

# 2005

# ILLINOIS

# REGISTER

RULES  
OF GOVERNMENTAL  
AGENCIES



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## DEPARTMENT OF CORRECTIONS

## NOTICE OF PROPOSED RULES

- 1) Heading of the Part: Transitional Housing Licensure for Sex Offenders on Parole, Probation, or Supervision
- 2) Code Citation: 20 Ill. Adm. Code 800
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
800.10	New Section
800.20	New Section
800.30	New Section
800.40	New Section
800.50	New Section
800.60	New Section
800.70	New Section
800.80	New Section
800.90	New Section
800.100	New Section
800.110	New Section
800.120	New Section
800.130	New Section
800.140	New Section
800.150	New Section
800.160	New Section
800.170	New Section
800.180	New Section
800.190	New Section
800.200	New Section
800.210	New Section
800.310	New Section
800.320	New Section
800.330	New Section
800.340	New Section
800.350	New Section
- 4) Statutory Authority: Unified Code of Corrections, 3-3-2, 3-3-7, 3-3-9, 3-14-2, 3-17-1, 3-17-5, 5-6-3, 5-6-4, 16.2, and 120 [730 ILCS 5/3-2-2, 3-3-7, 3-3-9, 3-14-2, 3-17-1, 3-17-5, 5-6-3, 5-6-3.1 and 5-6-4 and 110/16.2 and 152/120)] and the Sex Offender Management Board Act, 20 ILCS 4026.
- 5) A Complete Description of the Subjects and Issues Involved: To comply with PA 94-0161, this rulemaking sets forth licensing procedures for transitional housing facilities for

## DEPARTMENT OF CORRECTIONS

## NOTICE OF PROPOSED RULES

sex offenders on parole, probation, or supervision and sets operating standards and security requirements.

- 6) Will this proposed rulemaking replace an emergency rule currently in effect? Yes
- 7) Does this rulemaking contain an automatic repeal date? No
- 8) Do these proposed rules contain any incorporation by reference? Yes
- 9) Are there any other proposed rulemakings pending on this Part? No
- 10) Statement of Statewide Policy Objectives: These rules do not create or expand any State mandate.
- 11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may submit written comments during the 45-day First Notice Period which commences on the issue date of this publication of the *Illinois Register* to:

Beth Kiel, Rules Coordinator  
Illinois Department of Corrections  
1301 Concordia Court  
P. O. Box 19277  
Springfield, Illinois 62794-9277

(217) 522-2666, extension 6511

All written comments received after 45 days from the date of this publication will be considered, time permitting.

- 12) Initial Regulatory Flexibility Analysis:
  - A) Types of small businesses, small municipalities and not for profit corporations affected: Entities who provide housing to more than one sex offender on parole, probation, or supervision.
  - B) Reporting, bookkeeping or other procedures required for compliance: Transitional housing facilities will be required to inform the Department of case management information such as correspondence, treatment plans, efforts to relocate sex offenders to non-Transitional Housing, and other such information;

## DEPARTMENT OF CORRECTIONS

## NOTICE OF PROPOSED RULES

statistical information; and unusual incidents. Additionally, facilities will be required to: post a visible and conspicuous exterior sign identifying itself as a Department licensed transitional housing facility; notify the police department, public and private elementary and secondary schools, public libraries, and each residential home and apartment complex located within 500 feet of the facility of its licensure and of its continuing operation as a transitional housing facility annually; file with the office of the county clerk a certificate stating the name of the facility, the names of the operators of the facility, and the address of the facility; and publish the notice of the filing of the certificate in a newspaper of general circulation in the county filed at least once a week for three consecutive weeks.

- C) Types of professional skills necessary for compliance: Registered security staff and Sex Offender Management Board certified therapists.
- 13) Regulatory Agenda on which this rulemaking was summarized: This rule was not included on either of the two most recent agendas because: PA 94-161, the legislation mandating this licensure, was signed July 11, 2005.

The full text of the Proposed Rules is identical to that of the Emergency Rules found in this issue of the *Illinois Register* and begins on page 14358:

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Child Support Enforcement
- 2) Code Citation: 89 Ill. Adm. Code 160
- 3) Section Numbers: 160.65                      Proposed Action: Amendment
- 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 proposed amendment concerning child support enforcement pertains to appeals of administrative orders for support and the Quantitative Standard for Review that refers to the current financial ability of the non-custodial parent. The changes provide a technical correction on when a redetermination or request for an appeal of an administrative order may be initiated by the client and/or non-custodial parent pursuant to modification of the existing support obligations. When a client appeals an administrative order, if the Quantitative Standard for Review has not been met, either parent may request a redetermination; if the Quantitative Standard for Review has been met, either parent may petition the Department for a release from or modification of the order and receive a hearing.
- 6) Will this rulemaking replace an emergency rulemaking currently in effect? No
- 7) Does this rulemaking contain an automatic repeal date? No
- 8) Does this rulemaking contain incorporations by reference? No
- 9) Are there any other proposed amendments pending on this Part? Yes

<u>Sections</u>	<u>Proposed Action</u>	<u>Illinois Register Citation</u>
160.30	Amendment	April 29, 2005; 29 Ill. Reg. 5898
160.70	Amendment	March 25, 2005; 28 Ill. Reg. 4459
160.70	Amendment	April 29, 2005; 29 Ill. Reg. 5898
160.75	Amendment	March 25, 2005; 28 Ill. Reg. 4459

- 10) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.
- 11) 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:

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

Joanne Scattoloni  
Office of the General Counsel, Rules Section  
Illinois Department of Public Aid  
201 South Grand Avenue East, Third Floor  
Springfield, Illinois 62763-0002

(217)524-0081

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].

- 12) 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
- 13) Regulatory Agenda on Which this Rulemaking Was Summarized: July 2005

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~~PUBLIC AID~~

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 Application Fee 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)
- 160.65 Modification of Support Obligations

SUBPART D: ENFORCEMENT OF CHILD SUPPORT ORDERS

Section

- 160.70 Enforcement of Support Orders
- 160.71 Credit for Payments Made Directly to the Title IV-D Client

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 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

## 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 Statement of Child Support Account Activity

## SUBPART H: DEPARTMENT REVIEW OF DISTRIBUTION OF CHILD SUPPORT

- Section  
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].

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

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, 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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

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. \_\_\_\_\_, effective \_\_\_\_\_.

SUBPART C: ESTABLISHMENT AND MODIFICATION OF  
CHILD SUPPORT ORDERS**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 FSS 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 determined that a review would not be in the best interests of the child, whenever a change in financial circumstances of the

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

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 which 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 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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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## 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 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 FSS shall review any financial information concerning the responsible

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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relative. Where the responsible relative's information is not verified through an employer, wage stubs or income tax returns, the FSS shall seek other verification, e.g., subpoena of the responsible relative's income tax return.

- 2) The FSS shall determine the responsible relative's current financial ability in accordance with the guidelines contained in Section 160.60(c).
- 3) The FSS 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 FSS 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 FSS 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 FSS 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. ~~or~~
  - 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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 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 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.

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- 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 FSS 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 FSS 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
    - 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 FSS 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 FSS shall effect income withholding in accordance

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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with Section 160.60(d)(6).

- ii) The FSS 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 ~~above~~.
  - 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)(~~ii~~) 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 ~~above~~.
  - 3) Upon receipt of a request for a redetermination as set forth in [subsection \(g\)\(1\) subsections \(g\)\(1\)\(C\) and \(2\)\(C\)\(i\)](#) 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 (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.

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 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
    - 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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

- 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:
- i) the location of existing ~~orders~~order(s);
  - 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

## DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

## NOTICE OF PROPOSED AMENDMENT

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 29 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

## DEPARTMENT OF NATURAL RESOURCES

## NOTICE OF PROPOSED RULES

- 1) Heading of the Part: Illinois Resident Armed Forces Fee Exemptions
- 2) Code Citation: 17 Ill. Adm. Code 2510
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
2510.10	New Section
2510.20	New Section
2510.30	New Section
2510.40	New Section
2510.50	New Section
- 4) Statutory Authority: Implementing and authorized by Sections 805-305 of the Civil Administrative Code of Illinois [20 ILCS 805/805-305], Sections 20-47 of the Fish and Aquatic Life Code [515 ILCS 5/20-47] and by Section 3.1-4 of the Wildlife Code [520 ILCS 5/3.1-4].
- 5) A Complete Description of the Subjects and Issues Involved: Public Act 94-0313, effective July 25, 2005, amended the Civil Administrative Code of Illinois, the Fish and Aquatic Life Code and the Wildlife Code, to add provisions for Illinois resident military members who have served abroad, or guard or reserve members called to active duty, to receive free camping, hunting and fishing permits. This rule contains criteria for qualifying military members, including information on free privileges available and application requirements.
- 6) Will this rulemaking replace any emergency rulemaking currently in effect? Yes
- 7) Does this rulemaking contain an automatic repeal date? No
- 8) Does this rulemaking contain incorporations by reference? No
- 9) Are there any other proposed amendments pending on this Part? No
- 10) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.
- 11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on these proposed rules may be submitted in writing for a period of 45 days following publication of this Notice to:

Jack Price, Legal Counsel

## DEPARTMENT OF NATURAL RESOURCES

## NOTICE OF PROPOSED RULES

Department of Natural Resources  
One Natural Resources Way  
Springfield IL 62702-1271

217/782-1809

- 12) 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
- 13) Regulatory Agenda on which this rulemaking was summarized: July 2005

The full text of the Proposed Rules is identical to that of the Emergency rulemaking found in this copy of the *Illinois Register*, which begins on page 14396:

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Pay Plan
- 2) Code Citation: 80 Ill. Adm. Code 310
- 3) 

<u>Section Numbers:</u>	<u>Adopted Action:</u>
310.280	Amendment
310.410	Amendment
- 4) Statutory Authority: Authorized by Sections 8 and 8a of the Personnel Code [20 ILCS 415/8 and 8a]
- 5) Effective Date of Amendments: September 9, 2005
- 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. Copies of all Pay Plan amendments and collective bargaining contracts are available upon request from the Division of Technical Services.
- 9) Notices of Proposed Published in the Illinois Register: June 10, 2005; 29 Ill. Reg. 8253
- 10) Has JCAR issued a Statement of Objection to these amendments? Yes
- 11) Differences between proposal and final version: In the Table of Contents, "(Repealed)" was added to the Section 310.320 heading based on amendments adopted at 29 Ill. Reg. 13540.

Changes to the Source Notes reflect: the amendments adopted at 29 Ill. Reg. 9319, effective July 1, 2005; the peremptory amendments adopted at 29 Ill. Reg. 12076, effective July 15, 2005; the peremptory amendments adopted at 29 Ill. Reg. 13265, effective August 11, 2005; the amendments adopted at 29 Ill. Reg. 13540, effective August 22, 2005; and the peremptory amendment adopted at 29 Ill. Reg. 14098, effective September 2, 2005.

In Section 310.280 Designated Rate, the changes reflect the requests from the Departments of Children and Family Services, Commerce and Economic Opportunity, Human Services, Natural Resources, and Illinois State Police to remove designated rate

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

associated from positions. The designated rates removed are: \$85,104 annually for a Public Service Administrator, Position Number 37015-16-23-120-00-01, in the Department of Children and Family Services; \$86,474 annually for a Public Service Administrator, Position Number 37015-42-10-900-10-01, in the Department of Commerce and Economic Opportunity; \$142,368 annually for the Medical Administrator I, Option D, Position Number 26401-10-79-006-00-21, \$76,572 annually for the Public Service Administrator, Position Number 37015-10-23-100-30-01, \$105,475 annually for the Senior Public Service Administrator, Position Number 40070-10-65-000-00-01, and \$105,480 annually for the Senior Public Service Administrator, Position Number 40070-10-81-920-00-21, in the Department of Human Services; \$50,520 annually for an Administrative Assistant II, Position Number 00502-12-30-000-20-01, in the Department of Natural Resources; and \$117,828 annually for a Senior Public Service Administrator, Position Number 40070-21-10-000-00-01, and \$117,828 annually for a Senior Public Service Administrator, Position Number 40070-21-40-000-00-01, in Illinois State Police. These changes are made by amendments adopted at 29 Ill. Reg. 9319.

Also, in Section 310.280 Designated Rate, the designated rate of \$51,900 annually for a Private Secretary II, position number 34202-50-19-000-00-01, in the Illinois Labor Relations Board was removed. By agreement with the Joint Committee on Administrative Rules, Section 310.280 is amended to reflect the Department of Healthcare and Family Services, which was formerly named the Department of Public Aid. These changes are made with the proposed amendments adopted at 29 Ill. Reg. 13540. With the name change of the Department of Healthcare and Family Services, the listed agencies are placed in alphabetic order by agreement with the Joint Committee on Administrative Rules.

In Section 310.410, the Dentist II, and Oral Health Consultant titles with their corresponding MC salary range are removed. These changes are made with the peremptory amendments at 29 Ill. Reg. 12076. The Equal Pay Specialist title with its MC-04 salary range is removed from the merit compensation list. These changes are made by amendments adopted at 29 Ill. Reg. 13540.

- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will these amendments replace any emergency amendments currently in effect? No
- 14) Are there any amendments pending on this Part? Yes

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<u>Section Numbers</u>	<u>Proposed Action</u>	<u>Ill. Reg. Citation</u>
310.Appendix A, Table D	Amendment	28 Ill. Reg. 13949, 10/29/04
310.Appendix A, Table E	Amendment	28 Ill. Reg. 13949, 10/29/04
310.Appendix A, Table F	Amendment	28 Ill. Reg. 13949, 10/29/04
310.50	Amendment	29 Ill. Reg. 12683, 8/19/05
310.80	Amendment	29 Ill. Reg. 12683, 8/19/05
310.100	Amendment	29 Ill. Reg. 12683, 8/19/05
310.210	Amendment	29 Ill. Reg. 12683, 8/19/05
310.220	Amendment	29 Ill. Reg. 12683, 8/19/05
310.230	Amendment	29 Ill. Reg. 12683, 8/19/05
310.270	Amendment	29 Ill. Reg. 12683, 8/19/05
310.280	Amendment	29 Ill. Reg. 12683, 8/19/05
310.290	Amendment	29 Ill. Reg. 12683, 8/19/05
310.410	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table G	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table H	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table I	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table J	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table K	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table N	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table O	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table P	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table R	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table V	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table W	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table X	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table Y	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix A Table Z	Amendment	29 Ill. Reg. 12683, 8/19/05
310.Appendix B	Amendment	29 Ill. Reg. 12683, 8/19/05

- 15) Summary and Purpose of Amendments: In Section 310.280, Designated Rate, the Department of Public Health requested the change of the designated rate of \$134,000 annually for the Senior Public Service Administrator, position number 40070-20-80-000-00-81, to \$134,004 effective May 5, 2005. The designated rate is changed. The Department of Revenue requested the removal of the designated rates of \$76,668 annually for the Public Service Administrator, position number 37015-25-61-140-80-01, and \$74,904 annually for the Public Service Administrator, position number 37015-25-61-140-90-01, effective May 6, 2005. These designated rates are removed.

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

In Section 310.410, Jurisdiction, the Civil Service Commission approved the abolishment of the KidCare Supervisor I and II titles, and the establishment of the KidCare Supervisor title effective May 1, 2005. The KidCare Supervisor I and II titles, with their salary grades, are removed from, and the KidCare Supervisor title with its MC-07 salary range is added to, the merit compensation list.

- 16) Information and questions regarding these adopted amendments shall be directed to:

Mr. Jason Doggett  
Acting Manager  
Compensation Section  
Division of Technical Services and Agency Training and Development  
Bureau of Personnel  
Department of Central Management Services  
504 William G. Stratton Building  
Springfield IL 62706

217/782-7964  
Fax: 217/524-4570

- 17) Does this rulemaking require the preview of the Procurement Policy Board as specified in Section 5-25 of the Illinois Procurement Code [30 ILCS 50/5-25]? No

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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF ADOPTED 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
310.50	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 for Fiscal Year 2006
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
310.240	Hourly Rate
310.250	Member, Patient and Inmate Rate
310.260	Trainee Rate
310.270	Legislated and Contracted Rate
310.280	Designated Rate
310.290	Out-of-State or Foreign Service Rate

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

- 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  
 310.420 Objectives  
 310.430 Responsibilities  
 310.440 Merit Compensation Salary Schedule  
 310.450 Procedures for Determining Annual Merit Increases  
 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 Guidechart for Fiscal Year 2006  
 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 HR-190 (Department of Central Management Services – State of Illinois Building – SEIU) (Repealed)  
 310.TABLE B HR-200 (Department of Labor – Chicago, Illinois – SEIU) (Repealed)  
 310.TABLE C RC-069 (Firefighters, AFSCME) (Repealed)  
 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)

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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	HR-012 (Fair Employment Practices Employees, SEIU) (Repealed)
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 Grades – Monthly Rates of Pay for Fiscal Year 2006
310.APPENDIX C	Medical Administrator Rates for Fiscal Year 2006
310.APPENDIX D	Merit Compensation System Salary Schedule for Fiscal Year 2006
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 for Fiscal Year 2006

AUTHORITY: Implementing and authorized by Sections 8 and 8a of the Personnel Code [20 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;

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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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; peremptory 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; peremptory 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; peremptory amendment at 10 Ill. Reg. 13675, effective July 31, 1986; peremptory 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; peremptory amendment at 10 Ill. Reg. 19132, effective October 28, 1986; peremptory amendment at 10 Ill. Reg. 21097, effective December 9, 1986; amended at 11 Ill. Reg. 648, effective December 22, 1986; peremptory amendment at 11 Ill. Reg. 3363, effective February 3, 1987; peremptory amendment at 11 Ill. Reg. 4388, effective February 27, 1987; peremptory 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; peremptory amendment at 11 Ill. Reg. 13675, effective July 29, 1987; amended at 11 Ill. Reg. 14984, effective August 27, 1987; peremptory amendment at 11 Ill. Reg. 15273, effective September 1, 1987; peremptory amendment at 11 Ill. Reg. 17919, effective October 19, 1987; peremptory amendment at 11 Ill. Reg. 19812, effective November 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; peremptory amendment at 12 Ill. Reg. 3811, effective January 27, 1988; peremptory amendment at 12 Ill. Reg. 5459, effective March 3, 1988; amended at 12 Ill. Reg. 6073, effective March 21, 1988; peremptory 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; peremptory amendment at 12 Ill. Reg. 8135, effective April 22, 1988; peremptory 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; peremptory amendment at 12 Ill. Reg. 13306, effective July 27,

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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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 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

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

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 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

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

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, 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,

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

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. 2680, 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 maximum of 150 days; emergency expired March 14, 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

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

August 11, 2005; amended at 29 Ill. Reg. 13540, effective August 22, 2005; peremptory amendment at 29 Ill. Reg. 14098, effective September 2, 2005; amended at 29 Ill. Reg. 14166, effective September 9, 2005.

## SUBPART B: SCHEDULE OF RATES

**Section 310.280 Designated Rate**

The rate of pay for a specific position or class of positions where it is deemed desirable to exclude such from the other requirements of this Pay Plan shall be only as designated by the Governor.

Department of Commerce & Economic Opportunity

Private Secretary II (Pos. No. 34202-42-00-000-01-02)	<u>Annual Salary</u> 60,000
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Department of Healthcare and Family Services

<u>Senior Public Service Administrator</u> (Pos. No. 40070-33-20-000-00-61)	<u>Annual Salary</u> <u>\$123,060</u>
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Department of Human Services

Administrative Assistant I (Pos. No. 00501-10-68-010-80-21)	<u>Annual Salary</u> 55,200
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Medical Administrator V (Pos. No. 26406-10-76-000-00-01)	<u>Annual Salary</u> 186,000
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Illinois Labor Relations Board

Private Secretary II (Pos. No. 34202-50-19-000-00-01)	<u>Annual Salary</u> 51,900
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Department of Healthcare and Family Services

<del><u>Senior Public Service Administrator</u></del> (Pos. No. <del>40070-33-20-000-00-61</del> )	<del><u>Annual Salary</u></del> <del>123,060</del>
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## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Department of Public Health

Senior Public Service Administrator  
(Pos. No. 40070-20-80-000-00-81)

Annual Salary  
134,004~~134,000~~

Department of Revenue

~~Public Service Administrator  
(Pos. No. 37015-25-61-140-80-01)~~

~~Annual Salary  
76,668~~

~~Public Service Administrator  
(Pos. No. 37015-25-61-140-90-01)~~

~~Annual Salary  
74,904~~

(Source: Amended at 29 Ill. Reg. 14166, effective September 9, 2005)

## SUBPART C: MERIT COMPENSATION SYSTEM

**Section 310.410 Jurisdiction**

The Merit Compensation System shall apply to all classes of positions designated below and in the ALPHABETIC INDEX OF POSITION TITLES. Also see Section 310.495 for the application of the Merit Compensation System for those Broad-Band titles listed with their salary ranges in Section 310.Appendix G.

Position Title	Salary Plan
Accountant Supervisor	MC-05
Activity Therapist Supervisor	MC-07
Actuary III	MC-16
Administrative Assistant I	MC-04
Administrative Assistant II	MC-06
Agricultural Marketing Representative	MC-05
Assignment Coordinator	MC-07
Assistant Automotive Shop Supervisor	MC-03
Automotive Shop Supervisor	MC-07
Boat Safety Inspection Supervisor	MC-06
Building Construction Inspector I	MC-04
Building Construction Inspector II	MC-05
Business Manager	MC-05

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Commerce Commission Police Sergeant	MC-07
Corrections Leisure Activities Specialist III	MC-06
Corrections Leisure Activities Specialist IV	MC-07
Corrections Vocational School Supervisor	MC-05
Court Reporter Supervisor	MC-08
Data Processing Supervisor II	MC-04
Data Processing Supervisor III	MC-07
Dietary Manager I	MC-03
Dietary Manager II	MC-05
Disability Claims Analyst	MC-06
Economic Development Representative I	MC-05
Economic Development Representative II	MC-07
Elections Specialist I	MC-03
Elections Specialist II	MC-05
Elections Specialist III	MC-07
Electrical Engineer	MC-10
Employment Security Field Office Supervisor	MC-06
Engineering Technician IV	MC-07
Executive I	MC-05
Executive II	MC-07
Executive Secretary II	MC-01
Executive Secretary III	MC-02
Facility Fire Chief	MC-02
Guard Supervisor	MC-01
Guardianship Supervisor	MC-07
Highway Construction Supervisor I	MC-07
Highway Construction Supervisor II	MC-09
Historical Library Chief of Acquisitions	MC-06
Human Rights Mediator	MC-05
Human Rights Specialist III	MC-07
Human Services Casework Manager	MC-07
Industrial and Community Development Representative I	MC-05
Industrial and Community Development Representative II	MC-07
Internal Auditor I	MC-05
Internal Security Investigator I	MC-04
Internal Security Investigator II	MC-07
International Marketing Representative I	MC-05
<u>KidCare Supervisor</u>	<u>MC-07</u>

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

<del>Kidcare Supervisor I</del>	<del>MC-06</del>
<del>Kidcare Supervisor II</del>	<del>MC-07</del>
Laundry Manager I	MC-01
Liability Claims Adjuster II	MC-06
Librarian II	MC-05
Lottery Regional Coordinator	MC-07
Management Operations Analyst I	MC-06
Manuscripts Manager	MC-06
Meat and Poultry Inspector Supervisor	MC-05
Mental Health Administrator I	MC-05
Mental Health Administrator II	MC-07
Methods and Procedures Advisor III	MC-07
Mine Rescue Station Supervisor	MC-01
Office Administrator IV	MC-02
Office Administrator V	MC-03
Plumbing Consultant	MC-09
Police Lieutenant	MC-09
Private Secretary I	MC-02
Private Secretary II	MC-04
Property Tax Analyst III	MC-05
Public Aid Family Support Specialist II	MC-05
Public Aid Quality Control Supervisor	MC-07
Public Aid Staff Development Specialist III	MC-06
Public Health Program Specialist III	MC-07
Public Information Coordinator	MC-06
Radiologic Technologist Chief	MC-03
Rehabilitation Workshop Supervisor III	MC-05
Reimbursement Officer II	MC-05
Reproduction Service Supervisor I	MC-02
Reproduction Service Supervisor II	MC-04
Residential Care Program Supervisor I	MC-06
Retirement System Disability Specialist	MC-06
Safety Responsibility Analyst Supervisor	MC-02
Security Officer Chief	MC-04
Security Officer Lieutenant	MC-02
Security Therapy Aide IV	MC-05
Sign Shop Foreman	MC-06
Staff Development Specialist I	MC-05

## DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

## NOTICE OF ADOPTED AMENDMENTS

Staff Development Technician II	MC-03
Statistical Research Specialist III	MC-06
Statistical Research Supervisor	MC-07
Storekeeper III	MC-01
Supervising Vehicle Testing Compliance Officer	MC-06
Switchboard Chief Operator	MC-01
Technical Advisor I	MC-05
Technical Advisor II	MC-07
Telecommunications Supervisor	MC-07
Utility Engineer I	MC-05
Utility Engineer II	MC-07
Vehicle Emissions Compliance Supervisor	MC-05
Volunteer Services Coordinator III	MC-07
Waterways Construction Supervisor I	MC-05
Waterways Construction Supervisor II	MC-07

(Source: Amended at 29 Ill. Reg. 14166, effective September 9, 2005)

## ILLINOIS COMMERCE COMMISSION

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Digital Divide Elimination Infrastructure Fund
- 2) Code Citation: 83 Ill. Adm. Code 759
- 3) 

<u>Section Numbers</u> :	<u>Adopted Action</u> :
759.310	Amendment
759.320	Amendment
- 4) Statutory Authority: Implementing and authorized by Section 13-301.3 of the Public Utilities Act [220 ILCS 5/13-301.3]
- 5) Effective Date of Amendments: September 10, 2005
- 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 Commission's Springfield office and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: 04/08/05; 29 Ill. Reg. 4785
- 10) Has JCAR issued a Statement of Objection to these amendments? No
- 11) Differences between proposal and final version: None
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? No changes were required.
- 13) Will these amendments replace any emergency amendments currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendments: This rulemaking will delete references to the Illinois Procurement Code ("Code") and 44 Ill. Adm. Code 1 (rules implementing the Code) in Sections 759.310 and 759.320. Section 1-10(b)(2) of the Code [30 ILCS 500/1-10(b)(2)] specifically exempts grants from the application of the Code "except for the filing requirements of Section 20-80 [of the Code [20 ILCS 500/20-80]]". In actually formulating a request for grant proposal, the use of those procedures mandated by the

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENTS

Code is likely to cause delays in, and add costs to, the evaluation of grant proposals, as well as adding costs to the proposals themselves.

- 16) Information and questions regarding these adopted amendments shall be directed to:

Conrad S. Rubinkowski  
Office of General Counsel  
Illinois Commerce Commission  
527 East Capitol Avenue  
Springfield IL 62701

(217)785-3922

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

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENTS

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

PART 759  
DIGITAL DIVIDE ELIMINATION INFRASTRUCTURE FUND

SUBPART A: GENERAL PROVISIONS

Section	
759.110	Purpose
759.120	Definitions

SUBPART B: ELIGIBILITY

Section	
759.210	Eligible Entities
759.220	Eligible Uses
759.230	Eligible Areas

SUBPART C: REVIEW OF PROPOSALS

Section	
759.310	Proposal Content
759.320	Selection of Grant Recipients
759.330	Limitations and Obligations
759.340	Reporting

AUTHORITY: Implementing and authorized by Section 13-301.3 of the Public Utilities Act [220 ILCS 5/13-301.3].

SOURCE: Adopted at 27 Ill. Reg. 5735, effective April 1, 2003; amended at 29 Ill. Reg. 3019, effective March 1, 2005; amended at 29 Ill. Reg. 14183, effective September 10, 2005.

SUBPART C: REVIEW OF PROPOSALS

**Section 759.310 Proposal Content**

- a) Subject to appropriation and availability of funds, the Commission shall issue a Request for Grant Proposal ~~that, pursuant to the Illinois Procurement Code [30~~

## ILLINOIS COMMERCE COMMISSION

## NOTICE OF ADOPTED AMENDMENTS

~~ILCS 500], which~~ shall include instructions and formats for the submission of grant proposals.

- b) Proposal items: The grant proposal shall be docketed and shall include, at a minimum, the following sections:
- 1) A cover page;
  - 2) Ownership information of the applicant;
  - 3) An executive summary of the proposal;
  - 4) A description of the applicant, demonstrating that the applicant is an eligible entity (see Section 759.210);
  - 5) Current financial information for the applicant;
  - 6) The location of the proposed infrastructure project and a description of the area as it relates to the eligible area criteria. (see Section 759.230.);
  - 7) A description of the proposed infrastructure project, including its social and economic benefits;
  - 8) A detailed project budget and schedule by task, including a proposed completion date.

(Source: Amended at 29 Ill. Reg. 14183, effective September 10, 2005)

**Section 759.320 Selection of Grant Recipients**

Grantees shall be competitively selected by the Commission ~~pursuant to the Illinois Procurement Code and the Standard Procurement Rules (44 Ill. Adm. Code 1)~~. The Commission shall use the following criteria when reviewing proposals and awarding grants:

- a) The technical, financial and managerial resources and abilities of the applicant;
- b) The economic justification for the project, which includes the social and economic benefits of the project; and
- c) The location of the project.

ILLINOIS COMMERCE COMMISSION

NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 29 Ill. Reg. 14183, effective September 10, 2005)

## 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 Number:</u>	<u>Adopted Action:</u>
Section 2008.10	Amendment
Section 2008.35	New Section
Section 2008.40	Amendment
Section 2008.50	Amendment
Section 2008.60	Amendment
Section 2008.70	Amendment
Section 2008.71	Amendment
Section 2008.72	Amendment
Section 2008.73	Amendment
Section 2008.74	Amendment
Section 2008.75	Amendment
Section 2008.80	Amendment
Section 2008.81	Amendment
Section 2008.90	Amendment
Section 2008.100	Amendment
Section 2008.102	Amendment
Section 2008.APPENDIX B	Amendment
Section 2008.APPENDIX C	Amendment
Section 2008.APPENDIX D	Amendment
Section 2008.APPENDIX E	Amendment
Section 2008.APPENDIX F	Amendment
Section 2008.APPENDIX G	Amendment
Section 2008.APPENDIX H	Amendment
Section 2008.APPENDIX I	Amendment
Section 2008.APPENDIX J	Amendment
Section 2008.APPENDIX K	Amendment
Section 2008.APPENDIX L	Amendment
Section 2008.APPENDIX M	Renumbered, New Section
Section 2008.APPENDIX N	Renumbered, New Section
Section 2008.APPENDIX O	Renumbered
Section 2008.APPENDIX P	Renumbered
Section 2008.APPENDIX Q	Renumbered
Section 2008.APPENDIX R	Renumbered, Amendment
Section 2008.APPENDIX S	Renumbered, Amendment

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

Section 2008.APPENDIX T	Renumbered
Section 2008.APPENDIX U	Renumbered
Section 2008.APPENDIX V	Renumbered, Amendment

- 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 Amendments: September 8, 2005
- 6) Do these amendments contain an automatic repeal date? No
- 7) Do these amendments contain incorporations by reference? No
- 8) A copy of the adopted amendments, 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: May 27, 2005; 29 Ill. Reg. 7254
- 10) Has JCAR issued a Statement of Objection to these amendments? No
- 11) Differences between proposal and final version:
  - a) In the Table of Contents, add "2008.35 Effective Date".
  - b) In the Table of Contents, where Section 2008.APPENDIX H is identified, strike "\*\*\*" following "F".
  - c) In the Table of Contents, where Section 2008.APPENDIX L is identified, strike "\*\*\*" following "J".
  - d) A new Section entitled "**Section 2008.35 Effective Date**" has been added which reads:

"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."
  - e) Section 2008.71(b)(3), on the sixth line, add a period following "days" and also add "The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance".
  - f) Section 2008.72(e)(7) and (12) strike the asterisk.
  - g) Section 2008.73(m)(2) add "(1)" following "(m)".

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

- h) Section 2008.73(n)(2) strike "this" and change the subsection cross reference from "(m)" to "(n)" add "(2)" following "(n)".
- i) Section 2008.100(a)(2) move "A" down to the next line and allow "To the best of your knowledge; z" to remain where it is, as a stand alone introduction to the questions that follow. "To the best of your knowledge" has been eliminated from the remaining questions that follow. Change "Ai", "ii", "iii", to "A", "B" and "C". Change "B" to "D" and "Ci" to "E". Change "ii", "iii" and "iv" to "I", "ii" and "iii". Also change "Di", "ii" and "iii" to "F", "i" and "ii". And finally, change "E" to "G".
- j) Section 2008.APPENDIX B, in the table, add a row below the third and sixth row. There will be nothing in these rows for Plans A-E on the first page of the table, however placement of the columns and rows in the overall table is what's important. If the entire table could be viewed in landscape format, then the columns and rows would be lined-up as required. On the second page of the table, in the line that places these Plans in alphabetical order, strike the second asterisk for both Plan "F" and "J". Also in the text under the table, strike both asterisks on this first line twice and on the second line once. On the third page of this Appendix in the table heading strike both asterisks following "K" and "L". In the last row of the "K" column, change "\$[4000]" to "\$[\_\_\_\_\_]". In the last row of the "L" column, change "\$[2000]" to "\$[\_\_\_\_\_]".
- k) 2008.APPENDIX C, in the table, in the "**HOSPITALIZATION\***" row, where "- Additional 365 days" appears go to the "**YOU PAY**" column, and change "\$0" to "\$0\*\*". Immediately under this table add \*\*\* 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. In the next table, in the "**MEDICAL EXPENSES**" row, change "\$100..." to "\$[100]" in both the "**SERVICES**" and "**YOU PAY**" columns. Also in the "**CLINICAL LABORATORY SERVICES**" row, add "\$0" and strike "\$10" in the "**YOU PAY**" column. Atop of the next table add under the "**PARTS A & B**" heading add:

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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- l) Section 2008.APPENDIX D, in the table, in the "**HOSPITALIZATION\***" row, where "- Additional 365 days" appears go to the "**YOU PAY**" column, and change "\$0" to "\$0\*\*". Immediately under this table add \*\*\* 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

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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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." Atop of the next table add the following headings under the "PARTS A & B" heading:

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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- m) Section 2008.APPENDIX E, in the table, in the "HOSPITALIZATION\*" row, where "- Additional 365 days" appears go to the "YOU PAY" column, and change "\$0" to "\$0\*\*". Immediately under this table add **\*\* 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." Atop of the next table add the following headings under the "PARTS A & B" heading:

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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In the table, in the "HOME HEALTH CARE" row, in the first column add an asterisk following "First \$[100] of Medicare Approved Amounts". In the next block, in the "FOREIGN TRAVEL – NOT COVERED BY MEDICARE" row, change "First [\$ \_\_\_\_]" to "First { \$250 }". In the corresponding "YOU PAY" column change "[ \$ \_\_\_\_ ]" to "{ \$250 }". Also, the last entry in both the "PLAN PAYS" and "YOU PAY" column change "[ \$ \_\_\_\_ ]" to "{ \$50,000 }".

- n) Section 2008.APPENDIX F, in the table, in the "HOSPITALIZATION\*" row, where "- Additional 365 days" appears go to the "YOU PAY" column, and change "\$0" to "\$0\*\*". Immediately under this table add **\*\* 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." Atop of the next table add the following headings under the "PARTS A & B" heading:

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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In this table, in the "AT HOME RECOVERY ... " add **COVERED** and **strike** **COVERD**". Also, where "- Benefit for each visit" appears, go to the "PLAN PAYS" column, and change "[ \$ \_\_\_\_ ]" to "{ \$40 }". Additionally, the last entry in this column should be changed from "[ \$ \_\_\_\_ ]" to "{ \$1,600 }". In the next table, in the "FOREIGN TRAVEL – NOT COVERED BY MEDICARE" row, change "First [\$ \_\_\_\_]" to "First { \$250 }". In the corresponding "YOU PAY" column change "[ \$ \_\_\_\_ ]" to "{ \$250 }". Also, the

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last entry in both the "PLAN PAYS" and "YOU PAY" column change "\$\_\_\_\_\_" to "{\$50,000}".

- o) Section 2008.APPENDIX G, in the "HOSPITALIZATION\*" row, where "- Additional 365 days" appears go to the "YOU PAY" column, and change "\$0" to "\$0\*\*\*". Immediately under the table add **\*\*\* 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.** In the next table, in the "MEDICAL EXPENSES" row, where "First [\$100]" appears, under the "PLAN PAYS" column add "\$0" and strike "\$100 (Part B Deductible)". Also under the "YOU PAY" column add "\$[100] (Part B Deductible)" and strike "\$0". Atop of the next table add the following headings under the "PARTS A & B" heading:

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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In this table, in the "FOREIGN TRAVEL – NOT COVERED BY MEDICARE" row, change "First [\$\_\_\_\_]" to "First {\$250}". In the corresponding "YOU PAY" column change "\$\_\_\_\_\_" to "{\$250}". Also, the last entry in both the "PLAN PAYS" and "YOU PAY" column change "\$\_\_\_\_\_" to "{\$50,000}". In the next block, add "\*\*\*" before "PREVENTIVE MEDICAL CARE BENEFIT – ". Also change "- First [\$\_\_\_\_]" to "- First {\$120}" and strike the dash immediately there under as well. In the corresponding "PLAN PAYS" column change "\$\_\_\_\_\_" to "{\$120}". Finally, move the following text under the last table in this Appendix "\* Medicare benefits are subject to change. Please consult the latest Guide to Health Care insurance for People with Medicare." add an asterisk before the existing asterisk so there are two.

- p) Section 2008.APPENDIX H, in the heading for this Section, strike the double asterisk following "F". Add an open bracket at the beginning of the line that begins with two asterisks and a close bracket following the period. In the table, in the "HOSPITALIZATION\*" row, where "- Additional 365 days" appears, go to the "YOU PAY" column, and change "\$0" to "\$0\*\*\*". Immediately under this table add **\*\*\* 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.** In the title of the next table, strike the double asterisk following "F". In the next table, in the "**Part B Excess Charges**"

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row, the end "IN ADDITION TO [\$\_] DEDUTIBLE\*\*] YOU PAY" column, change "All costs" to "\$0". Atop of the next table add the following headings under the "PARTS A & B" heading:

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$_] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$_] DEDUCTIBLE**] YOU PAY
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In the next table, in the third column heading add an open bracket ahead of "AFTER" and a close bracket following "DEDUCTIBLE\*\*". In the fourth column heading add an open bracket ahead of "IN" and a close bracket following "DEDUCTIBLE\*\*". Also in the "FOREIGN TRAVEL – NOT COVERED BY MEDICARE" row, change "First [\$\_\_\_\_\_]" to "First { \$250 }". In the corresponding "[IN ADDITION TO [\$\_] DEDUCTIBLE\*\*] YOU PAY " column change "[ \$\_\_\_\_\_]" to "{ \$250 }". Finally, the last entry in both the "[AFTER YOU PAY [\$\_] DEDUCTIBLE\*\*] PLAN PAYS" and "[IN ADDITION TO [\$\_] DEDUCTIBLE\*\*] YOU PAY" column change "[ \$\_\_\_\_\_]" to "{ \$50,000 }".

- q) Section 2008.APPENDIX I, in the "HOSPITALIZATION\*" row, where "- Additional 365 days" appears, go to the "YOU PAY" column, and change "\$0" to "\$0\*\*". Immediately under this table add \*\*\* 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. Under the "PARTS A & B" heading add:

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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In this table, in the "HOME HEALTH CARE (con't)" row, where "- Benefit for each visit" appears, go to the "PLAN PAYS" column, and change "[ \$\_\_\_\_\_]" to "{ \$40 }". Also, the last entry in this column should be changed from "[ \$\_\_\_\_\_]" to "{ \$1,600 }". Atop of this last table add the following headings:

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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In the "FOREIGN TRAVEL – NOT COVERED BY MEDICARE" row, change "First [\$\_\_\_\_\_]" to "First { \$250 }". In the corresponding "YOU PAY" column change "[ \$\_\_\_\_\_]" to "{ \$250 }". Also, the last entry in both the "PLAN PAYS" and "YOU PAY" column change "[ \$\_\_\_\_\_]" to "{ \$50,000 }".

- r) Section 2008.APPENDIX J, in the table, in the "HOSPITALIZATION\*" row, where "- Additional 365 days" appears, go to the "YOU PAY" column, and change "\$0" to "\$0\*\*". In the "SKILLED NURSING FACILITY ..." row, in the "YOU PAY" column change "\$0\*\*" to "\$0". Immediately under this table add \*\*\* NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare

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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." Atop of the next table add the following headings under the "PARTS A & B" heading:

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
----------	---------------	-----------	---------

In the last table, in the "FOREIGN TRAVEL – NOT COVERED BY MEDICARE" row, change "First [\$\_\_\_\_\_]" to "First {\$250}". In the corresponding "YOU PAY" column change "[\$\_\_\_\_\_]" to "{\$250}". Also, the last entry in both the "PLAN PAYS" and "YOU PAY" column change "[\$\_\_\_\_\_]" to "{\$50,000}".

- s) Section 2008.APPENDIX K, in the table, in the "HOSPITALIZATION\*" row, where "- Additional 365 days" appears, go to the "YOU PAY" column, and change "\$0" to "\$0\*\*". Immediately under this table add **\*\*\* 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.** In this table, in the "AT HOME RECOVERY ... " add **"COVERED" and strike "COVERD"**. Where "- Benefit for each visit" appears, go to the "PLAN PAYS" column, and change "[\$\_\_\_\_\_]" to "{\$40}". Also, the last entry in this column should be changed from "[\$\_\_\_\_\_]" to "{\$1,600}". Atop of the next table add the following headings under the "PARTS A & B" heading:

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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In the last table, in the "FOREIGN TRAVEL – NOT COVERED BY MEDICARE" row, change "First [\$\_\_\_\_\_]" to "First {\$250}". In the corresponding "YOU PAY" column change "[\$\_\_\_\_\_]" to "{\$250}". Also, the last entry in both the "PLAN PAYS" and "YOU PAY" column change "[\$\_\_\_\_\_]" to "{\$50,000}". Also in this column strike the asterisk following "Charges".

- t) Section 2008.APPENDIX L, in the heading of this Section strike the double asterisk following "J". In the paragraph marked with two asterisks, on the fifth line strike "separate prescription drug deductible or the plan's" and delete "outpatient". Also add a close bracket following the period. In the table, in the "HOSPITALIZATION\*" row, where "- Additional 365 days" appears, go to the "YOU PAY" column, and change "\$0" to "\$0\*\*\*". Immediately under this table add **\*\*\* 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**

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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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." In the heading for the next table strike both asterisks following "J". Atop of the next table add the following headings under the "PARTS A & B" heading:

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$ ] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$ ] DEDUCTIBLE**] YOU PAY
----------	---------------	--	---

In the third table delete the cell line which divides "HOME HEALTH CARE" from "MEDICARE APPROVED SERVICES". Also in this column add "COVERED" and strike "COVERD". Where "- Benefit for each visit" appears, go to the "[AFTER YOU PAY [\$ ] DEDUCTIBLE\*\*] PLAN PAYS" column, and change "[\$ ]" to "{\$40}". Also, the last entry in this column should be changed from "[\$ ]" to "{\$1,600}". Move the following text under the last table in this Appendix "\*\*\*\* Medicare benefits are subject to change. Please consult the latest Guide to Health Care insurance for People with Medicare." add an asterisk before the existing asterisk so there are two. Atop of the last table add the following headings under "OTHER BENEFITS – NOT COVERED BY MEDICARE":

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$ ] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$ ] DEDUCTIBLE**] YOU PAY
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In the table, in the "FOREIGN TRAVEL – NOT COVERED BY MEDICARE" row, change "First [\$ ]" to "First {\$250}". In the corresponding "[IN ADDITION TO [\$ ] DEDUCTIBLE\*\*] YOU PAY" column change "[\$ ]" to "{\$250}". Also in the "FOREIGN TRAVEL – NOT COVERED BY MEDICARE" column strike the asterisk following "Charges" and in the corresponding "[AFTER YOU PAY [\$ ] DEDUCTIBLE\*\*] PLAN PAYS" and "[IN ADDITION TO [\$ ] DEDUCTIBLE\*\*] YOU PAY" columns change "[\$ ]" to "{\$50,000}". In the next block, add two asterisks ahead of "\*PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE" under the "SERVICES" column. Also strike "[\$ ]" and in the corresponding "[AFTER YOU PAY [\$ ] DEDUCTIBLE\*\*] PLAN PAYS" column and strike "[\$ ]" and add "\$120".

- u) Section 2008.APPENDIX M, add the following paragraph at the top of this Appendix: "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." In the next paragraph, on the second line change "\$[4000]" to "\$[ ]". In the table, in the second, third and fourth columns the numbers have been adjusted to line-up with the first column as well

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as having added brackets to dollars amounts as appropriate. In the "**SKILLED NURSING FACILITY ...**" block, in the "21st thru 100th day" row, in the "**MEDICARE PAYS**" column change "\$[109.50]" to "\$[\_\_\_\_\_]". Immediately under this table add an asterisk ahead of the two existing asterisks in the "**NOTICE**" paragraph. In the next table, in the "**Part B Excess Charges**" row, in the "**YOU PAY**" column change " [\$4000]" to "\$[\_\_\_\_\_]". Immediately under this table, on the second line change "[4000]" to "\$[\_\_\_\_\_]". In the last table, in the "**HOME HEALTH CARE**" column change "1<sup>st</sup>" to "first". In the second table, in the "**Part B Excess Charges**" row, in the "**YOU PAY**" column, change "\$[2000]" to "\$[\_\_\_\_\_]". Immediately under this table, in the paragraph on the first line change "\$[2000]" to "\$[\_\_\_\_\_]".

- v) Section 2008.APPENDIX N, in the second paragraph, on the second line change "\$[2000]" to "\$[\_\_\_\_\_]". In the table, in the "**SKILLED NURSING FACILITY ...**" block, in the "21st thru 100th day" row, in the "**MEDICARE PAYS**" column add an open bracket after the dollar sign. In the next table, in the "**BLOOD**" block, in the "Next \$[100] ..." row, in the "**MEDICARE PAYS**" column strike the asterisks.
- w) Section 2008.APPENDIX V, immediately under the Section heading add "Companies shall provide one of the following disclosures as prescribed by the directions contained in paragraph (o)." and strike the remaining text. In 2008.Appendix V (a), (b), (c), (d), (e), (f) and (g) add "Original disclosure statement for" and strike "For". In 2008.Appendix V (a) delete the following proposed text "Some health care services paid for by Medicare may also trigger the payment of benefits from this policy." and also "This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance." In (b) strike "- hospice.". In (e) add a dash in front of the "For more information ...." item. In (a) through (g), under the heading of "**Before You Buy This Insurance**", following "contact" add "your state insurance department or state [senior][health] insurance [counseling] [assistance] program [SHIP]" and strike "Senior Health Insurance Program through" and delete "the Divisions of Insurance". Also in (a) through (g) the order of "**These include:**" have been shuffled for consistency throughout this Appendix. The following text has been added as a new (h) and all subsequent subsections were alphabetically re-ordered accordingly:

"h) Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**  
**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

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**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.****Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services.

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.****Before You Buy This Insurance**

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP].

- w) In Section 2008.APPENDIX V (i), add "Alternative disclosure statement for" and delete "For".
- x) In Section 2008.APPENDIX V (i) through (n), under the "**Before You Buy This Insurance**" heading add "For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP]." And delete the proposed text.
- y) In Section 2008.APPENDIX V, add new (o) as follows:

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- o) Instructions for use of the disclosure statements for health insurance policies sold to Medicare beneficiaries that duplicate Medicare.
- 1) Section 1882 (d) of the federal Social Security Act (42 USC 1395ss) prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
  - 2) All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format type size, type proportional spacing, bold character, line spacing, and usage of boxes around text from those presented in the disclosure statements.
  - 3) State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
  - 4) Property/casualty and life insurance policies are not considered health insurance.
  - 5) Disability income policies are not considered to provide benefits that duplicate Medicare.
  - 6) Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
  - 7) The federal law does not preempt state laws that are more stringent than the federal requirements.
  - 8) The federal law does not preempt existing state form filing requirements.
  - 9) Section 1882 of the federal Social Security Act was amended in subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original

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disclosure statements or the alternative disclosure statements and not use both simultaneously.

- 10) In the disclosure language included under the heading **Before You Buy This Insurance**, that reads: "For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP]," insurers are to insert reference to the state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005."

In addition to the changes listed above, subpart headings were added throughout the Part for Subparts A through G.

- 12) Have all changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will these amendments replace an emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of rulemaking? With passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), there was an immediate need for states to amend their Medigap regulations in order to maintain certification of their regulatory programs. The regulatory framework for Medigap insurance is complex, but states will retain authority over this insurance product provided that their respective regulatory programs meet the minimum standards set forth by both the NAIC Medicare Supplement Insurance Minimum Standards Model Act (model Act) and its companion Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (model regulation) as authorized by federal law.

MMA impacts state Medigap regulations in many significant ways. For example, prescription drug benefits have been stripped from standard Medigap plans H, I, J and J with a high deductible (and prestandardized plans with prescription drug coverage, and waived state plans with prescription drug coverage) for current Medigap prescription drug plan insureds who choose to enroll in the new Medicare prescription drug program (Part D) after December 31, 2005. Issuers of Medigap plans H, I, J and J with a high deductible will be prohibited from offering prescription drug benefits to new enrollees after December 31, 2005.

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In addition, two new Medigap Plans, "K" and "L," featuring reduced first-dollar coverage, have been added to the current 10 + 2 standardized plans. Finally, other corresponding housekeeping changes have been made to Part 2008 as required for compliance with MMA.

- 16) Information and questions regarding these adopted amendments shall be directed to:

Cindy Colonius  
Department of Financial and Professional Regulation  
Division of Insurance  
320 West Washington Street  
Springfield, Illinois 62767-0001

(217) 524-0663

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

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## TITLE 50: INSURANCE

CHAPTER I: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION  
INSURANCE

## SUBCHAPTER Z: ACCIDENT AND HEALTH INSURANCE

## PART 2008

MINIMUM STANDARDS FOR INDIVIDUAL  
AND GROUP MEDICARE SUPPLEMENT INSURANCESUBPART A: GENERAL PROVISIONS

## Section

2008.10	Authority
2008.20	Purpose
2008.30	Applicability and Scope
<u>2008.35</u>	<u>Effective Date</u>
2008.40	Definitions

SUBPART B: COVERAGE, POLICY & BENEFIT PROVISIONS

2008.45	Creditable Coverage
2008.50	Policy Definitions and Terms
2008.60	Policy Provisions
2008.61	Benefit Conversion Requirements During Transition (Repealed)
2008.70	Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to the Effective Date of this Part
2008.71	Benefit Standards for Policies or Certificates Issued or Delivered on or After the Effective Date of this Part
2008.72	Standard Medicare Supplement Benefit Plans
2008.73	Medicare Select Policies and Certificates

SUBPART C: ENROLLMENT & ELIGIBILITY

2008.74	Open Enrollment
2008.75	Guaranteed Issue for Eligible Persons

SUBPART D: CLAIMS, REFUNDS & CREDITS

2008.76	Standards for Claims Payment
2008.80	Loss Ratio Standards and Refund or Credit of Premium

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SUBPART E: RATES, COMPENSATION AGREEMENTS,  
DISCLOSURE, REPLACEMENT & MARKETING

- 2008.81 Filing and Approval of Policies and Certificates and Premium Rates  
 2008.82 Permitted Compensation Arrangements  
 2008.90 Required Disclosure Provisions  
 2008.91 Instructions for Use of the Disclosure Statements for Health Insurance Policies  
 Sold to Medicare Beneficiaries that Duplicate Medicare  
 2008.100 Requirements for Application Forms and Replacement Coverage  
 2008.101 Standards for Marketing  
 2008.102 Appropriateness of Recommended Purchase and Excessive Insurance

SUBPART F: REPORTING & PROHIBITIONS

- 2008.103 Reporting of Multiple Policies  
 2008.104 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods  
 and Probationary Periods in Replacement Policies or Certificates

SUBPART G: MISCELLANEOUS PROVISIONS

- 2008.110 Severability  
 2008.120 Effective Date (Repealed)
- 2008.APPENDIX A Policy Checklist  
 2008.APPENDIX B Outline of Medicare Supplement Coverage – Cover Page  
 2008.APPENDIX C Plan A  
 2008.APPENDIX D Plan B  
 2008.APPENDIX E Plan C  
 2008.APPENDIX F Plan D  
 2008.APPENDIX G Plan E  
 2008.APPENDIX H Plan F or High Deductible Plan F\*\*  
 2008.APPENDIX I Plan G  
 2008.APPENDIX J Plan H  
 2008.APPENDIX K Plan I  
 2008.APPENDIX L Plan J or High Deductible Plan J\*\*  
 2008.APPENDIX M [Plan K Notice to Applicant Regarding Replacement of Accident  
and Sickness Insurance](#)  
 2008.APPENDIX N [Plan L Medicare Supplement Refund Calculation Format](#)  
 2008.APPENDIX O Notice of Medicare Changes ([Renumbered](#))

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<a href="#">2008.APPENDIX P</a>	Medicare Supplement Policies Report ( <a href="#">Renumbered</a> )
<a href="#">2008.APPENDIX Q</a>	Disclosure Statements ( <a href="#">Renumbered</a> )
<a href="#">2008.APPENDIX R</a>	<a href="#">Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage</a>
<a href="#">2008.APPENDIX S</a>	<a href="#">Medicare Supplement Refund Calculation Format</a>
<a href="#">2008.APPENDIX T</a>	<a href="#">Notice of Medicare Changes</a>
<a href="#">2008.APPENDIX U</a>	<a href="#">Medicare Supplement Policies Report</a>
<a href="#">2008.APPENDIX V</a>	<a href="#">Disclosure Statements</a>

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

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.

### SUBPART A: GENERAL PROVISIONS

#### **Section 2008.10 Authority**

This Part is issued by the Director [of the Department of Financial and Professional Regulation-Division](#) of Insurance ([Director](#)) pursuant to Section 401 of the Illinois Insurance Code [215 ILCS 5/401] which empowers the Director to make reasonable rules and regulations as may be necessary for making effective the insurance laws of this State. This Part implements Sections 363 and 363a of the Illinois Insurance Code [215 ILCS 5/363 and 363a].

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

#### **Section 2008.35 Effective Date**

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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: Added at 29 Ill. Reg. 14188, effective September 8, 2005)

**Section 2008.40 Definitions**

For the purposes of this Part:

Applicant means:

*in the case of an individual Medicare supplement policy, the person who 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~~~~Medicare+Choice~~ 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] and any of the Acts in Chapter 215 of the Illinois Compiled Statutes.~~

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.

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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 Medicare supplement policies or certificates.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Advantage~~Medicare+Choice~~ 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~~Medicare+Choice~~ medical savings account; and

Medicare Advantage~~Medicare+Choice~~ 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).

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

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

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

SUBPART B: COVERAGE, POLICY & BENEFIT PROVISIONS

**Section 2008.50 Policy Definitions and Terms**

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this Section.

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

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

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

"Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program.

"Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program.

"Duplication of Insurance" means a transaction wherein new accident and health

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insurance is to be purchased and it is known to the producer or should be known to the producer or the issuer, in the case of a direct response solicitation, that the new insurance will provide some of the benefits or coverages which the proposed insured already has under existing accident and health insurance.

"Health Care Expenses", for purposes of Section 2008.80, means expenses of a nonprofit health, hospital or medical service corporation, prepaid health plan or similar organization associated with the delivery of health care services in which providers of the health care services are reimbursed for such services on an other than fee for service basis which are analogous to incurred losses of insurers. ~~Such expenses shall not include:~~

~~Home office and overhead costs,  
Advertising costs,  
Commissions and other acquisition costs,  
Taxes,  
Capital costs,  
Administrative costs, and  
Claims processing costs.~~

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

"Medicare" shall be defined in the policy and certificate as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended", or "Title I, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

"Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

"Over-Insurance" means "duplication" of insurance to such extent that the combination of the existing insurance and the proposed insurance would substantially exceed any loss reasonably expected to be incurred.

"Physician" shall not be defined more restrictively than as defined in the Medicare

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program.

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

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

**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) 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](#)

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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 enrollment, accounting for any claims paid, if applicable.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

**Section 2008.70 Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to 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 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 amount and copayment percentage factors. Premiums may be

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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
  - 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 ~~of Insurance for this State~~, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.
  - 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

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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 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

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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;
- 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 29 Ill. Reg. 14188, effective September 8, 2005)

**Section 2008.71 Benefit Standards for Policies or Certificates Issued or Delivered on or After 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 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

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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 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 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

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group, the issuer shall:

- i) Offer the certificateholder the conversion opportunity described in 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;~~and~~
- 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, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within 90 days after the date the

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individual becomes entitled to such assistance.

- 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 Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or 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) Reinstatement 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~~which~~ is substantially equivalent to coverage in effect before the date of ~~thesueh~~ 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
  - iii) Shall provide for classification of premiums on terms at

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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 ~~All~~ 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, Diagnostic Related Group (DRG) day-outlier per diem 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.

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- 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.
- 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

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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 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) below and patient education to address preventive health care measures; and-
  - B) Preventive ~~Any one or a combination of the following preventive screening tests or preventive services, the~~ selection and frequency of which is determined to be considered medically appropriate by the attending physician;:-
    - i) ~~Digital rectal examination;~~
    - ii) ~~Dipstick urinalysis for hematuria, bacteriuria and proteinuria;~~
    - iii) ~~Pure tone (air only) hearing screening test, administered or ordered by a physician;~~
    - iv) ~~Serum cholesterol screening (every 5 years);~~
    - v) ~~Thyroid function test;~~
    - vi) ~~Diabetes screening.~~
  - ~~C) Tetanus and Diphtheria booster (every 10 years);~~
  - ~~D) Any other tests or preventive measures determined appropriate by~~

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~~the attending physician.~~

- ~~CE~~) 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 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

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- 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.

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

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- 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 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);

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- 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 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.
- 11) ~~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. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost effective, and~~

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~~offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.~~

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

**Section 2008.72 Standard Medicare Supplement Benefit 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 2008.71 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)(e)(11) of Section 2008.71~~ 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 ~~subsections (b) and (c) of~~ 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.
- e) Make-up of benefit plans:
  - 1) Standardized Medicare supplement benefit ~~Planplan~~ "A" shall be limited to the Basic ("Core") Benefits Common to all Benefit Plans, as defined in ~~subsection (b) of~~ Section 2008.71 ~~(b)~~ of this Part.
  - 2) Standardized Medicare supplement benefit ~~Planplan~~ "B" shall include only the following: The Core Benefit as defined in ~~subsection (b) of~~ Section 2008.71 ~~(b)~~ of this Part, plus the Medicare Part A Deductible as defined in ~~subsection (e)(1) of~~ Section 2008.71 ~~(c)(1)~~ of this Part.
  - 3) Standardized Medicare supplement benefit ~~Planplan~~ "C" shall include only the following: The Core Benefit as defined in ~~subsection (b) of~~ Section

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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 ~~subsections (e)(1), (2), (3) and (8) of~~ Section 2008.71(c)(1), (2), (3) and (8) of this Part respectively.

- 4) Standardized Medicare supplement benefit ~~Planplan~~ "D" shall include only the following: The Core Benefit as defined in ~~subsection (b) of~~ 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 ~~subsections (e)(1), (2), (8) and (10) of~~ Section 2008.71(c)(1), (2), (8) and (10) of this Part respectively.
- 5) Standardized Medicare supplement benefit ~~Planplan~~ "E" shall include only the following: The Core Benefit as defined in ~~subsection (b) of~~ 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 ~~subsections (e)(1), (2), (8) and (9) of~~ Section 2008.71(c)(1), (2), (8) and (9) of this Part respectively.
- 6) Standardized Medicare supplement benefit ~~Planplan~~ "F" shall include only the following: The Core Benefit as defined in ~~subsection (b) of~~ 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 ~~subsections (e)(1), (2), (3), (5) and (8) of~~ Section 2008.71(c)(1), (2), (3), (5) and (8) of this Part respectively.
- 7) Standardized Medicare supplement benefit high deductible ~~Planplan~~ "F\*" shall include only the following: 100% of covered expenses following the payment of the annual high deductible ~~Planplan~~ "F\*" deductible. The covered expenses include the Core Benefit as defined in ~~subsection (b) of~~ 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 ~~subsections (e)(1), (2), (3), (5) and (8) of~~ Section 2008.71(c)(1), (2), (3), (5) and (8) respectively. The annual high deductible ~~Planplan~~ "F\*" deductible shall consist of out-of-pocket

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expenses, other than premiums, for services covered by the Medicare supplement ~~Planplan~~ "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible ~~Planplan~~ "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 ~~Planplan~~ "G" shall include only the following: The Core Benefit as defined in ~~subsection (b) of~~ 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 ~~subsections (e)(1), (2), (4), (8) and (10) of~~ Section 2008.71(~~c~~)(1), (2), (4), (8) and (10) of this Part respectively.
- 9) Standardized Medicare supplement benefit ~~Planplan~~ "H" shall consist of only the following: The Core Benefit as defined in ~~subsection (b) of~~ 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 ~~subsections (e)(1), (2), (6) and (8) of~~ 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 ~~Planplan~~ "I" shall consist of only the following: The Core Benefit as defined in ~~subsection (b) of~~ 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 Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in ~~subsections (e)(1), (2), (5), (6), (8) and (10) of~~ 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 ~~Planplan~~ "J" shall consist of

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only the following: The Core Benefit as defined in ~~subsection (b) of~~ 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 ~~subsections (c)(1), (2), (3), (5), (7), (8), (9) and (10) of~~ 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 ~~Planplan~~ "J\*" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible ~~Planplan~~ "J\*" deductible. The covered expenses include the Core Benefit as defined in ~~subsection (b) of~~ 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 ~~subsections (c)(1), (2), (8) and (10) of~~ Section 2008.71(c)(1), (2), (8) and (10) respectively. The annual high deductible ~~Planplan~~ "J\*" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement ~~Planplan~~ "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);

- 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).

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- 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 29 Ill. Reg. 14188, effective September 8, 2005)

**Section 2008.73 Medicare Select Policies and Certificates**

- a) This Section shall apply to Medicare Select policies and certificates, as defined in this Section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Section.
- b) For the purposes of this Section:
- 1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.
  - 2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.
  - 3) "Medicare Select Issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.
  - 4) "Medicare Select Policy" or "Medicare Select Certificate" means respectively a Medicare supplement policy or certificate that contains restricted network provisions.
  - 5) "Network Provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.
  - 6) "Restricted Network Provision" means any provision which conditions the

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payment of benefits, in whole or in part, on the use of network providers.

7) "Service Area" means the geographic area approved by the Director within which an issuer is authorized to offer a Medicare Select policy.

- c) The Director ~~of Insurance~~ may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Director finds that the issuer has satisfied all of the requirements of this Part.
- d) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the Director ~~of Insurance~~ ~~of Insurance~~.
- e) A Medicare Select issuer shall file a proposed plan of operation with the Director ~~of Insurance~~ in a format prescribed by the Director. The plan of operation shall contain at least the following information:
- 1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:
    - A) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.
    - B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:
      - i) To deliver adequately all services that are subject to a restricted network provision; or
      - ii) To make appropriate referrals.
    - C) There are written agreements with network providers describing specific responsibilities.

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- D) Emergency care is available ~~twenty-four (24)~~ hours per day and ~~seven (7)~~ days per week.
- E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subsection shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.
- 2) A statement or map providing a clear description of the service area.
- 3) A description of the grievance procedure to be utilized.
- 4) A description of the quality assurance program, including:
- A) The formal organizational structure;
- B) The written criteria for selection, retention and removal of network providers; and
- C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.
- 5) A list and description, by specialty, of the network providers.
- 6) Copies of the written information proposed to be used by the issuer to comply with subsection (i) ~~below~~.
- 7) Any other information requested by the Director ~~of Insurance~~.
- f) A Medicare Select issuer shall:
- 1) File any proposed changes to the plan of operation, except for changes to the list of network providers, with the Director prior to implementing such changes. Such changes shall be considered approved by the Director after ~~thirty (30)~~ days unless specifically disapproved.

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- 2) An updated list of network providers shall be filed with the Director ~~of Insurance~~ at least quarterly.
- g) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:
    - 1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or condition; and
    - 2) It is not reasonable to obtain such services through a network provider.
  - h) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.
  - i) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:
    - 1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:
      - A) Other Medicare supplement policies or certificates offered by the issuer; and
      - B) Other Medicare Select policies or certificates.
    - 2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.
    - 3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in Plans K and L.
    - 4) A description of coverage for emergency and urgently needed care and other out of service area coverage.

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- 5) A description of limitations on referrals to restricted network providers and to other providers.
- 6) A description of the policyholder's right to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.
- 7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.
- j) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (i) ~~above~~ and that the applicant understands the restrictions of the Medicare Select policy or certificate.
- k) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.
  - 1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.
  - 2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.
  - 3) Grievances shall be considered in a timely manner and shall be transmitted to decision makers who have authority to investigate the issue and take corrective action.
  - 4) If a grievance is found to be valid, corrective action shall be taken promptly.
  - 5) All concerned parties shall be notified about the results of a grievance.
  - 6) The issuer shall report no later than each March 31<sup>st</sup> to the Director ~~of Insurance~~ regarding its grievance procedure. The report shall be in a format prescribed by the Director and shall contain the number of grievances filed in the past year and a summary of the subject, nature and

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resolution of such grievances.

- l) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.
- m) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for ~~six (6)~~ months.
  - 1) For the purposes of this subsection (m), a Medicare supplement policy or certificate will be considered to have "comparable or lesser" benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced.
  - 2) For the purposes of ~~this~~ subsection (m)(1), a "significant benefit" means coverage for the Medicare Part A deductible, ~~coverage for prescription drugs~~, coverage for at-home recovery services or coverage for Part B excess charges.
- n) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.
  - 1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.
  - 2) For the purposes of this subsection (n), a Medicare supplement policy or certificate will be considered to have "comparable or lesser" benefits

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unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subsection (n)(2), a "significant benefit" means coverage for the Medicare Part A deductible, ~~coverage for prescription drugs~~, coverage for at-home recovery services or coverage for Part B excess charges.

- o) A Medicare Select issuer shall comply with requests for data made by State or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

SUBPART C: ENROLLMENT & ELIGIBILITY

**Section 2008.74 Open Enrollment**

- a) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the 6 month period beginning with the first day of the month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection (a) without regard to age.
- b) If an applicant qualifies under subsection (a) of this Section and submits an application during the time period referenced in subsection (a) of this Section and, as of the date of application, has had a continuous period of creditable coverage:
  - 1) Of at least 6 months, the issuer shall not exclude benefits based on a preexisting condition, or
  - 2) That is less than 6 months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection (b)(2).

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- c) Except as otherwise provided in subsection (b) of this Section, [Section 2008.75](#) or Section 2008.104 of this Part, subsection (a) of this Section shall not be construed as preventing the exclusion of benefits under a policy, during the first 6 months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the 6 months before the coverage became effective.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

**Section 2008.75 Guaranteed Issue for Eligible Persons**

Pursuant to Section 1851(g) of the federal Social Security Act (P.L. 105-33) all Medicare supplement insurance policies shall be guaranteed issue to eligible persons who meet the requirements of this Section effective July 1, 1998.

- a) Guaranteed Issue
- 1) Eligible persons are those individuals described in subsection (b) of this Section who seek to enroll under the policy during the period specified in subsection (c), and who submit evidence of the date of termination, ~~or~~ [disenrollment, or Medicare Part D enrollment](#) with the application for a Medicare supplement policy.
  - 2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate described in subsection (e) of this Section that is offered and is available for issuance to new enrollees by the issuer; shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.
- b) Eligible person is an individual described in any of the following subsections:
- 1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual

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because the individual leaves the plan;

- 2) The individual is enrolled with a ~~Medicare Advantage~~~~Medicare+Choice~~ organization under a ~~Medicare Advantage~~~~Medicare+Choice~~ plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described in subsections (b)(2), (3), (4), (5) and (6) of this Section that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a ~~Medicare Advantage~~~~Medicare+Choice~~ Plan:
- A) The certification of the organization or plan under this Part has been terminated;
  - B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
  - C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;
  - D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
    - i) The organization offering the plan substantially violated a material provision of the organization's contract in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

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- ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
  - E) The individual meets such other exceptional conditions as the Secretary may provide;
- 3) The individual's enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under subsection (b)(2) of this Section and they enrolled under:
  - A) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);
  - B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
  - C) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
  - D) An organization under a Medicare Select policy;
- 4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
  - A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization;
  - B) Of other involuntary termination of coverage or enrollment under the policy;
  - C) The issuer of the policy substantially violated a material provision of the policy; or
  - D) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;
- 5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any

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~~Medicare Advantage~~~~Medicare+Choice~~ organization under a ~~Medicare Advantage~~~~Medicare+Choice~~ plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is voluntarily or involuntarily terminated during any period within the first 12 months of such subsequent enrollment; or

- 6) The individual, upon first enrolling under Part B of Medicare at age 65 or older, enrolls in a ~~Medicare Advantage~~~~Medicare+Choice~~ plan under Part C of Medicare or with a PACE provider under Section 1894 of the Social Security Act, and voluntarily or involuntarily disenrolls from the plan or program by not later than 12 months after the effective date of enrollment.

- 7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (e)(4).

c) Guaranteed Issue Time Periods

- 1) In the case of an individual described in subsection (b)(1) of this Section, the guaranteed issue period begins on the later of:

i) date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of ~~such a~~ termination or cessation) and ends 63 days thereafter ~~the date of the applicable notice; or~~

ii) the date that the applicable coverage terminates or ceases;

- 2) In the case of an individual described in subsection (b)(2), (b)(3), (b)(5) or (b)(6) of this Section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

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- 3) In the case of an individual described in subsection (b)(4)(A) of this Section;
- A) the guaranteed issue period begins on the earlier of:
- i)A) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; or, and
- ii)B) the date that the applicable coverage is terminated; and,
- B) ~~and~~ ends on the date that is 63 days after the date the coverage is terminated;
- 4) In the case of an individual described in subsection (b)(2), (b)(4)(B), (b)(4)(C), (b)(5) or (b)(6) of this Section who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date; ~~and~~
- 5) In the case of an individual described in subsection (b)(7), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60 day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and
- 6) In the case an individual described in subsection (b) of this Section but not described in the preceding provisions of this subsection (c), the guaranteed issue period begins on the effective date of the disenrollment and ends on the date that is 63 days after the effective date.
- d) Extended Medigap Access for Interrupted Trial Periods
- 1) In the case of an individual described in subsection (b)(5) of this Section whose enrollment with an organization or provider described in subsection (b)(5) of this Section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be

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deemed to be initial enrollment described in subsection (b)(5) of this Section;

- 2) In the case of an individual described in subsection (b)(6) of this Section whose enrollment with a plan or in a program described in subsection (b)(6) of this Section is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subsection (b)(6) of this Section; and
- 3) For purposes of subsections (b)(5) and (b)(6) of this Section, no enrollment of an individual with an organization or provider described in subsection (b)(5)(A) of this Section, or with a plan or in a program described in subsection (b)(6) of this Section, may be deemed to be an initial enrollment after the ~~two~~-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

e) Products to Which Eligible Persons are Entitled

The Medicare supplement policy to which eligible persons are entitled under:

- 1) Subsection (b)(1), (2), (3), and (4) of this Section is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, ~~or F~~ (including F with a high deductible), K or L offered by any issuer.
- 2) Subject to subsection (e)(2)(b), subsection~~Subsection~~ (b)(5) of this Section is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not available, a policy described in subsection (e)(1) of this Section. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subsection (e)(2) is:
  - A) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or
  - B) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.

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- 3) Subsection (b)(6) of this Section shall include any Medicare supplement policy offered by any issuer.
  - 4) Subsection (b)(7) of this Section is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.
- f) Notification Provisions
- 1) At the time of an event described in subsection (b) of this Section, because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (a) of this Section. Such notice shall be communicated contemporaneously with the notification of termination.
  - 2) At the time of an event described in subsection (b) of this Section, because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this Section, and of the obligations of issuers of Medicare supplement policies under subsection (a) of this Section. Such notice shall be communicated within 10 working days after the issuer receives notification of disenrollment.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

SUBPART D: CLAIMS, REFUNDS & CREDITS**Section 2008.80 Loss Ratio Standards and Refund or Credit of Premium**

- a) Loss Ratio Standards.
  - 1) A Medicare supplement policy form or certificate form shall not be

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delivered or issued for delivery unless the policy form or certificate form:

A) ~~Can~~ be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form, ~~calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices:~~

i)A) At least 75% of the aggregate amount of premiums earned in the case of group policies; or

ii)B) At least 65% of the aggregate amount of premiums earned in the case of individual policies.

B) Is calculated on the basis of incurred claims experience or incurred health care expenses, where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and on the basis of earned premiums for the period, in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

i) Home office and overhead cost;

ii) Advertising costs;

iii) Commissions and other acquisition costs;

iv) Taxes;

v) Capital costs;

vi) Administrative costs; and

vii) Claims processing costs.

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- 2) All filings of rates and rating schedules shall be made in compliance with 50 Ill. Adm. Code 916 and shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.
  - 3) For purposes of applying subsection (a) of this Section and Section 2008.81(c)(2) of this Part, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.
  - 4) For policies issued prior to April 28, 1996, expected claims in relation to premiums shall meet:
    - A) The originally filed anticipated loss ratio when combined with the actual experience since inception;
    - B) The appropriate loss ratio requirement from subsections (a)(1)(A) and (B) of this Section when combined with actual experience beginning April 28, 1996 to date; and
    - C) The appropriate loss ratio requirement from subsections (a)(1)(A) and (B) of this Section over the entire future period for which the rates are computed to provide coverage.
- b) Refund or Credit Calculation
- 1) An issuer shall collect and file with the Director by May 31 of each year the data contained in Appendix ~~SN~~ of this Part for each type in a standard Medicare supplement benefit plan.
  - 2) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall

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be excluded.

- 3) For the purposes of this Section, on policies or certificates issued prior to November 5, 1991, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 28, 1996. The first such report shall be due by May 31, 1998.
- 4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

c) Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued in this State before or after the effective date of this Part shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Director in accordance with the filing requirements and procedures prescribed by the Director. The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years.

- d) As soon as practicable, but prior to the effective date of revisions in Medicare benefits, every issuer of Medicare supplement policies or certificates in this State shall file with the Division~~Department~~:

- 1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as are necessary to justify the adjustment shall accompany the filing.

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- 2) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.
  - 3) If an issuer fails to make premium adjustments acceptable to the Director, the Director may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Section.
  - 4) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.
- e) **Public Hearings**  
The Director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this Part if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

SUBPART E: RATES, COMPENSATION AGREEMENT,  
DISCLOSURE, REPLACEMENT & MARKETING

**Section 2008.81 Filing and Approval of Policies and Certificates and Premium Rates**

- a) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this State unless the policy form or certificate form has been filed with and approved by the Director pursuant to 50 Ill. Adm. Code 916.

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- b) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the Director in the state in which the policy or certificate was issued.
- c) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Director pursuant to 50 Ill. Adm. Code 916.
- ~~d)~~e) Except as provided in subsection ~~(d)(e)(1)-below~~, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.
- 1) An issuer may offer, with the approval of the Director, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:
    - A) The inclusion of new or innovative benefits;
    - B) The addition of either direct response or producer marketing methods;
    - C) The addition of either guaranteed issue or underwritten coverage;
    - D) The offering of coverage to individuals eligible for Medicare by reason of disability.
  - 2) For the purposes of this Section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.
- ~~e)~~d) Except as provided in subsection ~~(e)(d)(1)-below~~, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Part that has been approved by the Director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous ~~12~~twelve months.
- 1) An issuer may discontinue the availability of a policy form or certificate

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form if the issuer provides to the Director in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Director, the issuer shall no longer offer for sale the policy form or certificate form in this State.

- 2) An issuer that discontinues the availability of a policy form or certificate form pursuant to subsection ~~(e)(d)~~(1) ~~above~~ shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the Director of the discontinuance. The period of discontinuance may be reduced if the Director determines that a shorter period is appropriate.
  - 3) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of subsection ~~(e)(d)~~.
  - 4) A change in the rating structure or methodology shall be considered a discontinuance under subsections ~~(e)(d)~~(1) and (2) ~~above~~ unless the issuer complies with the following requirements:
    - A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the Director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.
    - B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Director may approve a change to the differential which is in the public interest.
- ~~f)e)~~ Except as provided herein, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 2008.80 of this Part. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

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**Section 2008.90 Required Disclosure Provisions**

- a) General Rules
  - 1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.
  - 2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured or exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with an accompanying increase in premium during the policy term shall be agreed to in writing and signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.
  - 3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.
  - 4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."
  - 5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached

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thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded directly to him or her in a timely manner if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

- 6) Issuers of accident and sickness policies or certificates ~~that~~<sup>which</sup> provide hospital or medical expense coverage on an expense incurred or indemnity basis to ~~a person~~<sup>person(s)</sup> eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare approved by the Director ~~of Insurance~~ and in type size no smaller than 12 point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this Part. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.
- b) Identification Cards. Identification cards provided to the ~~policyholders~~<sup>policyholder(s)</sup> must reflect the name of the issuer rather than a corporate name and must also identify which plan coverage is being provided to the policyholder.
- c) Policy Checklist
  - 1) In order to determine what policy or certificate is appropriate and nonduplicative, a policy checklist must be completed in the presence of the applicant at the point of sale. Copies of the checklist, completed and duly signed are to be provided to the applicant and the issuer. This requirement does not apply to direct response solicitations.
  - 2) The checklist required by subsection (c)(1) of this Section shall provide substantially the form prescribed in Appendix A of this Part.
  - 3) Issuers issuing Medicare supplement policies for delivery in this State shall not issue a Medicare supplement policy unless all information requested in the policy checklist is provided.
- d) Notice Requirements

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- 1) As soon as practicable, but no later than 30 days prior to the annual effective date of Medicare benefit changes, an insurer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in the format prescribed in Appendix [TΘ](#) of this Part. Such notice shall:
    - A) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and
    - B) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.
  - 2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension. This notice shall be plainly printed in no smaller than 12 point type.
  - 3) Such notices shall not contain or be accompanied by any solicitation.
- e) [MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.](#)
- f) [Outline of Coverage Requirements for Medicare Supplement Policies](#)
- 1) Issuers shall provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant, and except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant.
  - 2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and

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the coverage originally applied for has not been issued.

- 3) In addition to the statement required by subsection ~~(f)~~(e)(2) of this Section, each revised outline of coverage accompanying a policy or certificate issued on a basis other than that originally applied for, shall contain the following notice appearing in no less than 12 point type:

WARNING: The (policy or certificate) you have received is not the same as the one for which you made application.

- 4) The outline of coverage provided to applicants pursuant to this subsection ~~(f)~~(e)(4) shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. Please see Appendix B of this Part. The outline of coverage shall be in the language and format prescribed in Appendix B in no less than 12 point type. All ~~Plans~~plans A through ~~LJ~~\* shall be shown on the cover page, and the ~~plans~~plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.
- 5) The outline of coverage shall follow the format in Appendix B of this Part. The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.

~~g)~~ Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies

- 1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 USC, Section 1395 et seq.), disability income policy, or other policy identified in Section 2008.30(b)(3) of this Part issued for delivery in this State to persons eligible for Medicare, shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice

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shall be in no less than 12 point type and shall contain the following language:

THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). IT DOES NOT FULLY SUPPLEMENT YOUR FEDERAL MEDICARE HEALTH INSURANCE. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

- 2) Using the applicable statement found in Appendix VQ of this Part, applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection (g)(1) of this Section shall disclose the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as part of, or together with, the application for the policy or certificate.

- h)g) Filing Requirements for Advertising  
An issuer of Medicare supplement insurance or benefits in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio or television medium to the Director of Insurance of this State for review by the Director to the extent it may be required under State law.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

### Section 2008.100 Requirements for Application Forms and Replacement Coverage

- a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has ~~another~~ Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer containing such questions and statements may be used.

1) ~~{STATEMENTS}~~:

- A4) You do not need more than one Medicare supplement policy.

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- ~~B2~~) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- ~~C3~~) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- ~~D4~~) If, after purchasing this policy, you become eligible for Medicaid, the~~The~~ benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days after becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days after losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- ~~E5~~) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days after losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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F) Counseling services may be available in this State to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the State Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

2) {QUESTIONS:}

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X".

To the best of your knowledge:;

A) Did you turn age 65 in the last 6 months?

Yes  No

B) Did you enroll in Medicare Part B in the last 6 months?

Yes  No

C) If yes, what is the effective date? \_\_\_\_\_

D) Are you covered for medical assistance through the State Medicaid program?

NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.

Yes  No

If yes:

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i) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes  No

ii) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes  No

E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START    /   /    END    /   /   

i) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes  No

ii) Was this your first time in this type of Medicare plan?

Yes  No

iii) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes  No

F) Do you have another Medicare supplement policy in force?

Yes  No

i) If so, with what company, and what plan do you have (optional for Direct Mailers)?

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ii) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes  No

G) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes  No

i) If so, with what company, and what kind of policy?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ii) What are your dates of coverage under the other policy?

START   /  /   END   /  /  

(If you are still covered under the other policy, leave "END" blank.)

1) ~~Do you have another Medicare supplement policy or certificate in force?~~

A) ~~If so, with which company?~~

B) ~~If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?~~

2) ~~Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?~~

A) ~~If so, with which company?~~

B) ~~What kind of policy?~~

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- 3) ~~Are you covered for medical assistance through the State Medicaid program?~~
- A) ~~As a Specified Low Income Medicare Beneficiary (SLMB)?~~
- B) ~~As a Qualified Medicare Beneficiary (QMB)?~~
- C) ~~For other Medicaid medical~~ benefits?
- b) Insurance producers shall list any other health insurance policies they have sold to the applicant.
- 1) List policies sold which are still in force.
- 2) List policies sold in the past 5 years which are no longer in force.
- c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.
- d) Upon determining that a sale will involve replacement of Medicare supplement, an issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of such notice signed by the applicant and the insurance producer shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage in the form prescribed in Appendix RM of this Part.
- e) The notice required by subsection (d) ~~above~~ for an issuer, other than a direct response issuer, shall be provided in the form prescribed in Appendix RM of this Part in no less than 12 point type.
- f) Subsections (1) and (2) of Appendix RM (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.102 Appropriateness of Recommended Purchase and Excessive Insurance**

- a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an insurance producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. For purposes of this subsection the insurer will be deemed to make reasonable efforts to determine the appropriateness of the recommended purchase if the insurer complies with the standards set forth in Sections 363a(5) and (6) of the Code.
- b) Any sale of a Medicare supplement policy or certificate~~coverage~~ that will provide an individual more than one Medicare supplement policy or certificate is prohibited.
- c) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

SUBPART F: REPORTING & PROHIBITIONS

SUBPART G: MISCELLANEOUS PROVISIONS

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX B Outline of Medicare Supplement Coverage – Cover Page**

[COMPANY NAME]

Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit ~~Plans~~Plan(s) \_\_\_\_\_ [insert ~~letters~~letter(s) of ~~plans~~plan(s) being offered]

~~These charts show Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows~~ 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: Included in All Plans.](#)

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 ~~in the case of hospital outpatient department services under a prospective payment system, applicable~~ copayments [for hospital outpatient services.](#)

Blood: First ~~3~~three 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	Skilled Nursing Facility	Skilled Nursing Facility
		Co-Insurance	Co-Insurance	Co-Insurance
	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	

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

				Preventive Care <u>NOT Covered by</u> <u>Medicare</u>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<b>F</b>	<b>F**</b>	<b>G</b>	<b>H</b>	<b>I</b>	<b>J</b>	<b>J**</b>
Basic Benefits	Basic Benefits					
Skilled Nursing <u>Facility</u> Co- Insurance	Skilled Nursing <u>Facility</u> Co- Insurance					
Part A Deductible	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	Foreign Travel Emergency					
	At-Home Recovery			At-Home Recovery	At-Home Recovery	At-Home Recovery
		<u>Basic Drugs</u> [\$_____]		<u>Basic Drugs</u> [\$_____]	<u>Extended Drugs</u> [\$_____]	<u>Extended Drugs</u> [\$_____]
					Preventive Care <u>NOT Covered</u> <u>by Medicare</u>	

\*\*Plans F and J also have an option called a high deductible Planplan F\*\* and a high deductible Planplan J\*\*. These high deductible plans pay the same ~~or offer the same~~ benefits as Plans F and J after one has paid a calendar year [\$\_\_\_\_\_] deductible. Benefits from high deductible Plansplans 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 ~~does~~ not include, ~~in plan J,~~ the plan's ~~separate prescription drug deductible or, in Plans F and J, 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.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

[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.

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

\*\* 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.

See Outlines of Coverage for details and exceptions.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**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.

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

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

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

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 L 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 of Insurance.]

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX C Plan A****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
<b>HOSPICE CARE</b>			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance 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 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
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
<b>Part B Excess Charges (Above Medicare Approved Amounts)</b>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<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>			
<del>BLOOD</del> -TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	<del>\$0\$10</del>

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

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

Remainder of Medicare Approved Amounts	80%	20%	\$0
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(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX D Plan B****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
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

## 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 co-insurance 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 (Above Medicare Approved Amounts)</b>	\$0	\$0	All costs
<u>Part B Excess Charges (Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<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>			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<del>BLOOD</del> -TEST FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
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**PARTS A & B**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<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 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX E Plan C****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
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 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
21st thru 100th day	All but [\$ _____ ] a day	Up to [\$ _____ ] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these	All but very limited co-insurance for out-patient	\$0	Balance

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

services	drugs and inpatient respite care		
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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 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
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>\$0</del>	<del>All cost</del>
<b><u>Part B Excess Charges</u></b> <b><u>(Above Medicare Approved Amounts)</u></b>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<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-</b> <del>BLOOD</del> TESTS 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	\$[100] (Part B Deductible)	\$0

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**(Plan C 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 <del>+\$250</del> each calendar year	\$0	\$0	<del>+\$250</del>
Remainder of Charges	\$0	80% to a lifetime maximum benefit of <del>+\$50,000</del>	20% and amounts over the <del>+\$50,000</del> lifetime maximum

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX F Plan D****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
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	Up to [\$ _____ ] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance 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</b> -IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>100%</del>	<del>\$0</del>
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
<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> - <del>BLOOD</del> -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			
First \$[100] of Medicare Approved Amounts*	\$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 <del>+\$40</del> 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	<del>+\$1,600</del>	

**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 <del>+\$250</del> each calendar year	\$0	\$0	<del>+\$250</del>
Remainder of Charges	\$0	80% to a lifetime maximum benefit of <del>+\$50,000</del>	20% and amounts over the <del>+\$50,000</del> lifetime maximum

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX G Plan E****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
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 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
21st thru 100th day	All but [\$_____] a day	Up to [\$_____] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to	All but very limited co-insurance for out-patient	\$0	Balance

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

receive these services	drugs and inpatient respite care		
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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 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*	\$0	<del>\$0</del> \$100 (Part B Deductible)	<del>\$[100]</del> (Part B Deductible)\$0
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
<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> <del>BLOOD-TESTS FOR DIAGNOSTIC SERVICES</del>	100%	\$0	\$0

**PARTS A & B**

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

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## NOTICE OF ADOPTED AMENDMENTS

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**

~~\* Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with 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 <del>†\$250†</del> each calendar year  Remainder of Charges	\$0  \$0	\$0  80% to a lifetime maximum benefit of <del>†\$50,000†</del>	<del>†\$250†</del>  20% and amounts over the <del>†\$50,000†</del> lifetime maximum
<b>**PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE</b>  Some annual physical and preventive tests and services <del>such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education,</del> administered or ordered by your doctor when not covered by Medicare  First <del>†\$120†</del> each calendar year  Additional charges	\$0  \$0	<del>†\$120†</del>  \$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 29 Ill. Reg. 14188, effective September 8, 2005)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX H Plan F or High Deductible Plan F\*\***

**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 ~~or offers the same~~ benefits as Plan F after one has paid a calendar year [\$ \_\_\_\_\_] deductible. Benefits from high deductible ~~Plan~~ 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
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			

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## NOTICE OF ADOPTED AMENDMENTS

First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$ _____] a day	Up to [\$ _____] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and in-patient 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 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 ~~or offers the same~~ benefits as Plan F after one has paid a calendar year [\$ \_\_\_] deductible. Benefits from the high deductible ~~Plan~~ 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
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>100%</del>	<del>\$0</del>
<u>Part B Excess Charges (Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>100%</u>	<u>\$0</u>
<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-</b>			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<del>BLOOD</del> -TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0
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**PARTS A & B**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>[AFTER YOU PAY [ \$ ____ ] DEDUCTIBLE**] PLAN PAYS</u>	<u>[IN ADDITION TO [ \$ ____ ] DEDUCTIBLE**] YOU PAY</u>
<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**

<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>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 <del>[\$250]</del> each calendar year	\$0	\$0	<del>[\$250]</del>
Remainder of Charges	\$0	80% to a lifetime maximum benefit of <del>[\$50,000]</del>	20% and amounts over the <del>[\$50,000]</del> lifetime maximum

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX I Plan G****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
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	Up to [\$_____] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance 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 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*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>80%</del>	<del>20%</del>
<u>Part B Excess Charges (Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>80%</u>	<u>20%</u>
<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>			
<del>BLOOD-TESTS FOR DIAGNOSTIC SERVICES</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>

**PARTS A & B**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<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)

## 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 <del>+\$40</del> 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	<del>+\$1,600</del>	

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<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 <del>+\$250</del> each calendar year	\$0	\$0	<del>+\$250</del>
Remainder of Charges	\$0	80% to a lifetime maximum benefit of <del>+\$50,000</del>	20% and amounts over the <del>+\$50,000</del> lifetime maximum

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX J Plan H****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 90th 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 100th 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 coinsurance 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 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, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
<u>Part B Excess Charges (Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>0%</u>	<u>All costs</u>
<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>			
<del>BLOOD</del> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

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

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

- 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 <del>[\$250]</del> each calendar year	\$0	\$0	<del>[\$250]</del>
Remainder of Charges	\$0	80% to a lifetime maximum benefit of <del>[\$50,000]</del>	20% and amounts over the <del>[\$50,000]</del> lifetime maximum
<b><del>BASIC OUTPATIENT PRESCRIPTION DRUGS – NOT COVERED BY MEDICARE</del></b>			
<del>First [\$_____] each calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>[\$_____]</del>
<del>Next [\$_____] each calendar year</del>	<del>\$0</del>	<del>50% [\$_____] calendar year maximum benefit</del>	<del>50%</del>
<del>Over [\$_____] each calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>All Costs</del>

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX K Plan I****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
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	<u>\$0**</u>
- 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	Up to [\$ _____] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

## 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 co-insurance 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 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*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>100%</del>	<del>\$0</del>
<u>Part B Excess Charges (Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>100%</u>	<u>\$0</u>
<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
<del>CLINICAL LABORATORY SERVICES- BLOOD-TESTS FOR DIAGNOSTIC SERVICES</del>	<del>100%</del>	<del>\$0</del>	<del>\$0</del>

**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			

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

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 <del>[\$40]</del> 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	<del>[\$1,600]</del>	

**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 <del>[\$250]</del> each calendar year	\$0	\$0	<del>[\$250]</del>
Remainder of Charges <sup>‡</sup>	\$0	80% to a lifetime maximum benefit of <del>[\$50,000]</del>	20% and amounts over the <del>[\$50,000]</del> lifetime maximum
<b>BASIC OUTPATIENT PRESCRIPTION DRUGS NOT COVERED BY MEDICARE</b>			
First [\$ _____] each calendar year	\$0	\$0	[\$ _____]
Next [\$ _____] each calendar year	\$0	50% <del>[\$ _____] calendar year maximum benefit</del>	50%
Over <del>[\$ _____] each calendar year</del>	\$0	\$0	All costs

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX L Plan J or High Deductible Plan J\*\***

**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 ~~or offers 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 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>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
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			

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but [\$_____] a day	Up to [\$_____] a day	\$0
101st day and after	\$0	\$0	All costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited co-insurance for out-patient drugs and in-patient 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 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 ~~or offers the same~~ benefits as Plan J after one has paid a calendar year [\$\_\_\_\_] deductible. Benefits from the high deductible ~~Plan~~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, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.</b>			
First \$[100] of Medicare Approved Amounts*	\$0	\$[100] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
<del>Part B Excess Charges (Above Medicare Approved Amounts)</del>	<del>\$0</del>	<del>100%</del>	<del>\$0</del>
<u>Part B Excess Charges (Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>100%</u>	<u>\$0</u>
<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- <del>BLOOD</del>-TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$ ____] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$ ____] DEDUCTIBLE**] YOU PAY
<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
AT-HOME RECOVERY SERVICES- NOT <del>COVERED</del> COVERED BY MEDICARE			
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 <del>+\$40</del> 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	<del>+\$1,600</del>	

**OTHER BENEFITS – NOT COVERED BY MEDICARE ~~Not Covered By Medicare~~**

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$ ____] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$ ____] DEDUCTIBLE**] 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 <del>+\$250</del> each calendar year	\$0	\$0	<del>+\$250</del>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

Remainder of Charges*	\$0	80% to a lifetime maximum benefit of <del>[\$50,000]</del>	20% and amounts over the <del>[\$50,000]</del> lifetime maximum
<b><del>BASIC OUTPATIENT PRESCRIPTION DRUGS NOT COVERED BY MEDICARE</del></b>			
<del>First [\$ ] each calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>[\$ ]</del>
<del>Next [\$ ] each calendar year</del>	<del>\$0</del>	<del>50% [\$ ] calendar year maximum benefit</del>	<del>50%</del>
<del>Over [\$ ] each calendar year</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>
<b><del>***PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE</del></b>			
<del>Some annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare</del>			
<del>First <del>[\$120]</del> each calendar year</del>	<del>\$0</del>	<del><del>[\$120]</del></del>	<del>\$0</del>
<del>Additional charges</del>	<del>\$0</del>	<del>\$0</del>	<del>All costs</del>

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

(Source: Amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX M Plan K ~~Notice to Applicant Regarding Replacement of Accident and Sickness Insurance~~**

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, general nursing and miscellaneous 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 90th day</u>	<u>All but \$[ ] a day</u>	<u>\$[ ] a day</u>	<u>\$0</u>
<u>91st 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>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<p><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></p> <p><u>First 20 days</u></p> <p><u>21<sup>st</sup> thru 100th day</u></p> <p><u>101st day and after</u></p>	<p><u>All approved amounts</u></p> <p><u>All but \$[ ] a day</u></p> <p><u>\$0</u></p>	<p><u>\$0</u></p> <p><u>Up to \$[ ] a day</u></p> <p><u>\$0</u></p>	<p><u>\$0</u></p> <p><u>Up to \$[ ] a day ♦</u></p> <p><u>All costs</u></p>
<p><b><u>BLOOD</u></b></p> <p><u>First 3 pints</u></p> <p><u>Additional amounts</u></p>	<p><u>\$0</u></p> <p><u>100%</u></p>	<p><u>50%</u></p> <p><u>\$0</u></p>	<p><u>50%♦</u></p> <p><u>\$0</u></p>
<p><b><u>HOSPICE CARE</u></b></p> <p><u>Available as long as your doctor certifies you are terminally ill and you elect to receive these services</u></p>	<p><u>Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care</u></p>	<p><u>50% of coinsurance or copayments</u></p>	<p><u>50% of coinsurance or copayments♦</u></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 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.

<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>	  \$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% ♦
<u>Part B Excess Charges (Above Medicare Approved Amounts)</u>	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$_]*)
<u>BLOOD</u> <u>First 3 pints</u> <u>Next \$[100] of Medicare Approved Amounts****</u> <u>Remainder of Medicare Approved Amounts</u>	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$[100] (Part B deductible)****♦ Generally 10% ♦
<u>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</u>	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**

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**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**

<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> <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 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>10%</u>	<u>10% ♦</u>

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

(Source: Appendix M renumbered to Appendix R; new Appendix M added at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX N Plan L Medicare Supplement Refund Calculation Format****For Calendar Year**

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, general nursing and miscellaneous 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 90th day</u>	<u>All but \$[ ] a day</u>	<u>\$[ ] a day</u>	<u>\$0</u>
<u>91st 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>

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

<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>			
First 20 days	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
21st thru 100th day	<u>All but \$[ ] a day</u>	<u>Up to \$[ ] a day</u>	<u>Up to \$[ ] a day♦</u>
101st day and after	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<b><u>BLOOD</u></b>			
First 3 pints	<u>\$0</u>	<u>75%</u>	<u>25% ♦</u>
Additional amounts	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<b><u>HOSPICE CARE</u></b>			
<u>Available as long as your doctor certifies you are terminally ill and you elect to receive these services</u>	<u>Generally, most Medicare eligible expenses for outpatient drugs and inpatient respite care</u>	<u>75% of coinsurance or copayments</u>	<u>25% of coinsurance or copayments ♦</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.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

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

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**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**

<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>			
<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 1st \$[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: Appendix N renumbered to Appendix S; new Appendix N added at 29 Ill. Reg. 14188, effective September 8, 2005)

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NOTICE OF ADOPTED AMENDMENTS

| **Section 2008.APPENDIX O NOTICE OF MEDICARE CHANGES (RENUMBERED)**

(Source: Appendix O renumbered to Appendix T at 29 Ill. Reg. 14188, effective September 8, 2005)

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DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

**Section 2008.APPENDIX P MEDICARE SUPPLEMENT POLICIES REPORT**  
**(RENUMBERED)**

(Source: Appendix P renumbered to Appendix U at 29 Ill. Reg. 14188, effective September 8, 2005)

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DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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| **Section 2008.APPENDIX Q Disclosure Statements (Renumbered)**

(Source: Appendix Q renumbered to Appendix V at 29 Ill. Reg. 14188, effective September 8, 2005)

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**Section 2008.APPENDIX RM Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage~~Accident and Sickness Insurance~~**

Insurance company's name and address

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished) you intend to terminate existing Medicare supplement or Medicare Advantage~~accident and sickness~~ insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide ~~thirty (30)~~ days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURANCE PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement or, if applicable, policy will not duplicate your existing Medicare supplement ~~Medicare~~ coverage because you intend to terminate your existing Medicare supplement or leave your Medicare Advantage Plan~~coverage~~. The replacement policy is being purchased for the following reason-reason(s) (Check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D for disenrollment. (Optional only for Direct Mailers)
- Disenrollment from a Medicare Advantage plan. Please explain reason.
- Other. (Please specify) \_\_\_\_\_

Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing, pre-existing condition limitations, please skip to statement 2 below.

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- 1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- 2) Section 363(7)(b) of the Illinois Insurance Code [215 ILCS 5/363(7)(b)] provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
- 3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

\_\_\_\_\_  
(Signature of Insurance Producer or Other Representative)

Typed Name and Address of Issuer or Insurance Producer

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
Date

\* Signature not required for direct response sales.

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NOTICE OF ADOPTED AMENDMENTS

(Source: Appendix R renumbered from Appendix M and amended at 29 Ill. Reg. 14188, effective September 8, 2005)

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Section 2008.APPENDIX SN Medicare Supplement Refund Calculation Format

Type (1) _____ SMSBP (2) _____	
For the State of _____	
Company Name _____	
NAIC Group Code _____	NAIC Company Code _____
Address _____	
Person Completing this Form _____	
Title _____	Telephone Number _____

  

Line	(a) Earned Premium (3)	(b) Incurred Claims (4)
1. Current Year's Experience		
a. Total (all policy years)	_____	_____
b. Current year's issues (z)	_____	_____
c. Net (for reporting purposes = 1a - 1b)	_____	_____
2. Past Year's Experience (all policy years)	_____	_____
3. Total Experience (net current year + past year's experience)	_____	_____
4. Refunds last year (excluding interest) _____		
5. Previous since Inception (excluding interest) _____		
6. Refunds since Inception (excluding interest) _____		
7. Benchmark Ratio since Inception _____ <b>(see worksheet for Ratio 1)</b>		
8. Experienced Ratio since Inception		
Total Actual Incurred Claims (line 3, col. b) / Total Premium After Refunds = Ratio 2		
Where Total Earned Premium after Refunds = Total Earned Premiums (line 3, col. a) - Refunds since Inception (line 6)		
9. Life Years Exposed Since Inception		
<b><i>If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.</i></b>		

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- |  |
|--|
| 10. Tolerance Permitted _____<br>(obtained from credibility table) |
|--|

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11. Adjustment to Incurred Claims for Credibility

Ratio 3 = Ratio 2 + Tolerance \_\_\_\_\_

**If ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.**

**If ratio 3 is less than the benchmark ratio, then proceed.**

12. Adjusted Incurred Claims = Total Earned Premiums (line 3, col. a) - Refunds since Inception (line 6) x Ratio 3 (line 11). \_\_\_\_\_

13. Refund = Total Earned Premium after Refunds – [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)] \_\_\_\_\_

Where Total Earned Premium after Refunds = Total Earned Premiums (line 3, col. a) – Refunds since Inception (line 6)

**If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.**

**Medicare Supplement Credibility Table**

<b>Life Years Exposed Since Inception</b>	<b>Tolerance</b>
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 – 999	15.0%
If less than 500, no credibility.	

- (1) Individual, Group, Individual Medicare Select, or Group Medicare Only.
- (2) "SMSBP" = Standard Medicare Supplement Benefit Plan-Use "P" for ~~prestandardized~~ **pre-standardized** plans.
- (3) Includes modal loadings and fees charged
- (4) Excludes Active Life Reserves
- (5) This is to be used as "Issue Year Earned Premium" for 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature \_\_\_\_\_

Title – please type \_\_\_\_\_

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Name – please type	Date
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## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

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**REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION  
FOR GROUP POLICIES  
For Calendar Year \_\_\_\_\_**

Type (1) \_\_\_\_\_ SMSBP (2) \_\_\_\_\_  
 For the State of \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_  
 Person Completing Form \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

(a3)	(b4)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o5)
Year	Earned Premium	Factor	(b4) x (c)	Cumulative Loss Ratio	(d) x (e)	Factor	(b4) x (g)	Cumulative Loss Ratio	(h) x (i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89

Total: (k): (l): (m): (n):

Benchmark Ratio Since Inception: Ratio 1 = (l + n) / (k + m): \_\_\_\_\_

- (1): Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
- (2): "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for pre-standardized plans.
- (3): Year 1 is the current calendar year-1  
Year 2 is the current calendar year-2 (etc.)  
(Example: If the current year is 1991, then Year 1 is 1990; Year 2 is 1989, etc.)
- (4): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- (5): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

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| (6): To include the earned premium for all years prior to as well as the 15<sup>th</sup> year to the current year.

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REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION  
FOR INDIVIDUAL POLICIES  
For Calendar Year \_\_\_\_\_

Type (1) \_\_\_\_\_ SMSBP (2) \_\_\_\_\_

For the State of \_\_\_\_\_

Company Name \_\_\_\_\_

NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_

Address \_\_\_\_\_

Person Completing Form \_\_\_\_\_

Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

(a3)	(b4)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o5)
Year	Earned Premium	Factor	(b4) x (c)	Cumulative Loss Ratio	(d) x (e)	Factor	(b4) x (g)	Cumulative Loss Ratio	(h) x (i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77

Total: (k): \_\_\_\_\_ (l): \_\_\_\_\_ (m): \_\_\_\_\_ (n): \_\_\_\_\_

Benchmark Ratio Since Inception: Ratio 1 = (l + n) / (k + m): \_\_\_\_\_

- (1): Individual, Group, Individual Medicare Select, or Group Medicare Only.
- (2): "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for pre-standardized plans.
- (3): Year 1 is the current calendar year-1  
Year 2 is the current calendar year-2 (etc.)  
(Example: If the current year is 1991, then Year 1 is 1990; Year 2 is 1989, etc.)
- (4): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- (5): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

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| [\(6\): To include the earned premium for all years prior to as well as the 15<sup>th</sup> year to the current year.](#)

(Source: Appendix S renumbered from Appendix N and amended at 29 Ill. Reg. 14188, effective September 8, 2005)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

Section 2008.APPENDIX **TO** Notice of Medicare Changes

(Company Name)

**NOTICE ON CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE**

The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

(A brief description of the revisions to Medicare Parts A & B with a parallel description of supplemental benefits with subsequent changes, including dollar amounts, provided by the Medicare supplement coverage in substantially the following format).

Services	Medicare Benefits	Your Medicare Supplement Coverage
	Effective (insert current calendar year) Medicare Will Pay	Effective (insert current calendar year) Your Coverage Will Pay
MEDICARE PART A SERVICES AND SUPPLIES		
Inpatient Hospital Services	All but _____ for first 60 days/benefit period	
Semi-Private Room & Board	All but _____ a day for 61 <sup>st</sup> - 90 <sup>th</sup> days/benefit period	
Miscellaneous Hospital Service & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but _____ a day for 91 <sup>st</sup> -150 <sup>th</sup> days (if individual chooses to use 60 nonrenewable lifetime reserve days)	
BLOOD	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in	

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Services	Medicare Benefits	Your Medicare Supplement Coverage
	Effective (insert current calendar year) Medicare Will Pay	Effective (insert current calendar year) Your Coverage Will Pay
	each calendar year	
SKILLED NURSING FACILITY CARE	100% of costs for first 20 days (after a 3 day prior hospital/confinement/benefit period) All but _____ a day for 21 <sup>st</sup> -100 <sup>th</sup> days /benefit period	
	Beyond 100 days – Nothing /benefit period	
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after ____ deductible/calendar year)	
PRESCRIPTION DRUGS	Inpatient prescription drugs 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after ____ deductible/calendar year)	
BLOOD	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after ____ deductible/calendar year)	

(Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.)

(Describe any coverage provisions changing due to Medicare modifications.)

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(Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.)

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT (POLICY) CONTACT: (COMPANY AND FOR AN INDIVIDUAL POLICY-NAME OF AGENT) (ADDRESS/PHONE NUMBER).

(Source: Appendix T renumbered from Appendix O at 29 Ill. Reg. 14188, effective September 8, 2005)

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**Section 2008.APPENDIX UP Medicare Supplement Policies Report**

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Due: March 1, annually

The purpose of this report is to provide information on each resident of this State who has more than one Medicare supplement policy or certificate in force. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (please type)

\_\_\_\_\_  
Date

(Source: Appendix U renumbered from Appendix P at 29 Ill. Reg. 14188, effective September 8, 2005)

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**Section 2008.APPENDIX ~~VQ~~ Disclosure Statements**

~~Companies shall provide one of the following disclosures as prescribed by the directions contained in paragraph (o). All types of health insurance policies that duplicate Medicare shall include one of the following disclosure statements according to the particular policy type involved, on the application or together with the application. The disclosure statement language and format may not vary in type size, type proportional spacing, bold character, line spacing or usage of boxes around text from those presented below.~~

- a) ~~Original disclosure statement for~~ For policies that provide benefits for expenses incurred for an accidental injury only:

<p><b>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</b></p>
--

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays hospital medical expenses up to the maximum stated in the policy.**

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

<p><b>Before You Buy This Insurance</b></p>
---

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare,

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- available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP] ~~Senior Health Insurance Program through your state insurance department.~~

- b) Original disclosure statement for ~~For~~ policies that provide benefits for specified limited services:

**IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when any of the services covered by the policy are also covered by Medicare.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- ~~hospice,~~
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

**Before You Buy This Insurance**

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP] ~~Senior Health Insurance Program through your~~

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~~state insurance department.~~

- c) ~~Original disclosure statement for~~ For policies that reimburse expenses for specified disease(s) or other specified impairments. This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions:

<p><b>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</b></p>
--

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays hospital or medical expenses up to the maximum stated in the policy.**

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice,
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

<p><b>Before You Buy This Insurance</b></p>
---

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling]

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~~[assistance] program [SHIP]Senior Health Insurance Program through your state insurance department.~~

- d) ~~Original disclosure statement for~~ For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy:

<b>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</b>
---

**This is not Medicare Supplement Insurance**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice,
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

<b>Before You Buy This Insurance</b>
--------------------------------------

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP]Senior Health Insurance Program through

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~~your state insurance department.~~

- e) Original disclosure statement for~~For~~ indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies:

<b>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</b>
---

**This is not Medicare Supplement Insurance**

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when any expenses or services covered by the policy are also covered by Medicare.**

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice,
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

<b>Before You Buy This Insurance</b>
--------------------------------------

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP] Senior Health Insurance Program through your state insurance department.

- f) Original disclosure statement for~~For~~ policies that provide benefits for both

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expenses incurred and fixed indemnity basis:

<b>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</b>
---

**This is not Medicare Supplement Insurance**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when:**

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

**Medicare generally pays for most or all of these expenses.****Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice care,
- [\[outpatient prescription drugs if you are enrolled in Medicare Part D\]](#),
- other approved items and services.

<b>Before You Buy This Insurance</b>
--------------------------------------

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact [your state insurance department](#) or [state \[senior\] \[health\] insurance \[counseling\]](#)

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

[assistance] program [SHIP]Senior Health Insurance Program through  
~~your state insurance department.~~

- g) Original disclosure statement for~~For~~ other health insurance policies not specifically identified in the previous statements:

<b>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS  INSURANCE DUPLICATES SOME MEDICARE BENEFITS</b>
--

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays the benefits stated in the policy and coverage for the same event is provided by Medicare.**

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice,
- [outpatient prescription drugs if you are enrolled in Medicare Part D].
- other approved items and services.

<b>Before You Buy This Insurance</b>
--------------------------------------

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP]Senior Health Insurance Program through your state insurance department.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

- h) Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE**  
**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization.
- physician services.
- [outpatient prescription drugs if you are enrolled in Medicare Part D].
- other approved items and services.

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

**Before You Buy This Insurance**

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP].

- i) Alternate disclosure statement for policies that provide benefits for specified limited services:

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE****Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.****Before You Buy This Insurance**

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP].

- j) Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice,
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

<b><u>Before You Buy This Insurance</u></b>
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- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP].

- k) Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.

<b><u>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS</u></b>
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## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**IS NOT MEDICARE SUPPLEMENT INSURANCE****Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice,
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.****Before You Buy This Insurance**

- Check the coverage in all health insurance policies you already have.
  - For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
  - For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP].
- l) Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE****Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

This insurance pays a fixed amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice,
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

<b><u>Before You Buy This Insurance</u></b>
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- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP].

- m) Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.

<b><u>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</u></b>
---

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice care,
- [outpatient prescription drugs if you are enrolled in Medicare Part D],
- other approved items and services.

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

<b><u>Before You Buy This Insurance</u></b>
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- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contract your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP].

- n) Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.

<b><u>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE</u></b>
---

**Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.**

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

**Medicare generally pays for most or all of these expenses.****Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization.
- physician services.
- hospice.
- [outpatient prescription drugs if you are enrolled in Medicare Part D].
- other approved items and services.

**This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.**

<b><u>Before You Buy This Insurance</u></b>
---

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP].

o) Instructions for use of the disclosure statements for health insurance policies sold to Medicare beneficiaries that duplicate Medicare.

- 1) Section 1882(d) of the federal Social Security Act (42 USC 1395ss) prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
- 2) All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format type size, type proportional spacing, bold

## DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

## NOTICE OF ADOPTED AMENDMENTS

- character, line spacing, and usage of boxes around text from those presented in the disclosure statements.
- 3) State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
  - 4) Property/casualty and life insurance policies are not considered health insurance.
  - 5) Disability income policies are not considered to provide benefits that duplicate Medicare.
  - 6) Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
  - 7) The federal law does not preempt state laws that are more stringent than the federal requirements.
  - 8) The federal law does not preempt existing state form filing requirements.
  - 9) Section 1882 of the federal Social Security Act was amended in subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.
  - 10) In the disclosure language included under the heading **Before You Buy This Insurance**, that reads: "For help in understanding your health insurance, contact your state insurance department or state [senior] [health] insurance [counseling] [assistance] program [SHIP]," insurers are to insert reference to the state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

(Source: Appendix V renumbered from Appendix Q and amended at 29 Ill. Reg. 14188, effective September 8, 2005)

## DEPARTMENT OF STATE POLICE

## NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Illinois Uniform Conviction Information Act
- 2) Code Citation: 20 Ill. Adm. Code 1215
- 3) 

<u>Section Numbers:</u>	<u>Proposed Action:</u>
1215.30	Amendment
1215.35	Amendment
1215.40	Amendment
1215.50	Amendment
- 4) Statutory Authority: Implementing and authorized by Section 19 of the Illinois Uniform Conviction Information Act [20 ILCS 2635/19] and authorized by Section 2605-15 of the Civil Administrative Code of Illinois [20 ILCS 2605/2605-15]
- 5) Effective Date of Amendments: September 12, 2005
- 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: 29 Ill. Reg. 7818; May 27, 2005
- 10) Has JCAR issued a Statement of Objection to these amendments? No
- 11) Differences between proposal and final version: One change was recommended by JCAR. That change is as follows:  
  
In Section 1215.50, Fees, "\$15 per submission" was changed to "\$15 per inquiry".
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? No agreements were issued by JCAR.
- 13) Will this rulemaking replace any emergency amendments currently in effect? No
- 14) Are there any amendments pending on this Part? No

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED AMENDMENTS

- 15) Summary and Purpose of Amendments? The amendments will update the fees for processing requests for conviction information, reflect processing of electronic requests, and add other minor changes.
- 16) Information and questions regarding these adopted amendments shall be directed to:

Mr. Keith Jensen  
Chief Legal Counsel  
Illinois State Police  
124 East Adams Street, Room 102  
Post Office Box 19461  
Springfield, Illinois 62794-9461

(217) 782-7658

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

## DEPARTMENT OF STATE POLICE

## NOTICE OF ADOPTED AMENDMENTS

TITLE 20: CORRECTIONS, CRIMINAL JUSTICE, AND LAW ENFORCEMENT  
CHAPTER II: DEPARTMENT OF STATE POLICEPART 1215  
ILLINOIS UNIFORM CONVICTION INFORMATION ACT

## SUBPART A: PROMULGATION

Section	
1215.10	Purpose
1215.20	Definitions

## SUBPART B: OPERATIONS FOR PROCESSING REQUESTS

Section	
1215.30	Written Request Procedures
1215.35	Automated Request Procedures
1215.40	Response Procedures
1215.50	Fees

AUTHORITY: Implementing and authorized by Section 19 of the Illinois Uniform Conviction Information Act [20 ILCS 2635/19] and authorized by Section 2605-15 of the Civil Administrative Code of Illinois [20 ILCS 2605/2605-15].

SOURCE: Adopted at 15 Ill. Reg. 1107, effective January 14, 1991; amended at 22 Ill. Reg. 6234, effective March 23, 1998; amended at 29 Ill. Reg. 14346, effective September 12, 2005.

## SUBPART B: OPERATIONS FOR PROCESSING REQUESTS

**Section 1215.30 Written Request Procedures**

- a) Requests for conviction information shall be made by completing a Conviction Information Request form provided by the Illinois State Police. These forms shall be made available through the Bureau of Identification, 260 North Chicago Street, Joliet, Illinois ~~60432-4072~~~~60431-1060~~. In order to be processed, Conviction Information Request forms shall at a minimum include a complete and accurate mailing address for the requester, ~~the requester's signature~~, an indication of whether the request is for licensing or employment purposes, and the record subject's name, race, sex, and date of birth. ~~Requests for employment or licensing purposes shall also be signed by the individual to whom the information request~~

## DEPARTMENT OF STATE POLICE

## NOTICE OF ADOPTED AMENDMENTS

~~pertains.~~

- b) If the request is for employment or licensing purposes, the requester shall ~~retain~~maintain a release on file for at least two years signed by the individual to whom the information pertains. The requester shall notify the individual named in the request that the individual has the obligation and responsibility to notify the requester within seven days if the information provided is incomplete or incorrect. A copy of the response furnished by the Department shall be provided by the requester to the individual named in the request.
- c) All requests shall be accompanied by the correct fee as established in Section 1215.50 and paid in the form of a check or money order, unless other payment arrangements are approved by the Department.

(Source: Amended at 29 Ill. Reg. 14346, effective September 12, 2005)

**Section 1215.35 Automated Request Procedures**

- a) Requests submitted in an automated format shall be made in accordance with record layout formats, software and hardware specifications, or other guidelines suitable for electronic transmission and reception of data by Department equipment.
- b) Automated Conviction Information Requests shall at a minimum include the record subject's name, race, sex and date of birth. The requester must also provide a complete and accurate mailing address, e-mail address, or fax number for the requester in order to receive responses. The requester must sign a user's agreement to be provided by the Department.
- c) If the request is for employment or licensing purposes, the requester shall maintain a release on file for at least two years signed by the individual to whom the information pertains. The requester shall notify the individual named in the request that the individual has the obligation and responsibility to notify the requester within seven days if the information provided is incomplete or incorrect. A copy of the response furnished by the Department shall be provided by the requester to the individual named in the request.
- d) All requests shall be accompanied by the correct fee as established in Section 1215.50 and paid in the form of a check or money order, unless other payment arrangements are approved by the Department.

## DEPARTMENT OF STATE POLICE

## NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 29 Ill. Reg. 14346, effective September 12, 2005)

**Section 1215.40 Response Procedures**

Prior to disseminating conviction information, the Department shall review its inprocess files to ensure that the information to be disseminated is complete. The Department shall ~~forward mail~~ responses to requests to the requester at the address, e-mail address, or fax number indicated on the Conviction Information Request form.

(Source: Amended at 29 Ill. Reg. 14346, effective September 12, 2005)

**Section 1215.50 Fees**

The ~~fees~~ fee for processing requests for conviction information shall be as follows: ~~set by the Director.~~

<u>Uniform Conviction Information Act fingerprint inquiries submitted electronically</u>	<u>\$15 per inquiry</u>
<u>Uniform Conviction Information Act electronic name inquiries</u>	<u>\$10 per name</u>
<u>Uniform Conviction Information Act name inquiries submitted on paper forms</u>	<u>\$16 per inquiry</u>
<u>Uniform Conviction Information Act fingerprint inquiries submitted on paper forms</u>	<u>\$20 per inquiry</u>

The ~~fees~~ fee shall not exceed the general costs for processing ~~such~~ requests. The general costs shall include, but are not limited to, personnel, supervision and training, hardware, software, network infrastructure, telephone, electric, equipment, printing, postage, facilities, forms, and miscellaneous related costs.

(Source: Amended at 29 Ill. Reg. 14346, effective September 12, 2005)

## STATE UNIVERSITIES RETIREMENT SYSTEM

## NOTICE OF ADOPTED AMENDMENT

- 1) Heading of the Part: Universities Retirement
- 2) Code Citation: 80 Ill. Adm. Code 1600
- 3) Section Number: 1600.123                      Proposed Action:  
New Section
- 4) Statutory Authority: 40 ILCS 5/15-177
- 5) Effective Date of Amendments: September 6, 2005
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this amendment contain incorporations by reference? No
- 8) A copy of the adopted amendment, including any material incorporated by reference, is on file at the SURS office and is available for public inspection.
- 9) Notices of Proposed Amendment Published in the Illinois Register: May 6, 2005; 29 Ill. Reg. 6233
- 10) Has JCAR issued a Statement of Objection to this amendment? No
- 11) Differences between proposal and final version: Subparagraphs (c) and (d) were added.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? There were no changes suggested since the Second Notice.
- 13) Will this rulemaking replace any emergency amendment currently in effect? No
- 14) Are there any amendments pending on this Part? Yes  

<u>Section Number:</u> 1600.35	<u>Proposed Action:</u> New Section	<u>Illinois Register Citation:</u> 29 Ill. Reg. 3012; February 25, 2005
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- 15) Summary and Purpose of Amendment: A new rule is added that allows the adjustment of the average percent time worked calculation done with respect to part-time/concurrent service under Section 15-134.1.
- 16) Information and questions regarding this adopted amendment shall be directed to:

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STATE UNIVERSITIES RETIREMENT SYSTEM

NOTICE OF ADOPTED AMENDMENT

Dan M. Slack, Executive Director  
State Universities Retirement System  
1901 Fox Drive,  
Champaign, IL 61820

(217) 378-8877 or (217) 378-8855

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

## STATE UNIVERSITIES RETIREMENT SYSTEM

## NOTICE OF ADOPTED AMENDMENT

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES  
SUBTITLE D: RETIREMENT SYSTEMS  
CHAPTER II: STATE UNIVERSITIES RETIREMENT SYSTEMPART 1600  
UNIVERSITIES RETIREMENT

## SUBPART A: MISCELLANEOUS PROCEDURES

Section	
1600.10	Definitions
1600.20	Dependency of Beneficiaries
1600.30	Crediting Interest on Employee Contributions and Other Reserves
1600.40	Election to Make Contributions Covering Leave of Absence at Less Than 50% Pay
1600.50	Election to Pay Contributions Based Upon Employment Which Preceded Certification as a Participant
1600.55	Election to Make Contributions Covering Periods of Military Leave
1600.60	Sick Leave Accrual Schedule
1600.70	Procedures to be followed in Medical Evaluation of Disability Claims
1600.80	Rules of Practice-Nature and Requirements of Formal Hearings
1600.90	Excess Benefit Arrangement
1600.100	Freedom of Information Act
1600.110	Open Meetings Act
1600.120	Twenty Percent Limitation on Final Rate of Earnings Increases
1600.121	Determination of Final Rate of Earnings Period
<a href="#">1600.123</a>	<a href="#">Part-time/Concurrent Service Adjustments</a>
1600.130	Procurement
1600.137	Overpayment Recovery
1600.140	Making Preliminary Estimated Payments

## SUBPART B: QUALIFIED ILLINOIS DOMESTIC RELATIONS ORDERS

Section	
1600.150	Definitions
1600.151	Requirements for a Valid Qualified Illinois Domestic Relations Order
1600.152	Curing Minor Deficiencies
1600.153	Filing a QILDRO with the System
1600.154	Modified QILDROs
1600.155	Benefits Affected by a QILDRO

## STATE UNIVERSITIES RETIREMENT SYSTEM

## NOTICE OF ADOPTED AMENDMENT

1600.156	Effect of a Valid QILDRO
1600.157	QILDROs Against Persons Who Became Members Prior to July 1, 1999
1600.158	Alternate Payee's Address
1600.159	Electing Form of Payment
1600.160	Automatic Annual Increases
1600.161	Expiration of a QILDRO
1600.162	Reciprocal Systems QILDRO Policy Statement
1600.163	Providing Benefit Information for Divorce Purposes

1600.APPENDIX A Chart Outlining Hearing Procedures (Repealed)

AUTHORITY: Implementing and authorized by 40 ILCS 5/15-177.

SOURCE: Amended September 2, 1977; amended at 2 Ill. Reg. 31, p.53, effective July 30, 1978; amended at 7 Ill. Reg. 8139, effective June 29, 1983; codified at 8 Ill. Reg. 19683; amended at 11 Ill. Reg. 15656, effective September 9, 1987; amended at 13 Ill. Reg. 18939, effective November 21, 1989; amended at 14 Ill. Reg. 6789, effective April 20, 1990; emergency amendment at 21 Ill. Reg. 4864, effective March 26, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 6095, effective May 2, 1997; amended at 21 Ill. Reg. 11962, effective August 13, 1997; amended at 21 Ill. Reg. 12653, effective August 28, 1997; amended at 22 Ill. Reg. 4116, effective February 9, 1998; amended at 23 Ill. Reg. 13667, effective November 1, 1999; amended at 25 Ill. Reg. 10206, effective July 30, 2001; amended at 28 Ill. Reg. 2292, effective January 23, 2004; expedited correction at 29 Ill. Reg. 7575, effective January 23, 2004; amended at 29 Ill. Reg. 2729, effective March 1, 2005; amended at 29 Ill. Reg. 11819, effective July 12, 2005; amended at 29 Ill. Reg. 14060, effective September 1, 2005; amended at 29 Ill. Reg. 14351, effective September 6, 2005.

## SUBPART A: MISCELLANEOUS PROCEDURES

**Section 1600.123 Part-time/Concurrent Service Adjustment**

This Section will clarify how the percentage of time employed for each such year of employment is determined for the service adjustment under Section 15-134.1(b) of the Illinois Pension Code. This percentage cannot exceed 100%.

- a) Determine the average monthly percent time worked.
  - 1) Establish the monthly full-time equivalent (FTE) earnings for each employer by dividing the monthly earnings from that employer by the percent time the participant worked for that employer for that month.

## STATE UNIVERSITIES RETIREMENT SYSTEM

## NOTICE OF ADOPTED AMENDMENT

2) Total the participant's earnings from all employers for that month and divide by the highest full-time equivalent.

3) This results in the average monthly percent time worked.

4) Example:

<u>Employer</u>	<u>Actual Monthly Earnings</u>	<u>Monthly % Time Worked</u>	<u>Monthly FTE</u>
<u>Employer #1</u>	<u>\$200</u>	<u>20%</u>	<u>\$1,000</u>
<u>Employer #2</u>	<u>\$375</u>	<u>30%</u>	<u>\$1,250 (highest)</u>
<u>Employer #3</u>	<u>\$420</u>	<u>40%</u>	<u>\$1,050</u>
<u>Total Actual</u>	<u>\$995</u>		

Average monthly percent time worked = 79.6% (\$995 divided by \$1,250)

b) Determine the percentage of time employed for each such year of employment.

1) Total the average monthly percent time worked for each month in the academic year for which the participant had earnings.

2) Divide this number by the total number of months during the academic year for which the participant had earnings.

3) This calculation results in the percentage of time employed for each such year of employment.

4) Example:

<u>Average monthly % time worked</u>	<u>Earnings in:</u>
<u>79.6</u>	<u>September</u>
<u>67.5</u>	<u>October</u>
<u>54.3</u>	<u>November</u>
<u>78.5</u>	<u>December</u>
<u>35.2</u>	<u>February</u>
<u>38.9</u>	<u>March</u>
<u>44.5</u>	<u>April</u>
<u>37.5</u>	<u>May</u>

## STATE UNIVERSITIES RETIREMENT SYSTEM

## NOTICE OF ADOPTED AMENDMENT

Total 436.08 months of earnings

Percentage of time employed for each such year of employment is 54.5% (436.0 divided by 8).

- c) In calculating a retirement annuity, if the participant's "percentage of time employed for each such year of employment is 50% or less for 3 or more years after September 1, 1959, service is granted for such employment in excess of 3 years", in the proportion that the percentage of time employed for each such year of employment bears to the average annual percentage of time employed during the period on which the final rate of earnings is based. An example calculation for this subsection (c) is:

<u>Year</u>	<u>Unadjusted Service</u>	<u>Percentage of Time Employed</u>	<u>Adjusted Service</u>
<u>1</u>	<u>1.00</u>	<u>25%</u>	<u>1.00</u>
<u>2</u>	<u>1.00</u>	<u>25%</u>	<u>1.00</u>
<u>3</u>	<u>1.00</u>	<u>30%</u>	<u>1.00</u>
<u>4</u>	<u>1.00</u>	<u>30%/57.50%</u>	<u>0.5217</u>
<u>5</u>	<u>1.00</u>	<u>45%/57.50%</u>	<u>0.7826</u>
<u>6</u>	<u>1.00</u>	<u>50%/57.50%</u>	<u>0.8696</u>
<u>7</u>	<u>1.00</u>	<u>55%</u>	<u>1.00</u>
<u>8</u>	<u>1.00</u>	<u>60%</u>	<u>1.00</u>
<u>9</u>	<u>1.00</u>	<u>65%</u>	<u>1.00</u>
	<u>9.00</u>		<u>8.1739</u>

In this example the final rate of earnings are based on years 6 through 9. The average annual percentage of time employed during the period on which the final rate of earnings is based is 57.5%. This is the sum of years 6 through 9 percentages divided by 4.

Years 1 through 6 have percentages of 50% or less and must be tested for adjustment. The participant receive 3 of these years without adjustment. To maximize the service that is used in the calculation of the retirement annuity, those years with the smallest percentages will be applied to the 3 years the participant receives without adjustment. In this example, that is years 1 through 3. Therefore, only years 4 through 6 require adjustment. To determine the adjusted service, divide the "percentage of time employed" by the "average annual percentage of time employed during the period on which the final rate of earnings

## STATE UNIVERSITIES RETIREMENT SYSTEM

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is based", then multiply by the unadjusted service. If year 4's unadjusted service had been 0.50 year, the adjusted service would have been  $30\%/57.5\% \times 0.50 = .2609$ .

- d) The service credit adjustment in subsection (c) is not made in determining the participant's eligibility for a retirement annuity, disability benefits, additional death benefits, or survivors' insurance.

(Source: Added at 29 Ill. Reg. 14351, effective September 6, 2005)

## DEPARTMENT OF CORRECTIONS

## NOTICE OF EMERGENCY RULES

- 1) Heading of the Part: Transitional Housing Licensure for Sex Offenders on Parole, Probation, or Supervision
- 2) Code Citation: 20 Ill. Adm. Code 800
- 3) 

<u>Section Numbers:</u>	<u>Emergency Action:</u>
800.10	New Section
800.20	New Section
800.30	New Section
800.40	New Section
800.50	New Section
800.60	New Section
800.70	New Section
800.80	New Section
800.90	New Section
800.100	New Section
800.110	New Section
800.120	New Section
800.130	New Section
800.140	New Section
800.150	New Section
800.160	New Section
800.170	New Section
800.180	New Section
800.190	New Section
800.200	New Section
800.210	New Section
800.220	New Section
800.300	New Section
800.310	New Section
800.320	New Section
800.330	New Section
800.340	New Section
800.350	New Section
- 4) Statutory Authority: Unified Code of Corrections, 3-3-2, 3-3-7, 3-3-9, 3-14-2, 3-17-1, 3-17-5, 5-6-3, 5-6-4, 16.2, and 120 [730 ILCS 5/3-2-2, 3-3-7, 3-3-9, 3-14-2, 3-17-1, 3-17-5, 5-6-3, 5-6-3.1 and 5-6-4 and 110/16.2 and 152/120)] and the Sex Offender Management Board Act, 20 ILCS 4026.

## DEPARTMENT OF CORRECTIONS

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- 5) Effective Date of Rules: September 9, 2005
- 6) If this emergency rulemaking is to expire before the end of the 150-day period, please specify the date on which it is to expire: N/A
- 7) Date Filed with the Index Department: September 9, 2005
- 8) A copy of the emergency amendment, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Reason for Emergency: The Department of Corrections is promulgating emergency rules to comply with the statutory mandate in Public Act 94-0161 that requires the Department of Corrections to have rules regarding the licensure of Transitional Housing for Sex Offenders on Parole, Probation, or Supervision in place within 60 days after the effective date of the legislation.
- 10) A Complete Description of the Subjects and Issues Involved: To comply with PA 94-0161, these rules sets forth licensing procedures for transitional housing facilities for sex offenders on parole, probation, or supervision and sets operating standards and security requirements.
- 11) Are there any proposed amendments to this Part pending? No
- 12) Statement of Statewide Policy Objectives: This rulemaking does not create or expand any State mandate.
- 13) Information and questions regarding this rule shall be directed to:

Name: Beth Kiel  
Illinois Department of Corrections  
Address: 1301 Concordia Court  
P. O. Box 19277  
Springfield, Illinois 62794-9277

Telephone: 217/522-2666, extension 6511

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

DEPARTMENT OF CORRECTIONS

NOTICE OF EMERGENCY RULES

TITLE 20: CORRECTIONS, CRIMINAL JUSTICE, AND LAW ENFORCEMENT

CHAPTER I: DEPARTMENT OF CORRECTIONS

SUBCHAPTER h: MISCELLANEOUS STANDARDS

PART 800

TRANSITIONAL HOUSING LICENSURE FOR SEX OFFENDERS  
ON PAROLE, PROBATION, OR SUPERVISION

SUBPART A: LICENSING PROCEDURES

Section

800.10 Applicability

EMERGENCY

800.20 Designees

EMERGENCY

800.30 Definitions

EMERGENCY

800.40 Transitional Housing, Treatment, and Referral Criteria

EMERGENCY

800.50 Licenses Required

EMERGENCY

800.60 Application Fees

EMERGENCY

800.70 Application for Licensure

EMERGENCY

800.80 Licensing Requirements

EMERGENCY

800.90 Responsibilities of the Governing Body

EMERGENCY

800.100 On-site Inspection of Programs, Security, and Operations

EMERGENCY

800.110 Background Investigations

EMERGENCY

800.120 Required Notices

EMERGENCY

800.130 Change of Ownership or Management or Corporate Dissolution

EMERGENCY

800.140 Application for Renewal of License

EMERGENCY

800.150 Grounds for Revocation, Termination, or Refusal to Issue or Renew a License

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## EMERGENCY

800.160 Complaints Concerning Licensees

## EMERGENCY

800.170 Investigation of Potential Deficiencies or Violations Concerning Licensees

## EMERGENCY

800.180 Disposition of Potential Deficiencies or Violations Concerning Licensees

## EMERGENCY

800.190 Closure Order

## EMERGENCY

800.200 Procedure for Revocation or Refusal to Renew a License

## EMERGENCY

800.210 Licensing Hearing

## EMERGENCY

800.220 Operation Without a License

## EMERGENCY

## SUBPART B: OPERATING STANDARDS

## Section

800.300 Administration

## EMERGENCY

800.310 Reports and Correspondence

## EMERGENCY

800.320 Records of Sex Offenders

## EMERGENCY

800.330 Security Procedures

## EMERGENCY

800.340 Searches

## EMERGENCY

800.350 Safety and Emergency Procedures

## EMERGENCY

AUTHORITY: Implementing and authorized by Sections 3-2-2, 3-3-7, 3-3-9, 3-14-2, 3-17-1, 3-17-5, 5-6-3, 5-6-3.1 and 5-6-4 of the Unified Code of Corrections [730 ILCS 5/3-2-2, 3-3-7, 3-3-9, 3-14-2, 3-17-1, 3-17-5, 5-6-3, 5-6-3.1 and 5-6-4], Section 16.2 of the Probation and Probation Officers Act [730 ILCS 110/16.2], Section 120 of the Sex Offender and Child Murderer Community Notification Law [730 ILCS 152/120], and the Sex Offender Management Board Act [20 ILCS 4026].

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SOURCE: Adopted by emergency rulemaking at 29 Ill. Reg. 14358, effective September 9, 2005.

## SUBPART A: LICENSING PROCEDURES

**Section 800.10 Applicability  
EMERGENCY**

This Subpart applies to the Department and any person, group of persons, corporations, or entity that intends to develop, establish, maintain, or operate Transitional Housing for sex offenders on parole, probation, or supervision.

**Section 800.20 Designees  
EMERGENCY**

Unless otherwise specified, whenever a title such as Director is used in this Subpart, it means the person who holds that title or the person who has been designated in writing to fulfill the duties of that title on a routine basis or during a temporary absence or an emergency.

**Section 800.30 Definitions  
EMERGENCY**

"Authorized Representative" means the individual in whom authority is vested for the management, control, and operation of all services at a Transitional Housing facility and for communication with the Department regarding the status of the licenses at that facility.

"Department" means the Illinois Department of Corrections.

"Director" means the Director of the Department.

"Facility" means the building or premises that are used for housing and services as specified in this Part.

"Governing Body" means the board of directors of a corporation or partners, owners, proprietors, members, managers, or other entity or persons legally responsible for the operation of the facility.

"License" means a document issued by the Department to allow the applicant to establish or operate a Transitional Housing facility.

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"Licensee" means those individuals, agencies, or organizations that hold a license.

"Licensing Administrator" means Department staff authorized by the Director to oversee the licensing process and operations of Transitional Housing facilities holding a license.

"Linkage Agreement" means a written agreement with an external person or organization to supplement existing services and to arrange for other services not directly provided by or at a Transitional Housing facility.

"Parole" means the conditional and revocable release of a committed person under the supervision of a parole officer.

"Probation" means a sentence of release upon set conditions of a convicted person under the supervision of a county probation officer.

"Sex offender" means a person who has been adjudicated guilty of a sex offense as defined in the Sex Offender Registration Act [730 ILCS 150].

"SOMB" means the Sex Offender Management Board.

"Supervising Authority" means the law enforcement entity responsible for the supervision of the sex offender on parole, probation, or supervision.

"Supervision" means the release of a person upon set conditions after an adjudication of guilt but prior to entry of conviction under the supervision of a county probation officer.

"Transitional Housing" means a Department licensed community based facility where a limited number of sex offenders on parole, probation, or supervision are temporarily placed and reside for monitoring, counseling, and treatment.

**Section 800.40 Transitional Housing, Treatment, and Referral Criteria  
EMERGENCY**

Applicants for a Transitional Housing license must:

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- a) Have a facility that is located more than 500 feet from any school, facility providing programs or services exclusively directed toward persons under 18 years of age, or playground.
- b) Have a physical structure that provides for security measures approved by the Department 24 hours per day and seven days per week.
- c) Limit residential occupancy of the facility to individuals over the age of 18.
- d) Provide housing to sex offenders on parole, probation, or supervision for a period not to exceed 90 days unless otherwise approved by the Director of the Department.
- e) Provide a structured environment for congregate living that shall offer regular scheduled group sessions that are held a minimum of three days per week; provide the opportunity, either in-house or a referral system for outside providers, for sex offender treatment with SOMB certified providers; and monitor the movement of all sex offenders on parole, probation, or supervision by maintaining a system of signing in and out. This record shall be available for review at all times by the Department, its parole agents, county probation officers, local police departments, and other supervision entities.
- f) Establish a budget that specifies monthly operating expenses and demonstrates sufficient income to meet these expenses plus emergency reserve by providing documentation of access to a minimum sum equivalent to the total of two months of operating expenses within 6 months of licensure.
- g) Notify immediately the supervising authority of any sex offender resident, whether or not on electronic detention or monitor, who has left the facility without properly signing out or has overstayed his or her leave time, who has been involved in criminal activity at the location, or who has contact with a law enforcement agency at the facility; and, in cases of emergency, this notifying contact shall include the requirement of first contacting the appropriate local law enforcement agency responsible for handling the emergency.
- h) Provide treatment and counseling plans for each sex offender to the Director for review and approval.

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- i) Have a written linkage agreement or agreements with SOMB certified providers to provide the opportunity of sex offender treatment to be paid for by the sex offender residents.
- j) Have a referral network to be utilized by sex offenders for necessary medical, mental health, substance abuse, and vocational or employment resources, and maintain any legally required confidentiality of identifying information.
- k) Have the ability for all sex offenders to be monitored electronically and allow the technicians for the electronic monitoring equipment on the premises as necessary.

**Section 800.50 Licenses Required  
EMERGENCY**

- a) No person on parole, probation, or supervision for a sex offense shall reside in a building or premises in which another person known to be a sex offender or known to have been placed on supervision for a sex offense resides, except in a Department licensed Transitional Housing facility. Any person, group of persons, corporation, or other entity who desires to develop, establish, maintain, or operate a Transitional Housing facility for sex offenders who are on parole, probation, or supervision must obtain a license from the Department prior to commencing operations. Transitional Housing licenses shall be issued for the specific level of the facility.
  - 1) Level I licenses shall be issued to facilities that may house more than one but not more than 20 sex offenders on parole, probation, or supervision.
  - 2) Level II licenses shall be issued to facilities that have a Department of Human Services license under 77 Ill. Adm. Code 2060 and that have less than ten sex offender residents or have ten percent of the total residency be sex offenders on parole, probation, or supervision whichever is less.
- b) Before a Transitional Housing license may be granted, the licensing applicant must certify its compliance with federal, State, and local laws as well as all applicable building, zoning, planning, land use, health, and sanitation regulations as specified in federal, State, or local laws or ordinances and with fire safety requirements of the State Fire Marshal.

**Section 800.60 Application Fees  
EMERGENCY**

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- a) The non-refundable application fee shall be \$250 per facility and must be submitted with each application for a license, renewal of a license, or relocation of a licensed facility.
- b) Payment shall be made by check or money order and payable to the Department. A separate check or money order shall be submitted with each facility application.
- c) No application fee shall be required of any unit of local, State, or federal government.

**Section 800.70 Application for Licensure  
EMERGENCY**

- a) An application for a license to operate Transitional Housing for sex offenders who are on parole, probation, or supervision, for renewal of a license, or to relocate a licensed facility shall be completed and signed by the governing body of the facility or its authorized representatives on forms prescribed and furnished by the Department. Forms are available by sending a written request to:

Illinois Department of Corrections  
1301 Concordia Court  
P. O. Box 19277  
Springfield, Illinois 62794-9277  
Attn: Sex Offender Transitional Housing Licensing Administrator

- b) The application shall be signed and dated by the organization representative and at least two of the corporate officers in the case of a corporate applicant, or by all partners or associates in the case of a partnership or association, be notarized, and include the following:
  - 1) Articles of incorporation and bylaws, including a statement indicating the facility's corporate status is in good standing with the Illinois Secretary of State and whether the institution is for profit or not-for-profit; or a copy of the entity's partnership agreement; or statement of ownership; or articles of organization; and a list of assumed names under which the entity is doing business, as applicable.
  - 2) A statement of purpose and range of services and a general description of the type of security established or to be established.

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- 3) The names and addresses of all owners or controlling parties of the organization and whether they are individuals, partnerships, corporate bodies, or subdivisions of other bodies, such as public agencies or religious, fraternal, or other charitable organizations. In the case of corporations, the names and addresses of all officers, directors, and stockholders owning five percent or more of the stock of the corporation, either beneficial or of record, shall be disclosed.
  - 4) Annual current operating budget and projected budget showing anticipated expenses and income and emergency reserve.
  - 5) Certification of compliance with applicable local building, zoning, health, sanitation, or other safety requirements as specified in federal, State, or local laws, and with fire safety requirements of the State Fire Marshal.
  - 6) Proof of fire, hazard, liability and other insurance coverage appropriate to the administration of Transitional Housing.
  - 7) A facility site plan of the proposed site in which the specific use of each building and the specific floor plan and an explanation of the facility locking, lighting, and communication features are included. All secure doors, windows, and perimeter structures, including fencing and gates, shall be shown.
  - 8) The program and operations plan for Transitional Housing submitted.
  - 9) The staffing plan that provides for continuous supervision and security that includes the number of staff, their minimum qualifications, pre-service orientation and on-going training for staff, and complete job descriptions and job titles.
  - 10) Documentation of background checks in accordance with Section 800.110.
  - 11) The appropriate application fee per Section 800.60.
  - 12) If applying for a Level II license, a copy of the Department of Human Services license.
- c) A new application shall be required whenever:

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- 1) An application for license has been withdrawn and the facility seeks to reapply;
  - 2) There is a change of facility location;
  - 3) There is a change of licensee's ownership, name, supervising agency, or corporate status or the individual who holds a license has died; or
  - 4) A new license is sought after the Department has either revoked a license or refused to renew a license.
- d) A new application may be submitted at any time after a license has been voluntarily surrendered or withdrawn by the applicant.
  - e) If the Department has refused to renew a license or has revoked a license, the facility may not reapply for licensure before the expiration of 12 months after the Department's action.
  - f) If the applicant's mailing address, but not the physical location, changes, the Department shall be notified immediately, but no later than ten days after the change. A current phone number and, if available, a fax number shall be provided to the Department.
  - g) The Department shall issue a license or a notification of refusal to issue a license within 180 days after the date the application was received and determined to be complete.

**Section 800.80 Licensing Requirements****EMERGENCY**

- a) A license to operate a Transitional Housing facility shall be valid for three years from the date issued unless revoked by the Department or voluntarily surrendered by the licensee.
- b) A license shall not be issued retroactively.
- c) The license shall include the level of the license, licensee's name, the facility name and address, the date issued, the license number, and the expiration date.

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- d) The license shall not be transferred to another person, organization, or sponsor, nor shall it be valid for a name, address, or part of the facility other than what is shown on the license.
- e) The facility shall adhere to the provisions specified on the license.
- f) The facility shall maintain a degree of financial solvency that assures compliance with the standards prescribed in this Part and assures adequate care and supervision of the sex offenders on parole, probation, or supervision.
- g) Financial records shall be maintained and kept in the State of Illinois where they shall be readily available for review by the Department.
- h) The Department shall be notified immediately if the facility is determined to be financially insolvent.
- i) At any time during the licensure period, additional services for sex offenders may be added at the facility at no extra licensing cost.
- j) Changes in the following shall occur only upon prior approval of the Department:
  - 1) The programming modality used by the facility;
  - 2) The residential capacity of the facility; or
  - 3) The security, operations, and treatment plans to be used by the facility.
- k) The licensee shall give 90 days notice to the Department prior to voluntarily closing or terminating its Transitional Housing facility. The notice shall state the proposed date of closing and the reason for the closing. The facility shall operate in compliance with the standards listed in this Part until the date of closure or until the sex offenders on parole, probation, or supervision are removed.
- l) The license certificate shall remain the property of the Department and shall be returned to the Department if there is a change in ownership, management, or location, or if the license is suspended, revoked, or modified.

**Section 800.90 Responsibilities of the Governing Body  
EMERGENCY**

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- a) The governing body of an incorporated facility shall be a board of directors composed of at least five persons. All board members shall be of reputable and responsible character. The governing body shall be responsible for maintaining the standards set forth in this Part.
- b) The governing body of a sole proprietorship or partnership shall be the partners, owners, proprietors, members, managers, or other entity or persons legally responsible for the operation of the facility.
- c) The governing body shall:
  - 1) Provide written by-laws, partnership agreements, articles of organization, or statements of ownership, as applicable;
  - 2) Assure that the facility operates at all times with an on-site administrator who, by official notice, is made known to the Department;
  - 3) Hold at least two meetings annually;
  - 4) Keep written records or minutes of all board meetings reflecting official actions by the board;
  - 5) Officially notify the Department of any major changes in the corporate structure or a change in the administration of the facility, including: articles of incorporation and by-laws, partnership agreements, articles of organization, board membership, officers, ownership, and changes in services provided by the facility;
  - 6) Establish written policies of the facility that shall be made available to all members of the governing body and employees of the facility, including services to be provided by the facility;
  - 7) Assure that staff have achieved appropriate competency levels for this type of facility and are administering the facility's established policies correctly;
  - 8) Assure that the facility has clearly outlined procedures to ensure continuity for sex offenders residing in the Transitional Housing and sufficient linkage agreements and programs to support the sex offenders;

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- 9) Provide and maintain physical facilities appropriate for the program and supporting services;
- 10) Maintain and keep all records and documents required by this Part in the State of Illinois where they shall be readily available for review by licensing representatives; and
- 11) Assure fidelity bonding of fiscally responsible officers and employees, elected or appointed, whether or not compensated by salary, against breach of fidelity duty or the loss of monies, securities or other property that the facility may sustain through any fraudulent or dishonest act or acts committed by any officer or employee acting alone or in collusion with others.

**Section 800.100 On-site Inspection of Programs, Security, and Operations  
EMERGENCY**

- a) Prior to recommending issuance of a license, the site of a Transitional Housing facility shall be inspected by licensing representatives.
- b) On-site reviews of programs, security, and operations shall be completed by Department licensure staff prior to recommendation for licensure and at least annually thereafter.
- c) License representatives, within 30 days after the application for licensure has been received and determined to be complete, shall schedule a visit to the facility. The purpose of the visit shall be to assess the housing and prepare a written report to the Licensing Administrator regarding:
  - 1) Compliance with applicable statutes, licensing procedures, and standards;
  - 2) The adequacy of security, programming, and care outlined in the program plan;
  - 3) The degree to which the program, as outlined, can reasonably be expected to ensure security, safety, continuity of care, and the provision of adequate planning and services;
  - 4) The adequacy of number of staff, staff qualifications, and training;

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- 5) The adequacy of the physical plant, site, and facility design in relation to implementing Transitional Housing; and
  - 6) Whether the quality assurance, security policies, and evaluation mechanisms developed by the facility can reasonably be expected to control the use of behavior management techniques and security practices within the facility and to minimize the frequency of unusual incidents within the program.
- d) In order to determine continuing compliance with applicable statutes and rules, a licensee's facility may, without prior notice, be visited periodically by authorized representatives of the Department.

**Section 800.110 Background Investigations  
EMERGENCY**

- a) No Transitional Housing applicant may receive a license from the Department, and no person may be employed by a licensed Transitional Housing facility, unless he or she provides written authorization for a background check that may include, but is not limited to:
  - 1) A check of the criminal justice information systems, including, but not limited to, those maintained by the Illinois Department of State Police, the Federal Bureau of Investigation, and the United States Department of Justice, to determine whether the person has been charged with a crime, and if so, the disposition of the charges; and
  - 2) A pre-employment drug test and an agreement to random drug testing when the Department or the facility has reasonable suspicion of abuse.
- b) The authorization required under this Section shall be on forms prescribed by the Department and shall include:
  - 1) Identifying information consisting of name, address, social security number, date of birth, height, weight, hair and eye color, and previous names and addresses;
  - 2) Fingerprints;

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- 3) A declaration under penalty of perjury regarding any prior criminal convictions other than a minor traffic violation; and
  - 4) Authorization for the Department to release the results of the investigation to the governing body or employer.
- c) Each facility license applicant and employee or prospective employee of a licensed facility shall submit to a fingerprinting process as determined by the Department.
  - d) For purposes of this Section only, employees who have been separated from the facility for six months or longer due to reasons other than approved leave time shall no longer be considered current employees. Upon their return to active duty, these individuals shall be required to again authorize a background investigation pursuant to this Section.
  - e) Employees and prospective employees of a multi-function agency otherwise exempt from the requirements of this Section, but whose duties may require that they be on the premises of a Transitional Housing facility, shall authorize the background investigation required by this Section.
  - f) An individual who has authorized the background investigation required by this Section may be employed by a Transitional Housing facility on a provisional or probationary basis pending the outcome of any required background investigation of federal records.

**Section 800.120 Required Notices  
EMERGENCY**

- a) Facility Postings
  - 1) Upon initial licensure and during the period of licensure, the licensee shall maintain at the main entrance a visible and conspicuous exterior sign in at least four inch high letters identifying the facility as a "Department of Corrections Licensed Transitional Housing Facility".
  - 2) The license issued by the Department shall be publicly displayed at the facility at all times.
- b) Facility Filing and Publication

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- 1) Upon initial licensure, the licensee shall file with the office of the county clerk of the county in which the facility is located a certificate setting forth the name the facility is operating under and the true or real full names of persons or entities operating the facility.
  - 2) The licensee shall publish the filing of the notice of licensure in a newspaper of general circulation published in the county in which the certificate is filed. The notice shall be published once per week for three consecutive weeks with the first publication within 15 days after the certificate is filed with the county clerk.
  - 3) Proof of publication shall be filed with the county clerk within 50 days from the date of filing the certificate. Unless proof of publication is made to the county clerk, the notification is void.
- c) The licensee shall notify the police department, public and private elementary and secondary schools, public libraries, and each residential home and apartment complex located within 500 feet of the Transitional Housing facility of its initial licensing as a Transitional Housing facility and its continuing operation as a Transitional Housing facility annually thereafter.
  - d) The Department shall, within one week of issuance of a Transitional Housing license, submit written notification to the Illinois State Police of the licensure, the address of the facility, and the maximum number of sex offenders that can be housed at the facility for inclusion on the Illinois State Police Offender Registry website.

**Section 800.130 Change of Ownership or Management or Corporate Dissolution  
EMERGENCY**

- a) Each Transitional Housing license issued shall be valid only for the premises and persons named in the application. Licensure is not transferable. A license shall become null and void when:
  - 1) A change in ownership occurs involving more than 25% of the aggregate ownership interest within a one year period or a significant change in management occurs; or

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- 2) A change in 50% or more in the board of directors of a not-for-profit corporation occurs within a one year period.
- b) In order to obtain a new license reflective of the change in ownership, the licensee shall submit an application and fees to the Department in accordance with Sections 800.60 and 800.70.
- c) Failure to notify the Department within ten calendar days after the changes in ownership listed in subsection (a) will result in the imposition of a license fee of \$350 for each affected license.
- d) A license shall become null, void, and of no further effect when there is any dissolution of a corporate licensee. Written notification shall be given to the Department within ten calendar days after the dissolution.
- e) A license issued to a corporation that is subsequently dissolved shall not be reactivated upon reinstatement of the corporation and the license is also subject to sanctions as provided in this Part. Such corporation shall reapply for licensure.
- f) In order to obtain a new license relative to reinstatement of a corporation, an application for initial licensure and the license application fee of \$250 per license shall be submitted to the Department. If the Department was not notified within ten calendar days of the dissolution of the corporation, the license fee will be \$350 for each affected license.

**Section 800.140 Application for Renewal of License  
EMERGENCY**

- a) Application forms for license renewal prescribed by the Department shall be requested by the facility from the Department prior to the expiration date of the Transitional Housing license. The completed application shall be submitted to the Department three months prior to the expiration date of the license.
- b) Upon receipt of the application for license renewal, the Department shall conduct a licensing study. The study shall include an on-site visit of the premises and a review of the records of the facility as the Department considers necessary in order to determine that the facility meets or continues to meet the licensing standards for a Transitional Housing facility. The licensing study shall be in writing and shall be reviewed and signed by the Director. The Department shall either:

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- 1) Renew the license if the Department is satisfied that the facility continues to maintain the minimum licensing standards; or
  - 2) Refuse to renew the license in accordance with Section 800.200.
- c) When a licensee has made timely and sufficient application for renewal of a license and the Department fails to render a decision on the application for renewal of the license prior to the expiration date of the license, the existing license shall continue in full force and effect for up to 30 days until the final Department decision has been made. The Department may, if good cause is shown, further extend the period in which the decision must be made for up to 30 days.

**Section 800.150 Grounds for Revocation, Termination, or Refusal to Issue or Renew a License  
EMERGENCY**

- a) The Department may revoke a license, refuse to renew a license, or refuse to issue a license of any Transitional Housing facility if there is a finding that the licensee or the licensee's governing body or employees did any of the following:
- 1) Failed to maintain standards prescribed by Department rules or applicable laws.
  - 2) Violated any of the provisions of the license issued.
  - 3) Acted to conceal, misrepresent, or falsify any condition, action, or omission that would demonstrate non-compliance with rules or procedures or a violation of any federal, State, or local law or court order.
  - 4) Failed to submit to the Department required reports or failed to make available to the Department any records required by the Department in conducting an investigation of the facility for licensing purposes.
  - 5) Failed or refused to submit to or fully cooperate with an investigation required by the Department.
  - 6) Failed or refused to admit authorized representatives of the Department at any time for the purpose of investigation.

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- 7) Failed to provide, maintain, equip, and keep in a safe, secure, and sanitary condition premises established or used for Transitional Housing required under standards prescribed by the Department rules or required by any law, regulation, or ordinance applicable to the location of the facility.
  - 8) Failed to publicly display its license and notices or to publish and file notification in accordance with Section 800.120.
  - 9) Failed to exercise reasonable care in the hiring, training, and supervision of facility personnel.
  - 10) Failed to report absences of sex offenders on parole, probation, or supervision.
  - 11) Failed to report to the Department unusual incidents.
  - 12) Failed to correct any condition that may jeopardize the health, safety, security, or welfare of sex offenders served by the facility.
  - 13) Failed to correct any condition or occurrence relating to the operation, security, or maintenance of the facility that violates this Part.
  - 14) Failed to maintain financial resources adequate to administer a Transitional Housing facility.
- b) If the continued operation of the Transitional Housing facility jeopardizes the health, safety, or welfare of the sex offenders being served or if adequate security is not maintained, the facility may be closed immediately in accordance with Section 800.190.

**Section 800.160 Complaints Concerning Licensees  
EMERGENCY**

Complaints concerning Transitional Housing facilities shall be directed orally or in writing to the Department's licensing representatives serving the facility, if known, or to:

Illinois Department of Corrections  
1301 Concordia Court  
P. O. Box 19277

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Springfield, Illinois 62794-9277

Attn: Sex Offender Transitional Housing Licensing Administrator  
(217) 522-2666

**Section 800.170 Investigation of Potential Deficiencies or Violations Concerning Licensees  
EMERGENCY**

- a) The Department shall initiate a timely investigation of allegations of potential deficiencies, violations, or evidence of grounds for revocation or termination.
- b) Department investigations may include an interview with the person making the allegation, if known, and with others who may have knowledge relevant to the alleged violation or deficiency.
- c) An unannounced visit by the licensing representative may be made to the location of the facility.
- d) The facility's refusal to allow the licensing representative to conduct the investigation or failure to otherwise cooperate in the investigation is basis for revocation of the facility license.

**Section 800.180 Disposition of Potential Deficiencies or Violations Concerning Licensees  
EMERGENCY**

- a) Within 15 business days after completion of the investigation, the Department shall make a formal finding determining whether there were violations of licensing procedures or standards or federal, State, or local laws.
- b) Within five calendar days after the Department makes a formal finding of violation, a letter shall be sent by registered mail, return receipt requested, to the licensee summarizing the findings.
- c) The letter shall:
  - 1) Cite the laws or licensing procedures or standards violated;
  - 2) Notify the licensee that within ten days after the receipt of the letter the licensee may send a written request to the Licensing Administrator requesting an informal review of the decision; and

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- 3) Notify the licensee that failure to correct the violations may result in revocation of the license or refusal to renew a license.
- d) If a request for informal review of the Department's findings is granted by the Licensing Administrator and the licensee indicates a willingness to correct the violations, a time period for compliance may be allowed as determined by the Licensing Administrator. When a time period is granted, a registered letter of notice shall be sent to the licensee specifying the time period granted to correct the violations that shall begin upon the licensee's receipt of the registered mail. A licensing representative may make unannounced on-site visits to determine whether the identified violations have been corrected within the time period permitted for compliance.
- e) If, at the conclusion of the period of time granted the licensee for correction of the findings, the licensee has failed to correct the identified violations or, if no time period for compliance was authorized, the Department shall proceed to revoke or refuse to renew the license in accordance with Section 800.200.
- f) If threats exist to the health, safety, or welfare of the sex offenders served or to the facility security systems or protocols, suspension or termination of the license may immediately result.

**Section 800.190 Closure Order  
EMERGENCY**

- a) Whenever the Department expressly finds that the continued operation of a Transitional Housing facility jeopardizes the health, safety, or welfare of the sex offenders served by the facility or that the facility is unable to maintain adequate security, the Department shall issue an order of closure directing that the operation of the facility as Transitional Housing for sex offenders terminate immediately and, if applicable, shall initiate license revocation proceedings within ten working days.
- b) A facility closed under this Section may not operate as a Transitional Housing facility during the pendency of any judicial review of the decision by the Department to issue an order of closure or to revoke or refuse to renew the license, except under court order.
  - 1) Those sex offenders on parole, probation, or supervision residing at the facility shall move out immediately to a residency approved by the

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supervision authority after any order of closure or revocation of or refusal to renew a license.

- 2) All sex offenders' records shall be released to the Licensing Administrator.

**Section 800.200 Procedure for Revocation or Refusal to Renew a License  
EMERGENCY**

- a) Except as otherwise provided in Section 800.190, the Department shall notify the licensee by registered mail, return receipt requested, prior to revocation or refusal to renew a license.
  - 1) The notice shall be sent to the address specified on the license or to the address of the ranking or presiding officer of the board of directors or any equivalent body operating the facility.
  - 2) The notice shall inform the licensee that he or she may, within ten days after receipt of the notice through registered mail, make a request to the Department for a public hearing before the Department and for a written statement of the charges.
- b) Upon receipt of a written request for a hearing by the licensee, the Department shall send to the licensee a notice of the hearing by registered mail, return receipt requested. The notice shall include:
  - 1) A written statement of the charges;
  - 2) A statement of the date, time, place, and nature of the hearing;
  - 3) The names and mailing addresses of the hearing officer, all parties, and all other persons to whom the Department gives notice of the hearing, unless otherwise held confidential by law; and
  - 4) A statement of the legal authority and jurisdiction under which the hearing is to be held.
- c) The statement of charges shall be provided in writing and shall contain:
  - 1) A plain and concise statement of the matters asserted and the consequences of the failure to respond;

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- 2) Citation of the federal, State, or local laws or rules and regulations alleged to be violated; and
- 3) Specific relief sought via this action.
- d) The hearing must be held within 30 days after the date of the postmark of the registered mail.
- e) The notice must be received by the licensee no later than 15 days prior to the date set for the hearing.
- f) The hearing shall be conducted in accordance with Section 800.210.
- g) If no request for a hearing is made within ten days after notification, the license shall be revoked or renewal denied.

**Section 800.210 Licensing Hearing  
EMERGENCY**

- a) At the date, time, and place designated, the Director, or an individual authorized in writing by the Director to function as the hearing officer, shall conduct a hearing regarding the revocation of a license or the refusal to renew a license to operate a Transitional Housing facility. The hearing shall be governed by the provisions contained in Article 10 of the Illinois Administrative Procedure Act [5 ILCS 100/Art.10], unless otherwise provided in this Section.
- b) Both the Department and the licensee, also referred to as parties, shall be allowed to present written and oral statements, testimony, and evidence that may be pertinent to the charges or to the defense. A person may appear and be heard on his or her own behalf or through an attorney at law authorized to practice in the State of Illinois.
- c) An attorney appearing in a representative capacity shall file a written notice of appearance identifying him or herself by name, address, and telephone number and identifying the party represented.
- d) Any pleadings, motions, affidavits in support of motions, and notices shall be served by the filing party upon all parties to the proceeding. Proof of service

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upon all parties shall be filed with the Department at the address listed in Section 800.160.

- 1) Service shall be made by delivering in person or by depositing in the United States mail, properly addressed with postage prepaid, one copy to each party entitled to the material. When any party has appeared by attorney, service upon the attorney shall be deemed service upon the party.
  - 2) Proof of service of any paper shall be by a certificate of attorney, affidavit, or acknowledgement.
- e) The hearing officer may direct parties or their attorneys to appear at a specified date, time, and place for a conference prior to the date set for the hearing or during the course of the hearing for the purpose of considering:
- 1) The simplification of issues;
  - 2) The necessity or desirability of amending the pleadings for the purpose of clarification, amplification, or limitation with respect to matters alleged in any pleading;
  - 3) The possibility of making admissions or stipulations of fact to the end of avoiding the unnecessary introduction of evidence;
  - 4) The procedure at the hearing;
  - 5) The limitation of the number of witnesses;
  - 6) The propriety of prior mutual exchange between or among parties of prepared testimony or exhibits; and
  - 7) Such other matters as may aid in the simplification of the evidence and disposition of the proceeding.
- f) All hearings conducted in any proceeding shall be open to the public, except that the hearing officer may close portions of the hearing based on considerations concerning the welfare and safety of the participants or witnesses. In the event of failure to appear at the hearing upon proper notice, the hearing may be held ex parte immediately.

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- g) The hearing officer shall have full authority to:
- 1) Rule upon all motions made in the course of a hearing;
  - 2) Rule upon all other matters arising in the course of the hearing; and
  - 3) Require, upon reasonable notice, any party to present further material or relative evidence upon any issue.
- h) If the respondent believes the hearing officer is biased against the respondent or if there is a conflict of interest, he or she shall petition the Director in writing at least five days prior to the date set for the hearing to appoint another hearing officer to hear the matter. The petition shall be accompanied by an affidavit setting forth the facts upon which the claim of bias or conflict of interest is based. The Director shall make a determination whether bias or conflict of interest exists, and may remove any hearing officer he or she finds biased or if a determination has been made that a conflict of interest exists.
- i) The technical rules of evidence shall not apply at any hearing. Any evidence having probative value and force, relevant and material to the facts at issue, shall be admitted in the proceedings, subject only to objections to the weight of the evidence as distinguished from admissibility per se. When the admissibility of evidence is in dispute and depends upon fairly arguable interpretations of law, the evidence shall be admitted.
- j) A party may conduct examinations or cross-examinations without rigid adherence to formal rules. The hearing officer before whom a matter is pending may, in his or her discretion, examine any of the witnesses at a hearing.
- k) Parties may by stipulation agree upon any facts involved in the proceeding. The facts stipulated shall be considered as evidence in the proceeding.
- l) The Department shall record the hearing via methods such as tape or stenography.
- 1) The record of the hearing shall be transcribed upon request of any party provided that the party pays the cost of the transcript.
  - 2) Suggested corrections to the transcript may be offered within ten days after the transcript is filed in the proceeding, unless the hearing officer permits suggested corrections to be official thereafter.

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- m) Subpoenas for the attendance of witnesses from any place in the State of Illinois, or for the production of relevant books and papers for a hearing in a pending proceeding, may be issued by the Department or the hearing officer upon the motion of any party. Service of subpoenas and payment of witness fees shall be as provided in the Civil Practice Act [735 ILCS 5].
- n) After initiation of a statement of charges, any party, upon written request made to the other party at least three business days prior to the hearing or within five business days after service of an additional pleading, shall be entitled to:
  - 1) Obtain the names and addresses of witnesses the other party intends to call to testify at the hearing; and
  - 2) Obtain all writings and documents the party proposes to offer in evidence.
- o) A party may serve on any other party a written request for the admission by the latter of the truth of any specified relevant fact set forth in the request or for the admission of genuineness of any relevant documents described in the request. Copies of the documents shall be served with the request unless copies have already been furnished.
- p) The hearing officer may continue the hearing from time to time, but not to exceed a single period of 30 days, unless special extenuating circumstances make further continuance feasible.
- q) Within 30 business days after the close of all proofs in the hearing, the hearing officer shall cause to be prepared and filed with the Department originals of findings of fact, conclusions of law, and a recommendation to the Director, together with the entire record in the proceeding.
- r) At any time prior to the entering of findings of facts, conclusions of law, and recommendations by the hearing officer, the parties may seek to terminate the matter by presenting to the Director an agreed order to which they all acknowledge their consent by affixing their respective signatures. Upon the Director's signing of such an order, the entire proceeding shall cease and each party shall be deemed to have waived administrative review.
- s) Within 30 business days after receipt of the findings of fact, conclusions of law, recommendations to the Director, and the entire record of the proceeding, the

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Director shall issue a final administrative decision. A copy of the decision shall be served on each party personally or by certified mail and shall include the findings of fact and conclusions of law. Final administrative decisions of the Department may be judicially reviewed pursuant to the Administrative Review Law [735 ILCS 5/Art. III].

- t) The time within which any act under this Section is to be done shall be computed by excluding the first business day and including the last business day.

**Section 800.220 Operation Without a License  
EMERGENCY**

- a) Whenever the Department determines that an unlicensed person or organization is engaging in housing that requires licensure pursuant to Section 800.50 of this Part, it shall issue a notice to that person or organization to cease and desist from engaging in the activity. The notice shall specify the licensure requirement and shall include citation of relevant sections of the Illinois Administrative Procedure Act and this Part.
- b) The Department's notice shall include the instruction that the recipient may submit written documentation to the Department within ten calendar days to support a claim that licensure is not required or that the recipient is properly authorized to engage in the rental activity.
- c) After the expiration of the ten day period, if the Department believes that the person or organization is unlicensed and continuing to engage in activity that requires licensure under this Part, the Department shall refer the matter to the appropriate State's Attorney or to the Office of the Attorney General.

## SUBPART B: OPERATING STANDARDS

**Section 800.300 Administration  
EMERGENCY**

- a) All licensed Transitional Housing facilities shall employ at least one full-time authorized representative who is responsible for the daily operations at the Transitional Housing facility.
- b) The Authorized Representative's name and contact information shall be provided to the Department, the probation office of the county in which the Transitional

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Housing facility is located, and the local police department. The Transitional Housing authorized representative may also function as a Transitional Housing manager.

- c) All licensed Transitional Housing facilities shall have on-site at all times at least one Transitional Housing manager who oversees all activities under the direction of the authorized representative. The Transitional Housing manager shall maintain at the facility a historical record of each sex offender placed at the facility and a file on each sex offender that includes the transition plan for residency in the area and anticipated length of stay at the facility, tracks the efforts made to implement this plan, contains the resident's treatment plan, and documents the sex offender's attendance at any treatment or group services within the facility. Such file shall be given to the supervising agent for the sex offender when the sex offender concludes his or her residency at the facility.
- d) All licensed Transitional Housing facilities shall maintain written qualifications and a description of the authority and responsibilities of the authorized representative.
- e) Either the authorized representative or an individual designated to act in the place of the authorized representative shall be scheduled at the facility and function as the on-call administrator at all times.
- f) All licensed Transitional Housing facilities shall have a minimum of one case manager for every 20 sex offender residents. The case manager shall:
  - 1) Develop and monitor individual treatment and case plans for each sex offender.
  - 2) Assist sex offenders in developing a long-term self-sufficiency plan to enable them to transition successfully into the community by providing linkage to resources such as housing, employment, and transportation.
  - 3) Maintain appropriate referral sources and contact persons for the sex offenders' referral for community-based services such as sex offender treatment, mental health services, substance abuse services, and healthcare.

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- 4) Assist in making appointments that facilitate the approved treatment plans for sex offenders, and where necessary, transport sex offenders to and from those appointments.
  - 5) Maintain thorough, accurate, and timely sex offender records, files, and correspondence.
  - 6) Prepare reports and presentations of information as required.
  - 7) Reinforce with sex offenders all program policies, rules, and expectations for participation in the program.
  - 8) Attend and participate in case reviews and present progress reports on each sex offender.
- g) Operations manuals shall be accessible to the Department.

**Section 800.310 Reports and Correspondence  
EMERGENCY**

- a) As correspondence, treatment plans, efforts to relocate sex offenders to non-Transitional Housing, and other such information becomes available or changes, the authorized representative shall submit copies of this information to the Department.
- b) **Annual Reports**  
The authorized representative shall submit by November 1 of each year to the Department an annual report that shall include, but not be limited to:
  - 1) Total number of sex offenders who have at any time resided in the Transitional Housing facility since January 1.
  - 2) Current number of sex offenders in residency at the Transitional Housing facility and the offenses of those offenders.
  - 3) Total number of sex offenders who exited Transitional Housing facility both through successful relocation and violations since January 1.
- c) **Unusual Incident Reports**

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- 1) Unusual incidents or situations that occur on the grounds of a Transitional Housing facility or that occur within the community involving an on-duty employee or a resident at the Transitional Housing facility shall be reported to the appropriate officials and completely documented by the witnessing employee or the employee who received notification of the incident prior to the end of his or her shift. The unusual incident report shall be maintained in a separate confidential administrative file and shall include the following:
  - A) The facility name.
  - B) The date and time of the incident.
  - C) The names and, if applicable, the identification numbers of the staff and residents involved in the incident.
  - D) The names and, if applicable, the identification numbers of witnesses to the incident.
  - E) A complete narrative of the facts and circumstances of the incident.
  - F) The signature of the reporting staff member and the date and time the report was written.
  - G) The signature of the reviewing supervisory staff member and the date and time the report was received.
  - H) An assessment by the authorized representative or designee and his or her signature and the date reviewed.
- 2) The authorized representative or designee shall report immediately, by telephone, to the Licensing Administrator and supervising authority any of the following types of incidents or situations that occur on the grounds of the facility or that involve an on-duty employee or resident away from the facility:
  - A) A resident's physical assault on any person where serious injury requires medical treatment.

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- B) An arrest of a resident.
  - C) Use of force by an employee, including use of physical force to restrain.
  - D) A resident's suicide attempt.
  - E) Any serious illness or injury that requires medical attention.
  - F) Any unauthorized absence of a resident.
  - G) Death of a resident.
  - H) Major property loss or damage.
  - I) Any serious fire or arson attempt.
  - J) Any resident or employee action that the facility may refer for prosecution of criminal charges.
  - K) Other incidents or situations that, in the opinion of the authorized representative, should be reported.
  - L) Any other incidents or situations that may result in legal action or require an administrative response by the Department.
- 3) The authorized representative of the Transitional Housing facility, after immediately informing the Licensing Administrator by telephone of the incident, shall ensure:
- A) An initial incident report is completed and transmitted to the Licensing Administrator by the next working day or within 72 hours after the incident if the incident occurs on the weekend. The initial report may be designated as the final report.
  - B) A progress report or final follow-up report is transmitted to the Licensing Administrator within 15 days after the incident, if applicable. A progress report shall be transmitted to the Licensing Administrator, as additional information is available, but not less

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frequently than every 90 days after the date of the last report until submission of the final report.

**Section 800.320 Records of Sex Offenders  
EMERGENCY**

- a) All Transitional Housing facilities shall establish and maintain a file on a current basis for each sex offender resident.
  - 1) The file shall include, at a minimum, the following applicable information: the sex offender's name, identification number, age, gender, and race or nationality; date of admission to the Transitional Housing facility; risk assessment; treatment and transition plans; treatment attendance; program agreements; releases of information documents; progress reports; reports of program violations; referrals to other agencies, therapists or counselors; record of visitors; date of release from the transition center, address of relocation residence; total number of days in the Transitional Housing facility; and related correspondence.
  - 2) File entries shall be dated and the source of the information and the author of the entry shall be identified.
  - 3) Files are confidential and shall be safeguarded from unauthorized and improper access, disclosure, and loss.
    - A) Files shall be marked "confidential".
    - B) Access to computerized records shall be controlled and restricted on a need-to-know basis. Security measures shall be taken to ensure the integrity and confidentiality of any computer record.
  - 4) Whenever a sex offender moves out of the facility, his or her file shall be transferred to the Department. The facility shall retain a copy of some or all of the contents of the file for its records, as needed, for up to five years.
  - 5) The Department shall have access to files upon request.
- b) The Department shall establish and maintain a file on a current basis for each sex offender residing in a Transitional Housing facility. The file shall include, at a minimum, efforts in placing the sex offender in non-transitional housing; efforts

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to place the offender in the county from which he or she was convicted; the anticipated length of stay of each offender in the Transitional Housing facility; the number of sex offenders residing in the Transitional Housing facility; and the services provided to the sex offender during the residency at the Transitional Housing facility.

**Section 800.330 Security Procedures  
EMERGENCY**

- a) All licensed Transitional Housing facilities shall maintain a security manual that contains policies and procedures related to the following and is consistent with provisions of this Section. At a minimum the security manual procedures shall include: counts, sex offender residents' outside movement, transportation, contraband control, facility inspection, sex offender and visitor searches, emergency plans, use of force, control of caustics, flammable, and toxic materials, facility program schedule, residential rules, mail, visits, use and storage of security equipment, crisis instructions and suicide prevention, investigations, reporting of unusual incidents, and relationship to local law enforcement.
- b) All licensed Transitional Housing facilities shall designate a point of issue for facility keys and security equipment, the point of control of the fire alarm system, staff, sex offender, and visitor sign-ins, and a place for mail.
- c) All licensed Transitional Housing facilities shall prohibit sex offender residents from congregating or loitering on the sidewalk or area immediately outside the facility
- d) All licensed Transitional Housing facilities shall conduct a security inspection of areas and security devices each week.
  - 1) The facility shall submit a written report of the shift and weekly inspections to the authorized representative.
  - 2) The inspections shall be reported on forms that contain, but are not limited to:
    - A) A list of all items or areas to be inspected and an indication that each item or area was inspected;
    - B) Any deficiency detected;

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- C) The name of the staff conducting the inspection;
  - D) Whether the inspection is a shift or weekly inspection; and
  - E) The date and time of the inspection.
- 3) Areas or items to be inspected shall include, but not be limited to:
- A) Living and activity areas;
  - B) Outdoor areas of the facility;
  - C) Fences and all perimeter areas;
  - D) Windows and screens;
  - E) Grills;
  - F) Doors and locks; and
  - G) Video systems, if any.
- e) Unusual incidents shall be reported in accordance with Section 800.310. Persons injured in an incident shall be provided with immediate access to medical services.
- f) Firearms shall be prohibited within all licensed Transitional Housing facilities, except where the weapon is under the control of law enforcement, parole, or probation officers.
- g) All licensed Transitional Housing facilities shall maintain identifying information on any vehicles being routinely operated by a sex offender resident on a regular basis and provide this information to the parole, probation, or other officers or agents of the supervising agency as requested.
- h) Additionally, Level I facilities shall have on premises 24 hours per day seven days per week at least one security guard registered in accordance with the Private Detective, Private Alarm, Private Security, and Locksmith Act of 2004 [225 ILCS 447] who shall:

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- 1) Conduct and document rounds of the facility and perimeter at least every six hours.
- 2) Ensure sex offender residents and visitors sign in and out of the facility.
- 3) Conduct daily living area inspections.

**Section 800.340 Searches  
EMERGENCY**

- a) The Department and parole, probation, and other officers or agents responsible for the supervision of the sex offenders residing in a licensed Transitional Housing facility shall be provided access on the premises at any time to perform searches of the sex offenders' living area and common areas.
- b) All licensed Transitional Housing facilities shall make available access keys to sex offender rooms and other belongings for the purpose of searching the sex offenders' living area and belongings when a sex offender is not present or is unwilling to cooperate in the search.
- c) All licensed Transitional Housing facilities shall post or give prior notice to visitors that visitors and their possessions shall be subject to search upon entry to the facility.

**Section 800.350 Safety and Emergency Procedures  
EMERGENCY**

- a) Fire Safety
  - 1) All licensed Transitional Housing facilities shall establish a written fire prevention plan, including at a minimum:
    - A) Provision for an adequate fire protection service;
    - B) A system of fire extinguisher inspection and testing of equipment at least quarterly or at intervals approved by the State Fire Marshal;
    - C) An annual inspection by the State Fire Marshal;

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- D) Availability of fire protection equipment at appropriate locations throughout the facility; and
  - E) Monthly inspection.
- 2) A comprehensive and thorough inspection of the facility shall be conducted annually or on a schedule approved by the State Fire Marshal to determine compliance with safety and fire prevention standards.
  - 3) The fire plan shall be reviewed annually and updated as needed.
- b) **Flammable, Toxic, and Caustic Materials**  
The use and storage of all flammable, toxic, and caustic materials shall be controlled. These materials must be under direct staff control and be properly stored and secured.
- c) **Emergency Communications**
- 1) All licensed Transitional Housing facilities shall provide for a communications system within the facility and between the facility and the community in the event of urgent, special, or unusual incidents or emergency situations.
  - 2) All licensed Transitional Housing facilities shall establish a written evacuation plan prepared in the event of a fire or a major emergency that shall be approved by the State Fire Marshal. The plan shall be reviewed annually and updated as needed. Revised plans shall be reissued and provided to the State Fire Marshal and to the local fire safety authority. The plan shall include the following:
    - A) Location of buildings and room floor plans;
    - B) Use of exit signs and directional arrows for traffic flow;
    - C) Location of publicly posted evacuation plans; and
    - D) Monthly drills in all occupied locations of the facility.
- d) **Emergency Plans**

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All facility personnel shall be trained in the implementation of written emergency plans.

- e) **Failure to Return**  
The facility shall establish a written plan regarding sex offenders who fail to return to the facility. The plan shall insure a timely coordinated response to the situation consistent with public safety. The plan shall be reviewed at least annually and updated as needed.

## DEPARTMENT OF NATURAL RESOURCES

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- 1) Heading of the Part: Illinois Resident Armed Forces Fee Exemptions
- 2) Code Citation: 17 Ill. Adm. Code 2510
- 3) 

<u>Section Numbers</u> :	<u>Emergency Action</u> :
2510.10	New Section
2510.20	New Section
2510.30	New Section
2510.40	New Section
2510.50	New Section
- 4) Statutory Authority: Implementing and authorized by Sections 805-305 of the Civil Administrative Code of Illinois [20 ILCS 805/805-305], Sections 20-47 of the Fish and Aquatic Life Code [515 ILCS 5/20-47] and by Section 3.1-4 of the Wildlife Code [520 ILCS 5/3.1-4].
- 5) Effective Date of Emergency Rules: September 9, 2005
- 6) If these emergency rules are to expire before the end of the 150-day period, please specify the date on which it is to expire: This Emergency will expire upon adoption of proposed rules (17 IAC 2510).
- 7) Date filed with the Index Department: September 7, 2005
- 8) A copy of the emergency rules, including any material incorporated by reference, is on file in the Department of Natural Resource's principal office and is available for public inspection.
- 9) Reason for Emergency: Public Act 94-0313, effective July 25, 2005, amended the Civil Administrative Code of Illinois, the Fish and Aquatic Life Code and the Wildlife Code, to add provisions for Illinois resident military members who have served abroad, or guard or reserve members called to active duty, to receive free camping, hunting and fishing permits. This emergency rule is necessary to immediately implement the provisions of this Public Act.
- 10) A Complete Description of the Subjects and Issues Involved: This emergency rule contains criteria for qualifying military members, including information on free privileges available and application requirements. Proposed rules are being filed at the same time as this emergency rule and the emergency rules will be replaced upon adoption of the proposed rules.

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DEPARTMENT OF NATURAL RESOURCES

NOTICE OF EMERGENCY RULES

- 11) Are there any other proposed rules pending on this Part? No
- 12) Statement of Statewide Policy Objective: Not Applicable
- 13) Information and questions regarding these rules shall be directed to:

Jack Price, Legal Counsel  
Department of Natural Resources  
One Natural Resources Way  
Springfield IL 62702-1271

217/782-1809

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

## DEPARTMENT OF NATURAL RESOURCES

## NOTICE OF EMERGENCY RULES

TITLE 17: CONSERVATION  
CHAPTER I: DEPARTMENT OF NATURAL RESOURCES  
SUBCHAPTER f: ADMINISTRATIVE SERVICESPART 2510  
ILLINOIS RESIDENT ARMED FORCES FEE EXEMPTIONS

## Section

- 2510.10 Purpose  
EMERGENCY
- 2510.20 Definitions  
EMERGENCY
- 2510.30 Fee Exemptions  
EMERGENCY
- 2510.40 Application  
EMERGENCY
- 2510.50 Violations  
EMERGENCY

**AUTHORITY:** Implementing and authorized by Section 805-305 of the Civil Administrative Code of Illinois [20 ILCS 805/805-305], Section 20-47 of the Fish and Aquatic Life Code [515 ILCS 5/20-47] and by Section 3.1-4 of the Wildlife Code [520 ILCS 5/3.1-4].

**SOURCE:** Adopted by emergency rulemaking at 29 Ill. Reg. 14396, effective September 9, 2005, for a maximum of 150 days.

**Section 2510.10 Purpose**  
**EMERGENCY**

The purpose of this Part is to acknowledge the contribution of *Illinois residents returning from service abroad or mobilization by the President of the United States as an active duty member of the United States Armed Forces, the Illinois National Guard, or the Reserves of the United States Armed Forces* [20 ILCS 805/805-305]. In recognition of their services, the Department of Natural Resources will waive specified fees for camping, fishing and hunting for the amount of time that the active duty member spent in service abroad or mobilized.

**Section 2510.20 Definitions**  
**EMERGENCY**

## DEPARTMENT OF NATURAL RESOURCES

## NOTICE OF EMERGENCY RULES

Active Duty – means active duty in the Armed Forces of the United States, as evidenced by a DD form 2, United States Uniformed Service Identification Card, marked "Active" or "Active Duty".

Department – means the Department of Natural Resources.

Members – means Illinois resident military, guard or reserve members.

Mobilization – means that Reserves or Guard Members were called to active duty by the President of the United States under Title 10 or Title 32, United States Code.

Service Abroad – means active duty service outside the states of the United States of America, its territories or possessions.

Verification of Service Abroad or Verification of Mobilization – means official documentation from the Department of Defense or the appropriate major command showing mobilization dates or service abroad dates. Acceptable documents include a DD-214; a letter from the Illinois Department of Military Affairs for members of the Illinois National Guard, the Regional Reserve Command for members of the Armed Forces Reserve, the Major Command covering Illinois for active duty members; or personnel records for State employees mobilized. A copy of orders shall not be accepted as verification.

**Section 2510.30 Fee Exemptions  
EMERGENCY**

- a) Illinois resident military members who have served abroad, or guard or reserve members who were mobilized are eligible for the following without fee:
  - 1) Camping, with no camping fee except:
    - A) camper is responsible for applicable utility fees; and
    - B) camper is responsible for applicable rent-a-tent fees and cabin fees.
  - 2) Sport fishing and hunting:
    - A) Members will be issued a current Combined Sportsman's License and Habitat Stamp.

## DEPARTMENT OF NATURAL RESOURCES

## NOTICE OF EMERGENCY RULES

- B) If requested by the member, one statewide archery deer permit will be issued upon verification if currently available. One free firearm deer permit for the county of choice (and the archery deer permit if not available at time of verification) will be mailed to the applicant when available.
- b) Non-resident military members are not eligible for no-fee hunting, fishing or camping.

**Section 2510.40 Application  
EMERGENCY**

- a) Military members are eligible for free sport fishing, hunting and camping for one year for each year served and for one year for each portion of a year served.
- b) To receive a camping pass, sportsman's license, habitat stamp and/or deer permit, eligible military members shall:
  - 1) Appear in person at the Department of Natural Resources headquarters:

Illinois Department of Natural Resources  
One Natural Resources Way  
Springfield, Illinois
  - 2) Apply within two years of their return from abroad or release from mobilization. Members released or who returned anytime in 2003 must apply before December 31, 2005.
  - 3) Provide verification of dates of service abroad or verification of dates of mobilization (see Section 2510.20).
  - 4) Provide a photo identification card.
- c) The Armed Forces Special Pass (camping) shall become effective on the date of application and shall expire on the same month and day in the year the entitlement expires.

## DEPARTMENT OF NATURAL RESOURCES

## NOTICE OF EMERGENCY RULES

- d) The Sportsman's License will expire March 31 of each year. A new Sportsman's License, stamp and deer permit may be obtained by following the procedures under subsection (b) or by showing an unexpired Armed Forces Special Pass.

**Section 2510.50 Violations****EMERGENCY**

- a) Violation of this Part is a petty offense [520 ILCS 5/3.5].
- b) Obtaining licenses, stamps, permits or an Armed Forces Special Pass by providing false information is a Class 4 Felony [720 ILCS 5/16-1].
- c) Misuse of the Armed Forces Special Pass, such as obtaining a campsite for others for times the member does not camp at the site, shall result in forfeiture of the pass, in addition to other penalties prescribed by law.

## STATE BOARD OF EDUCATION

NOTICE OF REFUSAL TO MEET THE OBJECTION OF THE JOINT COMMITTEE ON  
ADMINISTRATIVE RULES

- 1) Heading of the Part: Reading Improvement Program
- 2) Code Citation: 23 Ill. Adm. Code 260
- 3) Section Number: 260.55                      Action: Refusal
- 4) Date Notice of Emergency Amendment Published in the Register: July 1, 2005; 29 Ill. Reg. 9508
- 5) Date JCAR Statement of Objection Published in the Register: September 2, 2005, 29 Ill. Reg. 13595
- 6) Summary of Action Taken by the Agency: The State Board of Education has refused to modify or withdraw the emergency amendment that was the subject of this objection. JCAR's objection was a procedural one related to the fact that ISBE could have proposed ordinary amendments earlier, thereby avoiding emergency rulemaking. ISBE does acknowledge the basis for this objection. The agency used emergency rulemaking only in order to avoid prolonging a problematic situation for an additional year, as would have been inherent in ordinary rulemaking at this time. Withdrawal of the emergency amendment would not serve the goal of improving the operation of this program, and ISBE regrets the necessity for this refusal.

JOINT COMMITTEE ON ADMINISTRATIVE RULES  
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICE RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of September 6, 2005 through September 12, 2005 and have been scheduled for review by the Committee at its October 11, 2005 meeting in Chicago. 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>
10/21/05	<u>Secretary of State</u> , Limited Liability Company Act (14 Ill. Adm. Code 178)	7/22/05 29 Ill. Reg. 10570	10/11/05
10/21/05	<u>Secretary of State</u> , Uniform Limited Partnership Act (14 Ill. Adm. Code 171)	7/22/05 29 Ill. Reg. 10567	10/11/05
10/21/05	<u>Secretary of State</u> , Uniform Commercial Code (14 Ill. Adm. Code 180)	7/22/05 29 Ill. Reg. 10575	10/11/05
10/21/05	<u>Department of Financial and Professional Regulation – Division of Banking</u> , Residential Mortgage License Act of 1987 (38 Ill. Adm. Code 1050)	6/10/05 29 Ill. Reg. 8270	10/11/05

## EXECUTIVE ORDER

2005-9

**EXECUTIVE ORDER TO ESTABLISH THE BROADBAND DEPLOYMENT COUNCIL**

**WHEREAS**, the State of Illinois has historically been a leader in computer technology and applications, including University of Illinois Urbana-Champaign's role in the development of the Internet and the World Wide Web;

**WHEREAS**, the State of Illinois is an important hub of global information transfer;

**WHEREAS**, the future economic vitality of the State of Illinois depends on continued participation in the growing global information economy;

**WHEREAS**, the near future will bring further convergence of critical information and communications services and blur distinctions between such services as telephone, Internet, and television;

**WHEREAS**, telecommunications services in rural and low-income areas are not comparable to those available in our State's urban centers;

**WHEREAS**, the objective of universal, competitive, and affordable advanced telecommunications services will be achieved when public, private, and non-profit groups work together toward this goal;

**WHEREAS**, it is therefore necessary that state agencies work together to encourage and help coordinate the spread of universal, competitive, and affordable advanced telecommunications services;

**THEREFORE**, pursuant to the powers vested in me by Article V, Section 11 of the Constitution of the State of Illinois, I hereby order the following:

**I. Creation of the Illinois Broadband Deployment Council**

- (a) There is created the Illinois Broadband Deployment Council ("the Council"). The purpose of the Council is to ensure that, as soon as possible, advanced telecommunications services, including bidirectional communications transfer speeds of at least one megabit per second (1 mbps), are made available to the citizens of Illinois on a universal, competitive, and affordable basis.
- (b) The Council shall be governed by an Executive Committee composed of the following persons or their designees:
  - (1) the Lieutenant Governor, who shall also serve as the Executive Committee's Chairman;
  - (2) the Director of the Department of Commerce and Economic Opportunity;
  - (3) the Chairman of the Illinois Commerce Commission;
  - (4) the Secretary of the Illinois Department of Transportation;
  - (5) the Chairman of the Illinois State Toll Highway Authority;
  - (6) the Chairman of the Illinois Finance Authority;
  - (7) the State Superintendent of the Illinois State Board of Education;
  - (8) the Chairman of the Illinois Board of Higher Education;
  - (9) the Director of the Department of Central Management Services; and

## EXECUTIVE ORDER

- (10) at least 10 individuals appointed by the Governor. These appointments shall be made with consideration of the diversity of the State, including members representing rural areas, underserved urban areas, consumer interests, community interests, and commercial interests including incumbent and Competitive Local Exchange Carriers, and other entities providing communications or information services but not classified as Local Exchange Carriers.
- (c) The Council shall meet at least quarterly.
- (d) Appointed members of the Executive Committee shall serve two terms.

**II. Duties of the Illinois Broadband Deployment Council**

The Council shall be responsible for the following duties:

- (a) To identify those portions of the telecommunications infrastructure owned by agencies of the State of Illinois that can be made available for lease to commercial ventures, non-profit agencies, and local governments; and to establish standard procedures for pricing for least of such infrastructure;
- (b) To ensure where possible that any infrastructure improvement undertaken by an agency of the State of Illinois includes the installation of underground conduit that can be made available on a non-discriminatory basis to public, private, and non-profit entities interested in running fiber-optic lines for communications or information services through such conduit;
- (c) To encourage and facilitate the coordination of private and public telecommunications deployment, including local and regional efforts and public-private partnerships;
- (d) To be a clearinghouse for information about available State, federal, and private funding for private and public telecommunications deployment. This shall include working with the Illinois Finance Authority to develop loan, grant, and/or bond products suitable for telecommunications deployment projects;
- (e) To make recommendations to the General Assembly regarding telecommunications initiatives that require legislative approval, including the creation of a State entity that handles distribution of funds for private and public telecommunications projects;
- (f) To act as a liaison between any telecommunications deployment project and any entity controlling rights of way and other easements necessary for each project;
- (g) To foster competitions among all entities providing commercial communications or information services; and
- (h) To continually assess and catalog the telecommunications infrastructure of the State of Illinois for the purpose of determining the present and future needs of the State with respect to realizing the goals of competition, affordability, universal service, and securing the State's telecommunications and economic future.

EXECUTIVE ORDER

This order shall take effect immediately upon its adoption.

Issued by the Governor September 6, 2005.

Filed with the Secretary of State September 6, 2005.

## PROCLAMATIONS

**2005-293****Chief Justice William Rehnquist**

WHEREAS, born October 1, 1924 in Milwaukee, Wisconsin, William Hubbs Rehnquist was an American attorney, jurist, and political figure who served on the United States Supreme Court from 1972 until his death in 2005; and

WHEREAS, William Rehnquist served as a law clerk for Supreme Court Justice Robert H. Jackson and as Assistant Attorney General during the administration of President Richard Nixon; and

WHEREAS, in 1971, Richard Nixon nominated William Rehnquist to the United States Supreme Court as an Associate Justice. In 1986, President Ronald Reagan elevated him to the position of Chief Justice. Chief Justice William Rehnquist went on to preside over the court in this capacity for 19 years, making him the fourth-longest-serving Chief Justice after Melville Weston Fuller, Roger B. Taney, and John Marshall; and

WHEREAS, after a long bout with thyroid cancer, which he had publicly announced in October of 2004, Chief Justice Rehnquist passed away on September 3. He is survived by his three children, and among his many legacies, he will be remembered for helping to broaden the scope of state powers and establishing more governmental leniency towards state aid for religion; and

WHEREAS, on September 4, 2005, President George W. Bush issued an official proclamation ordering the flag of the United States of America to be flown at half-staff at the White House and on all public buildings and grounds, at all military posts and naval stations, and on all naval vessels of the Federal Government in the District of Columbia and throughout the United States and its Territories and possessions until sunset, Tuesday, September 13, 2005 in commemoration of Chief Justice Rehnquist's life and career. Illinois joins the President in this somber observance:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby order that all State facilities fly the flag of the United States of America at half-staff until sunset on Tuesday, September 13, 2005 in accordance with President Bush's proclamation and in honor and remembrance of Chief Justice William Rehnquist.

Issued by the Governor September 6, 2005.

Filed with the Secretary of the State September 6, 2005.

**2005-294****Hurricane Katrina Observance**

WHEREAS, on August 29, 2005, the Gulf Coast was ravaged by Hurricane Katrina, leaving thousands of people without homes and taking the lives of thousands more. Although the number of people killed is not yet known, it is feared that the total loss of life will be catastrophic; and

WHEREAS, in the wake of this terrible tragedy, states throughout the Union, including Illinois, as well as nations across the world are providing much needed assistance for the relief,

## PROCLAMATIONS

recovery and cleanup operations. There has also been a tremendous outpouring of support from individuals who are providing financial donations and volunteering their time to the affected region; and

WHEREAS, here in Illinois, we express our deepest sorrow to the families of those that have lost their lives during this disaster. As we unify as a nation to get through this difficult time, we join in honoring those many innocent victims; and

WHEREAS, on September 4, 2005, President George W. Bush issued an official proclamation ordering the flag of the United States of America to be flown at half-staff at the White House and on all public buildings and grounds, at all military posts and naval stations, and on all naval vessels of the Federal Government in the District of Columbia and throughout the United States and its Territories and possessions until sunset, Tuesday, September 20, 2005 in honor of the victims of Hurricane Katrina. Illinois joins the President in this somber observance:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby order that all State facilities fly the flag of the United States of America at half-staff until sunset on September 20, 2005 in mournful remembrance of the lives lost on the Gulf Coast.

Issued by the Governor September 6, 2005.

Filed with the Secretary of the State September 6, 2005.

**2005-295****ENQUTATASH DAY**

WHEREAS, in America, everyone has the opportunity to seek a better life, and when refugees arrive in Illinois from Africa, the Ethiopian Community Association of Chicago is there to greet and welcome them with open hearts and helping hands; and

WHEREAS, the Ethiopian Community Association was founded by five refugees who fled civil war in their homeland. Their goal was to bring together the scattered community of Ethiopian refugees and immigrants living in Chicago, with the hope that mutual aid and cooperation would ease the difficult adjustments they encountered while moving to the United States; and

WHEREAS, today, the Ethiopian Community Association is a thriving resettlement agency serving over 2,500 refugees and immigrants per year; and

WHEREAS, the Ethiopian Community Association offers a multitude of programs and services for refugees, including citizenship and civic education, community health outreach, employment counseling and training, financial and computer literacy training, housing assistance, and youth and family development. Furthermore, community members and staff work together to organize events that celebrate and promote Ethiopian culture; and

WHEREAS, one of those cultural events commemorates Enqutatash, the Ethiopian New Year, which falls on September 10:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim September 10, 2005 as **ENQUTATASH DAY** in tribute to the Ethiopian Community Association in Chicago, and to offer best wishes for happiness and success to all those they serve who came to our state in search of a better life.

## PROCLAMATIONS

Issued by the Governor September 6, 2005.

Filed with the Secretary of the State September 6, 2005.

**2005-296****FETAL ALCOHOL SYNDROME AWARENESS DAY**

WHEREAS, Fetal Alcohol Syndrome (FAS) is one of the most preventable causes of mental retardation and birth defects. Sadly, as many as 40,000 infants are still born every year in the United States with fetal alcohol effects; and

WHEREAS, FAS is a lifelong, mentally and physically disabling condition caused by mothers who drink during pregnancy; and

WHEREAS, research has found that even minimal drinking during pregnancy can kill developing brain cells and result in brain damage, facial deformities, and growth abnormalities. Heart, kidney, and liver defects are also common; and

WHEREAS, those with FAS typically have difficulty communicating, learning, and memorizing. Consequently, they have trouble in school and are often deficient in interpersonal skills; and

WHEREAS, unfortunately, there is no cure for FAS. However, with early detection and diagnosis, children with FAS can receive services that increase their chance for a better life; and

WHEREAS, since 1999, September 9 has been observed as International FAS Day to encourage expecting mothers to abstain from alcohol during their nine months of pregnancy;

THEREFORE, I, Rod Blagojevich, Governor of the State of Illinois, do hereby proclaim September 9, 2005 as **FETAL ALCOHOL SYNDROME AWARENESS DAY** in Illinois to raise awareness about Fetal Alcohol Syndrome, and to urge all expecting mothers to take extra precautions while pregnant for the health and well-being of their children.

Issued by the Governor September 7, 2005.

Filed with the Secretary of State September 7, 2005.

**2005-297****PUBLIC LANDS DAY**

WHEREAS, State treasures such as Lake Michigan, the Cahokia Mountains, and the Great Mississippi River ought to be preserved and protected for all of us, our children, and future generations to share and enjoy; and

WHEREAS, for that reason, Americans throughout the country will team up to celebrate Public Lands Day on September 24; and

WHEREAS, this innovative event attracts volunteers of all ages to give their time restoring and enhancing America's federal, state, and local public lands, including forests, lakes, parks, recreation areas, refuges, and wildlife habitats; and

WHEREAS, the National Environmental Education and Training Foundation works with local, State, and federal land management agencies to coordinate Public Lands Day; and

## PROCLAMATIONS

WHEREAS, this year, it is anticipated that more than 80,000 Americans will volunteer and more than \$11 million in needed improvements will be completed at over 600 sites throughout the country:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim September 24, 2005 as **PUBLIC LANDS DAY** in Illinois in support of the worthy efforts to preserve and protect the beauty and splendor of nature, which we share with all living creatures and life-forms.

Issued by the Governor September 7, 2005.

Filed with the Secretary of State September 7, 2005.

**2005-298****NATIONAL VAN LINES DAYS**

WHEREAS, founded in 1929 and incorporated by the State of Illinois in 1934, National Van Lines was founded in Chicago by Frank J. McKee; and

WHEREAS, National Van Lines was Frank's second attempt to establish his vision of a successful transportation business; and

WHEREAS, his dreams had once been dashed by a fire that destroyed all but one of the vans of his flourishing company; and

WHEREAS, with only one truck and \$500, Frank J. McKee and his son Frank L. McKee built up National Van Lines. Today, it is one of the most successful transportation businesses in the United States; and

WHEREAS, although they are no longer living, the McKees left a long, rich, and innovative history and tradition. Frank L. McKee developed the first multiple sleeper truck and trailer, and National Van Lines is also credited with beginning one of the first flatbed container trucking services, used today by all of the major van lines to move household goods; and

WHEREAS, Maureen Beal, daughter and granddaughter of the McKees, is now the president and chief executive officer, and this year, National Van Lines will celebrate their 75th anniversary at a convention in Chicago from September 28 to October 1:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim September 28 to October 1, 2005 as **NATIONAL VAN LINES DAYS** in Illinois during their 75th anniversary in honor and remembrance of Frank J. McKee and his son, and in recognition of the great strides the company has made to revolutionize the transportation industry.

Issued by the Governor September 7, 2005.

Filed with the Secretary of State September 7, 2005.

**2005-299****Y-ME ILLINOIS DAY**

## PROCLAMATIONS

WHEREAS, breast cancer is the second most common type of cancer in women, and approximately 211,000 women in the United States will be diagnosed with breast cancer this year; and

WHEREAS, in 1978, the Y-ME National Breast Cancer Organization was founded by two breast cancer patients, Mimi Kaplan and Ann Marcou, for the purpose of ensuring that no one confronts breast cancer alone; and

WHEREAS, Y-ME accomplishes their mission by raising awareness and providing peer support, and Y-ME Illinois has a multitude of programs and services available to support those afflicted with breast cancer here in this State; and

WHEREAS, open door support groups, teen and adult education workshops, the Gerry Weinberg Resource Library, the IlliNOISY Advocacy Network, the Sharon Rose Wig and Prosthesis Salon, and the 24-Hour Y-ME National Breast Cancer Hotline, are all offered without expense. Y-ME Illinois also issues a newsletter called In Touch to present the latest news on breast cancer issues; and

WHEREAS, these programs and services are only possible with the aid and support of the community, and the annual Y-ME Fashion Show is their major fundraiser; and

WHEREAS, this year, the Y-ME National Breast Cancer Organization celebrates the 25th anniversary of the Fashion Show, and Y-ME Illinois will celebrate their 5th Fashion Show on October 29:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim October 29, 2005 as **Y-ME ILLINOIS DAY** in recognition of the meritorious service Y-ME and Y-ME Illinois provides to those with cancer, and to encourage citizens of the State to support their worthy efforts.

Issued by the Governor September 9, 2005.

Filed with the Secretary of State September 9, 2005.

**2005-300****KIDS DAY AMERICA/INTERNATIONAL (BLAIR FAMILY CHIROPRACTIC)**

WHEREAS, a child's welfare is the foremost concern of every parent in and around the world; and

WHEREAS, for that reason, Kids Day America/International was established by Chiropractors to educate families and communities throughout the world about social issues that concern children's welfare, including health, safety, and the environment. Chiropractors achieve that by addressing drug and health issues, bicycle and fire safety, recycling, and many other important topics; and

WHEREAS, additionally, with the help and support of thousands of local dentists, county sheriff and police personnel, and photographers who all volunteer their time, every child that attends Kids Day has the opportunity to create and complete a Child Safety ID Card; and

WHEREAS, to date, more than 2,000 communities, and nearly 3 million children and their parents, have participated in this event; and

## PROCLAMATIONS

WHEREAS, this year, the Blair Family Chiropractic is the official chiropractic office representing the 11th annual Kids Day event in Columbia, Illinois on September 17, which will benefit the Special Olympics:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim September 17, 2005 as **KIDS DAY AMERICA/INTERNATIONAL** in Illinois in support of the commendable campaign by Kids Day and the Blair Family Chiropractic to protect our children so they can grow and succeed as all parents dream.

Issued by the Governor September 9, 2005.

Filed with the Secretary of State September 9, 2005.

**2005-301****KIDS DAY AMERICA/INTERNATIONAL (WALTON CLINIC OF CHIROPRACTIC)**

WHEREAS, a child's welfare is the foremost concern of every parent in and around the world; and

WHEREAS, for that reason, Kids Day America/International was established by Chiropractors to educate families and communities throughout the world about social issues that concern children's welfare, including health, safety, and the environment. Chiropractors achieve that by addressing drug and health issues, bicycle and fire safety, recycling, and many other important topics; and

WHEREAS, additionally, with the help and support of thousands of local dentists, county sheriff and police personnel, and photographers who all volunteer their time, every child that attends Kids Day has the opportunity to create and complete a Child Safety ID Card; and

WHEREAS, to date, more than 2,000 communities, and nearly 3 million children and their parents, have participated in this event; and

WHEREAS, this year, the Walton Clinic of Chiropractic is the official chiropractic office representing the 11th annual Kids Day event in Springfield, Illinois on September 17, which will benefit the Mini O'Beirne Crisis Nursery:

THEREFORE, I, Rod R. Blagojevich, Governor of the State of Illinois, do hereby proclaim September 17, 2005 as **KIDS DAY AMERICA/INTERNATIONAL** in Illinois in support of the commendable campaign by Kids Day and the Walton Clinic to protect our children so they can grow and succeed as all parents dream.

Issued by the Governor September 9, 2005.

Filed with the Secretary of State September 9, 2005.

# ILLINOIS ADMINISTRATIVE CODE Issue Index - With Effective Dates

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