs plus the grantee's expected participation in activities during the grant period (e.g., training and biennial exercises). The block grant shall be based on the amount determined by the Department to be an average of actual expenses approved by the Department over the most recent three-year period, plus any additional recurring costs, as determined to be necessary or required by the Department.
- b) Special requirement amounts shall be based on a grantee's/local government's preparation for or participation in an exercise or drill required outside of the biennial~~that occurs outside of the annual~~ exercise cycle. Such requests shall be made to the Agency~~Department~~ in writing, and will be subject to approval based upon available funds. Amounts disbursed~~dispersed~~ and approved by the Agency~~Department~~ as special requirements will not be considered in calculating future base grant awards.
- c) Special request amounts shall be based on requirements identified by a grantee/local government for specialty items to enhance the capability to implement nuclear emergency response plans. Examples of specialty items, include, but are not limited to, radios, computers, furniture or conference and training course fees~~such as special equipment needs. The~~ Such requests shall be made to the Agency~~Department~~ in writing, and will be subject to approval based upon available funds. Amounts disbursed~~dispersed~~ and approved by the Agency~~Department~~ as special requests will not be considered in calculating future base grant awards.

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- d) Special requirements and special requests approved by the Agency~~Department~~ after the initial disbursement~~dispersement~~ of the initial block-grant funds shall be incorporated into an amendment to the grant agreement, if necessary, before disbursement~~dispersement~~ of the additional block-grant funds.

(Source: Amended at 33 Ill. Reg. 9110, effective June 11, 2009)

**Section 501.60 Procedures for Awarding Future Block-Grants**

- a) Participating applicants~~local governments~~ shall submit to the Agency~~Department~~ by March 15~~April 30~~ of each year a grant application for the purpose of determining the amount of the block-grant award. The grant application shall be submitted on forms provided by the Agency. The application shall contain a brief description of the purpose for which the grant is being sought, the proposed term of the grant and an annual estimated spend plan covering the project expenses of the participating local government. The grant application shall also include the name, title, business address and phone number of the person designated to authenticate documents submitted on behalf of the local government and to act as point of contact for questions arising under the grant. The application shall be signed by the head of the local government organization~~and submitted on forms provided by the Department. Failure to meet the grant application submittal deadline may result in denial of the application if funds are no longer available due to allocation to other grants.~~
- b) Special request applications shall be submitted to the Department by January 1 and special requirement applications may be submitted any time throughout the year.
- c) Local governmental applicants who have not participated in the local compensation program~~plan~~ may be eligible to receive block-grant funds pursuant to Section 501.90 of this Part and subject to Agency~~Department~~ approval based upon available funds. Applicants shall contact the Agency~~Department~~ for the necessary application forms.

(Source: Amended at 33 Ill. Reg. 9110, effective June 11, 2009)

**Section 501.70 Contents of Grant Agreement and Disbursement~~Dispersement~~ of Block Grant Funds**

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- a) The ~~Agency Director~~ shall execute a grant agreement with each ~~grantee local government~~ to whom a grant is awarded. The grant agreement shall specify the parties to the grant, the term of the grant, the amount of the grant, method of payment of the ~~block~~ grant funds, permissible uses of the ~~block~~ grant funds, that documentation of expenditures be maintained by the grantee, that unspent ~~block~~ grant funds shall be returned to the State as required by the Illinois Grant Funds Recovery Act [30 ILCS 705], that the ~~Agency Department~~ may audit records required to be maintained to verify that grant monies were used for permissible uses under the grant, and that the grant agreement shall cease if funds for the grant are not appropriated by the General Assembly, and any other standard provisions required by the Comptroller to be included in grant agreements entered into by the State.
- b) ~~Upon execution of the grant agreement, the Department shall allocate funds to a grant account established for the participating local government in an amount equal to the grant award.~~ On July 1 of each year, or as soon thereafter as is practicable, the ~~Agency Department~~ shall disburse to the ~~grantee local government~~ ~~an the grant~~ amount ~~determined by the Agency for that fiscal year~~ equal to the approved grant expenses.

AGENCY NOTE: It is the ~~Agency's Department's~~ intent that ~~block~~ grant funds will be disbursed on July 1 of each year. However, such disbursement might be delayed for reasons beyond the ~~Agency's Department's~~ control (e.g., failure of the General Assembly to make appropriations before July 1).

(Source: Amended at 33 Ill. Reg. 9110, effective June 11, 2009)

**Section 501.80 Claims, Audit, Expenditure Record Requirements and ~~Block~~ Grant Fund Recovery Procedures**

- a) Grantees shall submit signed claim forms and a copy of the related receipts that verify expenditures of grant funds to the Agency for review by mail or fax to the following address or fax number:

IEMA  
Attention: DA&P IPRA Grants  
1035 Outer Park Drive  
Springfield, IL 62704  
Fax: 217/524-0026

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- 1) Claims are due as follows:
    - A) County grantee claim forms are due on a quarterly basis in accordance with the following schedule:
      - 1<sup>st</sup> Quarter (July-September): due October 31
      - 2<sup>nd</sup> Quarter (October-December): due January 31
      - 3<sup>rd</sup> Quarter (January-March): due April 30
      - 4<sup>th</sup> Quarter (April-June): due July 31
    - B) Claims from grantees from political subdivisions other than counties are due on a biannual basis in accordance with the following schedule:
      - 1<sup>st</sup> and 2<sup>nd</sup> Quarter (July-December): due January 31
      - 3<sup>rd</sup> and 4<sup>th</sup> Quarter (January-June): due July 31
    - C) Grantees who receive a grant for a special request or special requirement only shall submit the claim based on the quarter when the expenditure was made.
  - 2) After claims are received and reviewed by the Agency to ensure that expenditures are in accordance with approved spending plans, receipt of the claim and results of the review will be confirmed by return correspondence to the grantee.
  - 3) Failure to meet the claim submittal deadlines outlined in this Section may result in denial of the claim and may jeopardize future grant awards.
- ba) Participating ~~grantees~~local governments shall maintain, in separate files, documentation of expenditures under the grant that is readily accessible during an Agency-Department ~~audit~~ for a minimum of 5 years. ~~The Such~~ documentation shall be on forms provided by the Agency-Department.
- cb) The Agency-Department shall have the right to audit and obtain copies of the books, records, and any other recorded information of the grantee related to grantee expenses for which grantee received compensation under this Part.

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- de) If, through ~~an Agencya-Department~~ audit, the ~~AgencyDepartment~~ finds that the ~~grantee~~~~local government~~ has misspent or improperly held any ~~block~~ grant funds, the ~~AgencyDepartment~~ shall have the right of recovery of ~~thesuch block~~ grant funds in accordance with the provisions and procedures of the Illinois Grant Funds Recovery Act ~~[30 ILCS 705]~~.
- ed) The ~~AgencyDepartment~~ shall inform the ~~grantee~~~~local government~~ on whether future disbursements of the grant award are subject to adjustment in accordance with the provisions and procedures of the Illinois Grant Funds Recovery Act ~~[30 ILCS 705]~~.

(Source: Amended at 33 Ill. Reg. 9110, effective June 11, 2009)

**Section 501.90 ~~Standards for the~~ Determination of Permissible Uses of ~~Block~~ Grant Funds**

- a) The following ~~categories~~~~standards~~ are used by the ~~AgencyDepartment~~ staff ~~as a guide~~ in determining necessary activities and authorized expenses payable under ~~the provisions of~~ this Part. These ~~categories~~~~standards~~ are designed to achieve equality among known prospective grantees while taking into account the limitations imposed by the availability of appropriated funds.
- b) Necessary Activities:
- 1) ~~Plan development and maintenance.~~~~Response planning, preparation, radiological training and drills.~~
  - 2) ~~Preparation for and participation in training.~~~~Participation in the exercising of transportation and fixed facility nuclear response plans.~~
  - 3) ~~Preparation for and participation in exercises and drills.~~~~Internal post exercise critique and corrective action.~~
  - 4) ~~Maintenance of a specific capability to implement nuclear emergency response plans.~~
- c) Authorized Expenses:
- 1) Personnel Services

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- A) Wages, plus fringe benefits, actually paid to ~~local governmental~~ employees of the grantee for participation in necessary activities as described in subsection (b) of this Section.
  - B) Compensation shall be based on hourly rates for the number of hours of actual participation in necessary activities as described in subsection (b) of this Section. For personnel not normally paid at an hourly rate, an hourly rate shall be determined by dividing the periodic salary or contract amount by the number of hours required to be worked (or if there is no such requirement, the hours typically worked) within the period.
  - C) Compensation for volunteers of the grantee shall be a set hourly rate documented by local government resolution. The rate per hour shall not exceed the usual and customary amount paid to volunteers assisting the grantee in local government emergency preparedness functions. ~~"matching funds" type employees shall be limited to wages actually paid from the local government's share of total funds contributed.~~
- 2) ~~Individual~~ Travel
    - A) Travel allowances actually paid to ~~grantee~~local government employees or volunteers for travel performed in connection with their participation in necessary activities as described in subsection (b) of this Section.
    - B) Compensation for transportation, lodging, and per diem or meal expenses shall not exceed the rate in the State of Illinois Travel Regulations, 80 Ill. Adm. Code 3000, in effect at the time the expenditure was incurred, unless a ~~grantee~~local government ordinance, rule or regulation applicable to all employees of the ~~grantee~~local government specifies a higher rate.
  - 3) Equipment Use
    - A) Costs actually paid, incurred or obligated for ~~grantee~~local government owned or leased equipment used during or in connection with a necessary activity as specified in subsection (b)

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of this Section.

- B) Compensation for equipment use shall not exceed the current State of Illinois rate. Current rates can be found in the FEMA Schedule of Equipment Rates. Expenses for use of motorized equipment shall be fully documented. Documentation shall include the date of use, type of equipment, entity that used the equipment, miles or hours that the equipment was in use, and cost per mile for equipment use. ~~rates indicated in the following table without complete documentation:~~

<u>Type Equipment</u>	<u>Rate</u>	<u>Optional Rate</u>
Automobile	\$0.31 per mile	\$3.20 per hour of actual operation
Bus	\$0.60 per mile	\$8.80 per hour of actual operation
Emergency Vehicle (ambulance, fire truck, rescue vehicle)	Base rate, fee or service charge customary to the area of operation	None

- C) ~~Expenses for use of motorized equipment not listed in the table above shall be fully documented. Such documentation shall include the date of use, type of equipment, entity that used the equipment, miles or hours that the equipment was used, and cost per mile or hour for equipment use.~~

4) Telecommunications ~~Miscellaneous Expenses~~

- A) Emergency Operations Center (EOC) telecommunications costs include installation, service and maintenance charges for those telecommunication lines, circuits and equipment used to maintain the capability to implement nuclear emergency response plans. ~~Telecommunications~~

- i) ~~Installation, service and maintenance charges for those telecommunication lines, circuits and equipment used exclusively for exercising nuclear emergency response~~

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~~plans.~~

ii) ~~Telecommunication lines or circuit usage charges relating exclusively to the exercising of nuclear emergency response plans.~~

B) Monthly usage charges for EOC to include telecommunication lines and the circuit usage charges relating exclusively to maintaining the capability to implement nuclear emergency response plans.~~EOC Operational Materials: costs of maps, charts, plexiglass, status boards and similar materials relating exclusively to the exercising of nuclear emergency response plans.~~

5) Miscellaneous expenses include maintenance agreements, office supplies, postage or similar expenses related to maintaining the capability to implement nuclear emergency response plans.

(Source: Amended at 33 Ill. Reg. 9110, effective June 11, 2009)

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**Section 501.APPENDIX A Wording of the Block Grant Agreement (Repealed)**

~~The wording of a block grant agreement, which is entered into by the Department and local governments for the payment of funds in advance of anticipated expenditures to be incurred by local governments for their participation in the planning and response activities as specified in Section 501.90 of this Part, shall contain the following provisions except that the instructions in parentheses are to be replaced with the relevant information and the parentheses deleted:~~

~~STATE OF ILLINOIS  
DEPARTMENT OF NUCLEAR SAFETY  
INTERGOVERNMENTAL GRANT AGREEMENT~~

~~NO. \_\_\_\_\_~~

~~This Agreement is made and entered into by and between the Illinois Department of Nuclear Safety, 1035 Outer Park Drive, Springfield, IL 62704, hereinafter referred to as DEPARTMENT, and the \_\_\_\_\_ (name and address of the local governmental entity) ; hereinafter referred to as \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) .~~

Introductory Statement

~~The Illinois Nuclear Safety Preparedness Act [420 ILCS 5] (the Act) authorizes DEPARTMENT to compensate local governments from fees collected pursuant to Section 4 of the Act for expenses incurred in activities defined as necessary by the Director of the DEPARTMENT to implement and maintain the plans and programs authorized by the Act. The Intergovernmental Cooperation Act [5 ILCS 220] authorizes the creation of intergovernmental agreements and contracts between public agencies of this State. Both DEPARTMENT and (NAME AS SHOWN IN THE REFERENCE CLAUSE, i.e., VILLAGE, THE DISTRICT, ETC) are public agencies of this State. The Grant Funds Recovery Act [30 ILCS 705] provides for the recovery by DEPARTMENT of unused block grant funds.~~

Terms of Agreement

~~DEPARTMENT and \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) hereby agree as follows:~~

- ~~1) Purpose: The purpose of this grant is to encourage participation by \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) in the emergency planning and Response activities conducted by DEPARTMENT pursuant to the Act. Under~~

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~~this grant, DEPARTMENT hereby agrees to compensate (VILLAGE, THE DISTRICT, ETC) for expenses incurred in implementing plans and programs to deal with the possibility of a nuclear accident, as authorized by the Act.~~

2) ~~Term: This grant shall provide for compensation of funds expended between July 1, \_\_\_\_\_, through June 30, \_\_\_\_\_.~~

3) ~~Use: Permissible expenditures by (VILLAGE, THE DISTRICT, ETC) for which compensation will be made under this Agreement shall be those expenditures which are in accordance with the terms of the Act and with the standards set forth in 32 Ill. Adm. Code 501.90.~~

4) ~~Method of Payment: As soon as practicable after execution of this Agreement, DEPARTMENT shall disburse to (VILLAGE, THE DISTRICT, ETC) (SPELL OUT DOLLAR AMOUNT) (\$ \_\_\_\_\_), an amount equal to the DEPARTMENTALLY approved grant expenses that are anticipated to be incurred by (VILLAGE, THE DISTRICT, ETC) in State fiscal year \_\_\_\_\_. Payments under this Agreement shall be directed to:~~

~~(name and address of the Village,  
Village, District, etc)~~

5) ~~(VILLAGE, THE DISTRICT, ETC) shall maintain documentation of actual compensable expenditures made in accordance with Article 3 above. Such documentation shall be on forms provided by DEPARTMENT and subject to the provisions of 32 Ill. Adm. Code 501.80.~~

6) ~~Amount of Grant: The maximum amount payable to (VILLAGE, THE DISTRICT, ETC) under this Agreement shall be (SPELL OUT DOLLAR AMOUNT) (\$ \_\_\_\_\_).~~

7) ~~Recovery of Funds: As required by Section 4 of the Illinois Grant Funds Recovery Act [30 ILCS 705], all funds remaining at the end of this Agreement shall be returned to DEPARTMENT within 45 days. In the event that (VILLAGE, THE DISTRICT, ETC) is compensated by DEPARTMENT in excess of expenditures actually and legitimately compensable under this Agreement, (VILLAGE, THE DISTRICT, ETC) shall return said~~

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~~excess compensation to DEPARTMENT within 45 days after the date that DEPARTMENT makes such a request for payment. In addition, DEPARTMENT may pursue other recovery actions as specified in Section 6 of the Illinois Grant Funds Recovery Act [30 ILCS 705].~~

- 8) ~~Audit: DEPARTMENT may audit records required to be maintained under 32 Ill. Adm. Code 501.80 to verify that grant monies are being spent for permissible uses as specified in Article 3 of this grant agreement.~~
- 9) ~~Records and Reports: \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) shall maintain, for a minimum of 5 years after the completion of this Agreement, adequate books, records, and supporting documents to verify the amounts, recipients, and uses of all disbursements passing in conjunction with this Agreement. \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) shall make available, on request, all books, records, and supporting documents related to this Agreement for review and audit by the Auditor General and/or the DEPARTMENT. \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) agrees to cooperate fully with any audit conducted by the Auditor General or the DEPARTMENT and to provide full access to all relevant materials.~~
- 10) ~~Independence of \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) :- Any personnel, including contractors, who may be employed by \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) in connection with this Agreement shall not be considered for any purpose to be agents or employees of DEPARTMENT. Nothing in this Agreement shall be construed to render \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) an agent or employee of DEPARTMENT.~~
- 11) ~~Assignment: This Agreement shall not be assigned.~~
- 12) ~~Modification: No modification of this Agreement may be made unless agreed to in writing by both parties.~~
- 13) ~~Illinois Law: This Agreement shall be interpreted in accordance with Illinois law.~~
- 14) ~~Non-appropriation of Funds: This Agreement will cease immediately and without further liability, if in any fiscal year the Illinois General Assembly fails to appropriate or otherwise make available sufficient funds for this Agreement. In this event, \_\_\_\_\_ (VILLAGE, THE DISTRICT, ETC) will be paid for expenditures made during the period for which funds were available.~~

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- 15) ~~Termination: Each party reserves the right to terminate this Agreement upon 30 days written notice.~~
- 16) ~~International Anti-Boycott Certification:           (VILLAGE, THE DISTRICT, ETC)           certifies that neither           (VILLAGE, THE DISTRICT, ETC)           nor any substantially owned affiliated company is participating or shall participate in an international boycott in violation of the provisions of the U.S. Export Administration Act of 1979 or the regulations of the U.S. Department of Commerce promulgated under that Act (see 30 ILCS 582).~~
- 17) ~~Taxpayer Identification Number and Legal Status Disclosure:           (VILLAGE, THE DISTRICT, ETC)           shall complete the form entitled "CONTRACTOR'S FEDERAL TAXPAYER IDENTIFICATION NUMBER AND LEGAL STATUS DISCLOSURE CERTIFICATION FORM," which shall be provided by DEPARTMENT and made a part of this grant agreement.~~
- 18) ~~Contact persons and notices: DEPARTMENT's contact person for matters related to this Agreement is:~~

~~Illinois Department of Nuclear Safety  
 Division of Planning & Analysis  
 Head of Emergency Preparedness and Local Government Support  
 Section  
 1035 Outer Park Drive  
 Springfield, IL 62704  
 217/785-9863~~

~~(VILLAGE, THE DISTRICT, ETC)          's contact person is:~~

~~(NAME OF PERSON)            
          (NAME OF ENTITY)            
          (ADDRESS)            
          (PHONE NUMBER)~~

~~DEPARTMENT and           (VILLAGE, THE DISTRICT, ETC)           may, from time to time, designate in writing different contact persons or addresses. Unless otherwise specifically provided herein, all notices or submittals required or permitted pursuant to this Agreement shall be~~

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~~deemed given when personally delivered or upon three (3) days after being posted by certified or registered mail, return receipt requested, postage prepaid, to the designated contact person at the designated address.~~

~~IN WITNESS HEREOF, the parties hereto have caused this Agreement to be executed by their duly authorized representatives.~~

~~STATE OF ILLINOIS  
DEPARTMENT OF NUCLEAR SAFETY  
1035 Outer Park Drive  
Springfield, IL 62704~~

~~(NAME OF ENTITY)  
(ADDRESS)~~

~~BY: \_\_\_\_\_~~

~~BY: \_\_\_\_\_~~

~~TITLE: \_\_\_\_\_~~

~~TITLE: \_\_\_\_\_~~

~~DATE: \_\_\_\_\_~~

~~DATE: \_\_\_\_\_~~

~~FEIN: \_\_\_\_\_~~

(Source: Repealed at 33 Ill. Reg. 9110, effective June 11, 2009)

## SECRETARY OF STATE

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Uniform Partnership Act (1997)
- 2) Code Citation: 14 Ill. Adm. Code 166
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
166.20	Amend
166.25	Amend
166.45	Amend
166.60	Amend
166.80	Amend
- 4) Statutory Authority: Implementing and authorized by Section 1208 of the Illinois Uniform Partnership Act 1997 [805 ILCS 206/1208]
- 5) Effective Date of Rulemaking: July 6, 2009
- 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 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: March 6, 2009; 33 Ill. Reg. 3956
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between proposal and final version: Proposed new Section, Part 166.85, was removed.
- 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? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendments: Sections 166.20 and 166.25 are amended to conform to terminology in use. Section 166.45 is amended to correspond to the most

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recent versions of forms in use by the Department of Business Services. Section 166.60 is amended to correct the description of the business entities governed by the Uniform Partnership Act (1997) and this Part, and also to show the possessive when referring to the Department's files. An apparent transcription error is corrected in Section 166.80.

- 16) Information and questions regarding these adopted amendments shall be directed to:

Anthony Gordon, Assistant General Counsel  
Secretary of State  
100 West Randolph St., Suite 5-400  
Chicago, IL 60601

312/814-9509  
Fax: 312/814-5958  
tgordon1@ilsos.net

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

## SECRETARY OF STATE

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TITLE 14: COMMERCE  
SUBTITLE A: REGULATION OF BUSINESS  
CHAPTER I: SECRETARY OF STATEPART 166  
UNIFORM PARTNERSHIP ACT (1997)

Section	
166.10	Prohibited Terms in Title
166.15	Improper Names
166.20	Definitions
166.25	Applicability
166.30	Filing Location
166.35	Business Hours
166.40	Filing Requirements
166.45	Additional Requirements for Forms
166.50	Renewal Reports
166.55	Payment of Fees
166.60	Sale of Information
166.65	Refunds
166.70	Service of Process
166.75	Interrogatories
166.80	Right to Counsel

AUTHORITY: Implementing and authorized by Section 1208 of the Uniform Partnership Act [805 ILCS 206/1208].

SOURCE: Adopted at 32 Ill. Reg. 332, effective January 7, 2008; amended at 33 Ill. Reg. 9129, effective July 6, 2009.

**Section 166.20 Definitions**

In addition to the definitions contained in Section 101 of the Uniform Partnership Act [805 ILCS 206/101], the following definitions shall apply:

"Abstracts of Record" shall consist of a hard copy printout of the information shown on the computer records of the Department of Business Services of the Office of the Secretary of State.

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"Department" shall mean the Department of Business Services of the Office of the Secretary of State.

"Director" shall mean the Director of the Department of Business Services.

"Interrogatories" shall mean a written request for information to ascertain whether a limited liability partnership has complied with the provisions of the UPA.

"~~LLP~~" shall mean a ~~Registered~~ Limited Liability Partnership.

"Secretary" shall mean the Secretary of State of Illinois.

"UPA" shall mean the Uniform Partnership Act (1997) [805 ILCS 206].

"UPA Section" shall mean the unit of the Department that administers the provisions of the UPA.

(Source: Amended at 33 Ill. Reg. 9129, effective July 6, 2009)

**Section 166.25 Applicability**

The provisions of this Part shall be applicable to all ~~registered~~ limited liability partnerships that are, will be or may become subject to the provisions of the UPA.

(Source: Amended at 33 Ill. Reg. 9129, effective July 6, 2009)

**Section 166.45 Additional Requirements for Forms**

a) All documents required by this Act to be filed in the Office of the Secretary of State shall be made on the most recent version of forms prescribed and furnished by the Secretary of State. The Secretary of State employs the following forms:

- 1) Form UPA 303 Statement of Partnership Authority (see 805 ILCS 206/303);
- 2) Form UPA 304 Statement of Denial (see 805 ILCS 206/304);
- 3) Form UPA 704 ~~Limited Liability Partnership~~ Statement of Dissociation (see 805 ILCS 206/704);

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- 4) Form UPA 805 Statement of Dissolution [of Statement of Partnership Authority](#) (see 805 ILCS 206/805);
  - 5) Form UPA 907 LLP/LP Statement of Merger (see 805 ILCS 206/907);
  - 6) Form UPA 908 LLP/LLC Statement of Merger (see 805 ILCS 206/908);
  - 7) [Form UPA 1001 Limited Liability Partnership Statement of Qualification \(see 805 ILCS 206/1001\);](#)
  - 8) [Form UPA 1001\(e\)/1101\(f\) Statement of Withdrawal \(see 805 ILCS 206/1001\(e\) and 1102\(f\)\);](#)
  - 9) [Form UPA 1001\(h\)/1102\(g\) Statement of Amendment \(see 805 ILCS 206/1001\(h\) and 1102\(g\)\);](#)
  - ~~10)7)~~ Form UPA 1003(D) Application for Renewal of Domestic Limited Liability Partnership (see 805 ILCS 206/1003);
  - ~~11)8)~~ Form UPA 1003(F) [Renewal Statement](#)~~Application for Renewal~~ of Foreign Limited Liability Partnership (see 805 ILCS 206/1003);
  - 9) ~~Form UPA 1004 VWN Voluntary Withdrawal Notice (see 805 ILCS 206/1001(e) for domestic LLP) (see 805 ILCS 206/1102(f) for foreign LLP);~~
  - ~~10) Form UPA 1001 Limited Liability Partnership Statement of Qualification (see 805 ILCS 206/1001);~~
  - ~~12)11)~~ Form UPA 1102 Limited Liability Partnership Statement of Foreign Qualification (see 805 ILCS 206/1102);
  - ~~13)12)~~ Form UPA 1103 Affidavit of Compliance for Service on Secretary of State (see 805 ILCS 206/1103(e) and 14 Ill. Adm. Code 166.70);
  - ~~13) Form UPA 105 Statement of Amendment (see 805 ILCS 206/105);~~
- ~~b)14)~~ Fees for the above forms can be found at 805 ILCS 206/108.

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- |     **cb)** All documents filed with the Department shall contain the federal employer identification number of the limited liability partnership with respect to which the document was filed.
- |     **de)** All documents and attachments submitted by a limited liability partnership shall be typewritten on 8½ x 11" white paper.

(Source: Amended at 33 Ill. Reg. 9129, effective July 6, 2009)

**Section 166.60 Sale of Information**

- a) Information concerning any limited liability partnership shall be available to the public from the Department of Business Services upon written request, or by telephone or in person, or, if technology is available, on line through interactive computer.
- b) Information in the form of an abstract of record concerning the limited liability partnerships on file with the Department shall be printed from the computer file of the Department and shall consist of the limited liability partnership name, its date of qualification, its registered agent, the address of the office at which the records are maintained, the foreign jurisdiction where formed (if applicable), the date of filing with the Department, and the file number assigned by the Department. The fee for each abstract of record shall be \$25.
- c) Copies of all documents pertaining to limited liability partnerships on file with the Department are available:
  - 1) upon written request and payment of the required fee.
  - 2) by telephone request with advance payment using a credit card, a debit card or an electronic funds transfer.
  - 3) in person and with payment of the required fee at the Department's address set forth in Section 166.30.
- d) Computer connections by non-Department users:

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- 1) Computer terminal connections to the Secretary's computer may be provided to other State agencies. This service may be made available at no charge so long as the requesting agency incurs all costs and so long as the service does not substantially increase costs or network traffic on the Secretary's computer.
  - 2) Computer terminal connections may be allowed to commercial users provided that all costs are borne by the commercial user. The allowance of computer terminal connections shall be contingent upon the best interests of the Office of the Secretary of State, cost-effectiveness of providing the information through computer terminal connections as opposed to other methods, and other factors that may impede the operations of the Office of the Secretary of State. This service will be suspended at any time should the connection interfere with the Secretary's internal work schedules and processing.
  - 3) Fees for information supplied by means of computer connections between the Secretary of State's computers and those of any other agency, corporation, or person may be paid on an annual basis for all information delivered during that year, as determined by the Secretary and the agency or person to be the economically simplest way of billing. The proper fee shall be determined by negotiation between the agency or commercial user and the Director based upon telephone line charges, rental or purchase fees for terminals, and any other appropriate factors, such as the statutory fees set forth at 805 ILCS 206/108 for certificates of information, and the requirements of this Part.
  - 4) No users may print any list or abstract from the computer connection. Lists of UPA information including the names and information for all limited [liability](#) partnerships may only be purchased pursuant to the provisions of this Part. Computer connections are to be used only to look up information. No changes on the [Department's Departments](#) UPA files may be made by any computer connection user.
- e) Terms and conditions for computer maintained UPA information:
- 1) The information supplied by the Department to other agencies, commercial users, or other persons shall be in the abstract format only, as specified in subsection (b) of this Section.

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- 2) The fee for the entire file of current and expired limited liability partnerships shall be determined in accordance with the provisions of subsection (d)(3) of this Section. If the file is purchased on computer disc or tape, the purchaser shall supply the Department with computer disc, discs, tape or tapes, compatible with the Secretary's computer equipment, on to which discs or tapes the information shall be transferred.
- 3) All purchase requests shall be submitted in writing to the Director. Payment shall be made to the Department before delivery of the information to the purchaser. No refunds will be made after the request is approved by the Director. Payment shall be made by check or money order payable to the "Secretary of State", or by credit or debit card.
- 4) All commercial or other type purchasers shall sign a written agreement setting forth the terms and conditions required by Illinois law, and as may be deemed appropriate after negotiation between the Department and the purchaser.
- 5) The commercial purchaser shall not resell to any other purchaser the information obtained from the Department in the same form or format in which it is obtained from the Department. Resale of information in the same form or format shall result in cancellation of access to information by the Department. The commercial purchaser may sell the information to the subscribers of its computer or business information services only as information specific to an individual limited partnership, as needed by the subscriber.

(Source: Amended at 33 Ill. Reg. 9129, effective July 6, 2009)

**Section 166.80 Right to Counsel**

- a) Hearing procedures will be governed by 14 Ill. Adm. Code 150, Subpart A.
- b) Any party may appear and be heard through an attorney at law licensed to practice in the State of Illinois.
  - 1) Attorneys admitted to practice in states other than the State of Illinois may appear and be heard upon the attorney's verbal representation of written

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| documentation as to the attorney's admittance, ~~pursuant admittance,~~ pursuant to an order pro hac vice, entered by a judge of the circuit court of the county in which the hearing is conducted, as provided in Supreme Court Rule 707.

- 2) A natural person may appear and be heard on his or her own behalf.
- 3) A corporation, limited liability company, association or partnership may appear and present evidence by any bonafide officer, employee or representative.

- | c) Only an attorney properly licensed shall represent anyone else in any hearing in any matter involving the exercise of legal skill or knowledge. The standards of conduct shall be the same as before the Courts of the State of Illinois.

(Source: Amended at 33 Ill. Reg. 9129, effective July 6, 2009)

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

- 1) Heading of the Part: Pay Plan
- 2) Code Citation: 80 Ill. Adm. Code 310
- 3) 

<u>Section Numbers:</u>	<u>Peremptory Action:</u>
310.100	Amendment
310.490	Amendment
310.APPENDIX A TABLE Q	Amendment
310.APPENDIX A TABLE W	Amendment
- 4) Reference to the Specific State or Federal Court Order, Federal Rule or Statute which Requires this Peremptory Rulemaking: The Department of Central Management Services (CMS) is amending the Pay Plan (80 Ill. Adm. Code 310) Sections 310.100 and 310.490 to reflect the Memoranda of Understanding (MOU) between the CMS and the American Federation of State, County and Municipal Employees (AFSCME) signed May 26, 2009. The MOU provides that employees shall retain their Equivalent Earned Time (EET) upon their positions' representation by an AFSCME bargaining unit. Employees whose positions were certified as represented effective July 1, 2007 or after shall have previously unused EET restored no later than July 1, 2009. The use of the EET is approved by supervisors, prior to other benefit time excluding sick and personal business leave, in increments of fifteen minutes after the initial use of one-half hour, and granted under the same criteria as vacation time. The employees may substitute EET for sick leave in accordance with sick leave policies and procedures.

CMS is amending Section 310.Appendix A Table Q to reflect the Agreement between CMS and the Illinois Federation of Public Employees, Local 4408, AFT/AFL-CIO signed May 27, 2009. The Agreement provides for three payment or increases during fiscal years 2009 and 2010. Effective May 27, 2009, each bargaining unit employee shall receive a onetime cash payment of \$850, which shall be creditable for the State Employee Retirement System. Effective July 1, 2009, the monthly rates shall be increased by 2.5% for each classification. Effective January 1, 2010, the monthly rates shall be increased by 2.0% for each classification but a table with that effective date is not included in the amendments because of a calculation error in the rates. Once corrected through agreement with the bargaining unit, the table effective January 1, 2010 will be added through peremptory amendments.

CMS is amending Section 310.Appendix A Table W to reflect two Memoranda of Understanding between CMS and AFSCME signed May 13, 2009. The first MOU assigns the Fire Protection Specialist I title to the RC-062 bargaining unit and to the pay

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

grades RC-062-16 effective February 25, 2009. The second MOU assigns the Rehabilitation Workshop Supervisor III title to the RC-062 bargaining unit and to the pay grades RC-062-16 effective March 31, 2009. No position was excluded from bargaining unit representation by the Illinois Labor Relations Board.

- 5) Statutory Authority: Authorized by Sections 8, 8a and 9(7) of the Personnel Code [20 ILCS 415/8, 20 ILCS 415/8a and 20 ILCS 415/9(7)] and by Sections 4, 6, 15 and 21 of the Illinois Public Labor Relations Act [5 ILCS 315/4, 5 ILCS 315/6, 5 ILCS 315/15 and 5 ILCS 315/21]
- 6) Effective Date: June 12, 2009
- 7) A Complete Description of the Subjects and Issues Involved: In Sections 310.100(g) and 310.490(e), the sub-subsection (5) is added explaining retention, restoration and use of unused equivalent earned time for employees in AFSCME represented positions. The employees will not accumulate additional equivalent earned time.

In Section 310.Appendix A Table Q, the rate table effective July 1, 2007 is removed. A statement is added with respect to the onetime cash payment of \$850 that shall be effective May 27, 2009 and creditable for the State Employee Retirement System. The rate table effective July 1, 2009 is added.

In Section 310.Appendix A Table W, the Fire Protection Specialist I and Rehabilitation Workshop Supervisor III titles, their respective 15351 and 38196 title codes, and pay grade RC-062-16 are added to the title table.

- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Date filed with the Index Department: June 12, 1009
- 10) This and other Pay Plan amendments are available in the Division of Technical Services of the Bureau of Personnel.
- 11) Is this in compliance with Section 5-50 of the Illinois Administrative Procedure Act?  
Yes
- 12) Are there any other proposed amendments pending on this Part? Yes

Section Numbers:

Proposed Action: Illinois Register Citation:

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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310.47	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.80	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.100	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.130	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.220	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.260	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.270	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.410	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.490	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.500	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table A	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table B	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table D	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table F	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table H	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table I	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table J	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table K	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table N	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table O	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table R	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table V	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table W	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table X	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table Y	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix A Table Z	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix D	Amendment	33 Ill. Reg. 4588; April 3, 2009
310.Appendix G	Amendment	33 Ill. Reg. 4588; April 3, 2009

13) Statement of Statewide Policy Objectives: These amendments to the Pay Plan affect only the employees subject to the Personnel Code and do not set out any guidelines that affect local or other jurisdictions in the State.

14) Information and questions regarding this preemptory rulemaking shall be directed to:

Mr. Jason Doggett  
 Manager  
 Compensation Section  
 Division of Technical Services and Agency Training and Development

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DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PEREMPTORY AMENDMENTS

Bureau of Personnel  
Department of Central Management Services  
504 William G. Stratton Building  
Springfield IL 62706

217/782-7964  
Fax: 217/524-4570  
CMS.PayPlan@Illinois.gov

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

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES  
SUBTITLE B: PERSONNEL RULES, PAY PLANS, AND  
POSITION CLASSIFICATIONS

## CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 310  
PAY PLAN

## SUBPART A: NARRATIVE

Section	
310.20	Policy and Responsibilities
310.30	Jurisdiction
310.40	Pay Schedules
310.45	Comparison of Pay Grades or Salary Ranges Assigned to Classifications
310.47	In-Hiring Rate
310.50	Definitions
310.60	Conversion of Base Salary to Pay Period Units
310.70	Conversion of Base Salary to Daily or Hourly Equivalents
310.80	Increases in Pay
310.90	Decreases in Pay
310.100	Other Pay Provisions
310.110	Implementation of Pay Plan Changes
310.120	Interpretation and Application of Pay Plan
310.130	Effective Date
310.140	Reinstitution of Within Grade Salary Increases (Repealed)
310.150	Fiscal Year 1985 Pay Changes in Schedule of Salary Grades, effective July 1, 1984 (Repealed)

## SUBPART B: SCHEDULE OF RATES

Section	
310.205	Introduction
310.210	Prevailing Rate
310.220	Negotiated Rate
310.230	Part-Time Daily or Hourly Special Services Rate (Repealed)
310.240	Daily or Hourly Rate Conversion
310.250	Member, Patient and Inmate Rate
310.260	Trainee Rate

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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310.270	Legislated and Contracted Rate
310.280	Designated Rate
310.290	Out-of-State Rate (Repealed)
310.295	Foreign Service Rate (Repealed)
310.300	Educator Schedule for RC-063 and HR-010
310.310	Physician Specialist Rate
310.320	Annual Compensation Ranges for Executive Director and Assistant Executive Director, State Board of Elections (Repealed)
310.330	Excluded Classes Rate (Repealed)

## SUBPART C: MERIT COMPENSATION SYSTEM

Section	
310.410	Jurisdiction
310.415	Merit Compensation Salary Range Assignments
310.420	Objectives
310.430	Responsibilities
310.440	Merit Compensation Salary Schedule
310.450	Procedures for Determining Annual Merit Increases and Bonuses
310.455	Intermittent Merit Increase
310.456	Merit Zone (Repealed)
310.460	Other Pay Increases
310.470	Adjustment
310.480	Decreases in Pay
310.490	Other Pay Provisions
310.495	Broad-Band Pay Range Classes
310.500	Definitions
310.510	Conversion of Base Salary to Pay Period Units (Repealed)
310.520	Conversion of Base Salary to Daily or Hourly Equivalents
310.530	Implementation
310.540	Annual Merit Increase and Bonus Guidechart
310.550	Fiscal Year 1985 Pay Changes in Merit Compensation System, effective July 1, 1984 (Repealed)

## 310.APPENDIX A Negotiated Rates of Pay

310.TABLE A RC-104 (Conservation Police Supervisors, Laborers' – ISEA Local #2002)

310.TABLE B VR-706 (Assistant Automotive Shop Supervisors, Automotive Shop Supervisors and Meat and Poultry Inspector Supervisors, Laborers' –

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	ISEA Local #2002)
310.TABLE C	RC-056 (Site Superintendents and Natural Resource, Historic Preservation and Agriculture Managers, IFPE)
310.TABLE D	HR-001 (Teamsters Local #726)
310.TABLE E	RC-020 (Teamsters Local #330)
310.TABLE F	RC-019 (Teamsters Local #25)
310.TABLE G	RC-045 (Automotive Mechanics, IFPE)
310.TABLE H	RC-006 (Corrections Employees, AFSCME)
310.TABLE I	RC-009 (Institutional Employees, AFSCME)
310.TABLE J	RC-014 (Clerical Employees, AFSCME)
310.TABLE K	RC-023 (Registered Nurses, INA)
310.TABLE L	RC-008 (Boilermakers)
310.TABLE M	RC-110 (Conservation Police Lodge)
310.TABLE N	RC-010 (Professional Legal Unit, AFSCME)
310.TABLE O	RC-028 (Paraprofessional Human Services Employees, AFSCME)
310.TABLE P	RC-029 (Paraprofessional Investigatory and Law Enforcement Employees, IFPE)
310.TABLE Q	RC-033 (Meat Inspectors, IFPE)
310.TABLE R	RC-042 (Residual Maintenance Workers, AFSCME)
310.TABLE S	VR-704 (Corrections, Juvenile Justice and State Police Supervisors, Laborers' – ISEA Local #2002)
310.TABLE T	HR-010 (Teachers of Deaf, IFT)
310.TABLE U	HR-010 (Teachers of Deaf, Extracurricular Paid Activities)
310.TABLE V	CU-500 (Corrections Meet and Confer Employees)
310.TABLE W	RC-062 (Technical Employees, AFSCME)
310.TABLE X	RC-063 (Professional Employees, AFSCME)
310.TABLE Y	RC-063 (Educators, AFSCME)
310.TABLE Z	RC-063 (Physicians, AFSCME)
310.TABLE AA	NR-916 (Department of Natural Resources, Teamsters)
310.TABLE AB	VR-007 (Plant Maintenance Engineers, Operating Engineers) (Repealed)
310.APPENDIX B	Schedule of Salary Grade Pay Grades – Monthly Rates of Pay
310.APPENDIX C	Medical Administrator Rates (Repealed)
310.APPENDIX D	Merit Compensation System Salary Schedule
310.APPENDIX E	Teaching Salary Schedule (Repealed)
310.APPENDIX F	Physician and Physician Specialist Salary Schedule (Repealed)
310.APPENDIX G	Broad-Band Pay Range Classes Salary Schedule

AUTHORITY: Implementing and authorized by Sections 8 and 8a of the Personnel Code [20

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

ILCS 415/8 and 8a].

SOURCE: Filed June 28, 1967; codified at 8 Ill. Reg. 1558; emergency amendment at 8 Ill. Reg. 1990, effective January 31, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 2440, effective February 15, 1984; emergency amendment at 8 Ill. Reg. 3348, effective March 5, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 4249, effective March 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 5704, effective April 16, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 7290, effective May 11, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 11299, effective June 25, 1984; emergency amendment at 8 Ill. Reg. 12616, effective July 1, 1984, for a maximum of 150 days; emergency amendment at 8 Ill. Reg. 15007, effective August 6, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 15367, effective August 13, 1984; emergency amendment at 8 Ill. Reg. 21310, effective October 10, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 21544, effective October 24, 1984; amended at 8 Ill. Reg. 22844, effective November 14, 1984; emergency amendment at 9 Ill. Reg. 1134, effective January 16, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 1320, effective January 23, 1985; amended at 9 Ill. Reg. 3681, effective March 12, 1985; emergency amendment at 9 Ill. Reg. 4163, effective March 15, 1985, for a maximum of 150 days; emergency amendment at 9 Ill. Reg. 9231, effective May 31, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 9420, effective June 7, 1985; amended at 9 Ill. Reg. 10663, effective July 1, 1985; emergency amendment at 9 Ill. Reg. 15043, effective September 24, 1985, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 3325, effective January 22, 1986; amended at 10 Ill. Reg. 3230, effective January 24, 1986; emergency amendment at 10 Ill. Reg. 8904, effective May 13, 1986, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 8928, effective May 13, 1986; emergency amendment at 10 Ill. Reg. 12090, effective June 30, 1986, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 13675, effective July 31, 1986; preemptory amendment at 10 Ill. Reg. 14867, effective August 26, 1986; amended at 10 Ill. Reg. 15567, effective September 17, 1986; emergency amendment at 10 Ill. Reg. 17765, effective September 30, 1986, for a maximum of 150 days; preemptory amendment at 10 Ill. Reg. 19132, effective October 28, 1986; preemptory amendment at 10 Ill. Reg. 21097, effective December 9, 1986; amended at 11 Ill. Reg. 648, effective December 22, 1986; preemptory amendment at 11 Ill. Reg. 3363, effective February 3, 1987; preemptory amendment at 11 Ill. Reg. 4388, effective February 27, 1987; preemptory amendment at 11 Ill. Reg. 6291, effective March 23, 1987; amended at 11 Ill. Reg. 5901, effective March 24, 1987; emergency amendment at 11 Ill. Reg. 8787, effective April 15, 1987, for a maximum of 150 days; emergency amendment at 11 Ill. Reg. 11830, effective July 1, 1987, for a maximum of 150 days; preemptory amendment at 11 Ill. Reg. 13675, effective July 29, 1987; amended at 11 Ill. Reg. 14984, effective August 27, 1987; preemptory amendment at 11 Ill. Reg. 15273, effective September 1, 1987; preemptory amendment at 11 Ill. Reg. 17919, effective October 19, 1987; preemptory amendment at 11 Ill. Reg. 19812, effective November

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19, 1987; emergency amendment at 11 Ill. Reg. 20664, effective December 4, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 20778, effective December 11, 1987; preemptory amendment at 12 Ill. Reg. 3811, effective January 27, 1988; preemptory amendment at 12 Ill. Reg. 5459, effective March 3, 1988; amended at 12 Ill. Reg. 6073, effective March 21, 1988; preemptory amendment at 12 Ill. Reg. 7783, effective April 14, 1988; emergency amendment at 12 Ill. Reg. 7734, effective April 15, 1988, for a maximum of 150 days; preemptory amendment at 12 Ill. Reg. 8135, effective April 22, 1988; preemptory amendment at 12 Ill. Reg. 9745, effective May 23, 1988; emergency amendment at 12 Ill. Reg. 11778, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 12895, effective July 18, 1988, for a maximum of 150 days; preemptory amendment at 12 Ill. Reg. 13306, effective July 27, 1988; corrected at 12 Ill. Reg. 13359; amended at 12 Ill. Reg. 14630, effective September 6, 1988; amended at 12 Ill. Reg. 20449, effective November 28, 1988; preemptory amendment at 12 Ill. Reg. 20584, effective November 28, 1988; preemptory amendment at 13 Ill. Reg. 8080, effective May 10, 1989; amended at 13 Ill. Reg. 8849, effective May 30, 1989; preemptory amendment at 13 Ill. Reg. 8970, effective May 26, 1989; emergency amendment at 13 Ill. Reg. 10967, effective June 20, 1989, for a maximum of 150 days; emergency amendment expired on November 17, 1989; amended at 13 Ill. Reg. 11451, effective June 28, 1989; emergency amendment at 13 Ill. Reg. 11854, effective July 1, 1989, for a maximum of 150 days; corrected at 13 Ill. Reg. 12647; preemptory amendment at 13 Ill. Reg. 12887, effective July 24, 1989; amended at 13 Ill. Reg. 16950, effective October 20, 1989; amended at 13 Ill. Reg. 19221, effective December 12, 1989; amended at 14 Ill. Reg. 615, effective January 2, 1990; preemptory amendment at 14 Ill. Reg. 1627, effective January 11, 1990; amended at 14 Ill. Reg. 4455, effective March 12, 1990; preemptory amendment at 14 Ill. Reg. 7652, effective May 7, 1990; amended at 14 Ill. Reg. 10002, effective June 11, 1990; emergency amendment at 14 Ill. Reg. 11330, effective June 29, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14361, effective August 24, 1990; emergency amendment at 14 Ill. Reg. 15570, effective September 11, 1990, for a maximum of 150 days; emergency amendment expired on February 8, 1991; corrected at 14 Ill. Reg. 16092; preemptory amendment at 14 Ill. Reg. 17098, effective September 26, 1990; amended at 14 Ill. Reg. 17189, effective October 2, 1990; amended at 14 Ill. Reg. 17189, effective October 19, 1990; amended at 14 Ill. Reg. 18719, effective November 13, 1990; preemptory amendment at 14 Ill. Reg. 18854, effective November 13, 1990; preemptory amendment at 15 Ill. Reg. 663, effective January 7, 1991; amended at 15 Ill. Reg. 3296, effective February 14, 1991; amended at 15 Ill. Reg. 4401, effective March 11, 1991; preemptory amendment at 15 Ill. Reg. 5100, effective March 20, 1991; preemptory amendment at 15 Ill. Reg. 5465, effective April 2, 1991; emergency amendment at 15 Ill. Reg. 10485, effective July 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 11080, effective July 19, 1991; amended at 15 Ill. Reg. 13080, effective August 21, 1991; amended at 15 Ill. Reg. 14210, effective September 23, 1991; emergency amendment at 16 Ill. Reg. 711, effective December 26, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 3450, effective

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February 20, 1992; preemptory amendment at 16 Ill. Reg. 5068, effective March 11, 1992; preemptory amendment at 16 Ill. Reg. 7056, effective April 20, 1992; emergency amendment at 16 Ill. Reg. 8239, effective May 19, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 8382, effective May 26, 1992; emergency amendment at 16 Ill. Reg. 13950, effective August 19, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14452, effective September 4, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 238, effective December 23, 1992; preemptory amendment at 17 Ill. Reg. 498, effective December 18, 1992; amended at 17 Ill. Reg. 590, effective January 4, 1993; amended at 17 Ill. Reg. 1819, effective February 2, 1993; amended at 17 Ill. Reg. 6441, effective April 8, 1993; emergency amendment at 17 Ill. Reg. 12900, effective July 22, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 13409, effective July 29, 1993; emergency amendment at 17 Ill. Reg. 13789, effective August 9, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 14666, effective August 26, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 19103, effective October 25, 1993; emergency amendment at 17 Ill. Reg. 21858, effective December 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 22514, effective December 15, 1993; amended at 18 Ill. Reg. 227, effective December 17, 1993; amended at 18 Ill. Reg. 1107, effective January 18, 1994; amended at 18 Ill. Reg. 5146, effective March 21, 1994; preemptory amendment at 18 Ill. Reg. 9562, effective June 13, 1994; emergency amendment at 18 Ill. Reg. 11299, effective July 1, 1994, for a maximum of 150 days; preemptory amendment at 18 Ill. Reg. 13476, effective August 17, 1994; emergency amendment at 18 Ill. Reg. 14417, effective September 9, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 16545, effective October 31, 1994; preemptory amendment at 18 Ill. Reg. 16708, effective October 28, 1994; amended at 18 Ill. Reg. 17191, effective November 21, 1994; amended at 19 Ill. Reg. 1024, effective January 24, 1995; preemptory amendment at 19 Ill. Reg. 2481, effective February 17, 1995; preemptory amendment at 19 Ill. Reg. 3073, effective February 17, 1995; amended at 19 Ill. Reg. 3456, effective March 7, 1995; preemptory amendment at 19 Ill. Reg. 5145, effective March 14, 1995; amended at 19 Ill. Reg. 6452, effective May 2, 1995; preemptory amendment at 19 Ill. Reg. 6688, effective May 1, 1995; amended at 19 Ill. Reg. 7841, effective June 1, 1995; amended at 19 Ill. Reg. 8156, effective June 12, 1995; amended at 19 Ill. Reg. 9096, effective June 27, 1995; emergency amendment at 19 Ill. Reg. 11954, effective August 1, 1995, for a maximum of 150 days; preemptory amendment at 19 Ill. Reg. 13979, effective September 19, 1995; preemptory amendment at 19 Ill. Reg. 15103, effective October 12, 1995; amended at 19 Ill. Reg. 16160, effective November 28, 1995; amended at 20 Ill. Reg. 308, effective December 22, 1995; emergency amendment at 20 Ill. Reg. 4060, effective February 27, 1996, for a maximum of 150 days; preemptory amendment at 20 Ill. Reg. 6334, effective April 22, 1996; preemptory amendment at 20 Ill. Reg. 7434, effective May 14, 1996; amended at 20 Ill. Reg. 8301, effective June 11, 1996; amended at 20 Ill. Reg. 8657, effective June 20, 1996; amended at 20 Ill. Reg. 9006, effective June 26, 1996; amended at 20 Ill. Reg. 9925, effective July 10, 1996; emergency amendment at 20 Ill. Reg. 10213, effective July 15, 1996, for a maximum of 150 days; amended

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at 20 Ill. Reg. 10841, effective August 5, 1996; preemptory amendment at 20 Ill. Reg. 13408, effective September 24, 1996; amended at 20 Ill. Reg. 15018, effective November 7, 1996; preemptory amendment at 20 Ill. Reg. 15092, effective November 7, 1996; emergency amendment at 21 Ill. Reg. 1023, effective January 6, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 1629, effective January 22, 1997; amended at 21 Ill. Reg. 5144, effective April 15, 1997; amended at 21 Ill. Reg. 6444, effective May 15, 1997; amended at 21 Ill. Reg. 7118, effective June 3, 1997; emergency amendment at 21 Ill. Reg. 10061, effective July 21, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 12859, effective September 8, 1997, for a maximum of 150 days; preemptory amendment at 21 Ill. Reg. 14267, effective October 14, 1997; preemptory amendment at 21 Ill. Reg. 14589, effective October 15, 1997; preemptory amendment at 21 Ill. Reg. 15030, effective November 10, 1997; amended at 21 Ill. Reg. 16344, effective December 9, 1997; preemptory amendment at 21 Ill. Reg. 16465, effective December 4, 1997; preemptory amendment at 21 Ill. Reg. 17167, effective December 9, 1997; preemptory amendment at 22 Ill. Reg. 1593, effective December 22, 1997; amended at 22 Ill. Reg. 2580, effective January 14, 1998; preemptory amendment at 22 Ill. Reg. 4326, effective February 13, 1998; preemptory amendment at 22 Ill. Reg. 5108, effective February 26, 1998; preemptory amendment at 22 Ill. Reg. 5749, effective March 3, 1998; amended at 22 Ill. Reg. 6204, effective March 12, 1998; preemptory amendment at 22 Ill. Reg. 7053, effective April 1, 1998; preemptory amendment at 22 Ill. Reg. 7320, effective April 10, 1998; preemptory amendment at 22 Ill. Reg. 7692, effective April 20, 1998; emergency amendment at 22 Ill. Reg. 12607, effective July 2, 1998, for a maximum of 150 days; preemptory amendment at 22 Ill. Reg. 15489, effective August 7, 1998; amended at 22 Ill. Reg. 16158, effective August 31, 1998; preemptory amendment at 22 Ill. Reg. 19105, effective September 30, 1998; preemptory amendment at 22 Ill. Reg. 19943, effective October 27, 1998; preemptory amendment at 22 Ill. Reg. 20406, effective November 5, 1998; amended at 22 Ill. Reg. 20581, effective November 16, 1998; amended at 23 Ill. Reg. 664, effective January 1, 1999; preemptory amendment at 23 Ill. Reg. 730, effective December 29, 1998; emergency amendment at 23 Ill. Reg. 6533, effective May 10, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 7065, effective June 3, 1999; emergency amendment at 23 Ill. Reg. 8169, effective July 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 11020, effective August 26, 1999; amended at 23 Ill. Reg. 12429, effective September 21, 1999; preemptory amendment at 23 Ill. Reg. 12493, effective September 23, 1999; amended at 23 Ill. Reg. 12604, effective September 24, 1999; amended at 23 Ill. Reg. 13053, effective September 27, 1999; preemptory amendment at 23 Ill. Reg. 13132, effective October 1, 1999; amended at 23 Ill. Reg. 13570, effective October 26, 1999; amended at 23 Ill. Reg. 14020, effective November 15, 1999; amended at 24 Ill. Reg. 1025, effective January 7, 2000; preemptory amendment at 24 Ill. Reg. 3399, effective February 3, 2000; amended at 24 Ill. Reg. 3537, effective February 18, 2000; amended at 24 Ill. Reg. 6874, effective April 21, 2000; amended at 24 Ill. Reg. 7956, effective May 23, 2000; emergency amendment at 24 Ill. Reg. 10328, effective July 1, 2000, for a maximum of 150 days; emergency expired November 27,

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2000; preemptory amendment at 24 Ill. Reg. 10767, effective July 3, 2000; amended at 24 Ill. Reg. 13384, effective August 17, 2000; preemptory amendment at 24 Ill. Reg. 14460, effective September 14, 2000; preemptory amendment at 24 Ill. Reg. 16700, effective October 30, 2000; preemptory amendment at 24 Ill. Reg. 17600, effective November 16, 2000; amended at 24 Ill. Reg. 18058, effective December 4, 2000; preemptory amendment at 24 Ill. Reg. 18444, effective December 1, 2000; amended at 25 Ill. Reg. 811, effective January 4, 2001; amended at 25 Ill. Reg. 2389, effective January 22, 2001; amended at 25 Ill. Reg. 4552, effective March 14, 2001; preemptory amendment at 25 Ill. Reg. 5067, effective March 21, 2001; amended at 25 Ill. Reg. 5618, effective April 4, 2001; amended at 25 Ill. Reg. 6655, effective May 11, 2001; amended at 25 Ill. Reg. 7151, effective May 25, 2001; preemptory amendment at 25 Ill. Reg. 8009, effective June 14, 2001; emergency amendment at 25 Ill. Reg. 9336, effective July 3, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 9846, effective July 23, 2001; amended at 25 Ill. Reg. 12087, effective September 6, 2001; amended at 25 Ill. Reg. 15560, effective November 20, 2001; preemptory amendment at 25 Ill. Reg. 15671, effective November 15, 2001; amended at 25 Ill. Reg. 15974, effective November 28, 2001; emergency amendment at 26 Ill. Reg. 223, effective December 21, 2001, for a maximum of 150 days; amended at 26 Ill. Reg. 1143, effective January 17, 2002; amended at 26 Ill. Reg. 4127, effective March 5, 2002; preemptory amendment at 26 Ill. Reg. 4963, effective March 15, 2002; amended at 26 Ill. Reg. 6235, effective April 16, 2002; emergency amendment at 26 Ill. Reg. 7314, effective April 29, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 10425, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 10952, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13934, effective September 10, 2002; amended at 26 Ill. Reg. 14965, effective October 7, 2002; emergency amendment at 26 Ill. Reg. 16583, effective October 24, 2002, for a maximum of 150 days; emergency expired March 22, 2003; preemptory amendment at 26 Ill. Reg. 17280, effective November 18, 2002; amended at 26 Ill. Reg. 17374, effective November 25, 2002; amended at 26 Ill. Reg. 17987, effective December 9, 2002; amended at 27 Ill. Reg. 3261, effective February 11, 2003; expedited correction at 28 Ill. Reg. 6151, effective February 11, 2003; amended at 27 Ill. Reg. 8855, effective May 15, 2003; amended at 27 Ill. Reg. 9114, effective May 27, 2003; emergency amendment at 27 Ill. Reg. 10442, effective July 1, 2003, for a maximum of 150 days; emergency expired November 27, 2003; preemptory amendment at 27 Ill. Reg. 17433, effective November 7, 2003; amended at 27 Ill. Reg. 18560, effective December 1, 2003; preemptory amendment at 28 Ill. Reg. 1441, effective January 9, 2004; amended at 28 Ill. Reg. 2684, effective January 22, 2004; amended at 28 Ill. Reg. 6879, effective April 30, 2004; preemptory amendment at 28 Ill. Reg. 7323, effective May 10, 2004; amended at 28 Ill. Reg. 8842, effective June 11, 2004; preemptory amendment at 28 Ill. Reg. 9717, effective June 28, 2004; amended at 28 Ill. Reg. 12585, effective August 27, 2004; preemptory amendment at 28 Ill. Reg. 13011, effective September 8, 2004; preemptory amendment at 28 Ill. Reg. 13247, effective September 20, 2004; preemptory amendment at 28 Ill. Reg. 13656, effective September 27, 2004; emergency amendment at 28 Ill. Reg. 14174, effective October 15, 2004, for a

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maximum of 150 days; emergency expired March 13, 2005; preemptory amendment at 28 Ill. Reg. 14689, effective October 22, 2004; preemptory amendment at 28 Ill. Reg. 15336, effective November 15, 2004; preemptory amendment at 28 Ill. Reg. 16513, effective December 9, 2004; preemptory amendment at 29 Ill. Reg. 726, effective December 15, 2004; amended at 29 Ill. Reg. 1166, effective January 7, 2005; preemptory amendment at 29 Ill. Reg. 1385, effective January 4, 2005; preemptory amendment at 29 Ill. Reg. 1559, effective January 11, 2005; preemptory amendment at 29 Ill. Reg. 2050, effective January 19, 2005; preemptory amendment at 29 Ill. Reg. 4125, effective February 23, 2005; amended at 29 Ill. Reg. 5375, effective April 4, 2005; preemptory amendment at 29 Ill. Reg. 6105, effective April 14, 2005; preemptory amendment at 29 Ill. Reg. 7217, effective May 6, 2005; preemptory amendment at 29 Ill. Reg. 7840, effective May 10, 2005; amended at 29 Ill. Reg. 8110, effective May 23, 2005; preemptory amendment at 29 Ill. Reg. 8214, effective May 23, 2005; preemptory amendment at 29 Ill. Reg. 8418, effective June 1, 2005; amended at 29 Ill. Reg. 9319, effective July 1, 2005; preemptory amendment at 29 Ill. Reg. 12076, effective July 15, 2005; preemptory amendment at 29 Ill. Reg. 13265, effective August 11, 2005; amended at 29 Ill. Reg. 13540, effective August 22, 2005; preemptory amendment at 29 Ill. Reg. 14098, effective September 2, 2005; amended at 29 Ill. Reg. 14166, effective September 9, 2005; amended at 29 Ill. Reg. 19551, effective November 21, 2005; emergency amendment at 29 Ill. Reg. 20554, effective December 2, 2005, for a maximum of 150 days; preemptory amendment at 29 Ill. Reg. 20693, effective December 12, 2005; preemptory amendment at 30 Ill. Reg. 623, effective December 28, 2005; preemptory amendment at 30 Ill. Reg. 1382, effective January 13, 2006; amended at 30 Ill. Reg. 2289, effective February 6, 2006; preemptory amendment at 30 Ill. Reg. 4157, effective February 22, 2006; preemptory amendment at 30 Ill. Reg. 5687, effective March 7, 2006; preemptory amendment at 30 Ill. Reg. 6409, effective March 30, 2006; amended at 30 Ill. Reg. 7857, effective April 17, 2006; amended at 30 Ill. Reg. 9438, effective May 15, 2006; preemptory amendment at 30 Ill. Reg. 10153, effective May 18, 2006; preemptory amendment at 30 Ill. Reg. 10508, effective June 1, 2006; amended at 30 Ill. Reg. 11336, effective July 1, 2006; emergency amendment at 30 Ill. Reg. 12340, effective July 1, 2006, for a maximum of 150 days; preemptory amendment at 30 Ill. Reg. 12418, effective July 1, 2006; amended at 30 Ill. Reg. 12761, effective July 17, 2006; preemptory amendment at 30 Ill. Reg. 13547, effective August 1, 2006; preemptory amendment at 30 Ill. Reg. 15059, effective September 5, 2006; preemptory amendment at 30 Ill. Reg. 16439, effective September 27, 2006; emergency amendment at 30 Ill. Reg. 16626, effective October 3, 2006, for a maximum of 150 days; preemptory amendment at 30 Ill. Reg. 17603, effective October 20, 2006; amended at 30 Ill. Reg. 18610, effective November 20, 2006; preemptory amendment at 30 Ill. Reg. 18823, effective November 21, 2006; preemptory amendment at 31 Ill. Reg. 230, effective December 20, 2006; emergency amendment at 31 Ill. Reg. 1483, effective January 1, 2007, for a maximum of 150 days; preemptory amendment at 31 Ill. Reg. 2485, effective January 17, 2007; preemptory amendment at 31 Ill. Reg. 4445, effective February 28, 2007; amended at 31 Ill. Reg. 4982, effective March 15, 2007; preemptory amendment at 31 Ill.

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Reg. 7338, effective May 3, 2007; amended at 31 Ill. Reg. 8901, effective July 1, 2007; emergency amendment at 31 Ill. Reg. 10056, effective July 1, 2007, for a maximum of 150 days; preemptory amendment at 31 Ill. Reg. 10496, effective July 6, 2007; preemptory amendment at 31 Ill. Reg. 12335, effective August 9, 2007; emergency amendment at 31 Ill. Reg. 12608, effective August 16, 2007, for a maximum of 150 days; emergency amendment at 31 Ill. Reg. 13220, effective August 30, 2007, for a maximum of 150 days; preemptory amendment at 31 Ill. Reg. 13357, effective August 29, 2007; amended at 31 Ill. Reg. 13981, effective September 21, 2007; preemptory amendment at 31 Ill. Reg. 14331, effective October 1, 2007; amended at 31 Ill. Reg. 16094, effective November 20, 2007; amended at 31 Ill. Reg. 16792, effective December 13, 2007; preemptory amendment at 32 Ill. Reg. 598, effective December 27, 2007; amended at 32 Ill. Reg. 1082, effective January 11, 2008; preemptory amendment at 32 Ill. Reg. 3095, effective February 13, 2008; preemptory amendment at 32 Ill. Reg. 6097, effective March 25, 2008; preemptory amendment at 32 Ill. Reg. 7154, effective April 17, 2008; expedited correction at 32 Ill. Reg. 9747, effective April 17, 2008; preemptory amendment at 32 Ill. Reg. 9360, effective June 13, 2008; amended at 32 Ill. Reg. 9881, effective July 1, 2008; preemptory amendment at 32 Ill. Reg. 12065, effective July 9, 2008; preemptory amendment at 32 Ill. Reg. 13861, effective August 8, 2008; preemptory amendment at 32 Ill. Reg. 16591, effective September 24, 2008; preemptory amendment at 32 Ill. Reg. 16872, effective October 3, 2008; preemptory amendment at 32 Ill. Reg. 18324, effective November 14, 2008; preemptory amendment at 33 Ill. Reg. 98, effective December 19, 2008; amended at 33 Ill. Reg. 2148, effective January 26, 2009; preemptory amendment at 33 Ill. Reg. 3530, effective February 6, 2009; preemptory amendment at 33 Ill. Reg. 4202, effective February 26, 2009; preemptory amendment at 33 Ill. Reg. 5501, effective March 25, 2009; preemptory amendment at 33 Ill. Reg. 6354, effective April 15, 2009; preemptory amendment at 33 Ill. Reg. 6724, effective May 1, 2009; preemptory amendment at 33 Ill. Reg. 9138, effective June 12, 2009.

## SUBPART A: NARRATIVE

**Section 310.100 Other Pay Provisions**

- a) Transfer – Upon the assignment of an employee to a vacant position in a class with the same pay grade as the class for the position being vacated, the employee's base salary will not be changed. Upon separation from a position in a given class and subsequent appointment to a position in the same pay grade, no increase in salary will be given.
- b) Entrance Base Salary –
  - 1) Qualifications Only Meet Minimum Requirements – When a candidate

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only meets the minimum requirements of the class specification upon entry to State service, an employee's entrance base salary is the in-hiring rate or the minimum base salary of the pay grade.

- 2) **Qualifications Above Minimum Requirements** – If a candidate possesses directly-related education and experience in excess of the minimum requirements of the class specification, the employing agency may offer the candidate an entrance base salary that is not more than 10% above the candidate's current base salary. An entrance base salary offer more than 10% above the candidate's current base salary requires documentation in the candidate's CMS employment application (CMS-100) to support the higher entrance base salary offer and prior approval from the Director of Central Management Services. The approval is based on the candidate's documented directly-related education and experience exceeding the minimum requirements in the class specification, prior base salary history, staffing needs and requirements of the employing agency, and labor market influences on the recruitment for the position classification or position.
- 3) **Area Differential** – For positions where additional compensation is required because of dissimilar economic or other conditions in the geographical area in which the positions are established, a higher entrance step may be authorized by the Director of Central Management Services. Present employees receiving less than the new rate shall be advanced to the new rate.
- c) **Geographical Transfer** – Upon geographical transfer from or to an area for which additional compensation has been authorized, an employee will receive an adjustment to the appropriate salary level for the new geographical area of assignment effective the first day of the month following date of approval.
- d) **Differential and Overtime Pay** – An eligible employee may have an amount added to his/her base salary for a given pay period for work performed in excess of the normal requirements for the position and work schedule, as follows:
  - 1) **Shift Differential Pay** – An employee may be paid an amount in addition to his/her base salary for work performed on a regularly scheduled second or third shift. The additional compensation will be at a rate and in a manner approved by the Department of Central Management Services.

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The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstances.

- 2) Overtime Pay –
  - A) Eligibility – The Director of Central Management Services will maintain a list of titles and their overtime eligibility as determined by labor contracts, Federal Fair Labor Standards Act, or State law or regulations. Overtime shall be paid in accordance with the labor contracts, Federal Fair Labor Standards Act, and State law or regulations.
  - B) Compensatory Time – Employees who are eligible for compensatory time may request such time, which may be granted by the agency at its discretion, considering, among other things, its operating needs. Compensatory time shall be taken within the fiscal year it was earned at a time convenient to the employee and consistent with the operating needs of the agency. Compensatory time shall be accrued at the rate in which it is earned (straight time or time and a half), but shall not exceed 120 hours in any fiscal year. Compensatory time approved for non-union employees will be earned after 40 actual work hours in a workweek. Compensatory time not used by the end of the fiscal year in which it was earned shall be liquidated and paid in cash at the rate it was earned. Time spent in travel outside the normal work schedule shall not be accrued as compensatory time except as provided by labor contracts and the Federal Fair Labor Standards Act. At no time are overtime hours or compensatory time to be transferred from one agency to another agency.
- 3) Incentive Pay – An employee may be paid an amount in addition to his/her base salary for work performed in excess of the normal work standard as determined by agency management. The additional compensation shall be at a wage rate and in a manner approved by the Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing

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practices of other employers, and the equity of the particular circumstances.

- 4) Temporary Assignment Pay –
  - A) When Assigned to a Higher-Level Position Classification – A bargaining unit employee may be temporarily assigned to a bargaining unit position in a position classification having a higher pay grade and shall be eligible for temporary assignment pay. To be eligible for temporary assignment pay, the employee must be directed to perform the duties that distinguish the higher-level position classification and be held accountable for the responsibility of the higher classification. Employees shall not receive temporary assignment pay for paid days off except if the employee is given the assignment for 30 continuous days or more, the days off fall within the period of time and the employee works 75% of the time of the temporary assignment. Temporary assignment pay shall be calculated as if the employee received a promotion into the higher pay grade. In no event is the temporary assignment pay to be lower than the minimum rate of the higher pay grade or greater than the maximum rate of the higher pay grade.
  - B) When Required to Use Second Language Ability – Employees who are bilingual or have the ability to use sign language, Braille, or another second language (e.g., Spanish) and whose job descriptions do not require that they do so shall be paid temporary assignment pay when required to perform duties requiring the ability. The temporary assignment pay received is prorated based on 5% or \$100 per month, whichever is greater, in addition to the employee's base rate.
- e) Interim Assignment Pay – This subsection of the Pay Plan explains interim assignment pay as applied to certified non-bargaining unit employees in a salary grade position assigned to perform on a full-time interim basis and be accountable for the higher-level duties and responsibilities of the non-bargaining unit (salary grade or merit compensation (including broad-band and medical administrator)) position. On the effective date of the certified non-bargaining unit employee's interim assignment (80 Ill. Adm. Code 302.150(j)), the employee shall receive an

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adjustment as if the employee received a promotion into the higher pay grade or range.

- 1) When Assigned to the Salary Grade Position – When assigned to the salary grade position, the employee's base salary shall be advanced to the lowest step in the higher pay grade that represents at least a full step increase in the lower pay grade. When the employee's current rate is Step 8 in the lower pay grade, the employee shall be paid at the lowest step rate in the higher pay grade that results in an increase equal to at least 3%. To compute this, add 3% to the employee's current rate at Step 8 (then include longevity if the employee is receiving an increased rate based on longevity). Then place the employee on the lowest step in the higher pay grade that is at least equivalent to that amount. Upon interim assignment, the employee's creditable service date shall not change. Effective July 1, 2007, employees in interim assignment, which was effective prior to July 1, 2007, shall have the creditable service date as if not on a leave to serve in an interim assignment.
- 2) When Assigned to the Merit Compensation Position – When assigned to the merit compensation position, the employee's base salary shall receive an adjustment, which is an amount equivalent to between 8% and 15% of the employee's current base salary. In no event is the resulting salary to be lower than the minimum rate or greater than the maximum rate of the salary range to which the employee is being assigned. Upon interim assignment, the employee's creditable service date shall not change. Effective July 1, 2007, employees in interim assignment, which was effective prior to July 1, 2007, shall have the creditable service date as if not on a leave to serve in an interim assignment.
- f) Out-of-State Assignment – Employees who are assigned to work out-of-state on a temporary basis may receive an appropriate differential during the period of the assignment, as approved by the Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstances.
- g) Equivalent Earned Time –

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- 1) Eligibility – Employees who are non-union or represented by the VR-704 bargaining unit, exempt under the Federal Fair Labor Standards Act, and in positions not eligible for overtime compensation may receive equivalent earned time for hours worked in excess of the hours per week indicated in the approved work schedule (80 Ill. Adm. Code 303.300) assigned to the employee.
- 2) Restoration – Employees who are eligible for equivalent earned time shall have the balance of the employee's unused equivalent earned time at the close of business on June 30, 2007 restored as accrued equivalent earned time effective July 1, 2007.
- 3) Accrual –
  - A) Employees who are eligible for equivalent earned time shall request that time before working in excess of the hours per week indicated in the approved work schedule (80 Ill. Adm. Code 303.300) assigned to the employee. Requests for equivalent earned time may be granted by the agency at its discretion, considering its operating needs. Equivalent earned time shall be accrued at straight time only to a maximum of 160 hours at any time.
  - B) Equivalent earned time will accrue in no less than one-half hour increments. Time spent in travel outside the normal work schedule shall not be counted toward accrual of equivalent earned time.
- 4) Compensation – Any approved equivalent earned time shall be taken at a time convenient to the employee and consistent with the operating needs of the agency. At no time is equivalent earned time to be converted into cash payment or transferred from one agency to another agency.
- 5) Employees in Positions Represented by an American Federation of State, County and Municipal Employees Bargaining Unit – Employees shall retain their equivalent earned time upon their positions' representation by an American Federation of State, County and Municipal Employees bargaining unit. Employees whose positions were certified as represented effective July 1, 2007 or after shall have previously unused equivalent earned time restored no later than July 1, 2009. The use of the equivalent

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earned time is approved by supervisors, prior to other benefit time excluding sick and personal business leave, in increments of fifteen minutes after the initial use of one-half hour, and granted under the same criteria as vacation time. Employees may substitute equivalent earned time for sick leave in accordance to sick leave policies and procedures.

- h) Part-Time Work – Part-time employees whose base salary is other than an hourly or daily basis shall be paid on a daily basis computed by dividing the annual rate of salary by the total number of work days in the year.
- i) Lump Sum Payment – Lump sum payment shall be provided for accrued vacation, sick leave and unused compensatory overtime at the current base rate to those employees separated from employment under the Personnel Code. Leaves of absence and temporary layoff (per 80 Ill. Adm. Code 302.510) are not separations and therefore lump sum cannot be given in these transactions. Method of computation is explained in Section 310.70(a).

AGENCY NOTE – The method to be used in computing the lump sum payment for accrued vacation, sick leave and unused compensatory overtime payment for an incumbent entitled to shift differential during his/her regular work hours will be to use his/her current base salary plus the shift differential pay. Sick leave earned prior to January 1, 1984 and after December 31, 1997 is not compensable. Sick leave earned and not used between January 1, 1984 and December 31, 1997 will be compensable at the current base daily rate times one-half of the total number of compensable sick days.

- j) Salary Treatment Upon Return From Leave –
  - 1) An employee returning from Military Leave (80 Ill. Adm. Code 302.220 and 303.170), Peace Corps Leave (80 Ill. Adm. Code 302.230), Service-Connected Disability Leave (80 Ill. Adm. Code 303.135), Educational Leave (80 Ill. Adm. Code 302.215), Disaster Service Leave with Pay (80 Ill. Adm. Code 303.175), Family Responsibility Leave (80 Ill. Adm. Code 303.148), Leave to accept a temporary, emergency, provisional, exempt (80 Ill. Adm. Code 303.155) or trainee position, Leave to serve in domestic peace or job corps (80 Ill. Adm. Code 302.230) or leave to serve in an interim assignment will be placed on the step that reflects satisfactory performance increases to which he/she would have been entitled during his/her period of leave. Creditable service date will be

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maintained.

- 2) An employee returning to his/her former pay grade from any other leave (not mentioned in subsection (j)(1)) of over 14 days will be placed at the step on which he/she was situated prior to his/her leave, and his/her creditable service date will be extended by the duration of the leave.
- k) Salary Treatment Upon Reemployment –
- 1) Upon the reemployment of an employee in a class with the same pay grade as the class for the position held before layoff, the employee will be placed at the same salary step as held at the time of the layoff, and his/her creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.
  - 2) Upon the reemployment of an employee in a class at a lower salary range than the range of the class for the position held before layoff, the employee will be placed at the step in the lower pay grade that provides the base salary nearest in amount to, but less than, the current value of the step held at the time of layoff, and his/her creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.
- l) Reinstatement – The salary upon reinstatement should not provide more than a 10% increase over the candidate's current base salary or exceed the current value of the salary step held in the position where previously certified without prior approval by the Director of Central Management Services. In no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the pay grade.
- m) Extended Service Payment –
- 1) The Step 8 rate shall be increased by \$25 per month for those employees who have attained 10 years of service and have three years of creditable service on Step 8 in the same pay grade. This increase is suspended for non-union positions and employees.
  - 2) The Step 8 rate shall be increased by \$50 per month for those employees who have attained 15 years of service and have three years of creditable

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service on Step 8 in the same pay grade. This increase is suspended for non-union positions and employees.

- n) Bilingual Pay – Individual positions whose job descriptions require the use of sign language, Braille, or another second language (e.g., Spanish) shall receive 5% or \$100 per month, whichever is greater, in addition to the employee's base rate.

(Source: Amended by peremptory rulemaking at 33 Ill. Reg. 9138, effective June 12, 2009)

## SUBPART C: MERIT COMPENSATION SYSTEM

**Section 310.490 Other Pay Provisions**

- a) Transfer – Upon assignment of an employee to a vacant position in a class with the same salary range as the class for the position being vacated, the employee's base salary will not be changed. Upon separation and subsequent appointment to a position in the same salary range, no increase in salary will be given.
- b) Entrance Base Salary –
  - 1) When a candidate only meets the minimum requirements of the class specification upon entry to State service, an employee's entrance base salary is the in-hiring rate or the minimum base salary of the salary range.
  - 2) Qualifications Above Minimum Requirements – If a candidate possesses directly-related education and experience in excess of the minimum requirements of the class specification, the employing agency may offer the candidate an entrance base salary that is not more than 10% above the candidate's current base salary. An entrance base salary offer more than 10% above the candidate's current base salary requires documentation in the candidate's CMS employment application (CMS-100) to support the higher entrance base salary offer and prior approval from the Director of Central Management Services. The approval is based on the candidate's documented directly-related education and experience exceeding the minimum requirements in the class specification, prior base salary history, staffing needs and requirements of the employing agency, and labor market influences on the recruitment for the position classification or position.

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- 3) Area Differential – For positions where additional compensation is required because of dissimilar economic or other conditions in the geographical area in which the positions are established, a higher entrance salary may be authorized by the Director of Central Management Services. Present employees receiving less than the new rate of pay shall be advanced to the new rate.
- c) Geographical Transfer – Upon geographical transfer from or to an area for which additional compensation has been authorized, an employee will receive an adjustment to the appropriate salary level for the new geographical area of assignment, effective the first day of the month following the date of assignment.
- d) Differential and Overtime Pay – An eligible employee may have an amount added to the base salary for a given pay period for work performed in excess of the normal requirements for the position and work schedule, as follows:
  - 1) Shift Differential Pay – An employee may be paid an amount in addition to the base salary for work performed on a regularly scheduled second or third shift. The additional compensation will be at a rate and in a manner approved by the Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstances.
  - 2) Overtime Pay –
    - A) Eligibility – The Director of Central Management Services shall maintain a listing of classes of positions subject to the provisions of the Merit Compensation System that are eligible for overtime compensation. Classes in salary ranges MC-06 and below and, effective January 1, 2008, classes in salary ranges MS-23 and below are eligible for straight-time overtime unless exceptions are determined by the Director of Central Management Services or federal guidelines. Employees in these classes of positions who are assigned and perform work in excess of the normal work schedule as established by the agency shall be compensated at a straight-time rate on either a cash or compensatory time-off basis

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for all hours worked in excess of a normal work week. Overtime in less than one-half hour increments per day shall not be accrued. Classes in MC-07 and above and, effective January 1, 2008, classes in MS-24 and above are not eligible for overtime unless required by federal regulation or approved by the Director of Central Management Services. Exceptions must be requested by the employing agency and will be determined on the basis of the special nature of the situation, a substantial need to provide overtime compensation and a significant number of hours worked beyond the normal work schedule, and will be granted only for a specified time period for which the special situation is expected to exist.

- B) Compensatory Time – Employees who are eligible for compensatory time may request such time, which may be granted by the agency at its discretion, considering, among other things, its operating needs. Compensatory time shall be taken within the fiscal year it was earned at a time convenient to the employee and consistent with the operating needs of the agency. Compensatory time shall be accrued at the rate in which it is earned (straight time or time and a half), but shall not exceed 120 hours in any fiscal year. Compensatory time approved for non-union employees will be earned after 40 actual work hours in a workweek. Compensatory time not used by the end of the fiscal year in which it was earned shall be liquidated and paid in cash at the rate it was earned. Time spent in travel outside the normal work schedule shall not be accrued as compensatory time except as provided by labor contracts and the Federal Fair Labor Standards Act. At no time are overtime hours or compensatory time to be transferred from one agency to another agency.
- e) Equivalent Earned Time –
- 1) Eligibility – Employees who are non-union or represented by the VR-704 bargaining unit, exempt under the Federal Fair Labor Standards Act, and in positions not eligible for overtime compensation may receive equivalent earned time for hours worked in excess of the hours per week indicated in the approved work schedule (80 Ill. Adm. Code 303.300) assigned to the employee.

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- 2) Restoration – Employees who are eligible for equivalent earned time shall have the balance of the employee's unused equivalent earned time at the close of business on June 30, 2007 restored as accrued equivalent earned time effective July 1, 2007.
- 3) Accrual –
  - A) Employees who are eligible for equivalent earned time shall request that time before working in excess of the hours per week indicated in the approved work schedule (80 Ill. Adm. Code 303.300) assigned to the employee. Requests for equivalent earned time may be granted by the agency at its discretion, considering its operating needs. Equivalent earned time shall be accrued at straight time only to a maximum of 160 hours at any time.
  - B) Equivalent earned time will accrue in no less than one-half hour increments. Time spent in travel outside the normal work schedule shall not be counted toward accrual of equivalent earned time.
- 4) Compensation – Any approved equivalent earned time shall be taken at a time convenient to the employee and consistent with the operating needs of the agency. At no time is equivalent earned time to be converted into cash payment or transferred from one agency to another agency.
- 5) Employees in Positions Represented by an American Federation of State, County and Municipal Employees Bargaining Unit – Employees shall retain their equivalent earned time upon their positions' representation by an American Federation of State, County and Municipal Employees bargaining unit. Employees whose positions were certified as represented effective July 1, 2007 or after shall have previously unused equivalent earned time restored no later than July 1, 2009. The use of the equivalent earned time is approved by supervisors, prior to other benefit time excluding sick and personal business leave, in increments of fifteen minutes after the initial use of one-half hour, and granted under the same criteria as vacation time. Employees may substitute equivalent earned time for sick leave in accordance to sick leave policies and procedures.

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- f) Part-Time Work – Part-time employees whose base salary is other than an hourly or daily basis shall be paid on a daily rate basis computed by dividing the annual rate of salary by the total number of work days in the year.
- g) Out-of-State Assignment – Employees who are assigned to work out-of-state on a temporary basis may receive an appropriate differential during the period of the assignment, as approved by the Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstance.
- h) Lump Sum Payment – Lump sum payment shall be provided for accrued vacation, sick leave and unused compensatory overtime at the current base rate to those employees separated from employment under the Personnel Code. Leaves of absence and temporary layoff (per 80 Ill. Adm. Code 302.510) are not separations and therefore lump sum payments cannot be given in these transactions. Methods of computation are explained in Section 310.520(a).

AGENCY NOTE: The method to be used in computing lump sum payment for accrued vacation, sick leave and unused compensatory overtime for an incumbent entitled to shift differential during the regular work hours will be to use the current base salary plus the shift differential pay. Sick leave earned prior to January 1, 1984 and after December 31, 1997 is not compensable. Sick leave earned and not used between January 1, 1984 and December 31, 1997 will be compensable at the current base daily rate times one-half of the total number of compensable sick days.

- i) Salary Treatment upon Return from Leave –
  - 1) An employee returning from Military Leave (80 Ill. Adm. Code 302.220 and 303.170), Peace Corps Leave (80 Ill. Adm. Code 302.230), Service-Connected Disability Leave (80 Ill. Adm. Code 303.135), Educational Leave (80 Ill. Adm. Code 302.215), Disaster Service Leave with Pay (80 Ill. Adm. Code 303.175), Family Responsibility Leave (80 Ill. Adm. Code 303.148), Leave to accept a temporary, emergency, provisional, exempt (80 Ill. Adm. Code 303.155) or trainee position, Leave to serve in domestic peace or job corps (80 Ill. Adm. Code 302.230) or leave to serve in an interim assignment will have his/her salary established as determined

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appropriate by the employing agency and approved by the Director of Central Management Services. However, in no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the salary range. Creditable service date will be maintained.

- 2) An employee returning to his/her former salary range from any other leave (not mentioned in subsection (i)(1)) of over 14 days will be placed at the salary which the employee received prior to the leave and the creditable service date will be extended by the duration of the leave.
- j) Employees in classes that are made subject to the Merit Compensation System will retain their current salary, except that in no event is the resultant salary to be lower than the minimum rate or higher than the maximum rate of the new salary range.
- k) Temporary Assignment Pay When Required to Use Second Language Ability – Employees who are bilingual or have the ability to use sign language, Braille, or another second language (e.g., Spanish) and whose job descriptions do not require that they do so shall be paid temporary assignment pay when required to perform duties requiring the ability. The temporary assignment pay received is prorated based on 5% or \$100 per month, whichever is greater, in addition to the employee's base rate.
- l) Salary Treatment Upon Reemployment –
  - 1) Upon the reemployment of an employee in a class with the same salary range as the class for the position held before layoff, the employee will be placed at the same salary as held at the time of the layoff, and his creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.
  - 2) Upon the reemployment of an employee in a class at a lower salary range than the range of the class for the position held before layoff, the employee will be placed at the same salary as held at the time of layoff, except that if this exceeds the maximum of the new range, the employee will be placed at that maximum salary. The creditable service date will be adjusted to reflect that time on layoff does not count as creditable service time.

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- m) Reinstatement – The salary upon reinstatement should not provide more than a 10% increase over the candidate's current base salary or exceed the salary rate held in the position where previously certified without prior approval of the Director of Central Management Services. In no event is the resulting salary to be lower than the minimum rate or higher than the maximum rate of the salary range.
- n) Bilingual Pay – Individual positions whose job descriptions require the use of sign language, Braille, or another second language (e.g., Spanish) shall receive 5% or \$100 per month, whichever is greater, in addition to the employee's base rate.
- o) Clothing or Equipment Allowance – An employee may be paid an amount in addition to his/her base salary to compensate for clothing or equipment that is required in the performance of assigned duties. The amount will be determined by the Director of the employing agency, and will require approval of the Director of Central Management Services. The Director of Central Management Services will approve the manner and rate of this provision after considering the need of the employing agency, the treatment of other similar situations, prevailing practices of other employers, and the equity of the particular circumstance.
- p) Interim Assignment Pay – This subsection of the Pay Plan explains interim assignment pay as applied to certified non-bargaining unit employees in a merit compensation (including broad-band and medical administrator) position assigned to perform on a full-time interim basis and be accountable for the higher-level duties and responsibilities of the non-bargaining unit (salary grade or merit compensation (including broad-band and medical administrator)) position. On the effective date of the employee's interim assignment (80 Ill. Adm. Code 302.150(j)), the employee shall receive an adjustment as if the employee received a promotion into the higher pay grade or range.
  - 1) When Assigned to the Merit Compensation Position – When assigned to the merit compensation position, the adjustment is an amount equivalent to between 8% and 15% of the employee's current base salary. In no event is the resulting salary to be lower than the minimum rate or greater than the maximum rate of the salary range to which the employee is being assigned. Upon interim assignment, the employee's creditable service date shall not change. Effective July 1, 2007, employees in interim assignment, which was effective prior to July 1, 2007, shall have the creditable service date as if not on a leave to serve in an interim assignment.

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- 2) When Assigned to the Salary Grade Position – When assigned to the salary grade position, the adjustment is determined by taking the difference between the salary on the step equivalent to or greater than the employee's current base salary and the salary one step above that step and adding that difference to the employee's current base salary. Then place the employee on the lowest step in the higher pay grade that is at least equivalent to that amount. In no event is the resulting salary to be lower than the minimum rate or greater than the maximum rate of the pay grade to which the employee is being assigned. Upon interim assignment, the employee's creditable service date shall not change. Effective July 1, 2007, employees in interim assignment, which was effective prior to July 1, 2007, shall have the creditable service date as if not on a leave to serve in an interim assignment.
- q) International Differential Pay – For positions with a headquarters outside of the United States, a differential shall be made once a month to the base salary of the employee residing outside the United States to compensate for a change in the currency exchange rate.

(Source: Amended by preemptory rulemaking at 33 Ill. Reg. 9138, effective June 12, 2009)

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**Section 310.APPENDIX A Negotiated Rates of Pay****Section 310.TABLE Q RC-033 (Meat Inspectors, IFPE)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Plan Code</u>
Meat and Poultry Inspector	26070	RC-033	B
Meat and Poultry Inspector Trainee	26075	RC-033	B

**Effective July 1, 2007**

<u>Title</u>	<u>STEPS</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
<u>Meat and Poultry Inspector</u>	<u>3271</u>	<u>3413</u>	<u>3550</u>	<u>3684</u>	<u>3827</u>	<u>4043</u>	<u>4124</u>	<u>4165</u>
<u>Meat and Poultry Inspector Trainee</u>	<u>2775</u>	<u>2875</u>	<u>2985</u>	<u>3092</u>	<u>3201</u>	<u>3379</u>	<u>3444</u>	<u>3478</u>

**Effective January 1, 2008**

<u>Title</u>	<u>STEPS</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
Meat and Poultry Inspector	3369	3515	3657	3795	3942	4164	4248	4290
Meat and Poultry Inspector Trainee	2858	2961	3075	3185	3297	3480	3547	3582

Effective May 27, 2009, each bargaining unit employee shall receive a onetime cash payment of \$850.00 which shall be creditable for the State Employee Retirement System.

**Effective July 1, 2009**

<u>Title</u>	<u>STEPS</u>							
	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>	<u>6</u>	<u>7</u>	<u>8</u>
<u>Meat and Poultry Inspector</u>	<u>3453</u>	<u>3603</u>	<u>3748</u>	<u>3890</u>	<u>4041</u>	<u>4268</u>	<u>4354</u>	<u>4397</u>
<u>Meat and Poultry Inspector Trainee</u>	<u>2929</u>	<u>3035</u>	<u>3152</u>	<u>3265</u>	<u>3379</u>	<u>3567</u>	<u>3636</u>	<u>3672</u>

(Source: Amended by peremptory rulemaking at 33 Ill. Reg. 9138, effective June 12, 2009)

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**Section 310.APPENDIX A Negotiated Rates of Pay****Section 310.TABLE W RC-062 (Technical Employees, AFSCME)**

<u>Title</u>	<u>Title Code</u>	<u>Bargaining Unit</u>	<u>Pay Grade</u>
Accountant	00130	RC-062	14
Accountant Advanced	00133	RC-062	16
Accountant Supervisor	00135	RC-062	18
Accounting and Fiscal Administration Career Trainee	00140	RC-062	12
Activity Therapist	00157	RC-062	15
Activity Therapist Coordinator	00160	RC-062	17
Actuarial Assistant	00187	RC-062	16
Actuarial Examiner	00195	RC-062	16
Actuarial Examiner Trainee	00196	RC-062	13
Actuarial Senior Examiner	00197	RC-062	19
Actuary I	00201	RC-062	20
Actuary II	00202	RC-062	24
Agricultural Market News Assistant	00804	RC-062	12
Agricultural Marketing Generalist	00805	RC-062	14
Agricultural Marketing Reporter	00807	RC-062	18
Agricultural Marketing Representative	00810	RC-062	18
Agriculture Land and Water Resource Specialist I	00831	RC-062	14
Agriculture Land and Water Resource Specialist II	00832	RC-062	17
Agriculture Land and Water Resource Specialist III	00833	RC-062	20
Aircraft Pilot I	00955	RC-062	19
Aircraft Pilot II	00956	RC-062	22
Aircraft Pilot II – Dual Rating	00957	RC-062	23
Appraisal Specialist I	01251	RC-062	14
Appraisal Specialist II	01252	RC-062	16
Appraisal Specialist III	01253	RC-062	18
Arts Council Associate	01523	RC-062	12
Arts Council Program Coordinator	01526	RC-062	18
Arts Council Program Representative	01527	RC-062	15
Assignment Coordinator	01530	RC-062	20
Bank Examiner I	04131	RC-062	16
Bank Examiner II	04132	RC-062	19
Bank Examiner III	04133	RC-062	22

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Behavioral Analyst Associate	04355	RC-062	15
Behavioral Analyst I	04351	RC-062	17
Behavioral Analyst II	04352	RC-062	19
Business Administrative Specialist	05810	RC-062	16
Business Manager	05815	RC-062	18
Buyer	05900	RC-062	18
Capital Development Board Account Technician	06515	RC-062	11
Capital Development Board Art in Architecture Technician	06533	RC-062	12
Capital Development Board Construction Support Analyst	06520	RC-062	11
Capital Development Board Project Technician	06530	RC-062	12
Chemist I	06941	RC-062	16
Chemist II	06942	RC-062	19
Chemist III	06943	RC-062	21
Child Protection Advanced Specialist	07161	RC-062	19
Child Protection Associate Specialist	07162	RC-062	16
Child Protection Specialist	07163	RC-062	18
Child Support Specialist I	07198	RC-062	16
Child Support Specialist II	07199	RC-062	17
Child Support Specialist Trainee	07200	RC-062	12
Child Welfare Associate Specialist	07216	RC-062	16
Child Welfare Staff Development Coordinator I	07201	RC-062	17
Child Welfare Staff Development Coordinator II	07202	RC-062	19
Child Welfare Staff Development Coordinator III	07203	RC-062	20
Child Welfare Staff Development Coordinator IV	07204	RC-062	22
Children and Family Service Intern – Option I	07241	RC-062	12
Children and Family Service Intern – Option II	07242	RC-062	15
Clinical Laboratory Technologist I	08220	RC-062	18
Clinical Laboratory Technologist II	08221	RC-062	19
Clinical Laboratory Technologist Trainee	08229	RC-062	14
Communications Systems Specialist	08860	RC-062	23
Community Management Specialist I	08891	RC-062	15
Community Management Specialist II	08892	RC-062	17
Community Management Specialist III	08893	RC-062	19
Community Planner I	08901	RC-062	15
Community Planner II	08902	RC-062	17
Community Planner III	08903	RC-062	19
Conservation Education Representative	09300	RC-062	12
Conservation Grant Administrator I	09311	RC-062	18
Conservation Grant Administrator II	09312	RC-062	20

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Conservation Grant Administrator III	09313	RC-062	22
Construction Program Assistant	09525	RC-062	12
Correctional Counselor I	09661	RC-062	15
Correctional Counselor II	09662	RC-062	17
Correctional Counselor III	09663	RC-062	19
Corrections Apprehension Specialist	09750	RC-062	19
Corrections Industries Marketing Representative	09803	RC-062	17
Corrections Leisure Activities Specialist I	09811	RC-062	15
Corrections Leisure Activities Specialist II	09812	RC-062	17
Corrections Leisure Activities Specialist III	09813	RC-062	19
Corrections Parole Agent	09842	RC-062	17
Corrections Senior Parole Agent	09844	RC-062	19
Criminal Intelligence Analyst I	10161	RC-062	18
Criminal Intelligence Analyst II	10162	RC-062	20
Criminal Intelligence Analyst Specialist	10165	RC-062	22
Criminal Justice Specialist I	10231	RC-062	16
Criminal Justice Specialist II	10232	RC-062	20
Criminal Justice Specialist Trainee	10236	RC-062	13
Curator of the Lincoln Collection	10750	RC-062	16
Day Care Licensing Representative I	11471	RC-062	16
Developmental Disabilities Council Program Planner I	12361	RC-062	12
Developmental Disabilities Council Program Planner II	12362	RC-062	16
Developmental Disabilities Council Program Planner III	12363	RC-062	18
Dietitian	12510	RC-062	15
Disability Appeals Officer	12530	RC-062	22
Disability Claims Adjudicator I	12537	RC-062	16
Disability Claims Adjudicator II	12538	RC-062	18
Disability Claims Adjudicator Trainee	12539	RC-062	13
Disability Claims Analyst	12540	RC-062	21
Disability Claims Specialist	12558	RC-062	19
Disaster Services Planner	12585	RC-062	19
Document Examiner	12640	RC-062	22
Economic Development Representative I	12931	RC-062	17
Economic Development Representative II	12932	RC-062	19
Educator – Provisional	13105	RC-062	12
Employment Security Field Office Supervisor	13600	RC-062	20
Employment Security Manpower Representative I	13621	RC-062	12
Employment Security Manpower Representative II	13622	RC-062	14
Employment Security Program Representative	13650	RC-062	14

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Employment Security Program Representative – Intermittent	13651	RC-062	14H
Employment Security Service Representative	13667	RC-062	16
Employment Security Specialist I	13671	RC-062	14
Employment Security Specialist II	13672	RC-062	16
Employment Security Specialist III	13673	RC-062	19
Employment Security Tax Auditor I	13681	RC-062	17
Employment Security Tax Auditor II	13682	RC-062	19
Energy and Natural Resources Specialist I	13711	RC-062	15
Energy and Natural Resources Specialist II	13712	RC-062	17
Energy and Natural Resources Specialist III	13713	RC-062	19
Energy and Natural Resources Specialist Trainee	13715	RC-062	12
Environmental Health Specialist I	13768	RC-062	14
Environmental Health Specialist II	13769	RC-062	16
Environmental Health Specialist III	13770	RC-062	18
Environmental Protection Associate	13785	RC-062	12
Environmental Protection Specialist I	13821	RC-062	14
Environmental Protection Specialist II	13822	RC-062	16
Environmental Protection Specialist III	13823	RC-062	18
Environmental Protection Specialist IV	13824	RC-062	22
Equal Pay Specialist	13837	RC-062	17
Executive I	13851	RC-062	18
Executive II	13852	RC-062	20
Financial Institutions Examiner I	14971	RC-062	16
Financial Institutions Examiner II	14972	RC-062	19
Financial Institutions Examiner III	14973	RC-062	22
Financial Institutions Examiner Trainee	14978	RC-062	13
<a href="#">Fire Protection Specialist I</a>	<a href="#">15351</a>	<a href="#">RC-062</a>	<a href="#">16</a>
Flight Safety Coordinator	15640	RC-062	22
Forensic Scientist I	15891	RC-062	18
Forensic Scientist II	15892	RC-062	20
Forensic Scientist III	15893	RC-062	22
Forensic Scientist Trainee	15897	RC-062	15
Guardianship Representative	17710	RC-062	17
Habilitation Program Coordinator	17960	RC-062	17
Handicapped Services Representative I	17981	RC-062	11
Health Facilities Surveyor I	18011	RC-062	16
Health Facilities Surveyor II	18012	RC-062	19
Health Facilities Surveyor III	18013	RC-062	20
Health Services Investigator I – Opt. A	18181	RC-062	19

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Health Services Investigator I – Opt. B	18182	RC-062	20
Health Services Investigator II – Opt. A	18185	RC-062	22
Health Services Investigator II – Opt. B	18186	RC-062	22
Health Services Investigator II – Opt. C	18187	RC-062	25
Health Services Investigator II – Opt. D	18188	RC-062	25
Historical Documents Conservator I	18981	RC-062	13
Historical Exhibits Designer	18985	RC-062	15
Historical Research Editor II	19002	RC-062	14
Human Relations Representative	19670	RC-062	16
Human Resources Representative	19692	RC-062	17
Human Resources Specialist	19693	RC-062	20
Human Rights Investigator I	19774	RC-062	16
Human Rights Investigator II	19775	RC-062	18
Human Rights Investigator III	19776	RC-062	19
Human Rights Specialist I	19778	RC-062	14
Human Rights Specialist II	19779	RC-062	16
Human Rights Specialist III	19780	RC-062	18
Human Services Caseworker	19785	RC-062	16
Human Services Grants Coordinator I	19791	RC-062	14
Human Services Grants Coordinator II	19792	RC-062	17
Human Services Grants Coordinator III	19793	RC-062	20
Human Services Grants Coordinator Trainee	19796	RC-062	12
Human Services Sign Language Interpreter	19810	RC-062	16
Iconographer	19880	RC-062	12
Industrial and Community Development Representative I	21051	RC-062	17
Industrial and Community Development Representative II	21052	RC-062	19
Industrial Services Consultant I	21121	RC-062	14
Industrial Services Consultant II	21122	RC-062	16
Industrial Services Consultant Trainee	21125	RC-062	11
Industrial Services Hygienist	21127	RC-062	19
Industrial Services Hygienist Technician	21130	RC-062	16
Industrial Services Hygienist Trainee	21133	RC-062	12
Information Technology/Communication Systems Specialist I	21216	RC-062	19
Information Technology/Communication Systems Specialist II	21217	RC-062	24
Instrument Designer	21500	RC-062	18
Insurance Analyst III	21563	RC-062	14
Insurance Analyst IV	21564	RC-062	16
Insurance Company Claims Examiner II	21602	RC-062	19
Insurance Company Field Staff Examiner	21608	RC-062	16

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Insurance Company Financial Examiner Trainee	21610	RC-062	13
Insurance Performance Examiner I	21671	RC-062	14
Insurance Performance Examiner II	21672	RC-062	17
Insurance Performance Examiner III	21673	RC-062	20
Intermittent Unemployment Insurance Representative	21689	RC-062	12H
Internal Auditor I	21721	RC-062	17
Internal Security Investigator I, not Department of Corrections	21731	RC-062	18
Internal Security Investigator II, not Department of Corrections	21732	RC-062	21
Juvenile Justice Youth and Family Specialist, Option 1	21991	RC-062	18
Juvenile Justice Youth and Family Specialist, Option 2	21992	RC-062	20
KidCare Supervisor	22003	RC-062	20
Labor Conciliator	22750	RC-062	20
Laboratory Equipment Specialist	22990	RC-062	18
Laboratory Quality Specialist I	23021	RC-062	19
Laboratory Quality Specialist II	23022	RC-062	21
Laboratory Research Specialist I	23027	RC-062	19
Laboratory Research Specialist II	23028	RC-062	21
Land Acquisition Agent I	23091	RC-062	15
Land Acquisition Agent II	23092	RC-062	18
Land Acquisition Agent III	23093	RC-062	21
Land Reclamation Specialist I	23131	RC-062	14
Land Reclamation Specialist II	23132	RC-062	17
Liability Claims Adjuster I	23371	RC-062	14
Liability Claims Adjuster II	23372	RC-062	18
Library Associate	23430	RC-062	12
Life Sciences Career Trainee	23600	RC-062	12
Liquor Control Special Agent II	23752	RC-062	15
Local Historical Services Representative	24000	RC-062	17
Local Housing Advisor I	24031	RC-062	14
Local Housing Advisor II	24032	RC-062	16
Local Housing Advisor III	24033	RC-062	18
Local Revenue and Fiscal Advisor I	24101	RC-062	15
Local Revenue and Fiscal Advisor II	24102	RC-062	17
Local Revenue and Fiscal Advisor III	24103	RC-062	19
Lottery Regional Coordinator	24504	RC-062	19
Lottery Sales Representative	24515	RC-062	16
Management Operations Analyst I	25541	RC-062	18
Management Operations Analyst II	25542	RC-062	20
Manpower Planner I	25591	RC-062	14

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

Manpower Planner II	25592	RC-062	17
Manpower Planner III	25593	RC-062	20
Manpower Planner Trainee	25597	RC-062	12
Medical Assistance Consultant I	26501	RC-062	13
Medical Assistance Consultant II	26502	RC-062	16
Medical Assistance Consultant III	26503	RC-062	19
Mental Health Recovery Support Specialist I	26921	RC-062	17
Mental Health Recovery Support Specialist II	26922	RC-062	18
Mental Health Specialist I	26924	RC-062	12
Mental Health Specialist II	26925	RC-062	14
Mental Health Specialist III	26926	RC-062	16
Mental Health Specialist Trainee	26928	RC-062	11
Meteorologist	27120	RC-062	18
Methods and Procedures Advisor I	27131	RC-062	14
Methods and Procedures Advisor II	27132	RC-062	16
Methods and Procedures Advisor III	27133	RC-062	20
Methods and Procedures Career Associate I	27135	RC-062	11
Methods and Procedures Career Associate II	27136	RC-062	12
Methods and Procedures Career Associate Trainee	27137	RC-062	09
Metrologist Associate	27146	RC-062	15
Microbiologist I	27151	RC-062	16
Microbiologist II	27152	RC-062	19
Natural Resources Advanced Specialist	28833	RC-062	20
Natural Resources Coordinator	28831	RC-062	15
Natural Resources Specialist	28832	RC-062	18
Oral Health Consultant	30317	RC-062	18
Paralegal Assistant	30860	RC-062	14
Pension and Death Benefits Technician I	30961	RC-062	12
Pension and Death Benefits Technician II	30962	RC-062	19
Police Training Specialist	32990	RC-062	17
Program Integrity Auditor I	34631	RC-062	16
Program Integrity Auditor II	34632	RC-062	19
Program Integrity Auditor Trainee	34635	RC-062	12
Property Consultant	34900	RC-062	15
Public Aid Appeals Advisor	35750	RC-062	18
Public Aid Family Support Specialist I	35841	RC-062	17
Public Aid Investigator	35870	RC-062	19
Public Aid Investigator Trainee	35874	RC-062	14
Public Aid Lead Casework Specialist	35880	RC-062	17

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

Public Aid Program Quality Analyst	35890	RC-062	19
Public Aid Quality Control Reviewer	35892	RC-062	17
Public Aid Quality Control Supervisor	35900	RC-062	19
Public Aid Staff Development Specialist I	36071	RC-062	15
Public Aid Staff Development Specialist II	36072	RC-062	17
Public Health Educator Associate	36434	RC-062	14
Public Health Program Specialist I	36611	RC-062	14
Public Health Program Specialist II	36612	RC-062	16
Public Health Program Specialist III	36613	RC-062	19
Public Health Program Specialist Trainee	36615	RC-062	12
Public Information Coordinator	36750	RC-062	18
Public Information Officer I	37001	RC-062	12
Public Information Officer II	37002	RC-062	14
Public Information Officer III	37003	RC-062	19
Public Information Officer IV	37004	RC-062	21
Public Safety Inspector	37007	RC-062	16
Public Safety Inspector Trainee	37010	RC-062	10
Public Service Administrator, Options 8B and 8Y	37015	RC-062	23
Railroad Safety Specialist I	37601	RC-062	19
Railroad Safety Specialist II	37602	RC-062	21
Railroad Safety Specialist III	37603	RC-062	23
Railroad Safety Specialist IV	37604	RC-062	25
Real Estate Investigator	37730	RC-062	19
Real Estate Professions Examiner	37760	RC-062	22
Recreation Worker I	38001	RC-062	12
Recreation Worker II	38002	RC-062	14
Rehabilitation Counselor	38145	RC-062	17
Rehabilitation Counselor Senior	38158	RC-062	19
Rehabilitation Counselor Trainee	38159	RC-062	15
Rehabilitation Services Advisor I	38176	RC-062	20
Rehabilitation Workshop Supervisor I	38194	RC-062	12
Rehabilitation Workshop Supervisor II	38195	RC-062	14
<a href="#">Rehabilitation Workshop Supervisor III</a>	<a href="#">38196</a>	<a href="#">RC-062</a>	<a href="#">16</a>
Reimbursement Officer I	38199	RC-062	14
Reimbursement Officer II	38200	RC-062	16
Research Economist I	38207	RC-062	18
Research Scientist I	38231	RC-062	13
Research Scientist II	38232	RC-062	16
Research Scientist III	38233	RC-062	20

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

Resource Planner I	38281	RC-062	17
Resource Planner II	38282	RC-062	19
Resource Planner III	38283	RC-062	22
Retirement System Disability Specialist	38310	RC-062	19
Revenue Audit Supervisor (IL)	38369	RC-062	25
Revenue Audit Supervisor (states other than IL, CA or NJ)	38369	RC-062	27
Revenue Audit Supervisor (CA or NJ)	38369	RC-062	29
Revenue Auditor I (IL)	38371	RC-062	16
Revenue Auditor I (states other than IL, CA or NJ)	38371	RC-062	19
Revenue Auditor I (CA or NJ)	38371	RC-062	21
Revenue Auditor II (IL)	38372	RC-062	19
Revenue Auditor II (states other than IL, CA or NJ)	38372	RC-062	22
Revenue Auditor II (CA or NJ)	38372	RC-062	24
Revenue Auditor III (IL)	38373	RC-062	22
Revenue Auditor III (states other than IL, CA or NJ)	38373	RC-062	24
Revenue Auditor III (CA or NJ)	38373	RC-062	26
Revenue Auditor Trainee (IL)	38375	RC-062	12
Revenue Auditor Trainee (states other than IL, CA or NJ)	38375	RC-062	13
Revenue Auditor Trainee (CA or NJ)	38375	RC-062	15
Revenue Collection Officer I	38401	RC-062	15
Revenue Collection Officer II	38402	RC-062	17
Revenue Collection Officer III	38403	RC-062	19
Revenue Collection Officer Trainee	38405	RC-062	12
Revenue Computer Audit Specialist (IL)	38425	RC-062	23
Revenue Computer Audit Specialist (states other than IL, CA or NJ)	38425	RC-062	25
Revenue Computer Audit Specialist (CA or NJ)	38425	RC-062	27
Revenue Senior Special Agent	38557	RC-062	23
Revenue Special Agent	38558	RC-062	19
Revenue Special Agent Trainee	38565	RC-062	14
Revenue Tax Specialist I	38571	RC-062	12
Revenue Tax Specialist II (IL)	38572	RC-062	14
Revenue Tax Specialist II (states other than IL, CA or NJ)	38572	RC-062	17
Revenue Tax Specialist II (CA or NJ)	38572	RC-062	19
Revenue Tax Specialist III	38573	RC-062	17
Revenue Tax Specialist Trainee	38575	RC-062	10
Site Assistant Superintendent I	41071	RC-062	15

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

Site Assistant Superintendent II	41072	RC-062	17
Site Interpretive Coordinator	41093	RC-062	13
Site Services Specialist I	41117	RC-062	15
Site Services Specialist II	41118	RC-062	17
Social Service Consultant I	41301	RC-062	18
Social Service Consultant II	41302	RC-062	19
Social Service Program Planner I	41311	RC-062	15
Social Service Program Planner II	41312	RC-062	17
Social Service Program Planner III	41313	RC-062	20
Social Service Program Planner IV	41314	RC-062	22
Social Services Career Trainee	41320	RC-062	12
Social Worker I	41411	RC-062	16
Staff Development Specialist I	41771	RC-062	18
Staff Development Technician I	41781	RC-062	12
Staff Development Technician II	41782	RC-062	15
State Mine Inspector	42230	RC-062	19
State Police Field Specialist I	42001	RC-062	18
State Police Field Specialist II	42002	RC-062	20
Statistical Research Specialist I	42741	RC-062	12
Statistical Research Specialist II	42742	RC-062	14
Statistical Research Specialist III	42743	RC-062	17
Storage Tank Safety Specialist	43005	RC-062	18
Telecommunications Specialist	45295	RC-062	15
Telecommunications Systems Analyst	45308	RC-062	17
Telecommunications Systems Technician I	45312	RC-062	10
Telecommunications Systems Technician II	45313	RC-062	13
Terrorism Research Specialist I	45371	RC-062	18
Terrorism Research Specialist II	45372	RC-062	20
Terrorism Research Specialist III	45373	RC-062	22
Terrorism Research Specialist Trainee	45375	RC-062	14
Unemployment Insurance Adjudicator I	47001	RC-062	11
Unemployment Insurance Adjudicator II	47002	RC-062	13
Unemployment Insurance Adjudicator III	47003	RC-062	15
Unemployment Insurance Revenue Analyst I	47081	RC-062	15
Unemployment Insurance Revenue Analyst II	47082	RC-062	17
Unemployment Insurance Revenue Specialist	47087	RC-062	13
Unemployment Insurance Special Agent	47096	RC-062	18
Veterans Educational Specialist I	47681	RC-062	15
Veterans Educational Specialist II	47682	RC-062	17

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

Veterans Educational Specialist III	47683	RC-062	21
Veterans Employment Representative I	47701	RC-062	14
Veterans Employment Representative II	47702	RC-062	16
Volunteer Services Coordinator I	48481	RC-062	13
Volunteer Services Coordinator II	48482	RC-062	16
Volunteer Services Coordinator III	48483	RC-062	18
Wage Claims Specialist	48770	RC-062	09
Weatherization Specialist I	49101	RC-062	14
Weatherization Specialist II	49102	RC-062	17
Weatherization Specialist III	49103	RC-062	20
Weatherization Specialist Trainee	49105	RC-062	12
Workers Compensation Insurance Compliance Investigator	49640	RC-062	20

NOTE: For the Revenue Audit Supervisor, Revenue Auditor I, II and III and Revenue Auditor Trainee, Revenue Computer Audit Specialist and Revenue Tax Specialist II position classification titles only – The pay grade assigned to the employee is based on the location of the position and the residence held by the employee. In the same position classification, the employee holding a position and residence outside the boundaries of the State of Illinois is assigned to a different pay grade than the pay grade assigned to the employee holding a position within the boundaries of the State of Illinois. The pay grade assigned to the employee holding a position located within the boundaries of the State of Illinois is the pay grade with the (IL) indication next to the position classification. The pay grade assigned to the employee holding the position located outside the boundaries of the State of Illinois is determined by the location of the employee's residence (e.g., IL, CA or NJ or a state other than IL, CA or NJ). If the employee's residence moves to another state while the employee is in the same position located outside the boundaries of the State of Illinois, or moves into another position located outside the boundaries of the State of Illinois in the same position classification, the base salary may change depending on the location of the employee's new residence. If the employee remains in the position located outside the boundaries of the State of Illinois and moves residence from or into the boundaries of the State of Illinois, the base salary will change. In all cases, change in base salary shall be on a step for step basis (e.g., if the original base salary was on Step 5 in one pay grade, the new base salary will also be on Step 5 of the newly appropriate pay grade).

**Effective January 1, 2008**  
**Bargaining Unit: RC-062**

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
09	B	2554	2617	2682	2749	2834	2925	3015	3112	3204	3355	3489
09	Q	2657	2721	2789	2860	2948	3044	3137	3239	3336	3496	3636
09	S	2718	2785	2851	2920	3010	3105	3202	3304	3401	3563	3705
10	B	2638	2701	2769	2837	2941	3028	3128	3227	3327	3497	3637
10	Q	2743	2808	2878	2952	3058	3152	3258	3361	3466	3650	3797
10	S	2802	2871	2940	3013	3120	3216	3322	3425	3535	3719	3868
11	B	2731	2799	2871	2942	3042	3140	3253	3361	3465	3648	3795
11	Q	2841	2911	2984	3060	3169	3273	3390	3503	3614	3810	3962
11	S	2904	2974	3046	3121	3232	3335	3454	3569	3683	3877	4032
12	B	2838	2909	2982	3060	3172	3277	3399	3510	3640	3835	3988
12	Q	2954	3026	3103	3186	3303	3413	3544	3665	3798	4005	4165
12	S	3015	3088	3167	3248	3367	3478	3612	3734	3869	4077	4239
12H	B	17.46	17.90	18.35	18.83	19.52	20.17	20.92	21.60	22.40	23.60	24.54
12H	Q	18.18	18.62	19.10	19.61	20.33	21.00	21.81	22.55	23.37	24.65	25.63
12H	S	18.55	19.00	19.49	19.99	20.72	21.40	22.23	22.98	23.81	25.09	26.09
13	B	2942	3016	3093	3175	3292	3418	3545	3675	3813	4024	4185
13	Q	3060	3139	3221	3307	3429	3564	3703	3838	3979	4205	4373
13	S	3121	3203	3286	3370	3495	3632	3773	3906	4052	4278	4449
14	B	3062	3140	3226	3311	3437	3571	3727	3864	4010	4244	4414
14	Q	3188	3273	3360	3451	3583	3729	3891	4038	4192	4435	4612
14	S	3250	3335	3424	3516	3654	3797	3962	4108	4264	4505	4685
14H	B	18.84	19.32	19.85	20.38	21.15	21.98	22.94	23.78	24.68	26.12	27.16
14H	Q	19.62	20.14	20.68	21.24	22.05	22.95	23.94	24.85	25.80	27.29	28.38
14H	S	20.00	20.52	21.07	21.64	22.49	23.37	24.38	25.28	26.24	27.72	28.83
15	B	3180	3263	3352	3442	3595	3743	3889	4048	4198	4451	4629
15	Q	3312	3400	3494	3592	3750	3906	4063	4233	4388	4649	4836

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

15	S	3376	3463	3561	3659	3820	3974	4136	4303	4458	4723	4911
16	B	3321	3410	3503	3604	3765	3932	4095	4267	4436	4699	4886
16	Q	3459	3556	3657	3762	3932	4109	4281	4457	4636	4912	5109
16	S	3528	3626	3726	3833	4003	4182	4355	4529	4709	4980	5179
17	B	3468	3566	3669	3776	3950	4132	4307	4482	4664	4941	5139
17	Q	3618	3722	3831	3940	4129	4318	4499	4682	4873	5163	5370
17	S	3685	3791	3900	4011	4201	4392	4573	4754	4944	5238	5447
18	B	3645	3750	3858	3973	4165	4360	4558	4743	4934	5228	5437
18	Q	3806	3915	4031	4152	4357	4557	4765	4959	5156	5465	5684
18	S	3874	3983	4104	4221	4426	4629	4835	5031	5230	5535	5757
19	B	3836	3948	4064	4188	4401	4609	4823	5026	5235	5554	5776
19	J	3836	3948	4064	4188	4401	4609	4823	5026	5235	5554	5776
19	Q	4006	4126	4250	4376	4600	4814	5043	5253	5473	5803	6035
19	S	4078	4199	4323	4450	4673	4888	5114	5326	5547	5875	6110
20	B	4052	4174	4298	4425	4648	4865	5096	5318	5538	5874	6109
20	Q	4236	4362	4491	4625	4857	5086	5327	5556	5788	6141	6386
20	S	4305	4433	4563	4698	4929	5156	5398	5628	5859	6210	6458
21	B	4277	4406	4537	4672	4913	5150	5390	5636	5871	6237	6486
21	U	4277	4406	4537	4672	4913	5150	5390	5636	5871	6237	6486
21	Q	4470	4605	4740	4883	5136	5380	5634	5891	6137	6518	6778
21	S	4541	4676	4812	4956	5205	5453	5706	5963	6207	6590	6854
22	B	4520	4657	4798	4940	5197	5451	5708	5973	6221	6608	6873
22	Q	4725	4867	5013	5161	5432	5699	5966	6241	6503	6905	7181
22	S	4797	4938	5085	5235	5501	5770	6035	6314	6577	6979	7258
23	B	4798	4940	5087	5239	5517	5800	6076	6356	6632	7048	7331
23	Q	5013	5161	5317	5479	5768	6064	6349	6642	6931	7365	7659
23	S	5085	5235	5390	5550	5838	6134	6421	6714	7001	7436	7733
24	B	5104	5257	5414	5576	5873	6181	6477	6776	7082	7526	7827

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

24	J	5104	5257	5414	5576	5873	6181	6477	6776	7082	7526	7827
24	Q	5333	5492	5659	5830	6140	6459	6769	7080	7401	7866	8180
24	S	5405	5564	5730	5901	6209	6529	6840	7153	7474	7937	8254
25	B	5440	5602	5771	5944	6269	6600	6929	7258	7588	8075	8399
25	J	5440	5602	5771	5944	6269	6600	6929	7258	7588	8075	8399
25	Q	5685	5856	6029	6210	6552	6895	7242	7587	7931	8439	8777
25	S	5760	5926	6105	6284	6624	6966	7312	7657	8000	8511	8852
26	B	5749	5920	6101	6343	6690	7044	7402	7747	8096	8618	8963
26	U	5749	5920	6101	6343	6690	7044	7402	7747	8096	8618	8963
27	B	6077	6258	6447	6770	7139	7516	7898	8267	8638	9197	9565
27	J	6077	6258	6447	6770	7139	7516	7898	8267	8638	9197	9565
27	U	6077	6258	6447	6770	7139	7516	7898	8267	8638	9197	9565
28	B	6377	6567	6765	7105	7491	7887	8288	8675	9064	9651	10037
29	U	6692	6892	7100	7456	7861	8276	8698	9103	9512	10127	10532

**Effective January 1, 2009**  
**Bargaining Unit: RC-062**

Pay Grade	Pay Plan Code	S T E P S										
		1c	1b	1a	1	2	3	4	5	6	7	8
9	B	2592	2656	2722	2790	2877	2969	3060	3159	3252	3405	3541
9	Q	2697	2762	2831	2903	2992	3090	3184	3288	3386	3548	3691
9	S	2759	2827	2894	2964	3055	3152	3250	3354	3452	3616	3761
10	B	2678	2742	2811	2880	2985	3073	3175	3275	3377	3549	3692
10	Q	2784	2850	2921	2996	3104	3199	3307	3411	3518	3705	3854
10	S	2844	2914	2984	3058	3167	3264	3372	3476	3588	3775	3926
11	B	2772	2841	2914	2986	3088	3187	3302	3411	3517	3703	3852
11	Q	2884	2955	3029	3106	3217	3322	3441	3556	3668	3867	4021

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

11	S	2948	3019	3092	3168	3280	3385	3506	3623	3738	3935	4092
12	B	2881	2953	3027	3106	3220	3326	3450	3563	3695	3893	4048
12	Q	2998	3071	3150	3234	3353	3464	3597	3720	3855	4065	4227
12	S	3060	3134	3215	3297	3418	3530	3666	3790	3927	4138	4303
12H	B	17.73	18.17	18.63	19.11	19.82	20.47	21.23	21.93	22.74	23.96	24.91
12H	Q	18.45	18.90	19.38	19.90	20.63	21.32	22.14	22.89	23.72	25.02	26.01
12H	S	18.83	19.29	19.78	20.29	21.03	21.72	22.56	23.32	24.17	25.46	26.48
13	B	2986	3061	3139	3223	3341	3469	3598	3730	3870	4084	4248
13	Q	3106	3186	3269	3357	3480	3617	3759	3896	4039	4268	4439
13	S	3168	3251	3335	3421	3547	3686	3830	3965	4113	4342	4516
14	B	3108	3187	3274	3361	3489	3625	3783	3922	4070	4308	4480
14	Q	3236	3322	3410	3503	3637	3785	3949	4099	4255	4502	4681
14	S	3299	3385	3475	3569	3709	3854	4021	4170	4328	4573	4755
14H	B	19.13	19.61	20.15	20.68	21.47	22.31	23.28	24.14	25.05	26.51	27.57
14H	Q	19.91	20.44	20.98	21.56	22.38	23.29	24.30	25.22	26.18	27.70	28.81
14H	S	20.30	20.83	21.38	21.96	22.82	23.72	24.74	25.66	26.63	28.14	29.26
15	B	3228	3312	3402	3494	3649	3799	3947	4109	4261	4518	4698
15	Q	3362	3451	3546	3646	3806	3965	4124	4296	4454	4719	4909
15	S	3427	3515	3614	3714	3877	4034	4198	4368	4525	4794	4985
16	B	3371	3461	3556	3658	3821	3991	4156	4331	4503	4769	4959
16	Q	3511	3609	3712	3818	3991	4171	4345	4524	4706	4986	5186
16	S	3581	3680	3782	3890	4063	4245	4420	4597	4780	5055	5257
17	B	3520	3619	3724	3833	4009	4194	4372	4549	4734	5015	5216
17	Q	3672	3778	3888	3999	4191	4383	4566	4752	4946	5240	5451
17	S	3740	3848	3959	4071	4264	4458	4642	4825	5018	5317	5529
18	B	3700	3806	3916	4033	4227	4425	4626	4814	5008	5306	5519
18	Q	3863	3974	4091	4214	4422	4625	4836	5033	5233	5547	5769
18	S	3932	4043	4166	4284	4492	4698	4908	5106	5308	5618	5843

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

19	B	3894	4007	4125	4251	4467	4678	4895	5101	5314	5637	5863
19	J	3894	4007	4125	4251	4467	4678	4895	5101	5314	5637	5863
19	Q	4066	4188	4314	4442	4669	4886	5119	5332	5555	5890	6126
19	S	4139	4262	4388	4517	4743	4961	5191	5406	5630	5963	6202
20	B	4113	4237	4362	4491	4718	4938	5172	5398	5621	5962	6201
20	Q	4300	4427	4558	4694	4930	5162	5407	5639	5875	6233	6482
20	S	4370	4499	4631	4768	5003	5233	5479	5712	5947	6303	6555
21	B	4341	4472	4605	4742	4987	5227	5471	5721	5959	6331	6583
21	U	4341	4472	4605	4742	4987	5227	5471	5721	5959	6331	6583
21	Q	4537	4674	4811	4956	5213	5461	5719	5979	6229	6616	6880
21	S	4609	4746	4884	5030	5283	5535	5792	6052	6300	6689	6957
22	B	4588	4727	4870	5014	5275	5533	5794	6063	6314	6707	6976
22	Q	4796	4940	5088	5238	5513	5784	6055	6335	6601	7009	7289
22	S	4869	5012	5161	5314	5584	5857	6126	6409	6676	7084	7367
23	B	4870	5014	5163	5318	5600	5887	6167	6451	6731	7154	7441
23	Q	5088	5238	5397	5561	5855	6155	6444	6742	7035	7475	7774
23	S	5161	5314	5471	5633	5926	6226	6517	6815	7106	7548	7849
24	B	5181	5336	5495	5660	5961	6274	6574	6878	7188	7639	7944
24	J	5181	5336	5495	5660	5961	6274	6574	6878	7188	7639	7944
24	Q	5413	5574	5744	5917	6232	6556	6871	7186	7512	7984	8303
24	S	5486	5647	5816	5990	6302	6627	6943	7260	7586	8056	8378
25	B	5522	5686	5858	6033	6363	6699	7033	7367	7702	8196	8525
25	J	5522	5686	5858	6033	6363	6699	7033	7367	7702	8196	8525
25	Q	5770	5944	6119	6303	6650	6998	7351	7701	8050	8566	8909
25	S	5846	6015	6197	6378	6723	7070	7422	7772	8120	8639	8985
26	B	5835	6009	6193	6438	6790	7150	7513	7863	8217	8747	9097
26	U	5835	6009	6193	6438	6790	7150	7513	7863	8217	8747	9097
27	B	6168	6352	6544	6872	7246	7629	8016	8391	8768	9335	9708

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF PEREMPTORY AMENDMENTS

27	J	6168	6352	6544	6872	7246	7629	8016	8391	8768	9335	9708
27	U	6168	6352	6544	6872	7246	7629	8016	8391	8768	9335	9708
28	B	6473	6666	6866	7212	7603	8005	8412	8805	9200	9796	10188
29	U	6792	6995	7207	7568	7979	8400	8828	9240	9655	10279	10690

(Source: Amended by peremptory rulemaking at 33 Ill. Reg. 9138, effective June 12, 2009)

## DEPARTMENT ON AGING

## JULY 2009 REGULATORY AGENDA

a) Heading and Code Citations: Community Care Program, 89 Ill. Adm. Code 240

1) Rulemaking:

- A) Description: Incorporate specific policies for service provider agencies on the use of electronic timekeeping, respiratory services, and seclusion and restraint of participants in the Community Care Program.
- B) Statutory Authority: 20 ILCS 105/4.01(11) and 20 ILCS 105/4.02
- C) Scheduled meeting/hearing dates: No meetings or hearings are scheduled or anticipated.
- D) Date agency anticipates First Notice: The Department anticipates filing these proposed rulemaking projects during the next six months of this year.
- E) Effect on small businesses, small municipalities or not for profit corporations: Service provider agencies will need to determine appropriate implementation measures and provide training for supervisors and direct care workers to ensure compliance with these new policies under the Community Care Program.
- F) Agency contact person for information:  
  
Karen Alice Kloppe, Deputy General Counsel  
Illinois Department on Aging  
421 East Capitol Avenue, #100  
Springfield, Illinois 62701-1789  
(217) 785-3346
- G) Related rulemakings and other pertinent information: None

## BOARD OF HIGHER EDUCATION

## JULY 2009 REGULATORY AGENDA

- a) Part(s) (Heading and Code Citation): Illinois Consortium for Educational Opportunity Program (23 Ill. Adm. Code 2400)
- 1) Rulemaking:
- A) Description: The Board would like to repeal this Part since the original implementing and authorizing legislation was amended and a new Part has been adopted (23 Ill. Adm. Code 1080).
- B) Statutory Authority: Implementing and authorized by the Illinois Consortium for Educational Opportunity Act which was substantially amended by Public Act 93-862 [110 ILCS 930 as amended by P.A. 93-0862 effective July 1, 2004].
- C) Schedule meeting/hearing date: No meetings or hearings have been scheduled at this time.
- D) Date agency anticipates First Notice: August 2009.
- E) Effect on small businesses, small municipalities or not for profit corporations: None.
- F) Agency contact person for information:
- Karen Helland, Administrative Rules Coordinator  
Illinois Board of Higher Education  
431 East Adams Street, Second Floor  
Springfield, IL 62701-1404
- 217/557-7358
- G) Related rulemakings and other pertinent information: Part 1080 was adopted by the Board to reflect the changes to the Illinois Consortium for Educational Opportunity Act as amended by Public Act 93-862.
- b) Part(s) (Heading and Code Citation): Approval of Noninstructional Capital Projects (23 Ill. Adm. Code 1040)
- 1) Rulemaking:

## BOARD OF HIGHER EDUCATION

## JULY 2009 REGULATORY AGENDA

- A) Description: The Board will review this Part which may result in future changes.
- B) Statutory Authority: Implementing Sections 8 and 9.11 and authorized by Section 9.05 of the Board of Higher Education Act [110 ILCS 205/6 and 9.05].
- C) Schedule meeting/hearing date: No meetings or hearings have been scheduled.
- D) Date agency anticipates First Notice: Undetermined
- E) Effect on small businesses, small municipalities or not for profit corporations: None
- F) Agency contact person for information:  
  
Karen Helland, Administrative Rules Coordinator  
Illinois Board of Higher Education  
431 East Adams Street, Second Floor  
Springfield, IL 62701-1404  
  
217/557-7358
- G) Related rulemakings and other pertinent information: None.

## TEACHERS' RETIREMENT SYSTEM OF THE STATE OF ILLINOIS

## JANUARY 2009 REGULATORY AGENDA

a) Part(s) (Heading and Code Citation): The Administration and Operation of the Teachers' Retirement System, 80 Ill. Adm. Code 1650

1) Rulemaking:

- A) Description: The Retirement System will be promulgating rules governing entry into retirement status, as well as procurement rules.
- B) Statutory Authority: Implementing and authorized by Article 16 of the Illinois Pension Code [40 ILCS 5/Art. 16]
- C) Scheduled meeting/hearing dates: There is no proposed schedule of dates for meetings/hearings at this time.
- D) Date agency anticipates First Notice: Unknown
- E) Effect on small businesses, small municipalities or not for profit corporations: None
- F) Agency contact person for information:

Sandy Cochran  
Teachers' Retirement System  
Office of the General Counsel  
P.O. Box 19253  
2815 West Washington  
Springfield, Illinois 62794-9253

217/753-0375

- G) Related rulemakings and other pertinent information: None

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 June 9, 2009 through June 15, 2009 and have been scheduled for review by the Committee at its July 14, 2009 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>
7/23/09	<u>Secretary of State</u> , Regulations Under the Illinois Securities Law of 1953 (14 Ill. Adm. Code 130)	1/23/09 33 Ill. Reg. 1451	7/14/09
7/23/09	<u>Secretary of State</u> , Regulations Under the Business Opportunity Sales Law of 1995 (14 Ill. Adm. Code 135)	1/23/09 33 Ill. Reg. 1468	7/14/09
7/23/09	<u>Secretary of State</u> , Regulations Under the Illinois Business Brokers Act of 1995 (14 Ill. Adm. Code 140)	1/23/09 33 Ill. Reg. 1473	7/14/09
7/23/09	<u>Secretary of State</u> , Regulations Under the Illinois Loan Brokers Act of 1995 (14 Ill. Adm. Code 145)	1/23/09 33 Ill. Reg. 1479	7/14/09
7/25/09	<u>Illinois Racing Board</u> , Security Areas (11 Ill. Adm. Code 436)	4/24/09 33 Ill. Reg. 6021	7/14/09
7/25/09	<u>Illinois Racing Board</u> , Horseman's Bookkeeping System Licensees (11 Ill. Adm. Code 450)	4/24/09 33 Ill. Reg. 6025	7/14/09
7/25/09	<u>Illinois Racing Board</u> , Claiming Races (11 Ill. Adm. Code 510)	4/24/09 33 Ill. Reg. 6031	7/14/09

JOINT COMMITTEE ON ADMINISTRATIVE RULES  
ILLINOIS GENERAL ASSEMBLY

## SECOND NOTICES RECEIVED

7/25/09	<u>Illinois Racing Board</u> , General Licensee Rules (11 Ill. Adm. Code 1313)	4/24/09 33 Ill. Reg. 6035	7/14/09
7/25/09	<u>Illinois Racing Board</u> , Racing Rules (11 Ill. Adm. Code 1318)	4/24/09 33 Ill. Reg. 6040	7/14/09

## ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PUBLIC INFORMATION

## LISTING OF DERIVED WATER QUALITY CRITERIA

Pursuant to 35 Ill. Adm. Code 302.595 and 302.669, the following water quality criteria have been derived as listed. This listing updates revisions to existing criteria for the period January 1, 2009 through March 31, 2009

A cumulative listing of criteria as of July 31, 1993 was published in 17 Ill. Reg. 18904, October 29, 1993. Listings of waterbodies for which water quality criteria were used during subsequent three month periods were published in 18 Ill. Reg. 318, January 7, 1994; 18 Ill. Reg. 4457, March 18, 1994; 18 Ill. Reg. 8734, June 10, 1994; 18 Ill. Reg. 14166, September 9, 1994; 18 Ill. Reg. 17770, December 9, 1994; 19 Ill. Reg. 3563, March 17, 1995; 19 Ill. Reg. 7270, May 26, 1995; 19 Ill. Reg. 12527, September 1, 1995; 20 Ill. Reg. 649, January 5, 1996; 20 Ill. Reg. 4829, March 22, 1996; 20 Ill. Reg. 7549, May 30, 1996; 20 Ill. Reg. 12278, September 6, 1996; 20 Ill. Reg. 15619, December 6, 1996; 21 Ill. Reg. 3761, March 21, 1997; 21 Ill. Reg. 7554, June 13, 1997; 21 Ill. Reg. 12695, September 12, 1997; 21 Ill. Reg. 16193, December 12, 1997; 22 Ill. Reg. 5131, March 13, 1998; 22 Ill. Reg. 10689, June 12, 1998; 22 Ill. Reg. 16376, September 11, 1998; 22 Ill. Reg. 22423, December 28, 1998; 23 Ill. Reg. 3102, March 12, 1999; 23 Ill. Reg. 6979, June 11, 1999; 23 Ill. Reg. 11774, September 24, 1999; 23 Ill. Reg. 14772, December 27, 1999; 24 Ill. Reg. 4251, March 17, 2000; 24 Ill. Reg. 8146, June 9, 2000; 24 Ill. Reg. 14428, September 29, 2000; 25 Ill. Reg. 270, January 5, 2001; 25 Ill. Reg. 4049, March 16, 2001; 25 Ill. Reg. 7367, June 8, 2001; 25 Ill. Reg. 12186, September 21, 2001; 25 Ill. Reg. 16175, December 14, 2001; 26 Ill. Reg. 4974, March 29, 2002; 26 Ill. Reg. 13370, September 6, 2002; 27 Ill. Reg. 1736, January 31, 2003; 27 Ill. Reg. 7350, April 18, 2003; 27 Ill. Reg. 17128, November 7, 2003; 28 Ill. Reg. 5038, March 19, 2004; 28 Ill. Reg. 8363, June 11, 2004; 28 Ill. Reg. 12943, September 17, 2004; 29 Ill. Reg. 1449, January 21, 2005; 29 Ill. Reg. 7239, May 20, 2005; 29 Ill. Reg. 12672, August 12, 2005; 29 Ill. Reg. 18963, November 18, 2005; 30 Ill. Reg. 5458, March 17, 2006; 30 Ill. Reg. 9195, May 12, 2006 and 30 Ill. Reg. 14377, September 1, 2006; 31 Ill. Reg. 4941, March 23, 2007; 31 Ill. Reg. 7477, May 25, 2007; 31 Ill. Reg. 13233, September 14, 2007; 31 Ill. Reg. 15875, November 26, 2007; 32 Ill. Reg. 4271, March 21, 2008; 32 Ill. Reg. 8454, June 6, 2008; 32 Ill. Reg. 13595, August 15, 2008; 32 Ill. Reg. 19961, December 19, 2008; and 33 Ill. Reg. 3683, February 27, 2009.

Aquatic life and human health criteria for General Use (35 Ill. Adm. Code 303.201) and Lake Michigan Basin (35 Ill. Adm. Code 303.443) waters are listed below. General Use human health criteria are derived for protection of primary contact waters, criteria derived for waters not supportive of primary contact recreation are specified, where applicable. General Use and Lake Michigan Basin waters used as Public and Food Processing Water Supplies (35 Ill. Adm. Code 303.202) are subject to more stringent human health criteria as specified in their respective derivation procedures (35 Ill. Adm. Code 302.648 and 302.657 and 35 Ill. Adm. Code 302.585

## ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PUBLIC INFORMATION

## LISTING OF DERIVED WATER QUALITY CRITERIA

and 302.590, respectively). Newly derived criteria or criteria used in NPDES permitting this quarter are highlighted in bold print.

### General Use Criteria

Chemical: Acenaphthene	CAS #83-32-9
Acute criterion: 120 ug/l	Chronic criterion: 62 ug/l
Date criteria derived: November 14, 1991; revised February 1999	
Applicable waterbodies: Not used during this period.	
Chemical: Acenaphthylene	CAS # 208-96-8
Acute criterion: 190 ug/L	Chronic criterion: 15 ug/L
Date criteria derived: March 1, 1998	
Applicable waterbodies: Not used during this period.	
Chemical: Acetochlor	CAS #34256-82-1
Acute criterion: 150 ug/l	Chronic criterion: 12 ug/l
Date criteria derived: September 26, 2007	
Applicable waterbodies: Not used during this period.	
Chemical: Acetone	CAS #67-64-1
Acute criterion: 1,500 mg/l	Chronic criterion: 120 mg/l
Date criteria derived: May 25, 1993	
Applicable waterbodies: Not used during this period.	
Chemical: Acetonitrile	CAS #75-05-8
Acute criterion: 380 mg/l	Chronic criterion: 30 mg/l
Human health criterion (HTC): non-primary contact, 20 mg/L	
Date criteria derived: December 7, 1993; revised January 23, 2007	
Applicable waterbodies: Not used during this period.	
Chemical: Acrolein	CAS #107-02-8
Acute criterion: 2.7 µg/l	Chronic criterion: 0.22 µg/l
Date criteria calculated: February 1999; reviewed January 2008	
Applicable waterbodies: Not used during this period.	
Chemical: Acrylonitrile	CAS #107-13-4
Acute criterion: 910 ug/l	Chronic criterion: 73 ug/l
Human health criterion (HNC): 0.21 ug/l	
Date criteria derived: November 13, 1991	

## ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PUBLIC INFORMATION

## LISTING OF DERIVED WATER QUALITY CRITERIA

Applicable waterbodies: Not used during this period.	
Chemical: Anthracene	CAS #120-12-7
Acute criterion: 0.66 ug/L	Chronic Criterion: 0.53 ug/L
Human health criterion (HTC): 35 mg/l	
Date criteria derived: August 18, 1993, revised May 30, 2007	
Applicable waterbodies: Not used during this period.	
Chemical: Antimony	CAS #7440-36-0
Acute criterion: 1,200 ug/L	Chronic Criterion: 320 ug/L
Human health criterion (HTC): 12,000 ug/l	
Non-primary contact: 1,200 ug/l	
Public and food processing water supply: 6 ug/l	
Date criteria derived: September 29, 2008	
Applicable waterbodies: Not used during this period.	
Chemical: Atrazine	CAS #1912-24-9
Acute criterion: 82 ug/l	Chronic criterion: 9.0 ug/L
Date criteria derived: May 2, 2005	
Applicable waterbodies: Not used during this period.	
Chemical: Benzo(a)anthracene	CAS #56-55-3
Human health criterion (HNC): 0.16 ug/l	
Date criteria derived: August 10, 1993; revised February 1999	
Applicable waterbodies: Not used during this period.	
Chemical: Benzo(a)pyrene	CAS #50-32-8
Human health criterion (HNC): 0.016 ug/l	
Date criteria derived: August 10, 1993; revised February 1999	
Applicable waterbodies: Not used during this period.	
Chemical: Benzo(b)fluoranthene	CAS # 205-99-2
Human health criterion (HNC): 0.16 ug/l	
Date criteria derived: August 10, 1993; revised February 1999	
Applicable waterbodies: Not used during this period.	
Chemical: Benzo(k)fluoranthene	CAS #207-08-9
Human health criterion (HNC): 1.6 ug/l	
Date criteria derived: August 10, 1993; revised February 1999	
Applicable waterbodies: Not used during this period.	
Chemical: Carbon tetrachloride	CAS #56-23-5
Acute criterion: 3,500 ug/l	Chronic criterion: 280 ug/l
Human health criterion (HNC): 1.4 ug/l	

## ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PUBLIC INFORMATION

## LISTING OF DERIVED WATER QUALITY CRITERIA

Date criteria derived: June 18, 1993 Applicable waterbodies: Not used during this period.	
Chemical: Chlorobenzene	CAS #108-90-7
Acute criterion: 990 ug/l	Chronic criterion: 79 ug/l
Date criteria derived: December 11, 1991 Applicable waterbodies: Not used during this period.	
Chemical: Chloroethane	CAS #75-00-3
Acute criterion: 13 mg/l	Chronic criterion: 1 mg/l
Date criteria derived: December 11, 1991 Applicable waterbodies: Not used during this period.	
Chemical: Chloromethane	CAS #74-87-3
Acute criterion: 16 mg/l	Chronic criterion: 1.3 mg/l
Date criteria derived: December 11, 1991 Applicable waterbodies: Not used during this period.	
Chemical: Chloroform	CAS #67-66-3
Acute criterion: 1,900 ug/l	Chronic criterion: 150 ug/l
Human health criterion (HNC): 130 ug/l Date criteria derived: October 26, 1992 Applicable waterbodies: Not used during this period.	
Chemical: Chrysene	CAS #218-01-9
Human health criterion (HNC): 16 ug/l Date criteria derived: August 10, 1993; revised February 1999 Applicable waterbodies: Not used during this period.	
Chemical: Dibenz(a,h)anthracene	CAS #53-70-3
Human health criterion (HNC): 0.016 ug/l Date criteria derived : February, 1999, reviewed June 2007 Applicable waterbodies: Not used during this period.	
Chemical: 1,2-dichlorobenzene	CAS #95-50-1
Acute criterion: 210 ug/l	Chronic criterion: 17 ug/l
Date criteria derived: December 1, 1993 Applicable waterbodies: Not used during this period.	
Chemical: 1,3-dichlorobenzene	CAS #541-73-1
Acute criterion: 500 ug/l	Chronic criterion: 200 ug/l
Date criteria derived: July 31, 1991 Applicable waterbodies: Not used during this period.	
Chemical: 1,1-dichloroethane	CAS #75-34-3

## ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PUBLIC INFORMATION

## LISTING OF DERIVED WATER QUALITY CRITERIA

Acute criterion: 20 mg/l Date criteria derived: July 31, 1991 Applicable waterbodies: Not used during this period.	Chronic criterion: 2 mg/l
Chemical: 1,2-dichloroethane Acute criterion: 25 mg/l Human health criterion (HNC): 23 ug/l Date criteria derived: March 19, 1992 Applicable waterbodies: Not used during this period.	CAS #107-06-2 Chronic criterion: 4.5 mg/l
Chemical: 1,1-dichloroethylene Acute criterion: 3,000 ug/l Human health criterion (HNC): 0.95 ug/l Date criteria derived: March 20, 1992 Applicable waterbodies: Not used during this period.	CAS #75-35-4 Chronic criterion: 240 ug/l
Chemical: 1,2-dichloroethylene Acute criterion: 14 mg/l Date criteria derived: November 18, 2008 Applicable waterbodies: Not used during this period.	CAS #540-59-0 Chronic criterion: 1.1 mg/l
Chemical: 2,4-dichlorophenol Acute criterion: 630 ug/l Date criteria derived: November 14, 1991 Applicable waterbodies: Not used during this period.	CAS #120-83-2 Chronic criterion: 83 ug/l
Chemical: 1,2-dichloropropane Acute criterion: 4,800 ug/l Date criteria derived: December 7, 1993 Applicable waterbodies: Not used during this period.	CAS #78-87-5 Chronic criterion: 380 ug/l
Chemical: 1,3-dichloropropylene Acute criterion: 99 ug/l Date criteria derived: November 13, 1991 Applicable waterbodies: Not used during this period.	CAS #542-75-6 Chronic criterion: 7.9 ug/l
Chemical: 2,4-dimethyl phenol Acute criterion: 740 ug/l Date criteria derived: October 26, 1992 Applicable waterbodies: Not used during this period.	CAS #105-67-9 Chronic criterion: 220 ug/l
Chemical: 4,6-dinitro-o-cresol = 2-methyl-4,6-dinitrophenol Acute criterion: 29 ug/l Date criteria derived: November 14, 1991	CAS #534-52-1 Chronic criterion: 2.3 ug/l

## ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PUBLIC INFORMATION

## LISTING OF DERIVED WATER QUALITY CRITERIA

Applicable waterbodies: Not used during this period.	
Chemical: 2,4-dinitrophenol	CAS #51-28-5
Acute criterion: 85 ug/l	Chronic criterion: 4.1 ug/l
Date criteria derived: December 1, 1993	
Applicable waterbodies: Not used during this period.	
Chemical: 2,6-dinitrotoluene	CAS #606-20-2
Acute criterion: 1,900 ug/l	Chronic criterion: 150 ug/l
Date criteria derived: February 14, 1992	
Applicable waterbodies: Not used during this period.	
Chemical: Diquat	CAS #85-00-7
Acute criterion: 990 ug/l	Chronic criterion: 80 ug/l
Date criteria derived: January 30, 1996	
Applicable waterbodies: Not used during this period.	
Chemical: Ethyl mercaptan (ethanethiol)	CAS #75-08-1
Acute criterion: 17 ug/l	Chronic criterion: 2 ug/l
Date criteria derived: April 8, 2002	
Applicable waterbodies: Not used during this period.	
Chemical: Fluoranthene	CAS #206-44-0
Acute criterion: 4.3 ug/L	Chronic Criterion: 1.8 ug/L
Human health criterion (HTC): 120 ug/l	
Date criteria derived: August 10, 1993; revised June 6, 2007 (Acute/Chronic)	
Applicable waterbodies: Not used during this period.	
Chemical: Fluorene	CAS #86-73-7
Acute criterion: 59 ug/L	Chronic Criterion: 16 ug/L
Date criteria derived: June 6, 2007	
Applicable waterbodies: Not used during this period.	
Chemical: Formaldehyde	CAS #50-00-0
Acute criterion: 4.9 mg/l	Chronic criterion: 0.39 mg/l
Date criteria derived: January 19, 1993	
Applicable waterbodies: Not used during this period.	
Chemical: Hexachlorobenzene	CAS #118-74-1
Human health criterion (HNC): 0.00025 ug/l	
Date criteria derived: November 15, 1991	
Applicable waterbodies: Not used during this period.	
Chemical: Hexachlorobutadiene	CAS #87-68-3
Acute criterion: 35 ug/l	Chronic criterion: 2.8 ug/l

## ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PUBLIC INFORMATION

## LISTING OF DERIVED WATER QUALITY CRITERIA

Date criteria derived: March 23, 1992 Applicable waterbodies: Not used during this period.	
Chemical: Hexachloroethane	CAS #67-72-1
Acute criterion: 380 ug/l	Chronic criterion: 31 ug/l
Human health criterion (HNC): 2.9 ug/l Date criteria derived: November 15, 1991 Applicable waterbodies: Not used during this period.	
Chemical: n-Hexane	CAS #110-54-3
Acute criterion: 250 ug/l	Chronic criterion: 20 ug/l
Date criteria derived: April 8, 2002 Applicable waterbodies: Not used during this period.	
Chemical: Indeno(1,2,3-cd)pyrene	CAS #193-39-5
Human health criterion (HNC): 0.16 ug/l Date criteria calculated: February, 1992, reviewed June 2007 Applicable waterbodies: Not used during this period.	
Chemical: Isobutyl alcohol = 2-methyl-1-propanol	CAS #78-83-1
Acute criterion: 430 mg/l	Chronic criterion: 35 mg/l
Date criteria derived: December 1, 1993 Applicable waterbodies: Not used during this period.	
Chemical: Methylene chloride	CAS #75-09-2
Acute criterion: 17 mg/l	Chronic criterion: 1.4 mg/l
Human health criterion (HNC): 330 ug/l Non-primary contact: 490 ug/l Public and food processing water supply: 4.6 ug/l Date criteria derived: January 21, 1992; revised November 25, 2008 Applicable waterbodies: Not used during this period.	
Chemical: Methyl ethyl ketone	CAS #78-93-3
Acute criterion: 320 mg/l	Chronic criterion: 26 mg/l
Date criteria derived: July 1, 1992 Applicable waterbodies: Not used during this period.	
Chemical: 4-methyl-2-pentanone	CAS #108-10-1
Acute criterion: 46 mg/l	Chronic criterion: 1.4 mg/l
Date criteria derived: January 13, 1992 Applicable waterbodies: Not used during this period.	
Chemical: 2-methyl phenol	CAS #95-48-7
Acute criterion: 4.7 mg/l	Chronic criterion: 0.37 mg/l

## ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PUBLIC INFORMATION

## LISTING OF DERIVED WATER QUALITY CRITERIA

Date criteria derived: November 8, 1993 Applicable waterbodies: Not used during this period.	
Chemical: 4-methyl phenol	CAS #106-44-5
Acute criterion: 670 ug/l	Chronic criterion: 120 ug/l
Date criteria derived: January 13, 1992 Applicable waterbodies: Not used during this period.	
Chemical: Methyl tert-butyl ether (MTBE)	CAS #134-04-4
Acute criterion: 67 mg/l	Chronic criterion: 5.4 mg/l
Date criteria derived: September 18, 1997 Applicable waterbodies: Not used during this period.	
Chemical: Metolachlor	CAS #51218-45-2
Acute criterion: 380 ug/l	Chronic criterion: 30.4 ug/l
Date criteria derived: February 25, 1992; revised October 1, 2007 Applicable waterbodies: Not used during this period.	
Chemical: Naphthalene	CAS #91-20-3
Acute criterion: 510 ug/l	Chronic criterion: 68 ug/l
Date criteria derived: November 7, 1991; revised February 1999 Applicable waterbodies: Not used during this period.	
Chemical: 4-nitroaniline	CAS #100-01-6
Acute criterion: 1.5 mg/l	Chronic criterion: 0.12 mg/l
Date criteria derived: May 5, 1996 Applicable waterbodies: Not used during this period.	
Chemical: Nitrobenzene	CAS #98-95-3
Acute criterion: 15 mg/l	Chronic criterion: 8.0 mg/l
Human health criterion (HTC): 0.52 mg/l Date criteria derived: February 14, 1992; revised February 1999 Applicable waterbodies: Not used during this period.	
Chemical: Pentachlorophenol	
Acute criterion: 20 ug/l	Chronic criterion: 13 ug/l
Date criteria derived: national criterion at pH of 7.8, September 1986 Applicable waterbodies: Not used during this period.	
Chemical: Phenanthrene	CAS #85-01-8
Acute criterion: 46 ug/l	Chronic criterion: 3.7 ug/l
Date criteria derived: October 26, 1992 Applicable waterbodies: Not used during this period.	
Chemical: Propylene	CAS #115-07-1

## ENVIRONMENTAL PROTECTION AGENCY

## NOTICE OF PUBLIC INFORMATION

## LISTING OF DERIVED WATER QUALITY CRITERIA

Acute criterion: 4.0 mg/l Date criteria derived: April 8, 2002 Applicable waterbodies: Not used during this period.	Chronic criterion 0.40 mg/l
Chemical: Pyrene Human health criterion (HTC): 3.5 mg/l Date criteria derived: December 22, 1992 Applicable waterbodies: Not used during this period.	CAS #120-00-0
Chemical: Tetrachloroethylene Acute criterion: 1,200 ug/l Date criteria derived: March 23, 1992 Applicable waterbodies: Not used during this period.	CAS #127-18-4 Chronic criterion: 150 ug/l
Chemical: Tetrahydrofuran Acute criterion: 220 mg/l Date criteria derived: March 16, 1992 Applicable waterbodies: Not used during this period.	CAS #109-99-9 Chronic criterion: 17 mg/l
Chemical: 1,2,4-trichlorobenzene Acute criterion: 370 ug/l Date criteria derived: December 14, 1993; revised February 1999 Applicable waterbodies: Not used during this period.	CAS #120-82-1 Chronic criterion: 72 ug/l
Chemical: Thallium Acute criterion: 86 ug/l Human health criterion (HTC): 3.0 ug/l Non-primary contact: 3.0 ug/l Public and food processing water supply: 1.2 ug/l Date criteria derived: October 22, 2007; revised November 18, 2008 Applicable waterbodies: Not used during this period.	CAS #7440-28-0 Chronic criterion: 11 ug/l
Chemical: 1,1,1-trichloroethane Acute criterion: 4,900 ug/l Date criteria derived: October 26, 1992 Applicable waterbodies: Not used during this period.	CAS #71-55-6 Chronic criterion: 390 ug/l
Chemical: 1,1,2-trichloroethane Acute criterion: 19 mg/l Human health criterion (HNC): 12 ug/l Date criteria derived: December 13, 1993; revised February 1999 Applicable waterbodies: Not used during this period.	CAS #79-00-5 Chronic criterion: 4.4 mg/l
Chemical: Trichloroethylene	CAS #79-01-6

## ENVIRONMENTAL PROTECTION AGENCY

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## LISTING OF DERIVED WATER QUALITY CRITERIA

Acute criterion: 12,000 ug/l	Chronic criterion: 940 ug/l
Human health criterion (HNC): 25 ug/l	Non-primary contact: 26 ug/l
	Public and food processing water supply: 2.5 ug/l
Date criteria derived: October 23, 1992; revised November 18, 2008	
Applicable waterbodies: Not used during this period.	
Chemical: Vinyl chloride	CAS #75-01-4
Acute criterion: 22 mg/l	Chronic criterion: 1.7 mg/l
Human health criterion (HNC): 1.5 ug/l	Non-primary contact: 2 ug/l
	Public and food processing water supply: 0.025 ug/l
Date criteria derived: October 23, 1992; revised January 23, 2007; revised November 17, 2008	
Applicable waterbodies: Not used during this period.	

**Lake Michigan Basin Criteria**

Chemical: Antimony	CAS #7440-36-0
<u>Aquatic Life Criteria:</u>	
Acute criterion: 470 ug/l	Chronic criterion: 120 ug/l
Date criteria derived: September 29, 2008	
Applicable waterbodies: Not used during this period.	
Chemical: Bis(2-ethylhexyl)phthalate	CAS #117-81-7
<u>Aquatic Life Criteria:</u>	
Acute criterion: 76 ug/l	Chronic criterion: 17 ug/l
<u>Human Health Non-threshold Criteria:</u>	
Public and food processing water supply: 2.8 ug/l	
Non-drinking water: 3.2 ug/l	
Date criteria derived: June 20, 2006	
Applicable waterbodies: Not used during this period.	
Chemical: 1,2-dichloroethylene	CAS #540-59-0
<u>Aquatic Life Criteria:</u>	
Acute criterion: 8.8 mg/l	Chronic criterion: 0.98 mg/l

## ENVIRONMENTAL PROTECTION AGENCY

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Date criteria derived: November 18, 2008 Applicable waterbodies: Not used during this period.	
Chemical: Methylene Chloride	CAS #75-09-2
<u>Aquatic Life Criteria:</u>	
Acute criterion: 10,803 ug/l	Chronic criterion: 1,200 ug/l
<u>Human Health Non-threshold Criteria:</u>	
Public and food processing water supply: 47 ug/l	
Non-drinking water: 2,600 ug/l	
Date criteria derived: June 20, 2006 Applicable waterbodies: Not used during this period.	
Chemical: Thallium	CAS #7440-28-0
<u>Aquatic Life Criteria:</u>	
Acute criterion: 54 ug/l	Chronic criterion: 15 ug/l
<u>Human Health Threshold Criteria:</u>	
Public and food processing water supply: 1.3 ug/l	
Non-drinking water: 3.7 ug/l	
Date criteria derived: June 20, 2006; revised November 18, 2008 Applicable waterbodies: Not used during this period.	
Chemical: Vinyl Chloride	CAS #75-01-4
<u>Aquatic Life Criteria:</u>	
Acute criterion: 8,380 ug/l	Chronic criterion: 931 ug/l
<u>Human Health Non-threshold Criteria:</u>	
Public and food processing water supply: 0.25 ug/l	
Non-drinking water: 14.4 ug/l	
Date criteria derived: June 20, 2006 Applicable waterbodies: Not used during this period.	

For additional information concerning these criteria or the derivation process used in generating them, please contact:

Brian Koch  
Illinois Environmental Protection Agency  
Division of Water Pollution Control  
1021 North Grand Avenue East  
Post Office Box 19276  
Springfield, Illinois 62794-9276  
217-558-2012

**EXECUTIVE ORDER 2009-12****ESTABLISHMENT OF THE  
ADMISSIONS REVIEW COMMISSION**

**WHEREAS**, fairness and transparency in the administration of an educational system is a fundamental aspect of the public trust; and

**WHEREAS**, as Governor of the State of Illinois, it is my duty to ensure the fair and equitable treatment of candidates for admission to the various State Universities; and

**WHEREAS**, allegations of preferential treatment and undue influence have been raised with respect to the admissions process of the University of Illinois; and

**WHEREAS**, an independent commission is necessary to consider and recommend improvements to the practices and policies governing the admission of applicants to State Universities; and

**THEREFORE**, I, Patrick J. Quinn, Governor of Illinois, pursuant to the authority vested in me by Article V of the Illinois State Constitution of 1970, hereby order as follows:

**I. CREATION**

There is hereby created the Admissions Review Commission (hereinafter the "Commission") as an independent advisory body having the duties set forth in this document, with respect to the Office of the Governor.

**II. PURPOSE**

The purpose of the Commission is to review State University admissions practices and policies and to make recommendations as to any reforms that would improve the fairness and transparency of the admissions process. The Commission shall:

- a. Examine and evaluate the standards and criteria used to evaluate applicants for admission;
- b. Examine and evaluate any practices and policies, and the impact thereof, of affording applicants favorable consideration based on relationships with, or advocacy by, appointed or elected public officials, or persons affiliated with such officials;
- c. Examine and evaluate the strengths and weaknesses of State University admissions practices and policies, taking into account, among other factors, the "best practices" of other selective university systems;
- d. Review and consider the investigative findings of the Office of the Governor, Office of General Counsel regarding State University admissions practices and policies; and

**EXECUTIVE ORDER 2009-12****ESTABLISHMENT OF THE  
ADMISSIONS REVIEW COMMISSION**

- e. Submit, no later than August 8, 2009, a written report outlining its examination and evaluation, and making recommendations to the People of Illinois and to the Governor for improving the fairness and transparency of University admissions processes.

**III. MEMBERSHIP**

- a. The Commission shall be composed of a Chairperson and six (6) independent members, for a total membership of seven (7) Commission members. The Chairperson and the Commission members shall be appointed by the Governor. The Chairperson and the Commission members shall serve without compensation.
- b. The term of the Commission members shall terminate on August 8, 2009.

**IV. INDEPENDENCE**

- a. The Commission shall function as an independent advisory body, with the discretion to arrange its affairs and proceedings in the manner it deems appropriate.
- b. The Commission may, at its discretion, appoint individuals to serve as staff persons.

**V. TRANSPARENCY**

In addition to whatever policies or procedures it may adopt, all operations of the Commission will be subject to the provisions of the Illinois Freedom of Information Act (5 ILCS 140/1 et seq.) and the Illinois Open Meetings Act (5 ILCS 120/1 et seq.). This section shall not be construed so as to preclude other statutes from applying to the Commission and its activities.

**VI. EFFECTIVE DATE**

This Order shall take effect immediately upon its execution.

Pat Quinn, Governor

Issued by Governor: June 10, 2009  
Filed with Secretary of State: June 10, 2009

## PROCLAMATIONS

**2009-198****Police Officer Alejandro "Alex" Valadez**

WHEREAS, on Monday, June 1, Chicago Police Department Officer Alejandro "Alex" Valadez was fatally shot as he and his partner responded to investigate a call of shots fired. He was 27; and

WHEREAS, assigned to small team called Incident Response, Officer Valadez was remembered as an aggressive officer with good people skills that made him a perfect fit for the unit, which often responded to citizen complaints of narcotics or robberies; and

WHEREAS, Officer Valadez was one of three siblings to join the Chicago Police Department, and in just three short years, he had established himself as a go-to police officer, unafraid of challenging assignments or long hours; and

WHEREAS, since joining the Chicago Police Department in December 2005, Officer Valadez earned a department commendation and 22 honorable mentions; and

WHEREAS, Officer Valadez was a conscientious and professional officer who will be remembered for the dedication and commitment to duty that he showed throughout his career; and

WHEREAS, a funeral mass will be held on Saturday, June 6 for Officer Valadez:

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby order all State facilities to fly their flags at half-staff from sunrise on June 4, 2009 until sunset on June 6, 2009 in honor and remembrance of Officer Valadez, whose selfless service and sacrifice is an inspiration.

Issued by the Governor June 3, 2009

Filed by the Secretary of State June 15, 2009

**2009-199****Police Lieutenant Gregory Jonas**

WHEREAS, on Tuesday, June 2, veteran Centreville Police Department Lieutenant Gregory Jonas was fatally shot in the line of duty. He was 59; and

WHEREAS, Lieutenant Jonas joined the Alorton Police Department in 1976, where he worked for eight years. In 1995 Lieutenant Jonas joined the Centreville Police Department, and in 2004 he was promoted to the position of Lieutenant; and

## PROCLAMATIONS

WHEREAS, Lieutenant Jonas was a conscientious and professional officer who will be remembered for the dedication and commitment to duty that he showed throughout his career; and

WHEREAS, Lieutenant Jonas was remembered as a devoted son, husband, father, grandfather and friend, who enjoyed basketball, running, and cooking; and

WHEREAS, a funeral will be held on Saturday, June 6 for Lieutenant Jonas, who is survived by his wife, his mother, two sons, four daughters, ten grandchildren and a host of other relatives, colleagues, and friends:

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby order all State facilities to fly their flags at half-staff immediately until sunset on June 6, 2009 in honor and remembrance of Lieutenant Jonas, whose selfless service and sacrifice is an inspiration.

Issued by the Governor June 5, 2009

Filed by the Secretary of State June 15, 2009

**2009-200****Sergeant Justin J. Duffy**

WHEREAS, on Tuesday, June 2, Sergeant Justin J. Duffy, formerly of Moline, Illinois, died at age 31 of injuries sustained when an improvised explosive device detonated near his Humvee in Baghdad, Iraq, where Sergeant Duffy was serving in support of Operation Iraqi Freedom; and

WHEREAS, Sergeant Duffy, a paratrooper with the 82<sup>nd</sup> Airborne Division, was part of a unit that provided security for military leadership; and

WHEREAS, Sergeant Duffy lived in Moline until the 6<sup>th</sup> grade, when his family moved to Cozad, Nebraska. He enlisted in the Army in June 2007 and deployed to Iraq last November; and

WHEREAS, over the course of his service Sergeant Duffy earned a number of awards and decorations, including the Bronze Star Medal, the Purple Heart, the Army Commendation Medal, the Good Conduct Medal, the National Defense Service Medal, the Iraq Campaign Medal, the Global War on Terrorism Service Medal, the Army Service Ribbon, the Overseas Service Ribbon, the Combat Infantryman Badge and the Parachutist Badge; and

## PROCLAMATIONS

WHEREAS, a funeral will be held on Friday, June 12 for Sergeant Duffy, who is survived by his parents, two sisters, and a host of other relatives and friends:

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby order all State facilities to fly their flags at half-staff from sunrise on June 10, 2009 until sunset on June 12, 2009 in honor and remembrance of Sergeant Duffy, whose selfless service and sacrifice is an inspiration.

Issued by the Governor June 9, 2009

Filed by the Secretary of State June 15, 2009

**2009-201****Children's Day**

WHEREAS, children are the future of Illinois, it is important that we take action to ensure that they are provided a positive start to life; and

WHEREAS, in Illinois, we place the utmost value on the safety and welfare of our children, and we strongly support programs designed to advocate for their best interests; and

WHEREAS, it is important that all citizens work to promote an environment of hope and love for children; and

WHEREAS, the State of Illinois is dedicated to ensuring the health, education and well-being of our children, and we pledge to continue our commitment to ensuring a bright future for all our young people; and

WHEREAS, the second Sunday in June has been set aside as a day to celebrate children, and reaffirm our commitment to their needs:

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim June 14, 2009 as **CHILDREN'S DAY** in Illinois.

Issued by the Governor June 10, 2009

Filed by the Secretary of State June 15, 2009

**2009-202****Quebec National Day**

## PROCLAMATIONS

WHEREAS, the links between Illinois and Quebec are numerous, and stretch back centuries to the French-speaking missionaries and voyagers who left Quebec City and Montreal to explore the land of Illinois and eventually to settle here; and

WHEREAS, in 1969, Quebec established its delegation in the city of Chicago, due to the business and cultural preeminence of the city; and

WHEREAS, Quebec is active, along with Illinois, in both the Council of Great Lakes Governors and the Great Lakes Commission as an associate member; and

WHEREAS, today, trade between Illinois and Quebec exceeds \$3 billion U.S. dollars; and

WHEREAS, the staff of the Quebec Delegation in Chicago has established commercial links between Illinois and Quebec companies, and has brought Quebec performing artists, intellectuals, and writers to the theatres and universities of this state; and

WHEREAS, the Quebec Delegation in Chicago seeks to broaden the economic, cultural, educational and tourism links between Quebec and the Midwest; and

WHEREAS, every year on the 24<sup>th</sup> of June, which is Saint John the Baptist's Day, the people of Quebec celebrate their history and values with La Fête Nationale du Québec:

THEREFORE, I, Pat Quinn, Governor of the State of Illinois, do hereby proclaim June 24, 2009 as **QUEBEC NATIONAL DAY** in Illinois, in recognition of the numerous connections that link Illinois and Quebec, and encourage all citizens to join in this vibrant and spirited commemoration.

Issued by the Governor June 12, 2009

Filed by the Secretary of State June 15, 2009

**ILLINOIS ADMINISTRATIVE CODE**  
**Issue Index - With Effective Dates**

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