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INTRODUCTION

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

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

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

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

ILLINOIS REGISTER PUBLICATION SCHEDULE FOR 2009

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

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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENT

- 1) Heading of the Part: Standard Procurement
- 2) Code Citation: 44 Ill. Adm. Code 1
- 3) Section Number: 1.5037 Proposed Action:
New Section
- 4) Statutory Authority: Implementing Public Act 97-971 and authorized by The Illinois Procurement Code [30 ILCS 500]
- 5) A Complete Description of the Subjects and Issues Involved: This rulemaking provides supplemental information regarding registration requirements and requirements regarding the submission of bids/proposals and contracts, including timeframes for submission of registration certificates and the inclusion of contract certifications.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? Yes
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: The proposed amendment neither creates nor expands any State mandate on units of local government, school districts or community college districts.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may submit written comments within 45 days after the date of publication to:

Gina Wilson
Illinois Department of Central Management Services
720 Stratton Office Building
Springfield, Illinois 62706

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF PROPOSED AMENDMENT

217/785-1793

Or

Lynn Carter
Illinois Department of Central Management Services
Deputy General Counsel, Procurement
100 West Randolph Street, 4-607 JRTC
Chicago, Illinois 60601

312/814-1569

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: All businesses seeking to do or doing business with the State of Illinois will be affected equally.
 - B) Reporting, bookkeeping or other procedures required for compliance: State Board of Elections emergency rules regarding implementation of Public Act 95-971 identifies registration.
 - C) Types of professional skills necessary for compliance: Regulatory compliance skills
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the 2 most recent regulatory agendas because: it was not timely anticipated.

The full text of the Proposed Amendment is identical to the text of the Emergency Amendment and begins on page 3205 in this issue of the *Illinois Register*:

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

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

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

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

2008.APPENDIX JJ

New Section

- 4) Statutory Authority: Implementing Sections 363 and 363a and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/363, 363a and 401]
- 5) A Complete Description of the Subjects and Issues Involved: The proposed amendments will incorporate required federal changes from the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Genetic Information Nondiscrimination Act of 2008. The changes relating to the Genetic Information Nondiscrimination Act need to be adopted by June 1, 2009 as dictated by federal law. The MIPPA changes cannot be adopted prior to June 1, 2010 and this effective date has been written into the appropriate rule provisions by design.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This rulemaking will not require a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.
- 12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to comment on this proposed rulemaking may submit written comments no later than 45 days after the publication of this Notice to:

Eve Blackwell-Lewis
Senior Staff Attorney
Department of Financial and
Professional Regulation
Division of Insurance
320 West Washington, 4th Floor
Springfield, Illinois 62767-0001

or

Craig Cellini
Rules Coordinator
Department of Financial and
Professional Regulation
320 West Washington
3rd Floor
Springfield, Illinois 62767-0001

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

217/782-2867

217/785-0813

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: The proposed amendments will not have an affect on small businesses, small municipalities or not for profit corporations.
 - B) Reporting, bookkeeping or other procedures required for compliance: Please carefully review the proposed amendments.
 - C) Types of professional skills necessary for compliance: Insurance
- 14) Regulatory Agenda on which this rulemaking was summarized: January 2009

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

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

TITLE 50: INSURANCE

CHAPTER I: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2008

MINIMUM STANDARDS FOR INDIVIDUAL
AND GROUP MEDICARE SUPPLEMENT INSURANCE

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2008.20	Purpose
2008.30	Applicability and Scope
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2008.40	Definitions

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2008.60	Policy Provisions
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2008.67	Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or after June 1, 2010
2008.70	Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to February 11, 1992 the Effective Date of this Part
2008.71	Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery after or Delivered on or After February 11, 1992 and Prior to June 1, 2010 the Effective Date of this Part
2008.72	Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or after February 11, 1992 and Prior to June 1, 2010
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SUBPART D: CLAIMS, REFUNDS & CREDITS

- 2008.76 Standards for Claims Payment
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2008.82 Permitted Compensation Arrangements
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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 [for Medicare Supplement Plans Sold Prior to June 1, 2010](#)
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2008.APPENDIX H	Plan F or High Deductible Plan F (for plans issued prior to June 1, 2010)
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2008.APPENDIX GG	Plan K (for plans issued on or after June 1, 2010)
2008.APPENDIX HH	Plan L (for plans issued on or after June 1, 2010)
2008.APPENDIX II	Plan M (for plans issued on or after June 1, 2010)
2008.APPENDIX JJ	Plan N (for plans issued on or after June 1, 2010)

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

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

SUBPART A: GENERAL PROVISIONS

Section 2008.30 Applicability and Scope

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

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or a combination thereof, of the labor organizations.

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

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

Section 2008.35 Effective Date (Repealed)

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

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

Section 2008.40 Definitions

For the purposes of this Part:

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

"2010 Standardized Medicare supplement benefit plan", "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

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

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certificateholder (Section 363(2)(a) of the Code).

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

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

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

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

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

Department means the Illinois Department of Financial and Professional Regulation.

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

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

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

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

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

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social

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Security Amendments of 1965, as then constituted or later amended.

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

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

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

Medicare Advantage private fee-for-service plans.

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

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

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

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

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

SUBPART B: COVERAGE, POLICY & BENEFIT PROVISIONS

Section 2008.60 Policy Provisions

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

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

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Section 2008.64 Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or after June 1, 2010

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

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

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- A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.
- B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.
- C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subsection (a)(5)(E), the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder:
- i) Provides for continuation of the benefits contained in the group policy; or
 - ii) Provides for benefits that otherwise meet the requirements of this subsection.
- D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall
- i) Offer the certificateholder the conversion opportunity described in subsection (a)(5)(C); or
 - ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.
- E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

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

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- C) Reinstatement of coverages as described in subsections (a)(7)(A) and (B):
- i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
 - ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and
 - iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.
- b) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.
- 1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
 - 2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
 - 3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

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- 4) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
 - 5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;
 - 6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.
- c) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 2008.67 of this Part.
- 1) Medicare Part A Deductible: Coverage for 100% of the Medicare Part A inpatient hospital deductible amount per benefit period.
 - 2) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.
 - 3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
 - 4) Medicare Part B Deductible: Coverage for 100% of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
 - 5) One Hundred Percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
 - 6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for

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

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

Section 2008.67 Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or after June 1, 2010

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

- a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Section 2008.64(b) of this Part.
- b) If an issuer makes available any of the additional benefits described in Section 2008.64(c), or offers standardized benefit Plans K or L as described in subsections (f)(8) and (9) of this Section, then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subsection (a), a policy form or certificate form containing either standardized benefit Plan C as described in subsection (f)(3) or standardized benefit Plan F as described in subsection (f)(5).
- c) No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this State, except as may be permitted in subsection (g) and in Section 2008.73 of this Part.

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- d) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in Sections 2008.40 and 2008.50 of this Part. Each benefit shall be structured in accordance with the format provided in Section 2008.64(b) and (c) of this Part; or, in the case of plans K or L, in subsection (f)(8) or (f)(9) and list the benefits in the order shown. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.
- e) In addition to the benefit plan designations required in subsection (d) of this Section, an issuer may use other designations to the extent permitted by law.
- f) Make-up of 2010 Standardized Benefit Plans:
- 1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Section 2008.64(b) of this Part.
 - 2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible as defined in Section 2008.64(c)(1) of this Part.
 - 3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(1), (3), (4), and (6) of this Part, respectively.
 - 4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in Section 2008.64(b) of this Part), plus 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Section 2008.64(c)(1), (3), and (6) of this Part, respectively.
 - 5) Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this

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Part, plus 100% of the Medicare Part A deductible, the skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(1), (3), (4), (5), and (6), respectively.

- 6) Standardized Medicare supplement Plan F With High Deductible shall include only the following: 100% of covered expenses following the payment of the annual deductible set forth in subsection (f)(6)(B).
- A) The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(1), (3), (4), (5), and (6) of this Part, respectively.
- B) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by (regular) Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.
- 7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(1), (3), (5), and (6), respectively.
- 8) Standardized Medicare supplement Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

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- A) Part A Hospital Coinsurance 61st through 90th days: Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;
- B) Part A Hospital Coinsurance, 91st through 150th days: Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;
- C) Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
- D) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subsection (f)(8)(J);
- E) Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subsection (f)(8)(J);
- F) Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subsection (f)(8)(J);
- G) Blood: Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subsection (f)(8)(J);

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- H) Part B Cost Sharing: Except for coverage provided in subsection (f)(8)(I), coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subsection (f)(8)(J);
- I) Part B Preventive Services: Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
- J) Cost Sharing After Out-of-Pocket Limits: Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.
- 9) Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:
- A) The benefits described in subsections (f)(8)(A), (B), (C) and (I);
- B) The benefit described in subsections (f)(8)(D), (E), (F), (G) and (H), but substituting 75% for 50%; and
- C) The benefit described in subsection (f)(8)(J), but substituting \$2000 for \$4000.
- 10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this Part, plus 50% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Section 2008.64(c)(2), (3) and (6) of this Part, respectively.
- 11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 2008.64(b) of this

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

- A) the lesser of \$20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and
 - B) the lesser of \$50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.
- g) New or Innovative Benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

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

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

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a) General Standards.

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

- 1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.
- 2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
- 3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts, ~~amount and copayment percentage factors~~. Premiums may be modified to correspond with such changes.
- 4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:
 - A) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium, or
 - B) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.
- 5) An insurer shall:
 - A) Except as authorized by the Director, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material

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misrepresentation.

- B) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (a)(5)(D), the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:
- i) an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and
 - ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 2008.71(b) of this Part.
- C) If a membership in a group is terminated, the issuer shall:
- i) offer the certificateholder such conversion opportunities as are described in subsection (a)(5)(B); or
 - ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.
- D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have 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

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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 61st day through the 90th day in any Medicare benefit period;
 - 2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;
 - 3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;
 - 4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;
 - 5) Coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;
 - 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

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red blood cells, as defined under federal regulations) (42 CFR 409.87(a) 1988, no subsequent dates or editions) unless replaced in accordance with federal regulations (42 CFR 409.87(b) 1988, no subsequent dates or editions) or already paid for under Part A, subject to the Medicare deductible amount.

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

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

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

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

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changes.

- 4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
- 5) Each Medicare supplement policy shall be guaranteed renewable and:
 - A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual;
 - B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;
 - C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under [subsection ~~Section 2008.71~~\(a\)\(5\)\(E\)](#), the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):
 - i) Provides for continuation of the benefits contained in the group policy, or
 - ii) Provides for such benefits as otherwise meet the requirements of this subsection;
 - D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
 - i) Offer the certificateholder the conversion opportunity described in [subsection ~~Section 2008.71~~\(a\)\(5\)\(C\)](#), or
 - ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy;
 - E) If a group Medicare supplement policy is replaced by another

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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 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

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as of the date of termination of such entitlement.

- C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under [sectionSection](#) 226(b) of the Social Security Act and is covered under a group health plan as defined in [sectionSection](#) 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 is substantially equivalent to coverage in effect before the date of the suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and
 - iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

8) [If, after June 1, 2010, an issuer makes a written offer to the Medicare Supplement policyholders or certificateholders of one or more of its plans,](#)

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to exchange during a specified period from his or her 1990 Standardized plan (as described in Section 2008.72 of this Part) to a 2010 Standardized plan (as described in Section 2008.67 of this Part), the offer and subsequent exchange shall comply with the following requirements:

- A) An issuer need not provide justification to the Director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the Director.
- B) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.
- C) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than 6 months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.
- D) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

- b) Standards for Basic ("Core") Benefits Common to Benefit Plans A-J
Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.
 - 1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the

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extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

- 2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
 - 3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
 - 4) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
 - 5) Coverage for the coinsurance amount (or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount) of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
- c) Standards for Additional Benefits
The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 2008.72 of this Part.
- 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 21st day through the 100th 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

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deductible amount per calendar year regardless of hospital confinement.

- 4) Eighty Percent of the Medicare Part B Excess Charges: Coverage for 80% of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or State law, and the Medicare-approved Part B charge.
- 5) One Hundred Percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or State law, and the Medicare-approved Part B charge.
- 6) Basic Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- 7) Extended Outpatient Prescription Drug Benefit: Coverage for 50% of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- 8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care 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:

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

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- iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

B) Coverage Requirements and Limitations

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

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

\$1,600 per calendar year.

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.

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

- C) Coverage is excluded for:
 - i) Home care visits paid for by Medicare or other government programs; and
 - ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

- d) Standards for Plans K and L
 - 1) Standardized Medicare supplement benefit Plan "K" shall consist of the following:
 - A) Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th 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 91st through the 150th 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

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(d)(1)(J);

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

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- B) The benefits described in subsections (d)(1)(D), (E), (F), (G) and (H), but substituting 75% for 50%; and
- C) The benefit described in subsection (d)(1)(J), but substituting \$2000 for \$4000.

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

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

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

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plus the Medicare Part A Deductible as defined in Section 2008.71(c)(1) of this Part.

- 3) Standardized Medicare supplement benefit Plan "C" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in Section 2008.71(c)(1), (2), (3) and (8) of this Part respectively.
- 4) Standardized Medicare supplement benefit Plan "D" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (8) and (10) of this Part respectively.
- 5) Standardized Medicare supplement benefit Plan "E" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in Section 2008.71(c)(1), (2), (8) and (9) of this Part respectively.
- 6) Standardized Medicare supplement benefit Plan "F" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, 100% of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 2008.71(c)(1), (2), (3), (5) and (8) of this Part respectively.
- 7) Standardized Medicare supplement benefit high deductible Plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan "F" deductible. The covered expenses include the Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A deductible, Skilled Nursing Facility Care, the Medicare Part B deductible, 100% of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in Section 2008.71(c)(1), (2), (3), (5) and (8) respectively. The

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annual high deductible Plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12 month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

- 8) Standardized Medicare supplement benefit Plan "G" shall include only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80% of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (4), (8) and (10) of this Part respectively.
- 9) Standardized Medicare supplement benefit Plan "H" shall consist of only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in Section 2008.71(c)(1), (2), (6) and (8) of this Part respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- 10) Standardized Medicare supplement benefit Plan "I" shall consist of only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100% of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (5), (6), (8) and (10) of this Part respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- 11) Standardized Medicare supplement benefit Plan "J" shall consist of only the following: The Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A Deductible, Skilled Nursing Facility Care,

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Medicare Part B Deductible, 100% of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (3), (5), (7), (8), (9) and (10) of this Part respectively. The outpatient prescription drug benefit shall not be included in a Medicare Supplement policy sold after December 31, 2005.

- 12) Standardized Medicare supplement benefit high deductible Plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible Plan "J" deductible. The covered expenses include the Core Benefit as defined in Section 2008.71(b) of this Part, plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medicare Part B deductible, 100% of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit as defined in Section 2008.71(c)(1), (2), (8) and (10) respectively. The annual high deductible Plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan "J" policy, and shall be in addition to any other specific benefit deductible. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12 month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.
- f) Make-up of two Medicare supplement plans mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);
 - 1) Standardized Medicare supplement benefit Plan "K" shall consist of only those benefits described in Section 2008.71(d)(1).
 - 2) Standardized Medicare supplement benefit Plan "L" shall consist of only those benefits described in Section 2008.71(d)(2).
 - g) New or Innovative Benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the

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applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

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

SUBPART F: REPORTING & PROHIBITIONS

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

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

- a) An issuer of a Medicare supplement policy or certificate:
 - 1) shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and
 - 2) shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

- b) Nothing in subsection (a) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:
 - 1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or
 - 2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

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- c) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of the individual to undergo a genetic test.
- d) Subsection (c) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Part C of Title XI (42 USC 1320d-1320d-8) and section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 USC 1320d-2), as may be revised from time to time) and consistent with subsection (a).
- e) For purposes of carrying out subsection (d), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.
- f) Notwithstanding subsection (c), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:
- 1) The request is made pursuant to research that complies with 45 CFR 46 (2005) or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.
 - 2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of the child, to whom the request is made that:
 - A) compliance with the request is voluntary; and
 - B) non-compliance will have no effect on enrollment status or premium or contribution amounts.
 - 3) No genetic information collected or acquired under this subsection (f) shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

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- 4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection (f), including a description of the activities conducted.
- 5) The issuer complies with other conditions the Secretary may by regulation require for activities conducted under this subsection (f).
- g) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.
- h) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to the individual's enrollment under the policy in connection with the enrollment.
- i) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase shall not be considered a violation of subsection (h) if the request, requirement, or purchase is not in violation of subsection (g).
- j) For the purposes of this Section only:
 - 1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of the issuer.
 - 2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.
 - 3) "Genetic information" means, with respect to any individual, information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members of the individual. The term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, by the individual or any family member of the individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by the pregnant woman, or with respect to an individual or family member

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utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

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

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

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

[COMPANY NAME]

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

Benefit Plans _____ [insert letters of plans being offered]

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

See Outlines of Coverage sections for details about all plans.

BASIC BENEFITS FOR PLANS A-J:

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

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

Blood: First 3 pints of blood each year.

A	B	C	D	E
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery	
				Preventive Care NOT Covered by

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				Medicare
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F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits					
Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance					
Part A Deductible	Part A Deductible					
Part B 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
					Preventive Care NOT Covered by Medicare	Preventive Care NOT Covered by Medicare

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

NOTE:

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

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[COMPANY NAME]

Outline of Medicare Supplement Coverage – Cover Page 2

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

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

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

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

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

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See Outlines of Coverage for details and exceptions.

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PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

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

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

(for producers:)

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

(for direct response:)

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

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

[Include for each plan prominently identified on the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in Appendices C through 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.]

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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
SKILLED NURSING FACILITY CARE* 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
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

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NOTICE OF PROPOSED AMENDMENTS

HOSPICE CARE 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.

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NOTICE OF PROPOSED 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
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.			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	[\$100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
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
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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

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

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

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
61 st thru 90 th day	All but [\$_____] a day	[\$_____] a day	\$0
91 st 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
SKILLED NURSING FACILITY CARE*			
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 st thru 100 th day	All but [\$_____] a day	\$0	Up to [\$_____] a day
101 st day and after	\$0	\$0	All costs
BLOOD			

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NOTICE OF PROPOSED AMENDMENTS

First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE 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 outpatient 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
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.			
First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

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NOTICE OF PROPOSED AMENDMENTS

CLINICAL LABORATORY SERVICES			
TEST FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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

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

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NOTICE OF PROPOSED AMENDMENTS

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
61 st thru 90 th day	All but [\$_____] a day	[\$_____] a day	\$0
91 st 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
SKILLED NURSING FACILITY CARE*			
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 st thru 100 th day	All but [\$_____] a day	Up to [\$_____] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0

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Additional amounts	100%	\$0	\$0
HOSPICE CARE 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.

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NOTICE OF PROPOSED 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
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. First \$[100] of Medicare Approved Amounts*	\$0	\$[100] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD 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
CLINICAL LABORATORY SERVICES-TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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

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NOTICE OF PROPOSED AMENDMENTS

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

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

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

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NOTICE OF PROPOSED AMENDMENTS

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$ _____]	[\$ _____] (Part A Deductible)	\$0
61 st thru 90 th day	All but [\$ _____] a day	[\$ _____] a day	\$0
91 st 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
SKILLED NURSING FACILITY CARE* 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
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0

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NOTICE OF PROPOSED AMENDMENTS

HOSPICE CARE 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.

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NOTICE OF PROPOSED 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
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. First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD 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
CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE 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)

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Remainder of Medicare Approved Amounts	80%	20%	\$0
AT HOME RECOVERY SERVICES- NOT 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 \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS – Not Covered by Medicare

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

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

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$ _____]	[\$ _____] (Part A Deductible)	\$0
61 st thru 90 th day	All but [\$ _____] a day	[\$ _____] a day	\$0
91 st 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
SKILLED NURSING FACILITY CARE*			
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 st thru 100 th day	All but [\$ _____] a day	Up to [\$ _____] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0

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NOTICE OF PROPOSED AMENDMENTS

Additional amounts	100%	\$0	\$0
HOSPICE CARE 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.

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED 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
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. First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 generally 80%	\$0 generally 20%	\$[100] (Part B Deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[100] (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

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

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

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NOTICE OF PROPOSED AMENDMENTS

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

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

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

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

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

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

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

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

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

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NOTICE OF PROPOSED AMENDMENTS

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

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

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

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$___] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$___] DEDUCTIBLE**] YOU PAY
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.			
First \$[100] of Medicare Approved Amounts*	\$0	\$[100] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	generally 80%	generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
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
CLINICAL LABORATORY SERVICES-TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$___] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$___] DEDUCTIBLE**] YOU PAY
HOME HEALTH CARE 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

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

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

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NOTICE OF PROPOSED AMENDMENTS

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
61 st thru 90 th day	All but [\$_____] a day	[\$_____] a day	\$0
91 st 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
SKILLED NURSING FACILITY CARE*			
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 st thru 100 th day	All but [\$_____] a day	Up to [\$_____] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			

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First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE 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.

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

PARTS A & B

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

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Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES- NOT COVERD 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 \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$_____]	[\$_____] (Part A Deductible)	\$0
61 st thru 90 th day	All but [\$_____] a day	[\$_____] a day	\$0
91 st 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
SKILLED NURSING FACILITY CARE* 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 st thru 100 th day	All but [\$_____] a day	Up to [\$_____] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			

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

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

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			

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

OTHER BENEFITS – Not Covered By Medicare

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

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

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [\$ _____]	[\$ _____] (Part A Deductible)	\$0
61 st thru 90 th day	All but [\$ _____] a day	[\$ _____] a day	\$0
91 st 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
SKILLED NURSING FACILITY CARE* 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 st thru 100 th day	All but [\$ _____] a day	Up to [\$ _____] a day	\$0
101 st day and after	\$0	\$0	All costs
BLOOD			

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First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE 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.

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

PARTS A & B

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

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First \$[100] of Medicare Approved Amounts*	\$0	\$0	\$[100] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
AT-HOME RECOVERY SERVICES- NOT 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 \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

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

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

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

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

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

SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$ ___] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$ ___] DEDUCTIBLE**] YOU PAY
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. First \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 generally 80% \$0	\$[100] (Part B Deductible) generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[100] (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES- TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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SERVICES	MEDICARE PAYS	[AFTER YOU PAY [\$___] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO [\$___] DEDUCTIBLE**] YOU PAY
HOME HEALTH CARE 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 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 \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

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

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

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

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

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

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PLAN K

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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 First \$[100] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 10%	\$[100] (Part B deductible)****♦ All costs above Medicare approved amounts Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$])*
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$[100] (Part B deductible)**** ♦ Generally 10% ♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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

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

PLAN K**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE 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%	10%	10% ♦

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

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

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

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

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

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

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

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

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

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

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PLAN L

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
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 First \$[100] of Medicare Approved Amounts**** Preventive Benefits for Medicare covered services Remainder of Medicare Approved Amounts	\$0 Generally 75% or more of Medicare approved amounts Generally 80%	\$0 Remainder of Medicare approved amounts Generally 15%	\$[100] (Part B deductible)**** ♦ All costs above Medicare approved amounts Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of [\$_____])*
BLOOD First 3 pints Next \$[100] of Medicare Approved Amounts**** Remainder of Medicare Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% ♦ \$[100] (Part B deductible) ♦ Generally 5% ♦
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

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

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

PLAN L**PARTS A & B**

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

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

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

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

Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

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

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

Basic Benefits:

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

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

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	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency			
						Out-of-pocket limit \$[4140]; paid at 100% after limit reached	Out-of-pocket limit \$[2070]; paid at 100% after limit reached		

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

PREMIUM INFORMATION [Boldface Type]

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

DISCLOSURES [Boldface Type]

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

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

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

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

RIGHT TO RETURN POLICY [Boldface Type]

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

POLICY REPLACEMENT [Boldface Type]

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

NOTICE [Boldface Type]

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

[for producers:]

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

[for direct response:]

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARTS A & B

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

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

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

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

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

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<u>HOSPITALIZATION*</u>			
<u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____]</u>	<u>[\$ _____] (Part A Deductible)</u>	<u>\$0</u>
<u>61st 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>
<u>SKILLED NURSING FACILITY CARE*</u>			
<u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>

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

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

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

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

<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>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>

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

PARTS A & B

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

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

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

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

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

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

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

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

(Plan C Continued)

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

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

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

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

PARTS A & B

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

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

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

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NOTICE OF PROPOSED AMENDMENTS

Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
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(Source: Added at 33 Ill. Reg. _____, effective _____)

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

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

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

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

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<u>HOSPITALIZATION*</u>			
<u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____]</u>	<u>[\$ _____] (Part A Deductible)</u>	<u>\$0</u>
<u>61st 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>
<u>SKILLED NURSING FACILITY CARE*</u>			
<u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21st thru 100th day</u>	<u>All but [\$ _____] a day</u>	<u>Up to [\$ _____] a day</u>	<u>\$0</u>

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

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

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

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

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

<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>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>generally 80%</u>	<u>generally 20%</u>	<u>\$0</u>

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

PARTS A & B

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

OTHER BENEFITS – Not Covered by Medicare

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

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Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum
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(Source: Added at 33 Ill. Reg. _____, effective _____)

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NOTICE OF PROPOSED AMENDMENTS

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

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

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

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

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>[AFTER YOU PAY \$_____ DEDUCTIBLE**] PLAN PAYS</u>	<u>[IN ADDITION TO \$_____ DEDUCTIBLE**] YOU PAY</u>
<u>HOSPITALIZATION*</u> <u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____]</u>	<u>[\$ _____] (Part A Deductible)</u>	<u>\$0</u>
<u>61st 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>

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<u>- Beyond the Additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>SKILLED NURSING FACILITY CARE*</u> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare- approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21st thru 100th day</u>	<u>All but [\$ _____] a day</u>	<u>Up to [\$ _____] a day</u>	<u>\$0</u>
<u>101st day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>BLOOD</u>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>HOSPICE CARE</u> <u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/co-insurance for out-patient drugs and in-patient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

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

(Plan F or High Deductible Plan F Continued)

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

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

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

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

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

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

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

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

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

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

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

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>[AFTER YOU PAY \$ _____ DEDUCTIBLE**] PLAN PAYS</u>	<u>[IN ADDITION TO \$ _____ DEDUCTIBLE**] YOU PAY</u>
<u>HOSPITALIZATION*</u> <u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____]</u>	<u>[\$ _____] (Part A Deductible)</u>	<u>\$0</u>
<u>61st 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>

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<u>- Beyond the Additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>SKILLED NURSING FACILITY CARE*</u> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21st thru 100th day</u>	<u>All but [\$_____] a day</u>	<u>Up to [\$_____] a day</u>	<u>\$0</u>
<u>101st day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>BLOOD</u>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>HOSPICE CARE</u>			
<u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/co-insurance for out-patient drugs and in-patient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

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

(Plan F or High Deductible Plan F Continued)

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

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

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

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

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<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>
<u>HOME HEALTH CARE</u>			
<u>MEDICARE APPROVED SERVICES</u>			
– <u>Medically necessary skilled care services and medical supplies</u>	100%	\$0	\$0
– <u>Durable medical equipment</u>			
<u>First \$[100] of Medicare Approved Amounts*</u>	\$0	<u>[\$[100] (Part B Deductible)</u>	\$0
<u>Remainder of Medicare Approved Amounts</u>	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>
<u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u>			
<u>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</u>			
<u>First \$250 each calendar year</u>	\$0	\$0	\$250
<u>Remainder of Charges</u>	\$0	<u>80% to a lifetime maximum benefit of \$50,000</u>	<u>20% and amounts over the \$50,000 lifetime maximum</u>

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

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NOTICE OF PROPOSED AMENDMENTS

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

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

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

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<u>HOSPITALIZATION*</u>			
<u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but [\$ _____]</u>	<u>[\$ _____] (Part A Deductible)</u>	<u>\$0</u>
<u>61st 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>
<u>SKILLED NURSING FACILITY CARE*</u>			
<u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>

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

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

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

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

<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>\$0</u>	<u>\$0</u>	<u>\$[100] (Part B Deductible)</u>

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u>			

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<u>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</u>			
<u>First \$250 each calendar year</u>	<u>\$0</u>	<u>\$0</u>	<u>\$250</u>
<u>Remainder of Charges</u>	<u>\$0</u>	<u>80% to a lifetime maximum benefit of \$50,000</u>	<u>20% and amounts over the \$50,000 lifetime maximum</u>

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

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Section 2008.APPENDIX GG Plan K (for plans issued on or after June 1, 2010)

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

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

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

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

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<u>HOSPITALIZATION**</u> <u>Semiprivate room and board,</u> <u>general nursing and miscellaneous</u> <u>services and supplies</u>			
<u>First 60 days</u>	<u>All but \$[]</u>	<u>\$[] (50% of Part A deductible)</u>	<u>\$[] (50% of Part A deductible)♦</u>
<u>61st 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>

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<u>- Beyond the additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>SKILLED NURSING FACILITY CARE**</u> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21st thru 100th day</u>	<u>All but \$[] a day</u>	<u>Up to \$[] a day</u>	<u>Up to \$[] a day ♦</u>
<u>101st day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>BLOOD</u>			
<u>First 3 pints</u>	<u>\$0</u>	<u>50%</u>	<u>50%♦</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>HOSPICE CARE</u> <u>You must meet Medicare's requirements, including a doctor's certification of terminal illness.</u>	<u>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</u>	<u>50% of copayment/coinsurance</u>	<u>50% of Medicare copayment/coinsurance♦</u>

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

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

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

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

This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[___] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PLAN K

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PARTS A & B

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

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

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

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Section 2008.APPENDIX HH Plan L (for plans issued on or after June 1, 2010)

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

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

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

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

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<u>HOSPITALIZATION**</u> <u>Semiprivate room and board,</u> <u>general nursing and miscellaneous</u> <u>services and supplies</u>			
<u>First 60 days</u>	<u>All but \$[]</u>	<u>\$[] (75% of Part A deductible)</u>	<u>\$[] (25% of Part A deductible)♦</u>
<u>61st 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>

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<u>– Beyond the additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>SKILLED NURSING FACILITY CARE**</u> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21st thru 100th day</u>	<u>All but \$[] a day</u>	<u>Up to \$[] a day</u>	<u>Up to \$[] a day♦</u>
<u>101st day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>BLOOD</u>			
<u>First 3 pints</u>	<u>\$0</u>	<u>75%</u>	<u>25% ♦</u>
<u>Additional amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>HOSPICE CARE</u> <u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</u>	<u>75% of copayment/coinsurance</u>	<u>25% of copayment/coinsurance♦</u>

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

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

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

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

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

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NOTICE OF PROPOSED AMENDMENTS

PLAN LPARTS A & B

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<u>HOME HEALTH CARE MEDICARE APPROVED SERVICES</u>			
– <u>Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
– <u>Durable medical equipment</u>			
<u>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: Added at 33 Ill. Reg. _____, effective _____)

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Section 2008.APPENDIX II Plan M (for plans issued on or after June 1, 2010)**PLAN M****MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY*</u>
<u>HOSPITALIZATION*</u> <u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>61st thru 90th day</u>	<u>All but \$[992]</u>	<u>\$[496] (50% of Part A deductible)</u>	<u>\$[496] (50% of Part A deductible)</u>
<u>91st day and after:</u>	<u>All but \$[248] a day</u>	<u>\$[248] a day</u>	<u>\$0</u>
<u>– While using 60 lifetime reserve days</u>	<u>All but \$[496] a day</u>	<u>\$[496] a day</u>	<u>\$0</u>
<u>– Once lifetime reserve days are used:</u>			
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare eligible expenses</u>	<u>\$0**</u>
<u>– Beyond the additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>SKILLED NURSING FACILITY CARE*</u> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>
<u>21st thru 100th day</u>	<u>All but \$[124] a day</u>	<u>Up to \$[124] a day</u>	<u>\$0</u>
<u>101st day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>

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

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

PLAN M

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

* Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<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>1st \$[131] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>

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<u>Remainder of Medicare Approved Amounts</u>	<u>Generally 80%</u>	<u>Generally 20%</u>	<u>\$0</u>
<u>Part B Excess Charges</u> <u>(Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>BLOOD</u>			
<u>First 3 pints</u>	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
<u>Next \$[131] of Medicare Approved Amounts</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<u>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

PARTS A & B

<u>HOME HEALTH CARE MEDICARE APPROVED SERVICES</u>			
<u>– Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>– Durable medical equipment</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>1st \$[131] of Medicare Approved Amounts*</u>			
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$10</u>

OTHER BENEFITS – NOT COVERED BY MEDICARE

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<u>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</u>			
<u>Medically necessary emergency care services beginning during the first 670 days of each trip outside the USA</u>			
<u>First \$250 each calendar year</u>	<u>\$0</u>	<u>\$0</u>	<u>\$250</u>
<u>Remainder of Charges</u>	<u>\$0</u>	<u>80% to a lifetime maximum benefit of \$50,000</u>	<u>20% and amounts over the \$50,000 lifetime maximum</u>

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

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NOTICE OF PROPOSED AMENDMENTS

Section 2008.APPENDIX JJ Plan N (for plans issued on or after June 1, 2010)**PLAN N****MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

<u>SERVICES</u>	<u>MEDICARE PAYS</u>	<u>PLAN PAYS</u>	<u>YOU PAY</u>
<u>HOSPITALIZATION*</u> <u>Semiprivate room and board, general nursing and miscellaneous services and supplies</u>			
<u>First 60 days</u>	<u>All but \$[992]</u>	<u>\$(992)(Part A deductible)</u>	<u>\$0</u>
<u>61st thru 90th day</u>	<u>All but \$[248] a day</u>	<u>\$(248) a day</u>	<u>\$0</u>
<u>91st day and after:</u>			
<u>– While using 60 lifetime reserve days</u>	<u>All but \$[496] a day</u>		
<u>– Once lifetime reserve days are used:</u>		<u>\$(496) a day</u>	<u>\$0</u>
<u>– Additional 365 days</u>	<u>\$0</u>	<u>100% of Medicare eligible expenses</u>	
<u>– Beyond the additional 365 days</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>SKILLED NURSING FACILITY CARE*</u> <u>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital</u>			
<u>First 20 days</u>	<u>All approved amounts</u>	<u>\$0</u>	<u>\$0</u>

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<u>21st thru 100th day</u>	<u>All but \$[124] a day</u>	<u>Up to \$[124] a day</u>	<u>\$0</u>
<u>101st day and after</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>BLOOD</u>			
<u>First 3 pints</u>	<u>\$0</u>	<u>3 pints</u>	<u>\$0</u>
<u>Additional Amounts</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>HOSPICE CARE</u>			
<u>You must meet Medicare's requirements, including a doctor's certification of terminal illness</u>	<u>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</u>	<u>Medicare copayment/coinsurance</u>	<u>\$0</u>

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

PLAN N

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

* Once you have been billed \$[131] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<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>			

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

<u>1st \$[131] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>Generally 80%</u>	<u>Balance, other than up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</u>	<u>Up to \$[20] per office visit and up to \$[50] per emergency room visit. The copayment of up to \$[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</u>
<u>Part B Excess Charges</u> <u>(Above Medicare Approved Amounts)</u>	<u>\$0</u>	<u>\$0</u>	<u>All costs</u>
<u>BLOOD</u>			
<u>First 3 pints</u>	<u>\$0</u>	<u>All costs</u>	<u>\$0</u>
<u>Next \$[131] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>
<u>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>

PARTS A & B

<u>HOME HEALTH CARE MEDICARE APPROVED SERVICES</u>			
<u>– Medically necessary skilled care services and medical supplies</u>	<u>100%</u>	<u>\$0</u>	<u>\$0</u>
<u>– Durable medical equipment</u>			

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF PROPOSED AMENDMENTS

<u>1st \$[131] of Medicare Approved Amounts*</u>	<u>\$0</u>	<u>\$0</u>	<u>\$[131] (Part B deductible)</u>
<u>Remainder of Medicare Approved Amounts</u>	<u>80%</u>	<u>20%</u>	<u>\$0</u>

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Veterans' Health Insurance Program
- 2) Code Citation: 89 Ill. Adm. Code 128
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
128.100	Amended
128.110	Amended
128.240	Amended
128.330	Amended
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 95-0755
- 5) Complete Description of the Subjects and Issues Involved: This rulemaking implements Public Act 95-755, which replaced the original statutory authority for the Veterans' Health Insurance Program from 330 ILCS 125 to 330 ILCS 126. The Department of Healthcare and Family Services adopted a new Part (89 Ill. Adm. Code 128) to regulate eligibility determination and application processing for this Program under the original authority. Because that statute contained a sunset date, the replacement authorizing legislation (PA 95-755) necessitated this rulemaking. Besides correcting statutory authority references, the rulemaking changes the eligibility standard from 25% to 50% of the federal poverty level (in addition to the county-specific Geographic Means Test used by the federal V.A.), removes September 2006 as the Program's starting date, and deletes the premium waiver for the first two months of prospective coverage.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 12) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

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

217/557-7157

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

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

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

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 128

VETERANS' HEALTH INSURANCE PROGRAM

SUBPART A: GENERAL PROVISIONS

Section

128.100	General Description
128.110	Definitions

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section

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

AUTHORITY: The Veterans' Health Insurance Program Act of 2008 [330 ILCS 126]

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

SUBPART A: GENERAL PROVISIONS

Section 128.100 General Description

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

This Part implements the Veterans' Health Insurance Program Act [of 2008 \[330 ILCS 126\]](#)~~[330 ILCS 125]~~ that authorizes the Department to administer a program to offer uninsured veterans in Illinois access to health benefits. The Department coordinates with the Illinois Department of Veterans' Affairs to assist veterans to apply for the program. Eligible veterans are not eligible for Veterans Administration Healthcare or other State-administered health benefits. The Department shall provide health benefits coverage to eligible veterans through purchasing or providing health care benefits. When cost-effective, the Department may offer veterans subsidies toward the cost of privately sponsored health insurance, including employer-sponsored health insurance.

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

Section 128.110 Definitions

For the purpose of this Part, the terms shall be defined as follows:

"Act" means the Veterans' Health Insurance Program Act [of 2008 \[330 ILCS 126\]](#)~~[330 ILCS 125]~~.

"Department" means the Department of Healthcare and Family Services and any successor agencies.

"DVA" means the Illinois Department of Veterans Affairs.

"Family" means the veteran applying for the program and the following individuals living with the veteran who are counted in determining eligibility:

The spouse of the veteran

Children under 19 years of age of the veteran or the veteran's spouse

If the veteran or the spouse is pregnant, the unborn children.

"Federal Poverty Level" means the federal poverty income guidelines as established by the federal Department of Health and Human Services and published in the Federal Register.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

"Health Insurance" means health insurance coverage as defined in 215 ILCS 105/2.

"Practitioner" means a physician (including a hospital billing a physician office visit), osteopath, podiatrist, optometrist, chiropractor, advanced practice nurse, Federally Qualified Health Center, Rural Health Clinic or Encounter Rate Clinic.

"Program" means the program created under the Veterans' Health Insurance Program Act and this Part, commonly called Veterans Care.

"Resident" means an individual who has an Illinois residence, as provided in Section 5-3 of the Illinois Public Aid Code.

"Uninsured" means the person is not covered by group or individual health insurance that provides coverage for hospitalization and physician visits.

"Veteran" means an individual who served for at least 180 consecutive days after initial training in any branch of the U.S. military including the Reserves and National Guard. The veteran must not be currently on active duty in the U.S. military.

"Veterans Administration Geographic Means Test" means the income guidelines established by the U.S. Veterans Administration annually by county and published in the Federal Register for determining eligibility for Veterans Administration healthcare.

"Veterans Administration Healthcare" means any of the health programs or services provided or administered by the U.S. Department of Veterans Affairs.

"Veterans Care" means the common name for this program under the Act.

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

SUBPART B: GENERAL ELIGIBILITY AND ENROLLMENT

Section 128.240 Eligibility Determination and Enrollment Process

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- a) The applicant's military discharge status, time spent in active duty, health insurance status and eligibility for Veterans Administration healthcare will be reviewed first.
- b) For the purpose of determining eligibility under this Part, applicants who are not found ineligible under subsection (a) of this Section will be screened for eligibility for medical assistance under the Public Aid Code or health benefits, including rebates, under the Children's Health Insurance Program Act. Veterans who are likely to be eligible for these other programs will be directed to apply for them. Veterans may be enrolled under this Part while an application for coverage under another program is pending.
- c) If the monthly countable income is below the Veterans Care income standard, the application will be approved if all other factors of eligibility are met. The Veterans Care income standard is ~~50~~25 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold. ~~If fewer than 1,500 veterans are enrolled in the program by February 1, 2007, the Department may determine, at its sole discretion, that resources are available to raise this standard to 50 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold effective March 1, 2007.~~
 - 1) If the veteran's income is equal to or less than 25 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold, the veteran shall be enrolled in Veterans Care Premium Level I.
 - 2) If the veteran's income is more than 25 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold and equal to or less than 50 percent of the Federal Poverty Level plus the Veterans Administration Geographic Means Test threshold, the veteran shall be enrolled in Veterans Care Premium Level II.
- d) Applicants will be notified, in writing, regarding the outcome of their eligibility determination.
- e) Eligibility determinations for the program made by the 10th day of a month will be effective the first day of the following month. Eligibility determinations for the program made after the 10th day of a month will be effective no later than the first day of the second month following that determination.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- f) The duration of eligibility for the program will be 12 months unless one of the events described in Section 128.210(b) occurs or the Department shortens the enrollment period to maintain program spending within available funding.
- g) Veterans may obtain backdated medical coverage for the month of application plus up to three months prior to the month of application, ~~but no earlier than the beginning of the program on September 1, 2006.~~ This coverage shall be subject to the veteran paying the premiums for the months of backdated coverage requested. The veteran may choose the month for which backdated coverage will begin. Backdated months of coverage shall be consecutive beginning with the initial month of backdated coverage requested.
- h) At the sole discretion of the Department, the Department may reduce the income threshold established in subsection (c) of this Section if necessary to keep the cost of the program within available funding.

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

Section 128.330 Premium Requirements

- a) Veterans enrolled in Veterans Care must pay a monthly premium as follows:
- 1) Veterans Care Premium Level I: \$40 per month.
 - 2) Veterans Care Premium Level II: \$70 per month.
- ~~b) No premium is charged for the first two months of prospective eligibility for first-time participants whose initial month of coverage, not counting backdated months, begins prior to January 1, 2008.~~
- ~~b)e)~~ Premiums are billed by and payable to the Department, or its authorized agent, on a monthly basis.
- ~~c)d)~~ The premium due date is the 20th day of the month preceding the month of coverage.
- ~~d)e)~~ The premium may increase during the eligibility period if the Department makes a decision to increase premiums to keep the ~~program~~Program costs within available funding.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

| [e\)†](#) Premiums for backdated months must be received by the 90th day after the date of eligibility determination. Coverage for backdated months is not provided if the payment is not received by the due date.

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Child Support Enforcement
- 2) Code Citation: 89 Ill. Adm. Code 160
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
160.60	Amendment
160.65	Amendment
- 4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]
- 5) Complete Description of the Subjects and Issues Involved: The proposed amendments make a technical change to reflect the modification in definition of "family support specialist" (FSS) to "child support worker".
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.
- 12) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

217/557-7157

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

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

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not-for-profit corporations affected: None
 - B) Reporting, bookkeeping or other procedures required for compliance: None
 - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this Rulemaking was Summarized: July 2008

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

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES

CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

SUBCHAPTER f: COLLECTIONS

PART 160

CHILD SUPPORT ENFORCEMENT

SUBPART A: GENERAL PROVISIONS

Section

160.1	Incorporation by Reference
160.5	Definitions
160.10	Child Support Enforcement Program
160.12	Administrative Accountability Process
160.15	Fees for IV-D Non-TANF Cases
160.20	Assignment of Rights to Support
160.25	Recoupment

SUBPART B: COOPERATION WITH CHILD SUPPORT ENFORCEMENT

Section

160.30	Cooperation With Support Enforcement Program
160.35	Good Cause for Failure to Cooperate with Support Enforcement
160.40	Proof of Good Cause For Failure to Cooperate With Support Enforcement
160.45	Suspension of Child Support Enforcement Upon a Claim of Good Cause

SUBPART C: ESTABLISHMENT AND MODIFICATION OF
CHILD SUPPORT ORDERS

Section

160.60	Establishment of Support Obligations
160.61	Uncontested and Contested Administrative Paternity and Support Establishment
160.62	Cooperation with Paternity Establishment and Continued Eligibility Demonstration Program (Repealed)
160.64	Compromise of Assigned Obligations
160.65	Modification of Support Obligations

SUBPART D: ENFORCEMENT OF CHILD SUPPORT ORDERS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section	
160.70	Enforcement of Support Orders
160.71	Credit for Payments Made Directly to the Title IV-D Client
160.75	Withholding of Income to Secure Payment of Support
160.77	Certifying Past-Due Support Information or Failure to Comply with a Subpoena or Warrant to State Licensing Agencies
160.80	Amnesty – 20% Charge (Repealed)
160.85	Diligent Efforts to Serve Process
160.88	State Case Registry
160.89	Interest

SUBPART E: EARMARKING CHILD SUPPORT PAYMENTS

Section	
160.90	Earmarking Child Support Payments

SUBPART F: DISTRIBUTION OF SUPPORT COLLECTIONS

Section	
160.95	State Disbursement Unit
160.100	Distribution of Child Support for TANF Recipients
160.110	Distribution of Child Support for Former AFDC or TANF Recipients Who Continue to Receive Child Support Enforcement Services
160.120	Distribution of Child Support Collected While the Client Was an AFDC or TANF Recipient, But Not Yet Distributed at the Time the AFDC or TANF Case Is Cancelled
160.130	Distribution of Intercepted Federal Income Tax Refunds
160.132	Distribution of Child Support for Non-TANF Clients
160.134	Distribution of Child Support For Interstate Cases
160.136	Distribution of Support Collected in IV-E Foster Care Maintenance Cases
160.138	Distribution of Child Support for Medical Assistance No Grant Cases

SUBPART G: STATEMENT OF CHILD SUPPORT ACCOUNT ACTIVITY

Section	
160.140	Quarterly Notice of Child Support Account Activity

SUBPART H: DEPARTMENT REVIEW OF DISTRIBUTION OF CHILD SUPPORT

Section

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- 160.150 Department Review of Distribution of Child Support for TANF Recipients
160.160 Department Review of Distribution of Child Support for Former AFDC or TANF Recipients

AUTHORITY: Implementing and authorized by Sections 4-1.7, Art. X, 12-4.3, and 12-13 of the Illinois Public Aid Code [305 ILCS 5/4-1.7, Art. X, 12-4.3 and 12-13].

SOURCE: Recodified from 89 Ill. Adm. Code 112.78 through 112.86 and 112.88 at 10 Ill. Reg. 11928; amended at 10 Ill. Reg. 19990, effective November 14, 1986; emergency amendment at 11 Ill. Reg. 4800, effective March 5, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9129, effective April 30, 1987; amended at 11 Ill. Reg. 15208, effective August 31, 1987; emergency amendment at 11 Ill. Reg. 1563, effective December 31, 1987, for a maximum of 150 days; amended at 12 Ill. Reg. 9065, effective May 16, 1988; amended at 12 Ill. Reg. 18185, effective November 4, 1988; emergency amendment at 12 Ill. Reg. 20835, effective December 2, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 22278, effective January 1, 1989; amended at 13 Ill. Reg. 4268, effective March 21, 1989; amended at 13 Ill. Reg. 7761, effective May 22, 1989; amended at 13 Ill. Reg. 14385, effective September 1, 1989; amended at 13 Ill. Reg. 16768, effective October 12, 1989; amended at 14 Ill. Reg. 18759, effective November 9, 1990; amended at 15 Ill. Reg. 1034, effective January 21, 1991; amended at 16 Ill. Reg. 1852, effective January 20, 1992; amended at 16 Ill. Reg. 9997, effective June 15, 1992; amended at 17 Ill. Reg. 2272, effective February 11, 1993; amended at 17 Ill. Reg. 18844, effective October 18, 1993; amended at 18 Ill. Reg. 697, effective January 10, 1994; amended at 18 Ill. Reg. 12052, effective July 25, 1994; amended at 18 Ill. Reg. 15083, effective September 23, 1994; amended at 18 Ill. Reg. 17886, effective November 30, 1994; amended at 19 Ill. Reg. 1314, effective January 30, 1995; amended at 19 Ill. Reg. 8298, effective June 15, 1995; amended at 19 Ill. Reg. 12675, effective August 31, 1995; emergency amendment at 19 Ill. Reg. 15492, effective October 30, 1995, for a maximum of 150 days; amended at 20 Ill. Reg. 1195, effective January 5, 1996; amended at 20 Ill. Reg. 5659, effective March 28, 1996; emergency amendment at 20 Ill. Reg. 14002, effective October 15, 1996, for a maximum of 150 days; amended at 21 Ill. Reg. 1189, effective January 10, 1997; amended at 21 Ill. Reg. 3922, effective March 13, 1997; emergency amendment at 21 Ill. Reg. 8594, effective July 1, 1997, for a maximum of 150 days; emergency amendment at 21 Ill. Reg. 9220, effective July 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 12197, effective August 22, 1997; amended at 21 Ill. Reg. 16050, effective November 26, 1997; amended at 22 Ill. Reg. 14895, effective August 1, 1998; emergency amendment at 22 Ill. Reg. 17046, effective September 10, 1998, for a maximum of 150 days; amended at 23 Ill. Reg. 2313, effective January 22, 1999; emergency amendment at 23 Ill. Reg. 11715, effective September 1, 1999, for a maximum of 150 days; emergency amendment at 23 Ill. Reg. 12737, effective October 1, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 14560, effective December 1, 1999; amended at 24 Ill. Reg. 2380,

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

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effective January 27, 2000; amended at 24 Ill. Reg. 3808, effective February 25, 2000; emergency amendment at 26 Ill. Reg. 11092, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17822, effective November 27, 2002; amended at 27 Ill. Reg. 4732, effective February 25, 2003; amended at 27 Ill. Reg. 7842, effective May 1, 2003; emergency amendment at 27 Ill. Reg. 12139, effective July 11, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18891, effective November 26, 2003; amended at 28 Ill. Reg. 4712, effective March 1, 2004; emergency amendment at 28 Ill. Reg. 10225, effective July 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 15591, effective November 24, 2004; emergency amendment at 29 Ill. Reg. 2743, effective February 7, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 10211, effective June 30, 2005; amended at 29 Ill. Reg. 14995, effective September 30, 2005; emergency amendment at 30 Ill. Reg. 5426, effective March 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 8897, effective May 1, 2006; amended at 30 Ill. Reg. 13393, effective July 28, 2006; amended at 31 Ill. Reg. 12771, effective August 27, 2007; emergency amendment at 32 Ill. Reg. 543, effective January 1, 2008, for a maximum of 150 days; amended at 32 Ill. Reg. 6511, effective March 31, 2008; amended at 32 Ill. Reg. 16805, effective October 6, 2008; amended at 33 Ill. Reg. 591, effective January 5, 2009; amended at 33 Ill. Reg. _____, effective _____.

SUBPART C: ESTABLISHMENT AND MODIFICATION OF
CHILD SUPPORT ORDERS**Section 160.60 Establishment of Support Obligations**

a) Definitions

- 1) "Child support worker" "FSS" means any Division of Child Support Enforcement personnel Family Support Specialist performing assigned duties, his or her supervisory staff and any other person assigned responsibility by the Director of the Department.
- 2) "Service" or "Served" means notice given:
 - A) by personal service, certified mail (with or without return receipt requested) or restricted delivery,
 - B) *by a person who is licensed or registered as a private detective under the Private Detective, Private Alarm, Private Security, and Locksmith Act of 2004 [225 ILCS 447] or by a registered employee of a private detective agency certified under that Act, or*

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- C) *in counties with a population of less than 2,000,000* [305 ILCS 5/10-4], by any method provided by law for service of summons. (See Sections 2-202, 2-203 and 2-206 of the Code of Civil Procedure [735 ILCS 5/2-202, 2-203 and 2-206].)
- 3) "Support Statutes" means the following:
 - A) Article X of the Illinois Public Aid Code [305 ILCS 5/Art. X];
 - B) The Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5];
 - C) The Non-Support Punishment Act [750 ILCS 16];
 - D) The Uniform Interstate Family Support Act [750 ILCS 22];
 - E) The Illinois Parentage Act of 1984 [750 ILCS 45]; and
 - F) Any other statute in another state that provides for child support.
 - 4) "Retroactive support" means support for a period prior to the date a court or administrative support order is entered.
 - 5) "Child's needs" means:
 - A) the custodial parent's statement of the associated costs, including, but not limited to, providing a child with: food, shelter, clothing, schooling, recreation, transportation and medical care; or
 - B) the State's current minimum hourly wage multiplied by 40 hours per work week, multiplied by 4.3 weeks per month, multiplied by the applicable child support guideline percentage contained in subsection (c)(1) of this Section.
- b) Responsible Relative Contact
 - 1) Timing and Purpose of Contact

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

- A) The Department shall contact and interview responsible relatives in Title IV-D cases to establish support obligations, following the IV-D client interview.
 - B) The purpose of contact and interview shall be to obtain relevant facts, including income information (for example, paycheck stubs, income tax returns) necessary to determine the financial ability of such relatives for use in obtaining stipulated, consent and other court orders for support and in entering administrative support orders, pursuant to the support statutes.
- 2) At least ten working days in advance of the interview, the Department shall notify each responsible relative contacted of his support obligation, by ordinary mail, which notice shall contain the following:
- A) the Title IV-D case name and identification number;
 - B) the names and birthdates of the persons for whom support is sought or other information identifying such persons, such as a prior court number;
 - C) that the responsible relative has a legal obligation to support the named persons;
 - D) the date, time, place and purpose of the interview and that the responsible relative may be represented by counsel; and
 - E) that the responsible relative should bring specified information regarding his income and resources to the interview.
- 3) The Department shall notify each Title IV-D client of the date, time and place of the responsible relative interview and that the client may attend if he or she chooses.
- c) Determination of Financial Ability
- 1) In cases handled under subsection (d) of this Section, the [child support worker](#)~~Family Support Specialist~~ shall determine the amount of child support and enter an administrative support order on the following basis:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Number of Children	Percent of Responsible Relative's Net Income
1	20%
2	28%
3	32%
4	40%
5	45%
6 or more	50%

- A) "Net Income" is the total of all income from all sources, minus the following deductions:
- i) Federal income tax (properly calculated withholding or estimated payments);
 - ii) State income tax (properly calculated withholding or estimated payments);
 - iii) Social Security (FICA payments);
 - iv) Mandatory retirement contributions required by law or as a condition of employment;
 - v) Union dues;
 - vi) Dependent and individual health/hospitalization insurance premiums;
 - vii) Prior obligations of support or maintenance actually paid pursuant to a court order or administrative support order;
 - viii) Expenditures for repayment of debts that represent reasonable and necessary expenses for the production of income;
 - ix) Medical expenditures necessary to preserve life or health; and

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- x) Reasonable expenditures for the benefit of the child and the other parent, exclusive of gifts.
- B) The deductions in subsections (c)(1)(A)(viii), (ix) and (x) of this Section shall be allowed only for the period that such payments are due. The Department shall enter administrative support orders that contain provisions for an automatic increase in the support obligation upon termination of such payment period.
- 2) In de novo hearings provided for in subsection (d)(5)(H) of this Section and 89 Ill. Adm. Code 104.102, the Department's hearing officer shall determine the minimum amount of child support as follows:

Number of Children	Percent of Responsible Relative's Net Income
1	20%
2	28%
3	32%
4	40%
5	45%
6 or more	50%

- A) "Net Income" is the total of all income from all sources, minus the following deductions:
- i) Federal income tax (properly calculated withholding or estimated payments);
- ii) State income tax (properly calculated withholding or estimated payments);
- iii) Social Security (FICA payments);
- iv) Mandatory retirement contributions required by law or as a condition of employment;
- v) Union dues;
- vi) Dependent and individual health/hospitalization insurance

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premiums;

- vii) Prior obligations of support or maintenance actually paid pursuant to a court order or administrative support order;
 - viii) Expenditures for repayment of debts that represent reasonable and necessary expenses for the production of income;
 - ix) Medical expenditures necessary to preserve life or health; and
 - x) Reasonable expenditures for the benefit of the child and the other parent, exclusive of gifts.
- B) The deductions in subsections (c)(2)(A)(viii), (ix) and (x) of this Section shall be allowed only for the period that such payments are due. The Department shall enter administrative support orders that contain provisions for an automatic increase in the support obligation upon termination of such payment period.
- C) The above guidelines shall be applied in each case unless the Department finds that application of the guidelines would be inappropriate after considering the best interests of the child in light of evidence including but not limited to one or more of the following relevant factors:
- i) the financial resources and needs of the child;
 - ii) the financial resources and needs of the custodial parent;
 - iii) the standard of living the child would have enjoyed had the marriage not been dissolved, the separation not occurred or the parties married;
 - iv) the physical and emotional condition of the child, and his educational needs; and
 - v) the financial resources and needs of the non-custodial

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parent.

- D) Each order requiring support that deviates from the guidelines shall state the amount of support that would have been required under the guidelines. The reason or reasons for the variance from the guidelines shall be included in the order.
- 3) In cases referred for judicial action under subsection (e) of this Section, the Department's legal representative shall ask the court to determine the amount of child support due in accord with Section 505 and medical support in accordance with Section 505.2 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505].
- 4) All orders for support shall include a provision for the health care coverage of the child. In all cases where health insurance coverage is not being furnished by the responsible relative to a child to be covered by a support order, the Department shall enter administrative, or request the court to enter, support orders requiring the relative to provide such coverage when a child can be added to an existing insurance policy at reasonable cost or indicating what alternative arrangement for health insurance coverage is being provided. Net income shall be reduced by the cost thereof in determining the minimum amount of support to be ordered.
- 5) In cases where the net income of the responsible relative cannot be determined because of default or any other reason, the Department shall order or request the court to order the responsible relative to pay retroactive support for the prior period in the amount of the child's needs as defined by subsection (a)(5)(A) or (B) of this Section when the IV-D client requests that such an order for retroactive support be entered or requested.
- 6) The final order in all cases shall state the support level in dollar amounts.
- 7) If there is no net income because of the unemployment of a responsible relative who resides in Illinois and is not receiving General Assistance in the City of Chicago and has children receiving cash assistance in Illinois, the Department, when proceeding under subsection (d) of this Section, shall order, or, when proceeding under subsection (e) of this Section, shall request the court to order the relative to report for participation in job

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search, training or work programs established for such relatives. In TANF cases, the Department shall order, when proceeding under subsection (d) of this Section, or, when proceeding under subsection (e) of this Section, shall request the court to order payment of past-due support pursuant to a plan and, if the responsible relative is unemployed, subject to a payment plan and not incapacitated, that the responsible relative participate in job search, training and work programs established under Section 9-6 and Article IXA of the Illinois Public Aid Code [305 ILCS 5/9-6 and Art. IXA].

- 8) The Department shall enter administrative support orders, or request the court to enter support orders, that include a provision requiring the responsible relative to notify the Department, within seven days:
 - A) of any new address of the responsible relative;
 - B) of the name and address of any new employer or source of income of the responsible relative;
 - C) of any change in the responsible relative's Social Security Number;
 - D) whether the responsible relative has access to health insurance coverage through the employer or other group coverage; and
 - E) if so, the policy name and number and the names of persons covered under the policy.
- 9) The Department shall enter administrative support orders, or request the court to enter support orders, that include a date on which the current support obligation terminates. The termination date shall be no earlier than the date on which the child covered by the order will attain the age of majority or is otherwise emancipated. The order for support shall state that the termination date does not apply to any arrearage that may remain unpaid on that date. The provision of a termination date in the order shall not prevent the order from being modified.
- 10) The Department shall enter administrative support orders, or request the court to enter support orders, that include a statement that if there is an unpaid arrearage or delinquency equal to at least one month's support

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obligation on the termination date stated in the order for support or, if there is no termination date stated in the order, on the date the child attains the age of majority or is otherwise emancipated, then the periodic amount required to be paid for current support of that child immediately prior to that date shall automatically continue to be an obligation, not as current support but as periodic payment toward satisfaction of the unpaid arrearage or delinquency.

- 11) At the request of the IV-D client, the Department shall enter administrative support orders, or request the court to enter support orders, that include provisions for retroactive support, as follows:
 - A) In cases handled under subsection (d) of this Section, the Department shall order the period of retroactive support to begin with the later of two years prior to the date of entry of the administrative support order or the date of the married parties' separation (or the date of birth of the child for whom support is ordered, if the child was born out of wedlock).
 - B) In de novo hearings provided for in subsection (d)(5)(H) of this Section and 89 Ill. Adm. Code 104.102, the Department's hearing officer shall order the period of retroactive support to begin with the later of two years prior to the date of entry of the administrative support order or the date of the married parties separation (or the date of birth of the child for whom support is ordered, if the child was born out of wedlock), unless, in cases where the child was born out of wedlock, the hearing officer, after having examined the factors set forth in Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14] and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505] decides that another date is more appropriate.
 - C) In cases referred for judicial action under subsection (e) of this Section, the Department's legal representative shall ask the court to determine the date retroactive support is to commence in accord with Article X of the Illinois Public Aid Code [305 ILCS 5/Art. X], Sections 510 and 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/510 and 505], and Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14].

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- d) Administrative Process
- 1) Use of Administrative Process
- A) Unless otherwise directed by the Department, the [child support worker](#)~~FSS~~ shall establish support obligations of responsible relatives through the administrative process set forth in this subsection (d), in Title IV-D cases, wherein the court has not acquired jurisdiction previously, in matters involving:
- i) presumed paternity as set forth in Section 5 of the Illinois Parentage Act of 1984 [750 ILCS 45/5] and support is sought from one or both parents;
 - ii) alleged paternity and support is sought from the mother;
 - iii) an administrative paternity order entered under Section 160.61 and support is sought from the man determined to be the child's father, or from the mother, or both;
 - iv) an establishment of parentage in accordance with Section 6 of the Illinois Parentage Act of 1984 [750 ILCS 45/6]; and
 - v) an establishment of parentage under the laws of another state, and support is sought from the child's father, or from the mother, or both.
- B) In addition to those items specified in subsection (b)(2) of this Section, the notice of support obligation shall inform the responsible relative of the following:
- i) that the responsible relative may be required to pay retroactive support as well as current support; and
 - ii) that in its initial determination of child support under subsection (c) of this Section, the Department will only consider factors listed in subsections (c)(1)(A)(i) through (x) of this Section; and

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- iii) that the Department will enter an administrative support order based only on those factors listed in subsections (c)(1)(A)(i) through (x) of this Section; and
- iv) that in order for the Department to consider other factors listed in subsection (c)(2)(C) of this Section, Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14], and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505], either the responsible relative or the client must request a de novo hearing within 30 days after mailing or delivery of the administrative support order; and
- v) that both the client and the responsible relative have a right to request a de novo hearing within 30 days after the mailing or delivery of an administrative support order, at which time a Department hearing officer may consider other factors listed in subsection (c)(2)(C) of this Section, Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14], and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505]; and
- vi) that unless the client and/or the responsible relative requests a de novo hearing within 30 days after the order's mailing or delivery, the administrative support order will become a final enforceable order of the Department; and
- vii) that upon failure of the responsible relative to appear for the interview or to provide necessary information to determine net income, an administrative support order may be entered by default or the Department may seek court determination of financial ability based upon the guidelines.

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- 2) The [child support worker](#)~~FSS~~ shall determine the ability of each responsible relative to provide support in accordance with subsection (c) of this Section when such relative appears in response to the notice of support obligation and provides necessary information to determine net

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income. An administrative support order shall be entered which shall incorporate the resulting support amount therein. When requested by the IV-D client, the [child support workerFSS](#) shall also determine (and incorporate in the administrative support order) the amount of retroactive support the responsible relative shall be required to pay by applying the relative's current net income (unless the relative provides necessary information to determine net income for the prior period) to the support guidelines in accordance with subsection (c) of this Section. The [child support workerFSS](#) shall reduce the total amount of retroactive support determined by the amount of cash contributions made by the responsible relative to the IV-D client for the benefit of the child during the retroactive period as specified in the IV-D client's affidavit of direct contribution. In no event shall credit be given in excess of the total amount of the retroactive support determined.

3) Failure to Appear

- A) In instances in which the responsible relative fails to appear in response to the notice of support obligation or fails to provide necessary information to determine net income, the [child support workerFSS](#) shall enter an administrative support order by default, except as provided in subsection (d)(3)(D) of this Section. The terms of the order shall be based upon the needs of the child for whom support is sought, as defined by subsection (a)(5) of this Section. No default order shall be entered when a responsible relative fails to appear at the interview unless the relative shall have been served as provided by law with a notice of support obligation.
- B) The [child support workerFSS](#) may issue a subpoena to a responsible relative who fails to appear for interview, or who appears and furnishes income information, when the [child support workerFSS](#) has information from the Title IV-D client, the relative's employer or any other reliable source indicating that:
- i) financial ability, as determined from the guidelines contained in subsection (c) of this Section, exceeds the amount indicated in case of default, as indicated in subsection (d)(3)(A) of this Section; or

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- ii) income exceeds that reported by the relative.
- C) The [child support workerFSS](#) will not issue a subpoena under subsection (d)(3)(B) of this Section where the information from the Title IV-D client, the responsible relative's employer or other source concerning the relative's financial ability is verified through documentation such as payroll records, paycheck stubs or income tax returns.
- D) In instances in which the relative fails or refuses to accept or fully respond to a Department subpoena issued to him pursuant to subsection (d)(3)(B) of this Section, the [child support workerFSS](#) may enter a temporary administrative support order by default, in accordance with subsection (d)(3)(A) of this Section, and may then, after investigation and determination of the responsible relative's financial ability to support, utilizing existing State and federal sources (for example, Illinois Department of Employment Security), client statements, employer statements, or the use of the Department's subpoena powers, enter a support order in accord with subsection (c)(1) of this Section.
- 4) The Department shall register, enforce or modify an order entered by a court or administrative body of another state, and make determinations of controlling order where appropriate, in accordance with the provisions of the Uniform Interstate Family Support Act [750 ILCS 22].
- 5) An administrative support order shall include the following:
- A) the Title IV-D case name and identification number;
 - B) the names and birthdates of the persons for whom support is ordered;
 - C) the beginning date, amount and frequency of support;
 - D) any provision for health insurance coverage ordered under subsection (c)(4) of this Section;

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- E) a provision for retroactive support ordered under subsection (c)(11), including the total retroactive support obligation and the beginning date, amount (that shall not be less than 20 percent of the current support amount) and frequency of payments to be made until the retroactive support obligation is paid in full;
- F) the amount of any arrearage that has accrued under a prior support order and the beginning date, amount (that shall not be less than 20 percent of the support order) and frequency of payments to be made until the arrearage is paid in full;
- G) a provision requiring that support payments be made to the State Disbursement Unit;
- H) a statement informing the client and the responsible relative that they have 30 days from the date of mailing of the administrative support order in which to petition the Department for a release from or modification of the order and receive a hearing in accordance with 89 Ill. Adm. Code 104.102 and subsection (c)(2) of this Section, except that for orders entered as a result of a decision after a de novo hearing, the statement shall inform the client and the responsible relative that the order is a final administrative decision of the Department and that review is available only in accord with provisions of the Administrative Review Law [735 ILCS 5/Art III];
- I) except where the order was entered as a result of a decision after a de novo hearing, a statement that the order was based upon the factors listed in subsection (c)(1)(A) of this Section and that in order to have the Department consider other factors listed in subsection (c)(2)(C) of this Section, Section 14(b) of the Illinois Parentage Act of 1984 [750 ILCS 45/14] and Section 505 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/505], either the responsible relative or the client must request a de novo hearing within 30 days after mailing or delivery of the administrative support order; and
- J) in each administrative support order entered or modified on or after January 1, 2002, a statement that a support obligation required

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under the order, or any portion of a support obligation required under the order, that becomes due and remains unpaid for 30 days or more shall accrue simple interest at the rate of nine percent per annum.

- 6) Every administrative support order entered on or after July 1, 1997, shall include income withholding provisions based upon and containing the same information as prescribed in Section 160.75. The Department shall also prepare and serve income withholding notices after entry of an administrative support order and effect income withholding in the same manner as prescribed in Section 160.75.
- 7) The Department shall provide to each client and each responsible relative a copy of each administrative support order entered, no later than 14 days after entry of such order, by:
 - A) delivery at the conclusion of an interview where financial ability to support was determined. An acknowledgment of receipt signed by the client or relative or a written statement identifying the place, date and method of delivery signed by the Department's representative shall be sufficient for purposes of notice to that person.
 - B) regular mail to the party not receiving personal delivery where the relative fails or refuses to accept delivery, where either party does not attend the interview, or the orders are entered by default.
- 8) In any case where the administrative support process has been initiated for the custodial parent and the non-marital child, and the custodial parent and the non-marital child move outside the original county, the administrative support case shall remain in the original county unless a transfer to the other county in which the custodial parent and the non-marital child reside is requested by either party or the Department and the hearing officer assigned to the original county finds that a change of venue would be equitable and not unduly hamper the administrative support process.
- 9) In any case in which an administrative support order is entered to establish and enforce an arrearage only, and the responsible relative's current support obligation has been terminated, the administrative support order

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shall require the responsible relative to pay a periodic amount equal to the terminated current support amount until the arrearage is paid in full.

- e) Judicial Process
 - 1) The Department shall refer Title IV-D cases for court action to establish support obligations of responsible relatives, pursuant to the support statutes (see subsection (a)(3) of this Section) in matters requiring the determination of parentage (except when paternity is to be determined administratively under Section 160.61), when the court has acquired jurisdiction previously and in instances described in subsection (d)(3)(D) of this Section, and as otherwise determined by the Department.
 - 2) The Department shall prepare and transmit pleadings and obtain or affix appropriate signature thereto, which pleadings shall include, but not be limited to, petitions to:
 - A) intervene;
 - B) modify;
 - C) change payment path;
 - D) establish an order for support;
 - E) establish retroactive support when the IV-D client requests it;
 - F) establish past-due support;
 - G) establish parentage;
 - H) obtain a rule to show cause;
 - I) enforce judicial and administrative support orders; and
 - J) combinations of the above.
 - 3) Department legal representatives shall request that judicial orders for support require payments to be made to the State Disbursement Unit in

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accordance with Section 10-10.4 of the Illinois Public Aid Code [305 ILCS 5/10-10.4], Section 507.1 of the Illinois Marriage and Dissolution of Marriage Act [750 ILCS 5/507.1], Section 320 of the Uniform Interstate Family Support Act [750 ILCS 22/320], Section 21.1 of the Illinois Parentage Act of 1984 [750 ILCS 45/21.1] and Section 25 of the Non-Support Punishment Act [750 ILCS 16/25].

- f) Petitions for Release from Administrative Support Orders – Extraordinary Remedies
- 1) Notwithstanding the statements required by subsections (d)(5)(H) and (d)(5)(I) of this Section, more than 30 days after the entry of an administrative support order under subsection (d) of this Section, a party aggrieved by entry of an administrative support order may petition the Department for release from the order on the same grounds as are provided for relief from judgments under Section 2-1401 of the Code of Civil Procedure.
 - 2) Petitions under this subsection (f) must:
 - A) cite a meritorious defense to entry of the order;
 - B) cite the exercise of due diligence in presenting that defense to the Department;
 - C) be filed no later than two years following the entry of the administrative support order, except that times listed below shall be excluded in computing the two years:
 - i) time during which the person seeking relief is under legal disability;
 - ii) time during which the person seeking relief is under duress;
 - iii) time during which the ground for relief is concealed from the person seeking relief;
 - D) be supported by affidavit or other appropriate showing as to matters not supported by the record.

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- 3) Notice of the filing of the petition must be given and a copy of the petition must be served on the other parent, caretaker or responsible relative by certified mail, return receipt requested, or by any manner provided by law for service of process. The filing of a petition under this subsection (f) does not affect the validity of the administrative support order.

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

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 [child support workerFSS](#) 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

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- 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:
 - 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

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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 responsible relative becomes known through representations of the relative or of the client or from independent sources, and such change would materially affect ability to support.
- 3) The Department shall determine that a review of an order for support would not be in the best interests of the child if there has been a finding of good cause, and it has been determined that support enforcement may not proceed without risk of harm to the child or caretaker relative.
- c) Notice of the Right to Request a Review
- 1) In each Title IV-D case the Department shall provide notice not less than once every three years to each parent subject to an order for support in the case. The notice may be included in the order and shall inform the parent of the right to request a review of the order, where to request a review and the information ~~that~~^{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

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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 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.

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- 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 [child support workerFSS](#) shall review any financial information concerning the responsible relative. Where the responsible relative's information is not verified through an employer, wage stubs or income tax returns, the [child support workerFSS](#) shall seek other verification, e.g., subpoena of the responsible relative's income tax return.
- 2) The [child support workerFSS](#) shall determine the responsible relative's current financial ability in accordance with the guidelines contained in Section 160.60(c).
- 3) The [child support workerFSS](#) 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 [child support workerFSS](#) 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 [child support workerFSS](#) 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 [child support workerFSS](#) 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.

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- 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.
 - B) The Department will only take action to modify the order to require health insurance for the child covered by the order.
 - C) Either parent may request a redetermination within 30 calendar days after the date of the notice by:
 - i) signing and returning the request for a redetermination to the Department; and
 - ii) providing financial documentation or information concerning the child's health care needs not furnished previously, which will substantiate the request.
- 2) When the review indicates the Quantitative Standard for Review has been met, the client and responsible relative will be advised that:
 - A) The Department will take action to modify the existing order for support in accordance with the review results.
 - B) In cases involving the judicial process, each parent will be informed 30 calendar days in advance of the hearing date and will have the opportunity to contest the review results at that time.
 - C) In cases where an administrative order for support is entered in accordance with subsection (h) of this Section:
 - i) The client and responsible relative will be advised that he or she has until 30 calendar days after the date of mailing of the administrative order for support in which to petition the Department for a release from or modification of the order and receive a hearing in accordance with 89 Ill. Adm. Code 104.102. The client will be further advised that he or she

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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.
 - 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 [child support worker](#)~~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 [child support worker](#)~~FSS~~ shall:

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- 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 [child support worker](#)~~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 [child support worker](#)~~FSS~~ shall effect income withholding in accordance with Section 160.60(d)(6).
 - ii) The [child support worker](#)~~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.
- 2) Upon receipt of a petition for a release from or modification of an administrative order for support as described in subsection (g)(2)(C) of this Section within 30 calendar days after the date of mailing of such order, the Department will provide a hearing in accordance with 89 Ill. Adm. Code 104.102. The 30 calendar day period shall be calculated in accordance with subsection (g)(3) of this Section.
- 3) Upon receipt of a request for a redetermination as set forth in subsection (g)(1) of this Section within 30 calendar days after the date of mailing of the notice, the Department shall conduct such redetermination. The 30 calendar day period shall be calculated in accordance with subsection (g)(3) of this Section.

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- 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.
 - 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

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- 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
 - 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

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- 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;
 - ii) the present residence of each party; and
 - iii) whether a particular state has jurisdiction over the parties.
 - F) In any case coming under the provisions of subsections (j)(1)(A), (B) and (C) of this Section, in which the Department has determined to request a review of an order for support in another state, the Department shall:
 - i) send a request for review to that state within 20 calendar days after receipt of sufficient information to conduct the review and provide that state with sufficient information on the requestor of review to act on the request; and
 - ii) send to the parent in Illinois a copy of any notice issued by the responding state in connection with the review and modification of the order, within five working days after receipt of such notice by the Department.
- 2) Responding Cases
- A) Within 15 calendar days after receipt of a request for a review of an order for support in Illinois as the responding state, the Department shall determine whether a review should be conducted in accordance with subsection (b)(1) of this Section.
 - B) Within 180 calendar days after determining that a review should be conducted or locating the non-requesting parent, whichever occurs later, the Department shall take the actions specified in subsection (i)(4) of this Section.

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

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- 1) Heading of the Part: Forestry Development Cost-Share Program
- 2) Code Citation: 17 Ill. Adm. Code 1536
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
1536.10	Amendment
1536.20	Amendment
1536.25	Amendment
1536.30	Amendment
1536.40	Amendment
1536.50	Repealed
1536.51	New Section
1536.55	New Section
1536.60	Amendment
1536.65	Amendment
1536.70	Amendment
1536.75	New Section
1536.77	New Section
1536.80	Amendment
1536.90	Amendment
1536.100	Amendment
- 4) Statutory Authority: Implementing and authorized by the Illinois Forestry Development Act [525 ILCS 15]
- 5) A Complete Description of the Subjects and Issues Involved: Existing regulations in this Part do not fully address changes and developing management issues that have increasingly become important to the program's implementation. The amendments to this Part are being proposed to provide a more diverse cost-share program to landowners in management of their forest lands by providing a revised/increased cost basis for implementation of forest management practices outlined in approved forest management plans. The amendments add new regulations, remove outdated regulations, add documentation requirements and provide for additional cost sharing opportunities to address control of invasive and exotic species, forestry best management practices and increased costs of existing practices.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

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- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on the proposed rulemaking may be submitted in writing for a period of 45 days following publication of this Notice to:

William K. Richardson, General Counsel
Department of Natural Resources
One Natural Resources Way
Springfield IL 62702-1271

217/782-1809

- 13) Initial Regulatory Flexibility Analysis:
 - A) Types of small businesses, small municipalities and not for profit corporations affected: The purpose of the revisions to the this Part is to assist in reimbursing a portion of the costs incurred by Forest Landowners enrolled in the Forestry Development Act Program with implementation of approved management practices described within their Forest Management Plan (17 Ill. Adm. Code 1537) while sustaining and managing Forest Resources throughout the State. These practices are often completed by small business Forestry Consultants working for individual landowners.
 - B) Reporting, bookkeeping or other procedures required for compliance: The private landowner must: enter into a 10 year agreement with the Department to manage his/her forestland in accordance with his/her approved Forest Management Plan, provide documentation of expenses to be reimbursed for up to 75% of the practice costs and maintain the practice for 10 years or otherwise be required to pay back the monies received. Landowners must allow inspection by the Department for:

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completion, approval of practice requirements and continued practice maintenance.

- C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: January 2009

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

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TITLE 17: CONSERVATION
 CHAPTER I: DEPARTMENT OF NATURAL RESOURCES
 SUBCHAPTER d: FORESTRY

PART 1536
 FORESTRY DEVELOPMENT COST-SHARE PROGRAM

Section

1536.10	General
1536.20	Eligibility
1536.25	Preparation of Forest Management Plans
1536.30	Planting Trees and Direct Seeding
1536.40	Fencing to Protect Forests and Plantations
1536.50	Tending Forest Stands (Repealed)
1536.51	Timber Stand Improvement
1536.55	Pruning Crop Trees
1536.60	Firebreaks to Protect Forests
1536.65	Reducing Wildlife Damage
1536.70	Site Preparation for Natural Regeneration
1536.75	Forestry Best Management Practices
1536.77	Invasive and Exotic Species Control
1536.80	Appeal
1536.90	Information
1536.100	Penalty

AUTHORITY: Implementing and authorized by the Illinois Forestry Development Act [525 ILCS 15].

SOURCE: Adopted and codified at 8 Ill. Reg. 13689, effective July 25, 1984; amended at 9 Ill. Reg. 14286, effective September 5, 1985; amended at 10 Ill. Reg. 6838, effective April 3, 1986; amended at 10 Ill. Reg. 18168, effective October 15, 1986; amended at 11 Ill. Reg. 18632, effective November 2, 1987; amended at 14 Ill. Reg. 18244, effective October 29, 1990; amended at 17 Ill. Reg. 16485, effective September 27, 1993; recodified by changing the agency name from Department of Conservation to Department of Natural Resources at 20 Ill. Reg. 9389; amended at 22 Ill. Reg. 10473, effective June 1, 1998; amended at 33 Ill. Reg. _____, effective _____.

Section 1536.10 General

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The purpose of this program is to encourage the planting, management, sustainable use, and regeneration of forests.

- a) Timber growers ~~and/or landowners~~ participating in this program may also be eligible for federal forestry cost-share programs administered by agencies of the United States.
- b) An application for the cost-shared practice must be signed and dated~~completed~~ by the timber grower or the timber grower's legally authorized agent and/or landowner and submitted to an~~the~~ Illinois Department of Natural Resources' Resource's District Forester, ~~hereinafter referred to as the (IDNR District Forester)~~. The requirements for installation of the practice must~~will~~ be described in the approved forest management plan, ~~hereafter called the "(Plan)".~~ The cost-shared practice shall~~can~~ not be started until the application is approved by the IDNR District Forester.
- c) Reimbursement~~The reimbursement~~ for ~~the~~ approved cost-shared practice will be based on the timber grower's landowner's documentation of practice installation cost ~~to install the practice~~ and shall~~will~~ not exceed the established cost-share percentages and will not exceed maximum amounts per unit allowed in this Part.
- d) Timber growers ~~and/or landowners~~ must provide an itemized statement with paid receipts for qualifying expenses of practice implementation costs of more than \$10 in the implementation of the approved practice. ~~In determining the cost of a timber grower and/or landowner or family member doing the practices, the labor rate shall not exceed \$12 per hour.~~ Reimbursement for amounts less than \$50 will not be processed for payment.
- e) This is a reimbursement cost-share program. Advance payment will not be allowed. Furthermore, cost-share payment will not~~cannot~~ be made to a third party or to vendors.
- f) When federal~~Federal~~ or other cost-share programs~~program practices~~ are utilized concurrently with the Illinois Forestry Development Act (FDA~~FDA~~) Cost-Share Program, the cost-share percentage shall equal the percentage of the other concurrent cost-share program in effect in the county where the practice is installed. The FDA~~FDA~~ cost-share percentage and the maximum cost share~~not to exceed per practice unit amount~~ shall be adjusted proportionately from the

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standard rate now in effect. Timber growers ~~will and/or landowners may~~ not be reimbursed more than the actual cost ~~nor not to exceed~~ the base cost of the practice. When federal or other cost-share programs utilize a flat rate payment, the standard FDA cost-share rate will be used in determining eligible reimbursement. The combined FDA and federal reimbursements will not be more than the actual cost nor the established base cost of the practice. The base cost represents the Statewide average cost of implementing the practice amount upon which the cost-share maximum is derived. The adjusted maximum fixed rate is determined by taking the federal cost-share percent rate times the average cost per acre. Federal programs will be used for initial payment.

- g) A practice ~~will not~~ be repeated for FDA cost share on the same area and within a 10 year period and must be maintained effective for a minimum of 10 years, except as allowed under Sections 1536.30 and 1536.70.
- h) Property upon which cost-shared practices are installed must be protected from wildlife and grazing by measures set forth in the Plan.
- i) Chemicals used in performing ~~practices this practice~~ must be federally, State and locally registered and must be applied strictly in accordance with authorized registered uses, directions on the label, and other ~~federal~~ Federal and State requirements.
- j) If a timber sale has occurred according to an approved Plan within 2 State of Illinois fiscal years prior to the approval of a cost-shared practice, then ~~landowners and/or~~ timber growers will have their cost-share increased by an amount not to exceed 50% of their harvest fee. The combined payment for the practice and the harvest fee rebate shall not exceed 100% of the landowner's and/or timber grower's practice cost. Landowners and/or timber growers who sold timber based upon provisions of the Plan shall have priority for harvest fee rebates. Federal cost share programs cannot be used with the harvest fee rebate.
- k) While this program may be combined with a federal program for implementation of a specific practice, it cannot be combined with another State program for the same practice.
- l) Only approved and satisfactorily completed practices provide the basis for reimbursement to landowners. All components must be completed and approved before payment is ~~authorized~~ approved.

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m) Cost-share practices shall not be authorized for any action that is determined to be harmful to threatened or endangered species or their habitat.

n) Cost-share payments shall not be authorized for practices less than one acre.

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

Section 1536.20 Eligibility

a) Participation in the program is limited to ~~landowners and/or~~ timber growers who own or operate at least 5 contiguous acres of land enrolled in the Illinois Forest Development Act Program in this State. A forest must be at least 100 feet wide and must be systematically managed for the production of timber.

b) The property on which the cost-shared practices ~~are will be~~ installed must have an approved forest management plan as described in 17 Ill. Adm. Code 1537, except for a cost-share application for "preparation of forest management plans" practice under Section 1536.25.

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

Section 1536.25 Preparation of Forest Management Plans

This practice provides timber growers ~~and/or landowners~~ with an additional~~another~~ opportunity to obtain professional ~~conservation~~ assistance in Plan preparation.

a) This cost-share practice is valid only when a ~~timber~~ grower ~~and/or landowner~~ pays a consultant~~another party~~ for preparation of a Plan. The timber grower ~~and/or landowner~~ must approve and sign the Plan Certification Form before the ~~IDNR District~~ Forester will authorize reimbursement ~~for~~ the cost-share of the Plan practice.

b) A cost-share application for this practice must be submitted and approved by the ~~IDNR District~~ Forester prior to initiation of a Plan. ~~However, for all other cost-share practices, an approved Plan must be in effect prior to submission of a cost-share application.~~

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- c) The Plan must meet the conditions, requirements, standards and specifications ~~as contained in [the FDA, IFDA and 17 Ill. Adm. Code 1537](#) and this Part. [Additional information to clarify the requirements mentioned above are listed in two publications published by the Illinois Technical Forestry Association: "Recommended Silvicultural and Management Practices for Illinois Hardwood Forest Types" \(1972\), Extension Forester, Illinois Cooperative Extension Service, University of Illinois, 110 Mumford Hall, Urbana, IL 61801 \(no later editions or amendments are included\) and "Forest Planting Practices for Illinois" \(1974\), Illinois Technical Forestry Association, Inc., c/o Department of Forestry, 211 Mumford Hall, Urbana, IL 61081 \(no later editions or amendments are included\).](#)~~
- d) Components eligible for ~~cost-share reimbursement~~[cost-sharing](#) can include: reconnaissance, travel costs, secretarial, mailing and telephone costs, forest inventory, data analysis and plan writing.
- e) Reconnaissance notes,~~;~~[;](#) field data,~~;~~[;](#) inventory per acre and per stand,~~;~~[;](#) and analysis of forest inventory must be submitted ~~to the IDNR Forester~~[to the District Forester](#).
- f) All ~~eligible land within of the land in~~[eligible land within](#) a county owned by the same ~~individual, partnership or corporation~~[individual\(s\), partnership\(s\) or corporation\(s\)](#) shall be included in a single Plan ~~and approved on one Certification Form. Plan amendments that~~[Amendments of Plans to](#) increase acreage during the 10 year lifespan of a Plan shall be ~~added to the original Plan Certification Form~~[cost-shared as described below](#).
- g) Cost-share rate for Plans ~~and Plan revisions of silviculture and management on existing forest stands~~[and Plan revisions of silviculture and management on existing forest stands](#) shall be 75% of the owner's cost, not to exceed: ~~\$7 per acre.~~
- 1) [\\$250 \(for Plans between 5-25 acres\);](#)
 - 2) [\\$100 plus \\$7 per acre \(for Plans greater than 25 acres\).](#)
- ~~h) Cost share rate for reforestation and afforestation Plans as defined in 17 Ill. Adm. Code 1537 shall be 75% of the landowner's cost not to exceed \$4 per acre.~~
- ~~h)i) Fractional acres for all Plans shall be rounded to the nearest acre for cost-share payment as follows: .01 to .49 acres will be rounded down and .50 to .99 shall be rounded up.~~

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

Section 1536.30 Planting Trees and Direct Seeding

The purpose of this practice is to establish a stand of forest trees for timber production, ~~compatible uses purposes and compatible multiple uses~~ and ~~to provide general~~ environmental benefits.

- a) ~~IDNR~~~~The District Forester~~ shall determine the suitability of the land for site preparation and tree planting, considering soil erodibility and the economic feasibility of soil stability practices, such as timing of the practice and ground cover requirements.
- b) ~~Cost share~~~~Cost-sharing~~ is not authorized for:
 - 1) ~~planting trees or direct seeding on less than 1 acre or~~ planting ~~fewer~~less than 435 trees per acre unless ~~the Plan is~~ specifically modified later, under ~~subsections Section 1536.30(c)(2)(ED)(iii) and (c)(3)~~ as approved by ~~thea~~ ~~IDNR~~~~District~~ Forester.
 - 2) planting or culture of fruit or nut orchards, ~~windbreaks~~, Christmas trees or planting for ornamental, landscaping or ~~violation~~mitigation purposes. For the purposes of this subsection (b), "mitigation" ~~refers to the process of rectifying or compensating for the impact on a wetland or other habitat of a specific development project, as required by local, State or federal law or regulation~~means alleviation, reduction, abatement or diminution of a ~~condition that is prohibited by State or federal law or regulation~~.
 - 3) irrigation of planted trees.
 - 4) ~~species not approved by the IDNR Forester~~.
- c) Cost-Share Rates/Specification:
 - 1) Site Preparation – 75% of the actual cost, not to exceed a variable amount ranging from \$30 to ~~\$500~~~~\$180~~ per acre, as determined by the Plan preparer and approved by the ~~IDNR~~~~District~~ Forester. The Plan preparer conducts a careful field inspection of current vegetation cover on the site

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~~to be prepared,~~ and then uses categories and amounts in subsection (c)(1)(~~A~~)(~~B~~) to make a determination about the cost-share rate per acre.

~~A) Cost-share categories and corresponding variable cost-share amounts shall be prorated per acre, per category, and shall be approved by the District Forester.~~

~~A~~)~~B~~) Cost-share categories and variable ~~cost~~Cost-share payments ~~are~~follow:

Category	Variable Cost-Share Amounts Not to Exceed; (Per Acre)
i) rutting <u>Primarily annual vegetation,</u> or heavy residues that <u>which</u> will cause some difficulty in normal planting.	\$30
ii) 60% <u>Sixty percent</u> or more of area in perennial grasses <u>and/or broadleaf broad leaved</u> herbaceous plants. Or up <u>up</u> to 40% of area in light woody cover, stems 2 <u>two</u> inches or less diameter at ground line.	\$60
iii) More than 40% of area occupied by woody vegetation, briars, vines, or woody stems 2 <u>two</u> inches diameter or less at ground line, but can include up to 50 <u>25</u> stems per acre greater than 2 <u>two</u> inches at ground line.	\$90
iv) More than 40% of area occupied by woody vegetation greater than 2 <u>two</u> inches diameter at ground line; or more than 50 <u>25</u> stems per acre greater than 2 <u>two</u> inches diameter at ground line.	\$180

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v) More than 80% of area occupied by woody vegetation greater than 2 inches diameter at ground line; or more than 100 stems per acre greater than 2 inches diameter at ground line. \$500

~~B)C)~~ This practice component is limited to areas having undesirable vegetation (such as grass sod, perennials and annual broadleaved plants and trees or shrubs). These areas will be ~~planted~~replanted to desirable tree species.

~~C)D)~~ Measures necessary to minimize erosion must be undertaken ~~and plantings must be~~ according to prescribed standards set forth in the approved Plan. Measures may include, but are not limited to, hand planting, machine planting on contour, establishment of temporary herbaceous cover, the use of herbicides for minimum disturbance of established cover and similar accepted practices as set forth in the approved Plan. Temporary herbaceous cover means oats, rye, wheat or similar grain.

~~D)E)~~ Removal may be undertaken mechanically with machinery ~~including all normal farm tillage implements~~, chopping or sawing. Herbicides and/or prescribed fire may also be used with mechanical measures or to replace mechanical measures.

2) Tree Planting Bare Root Stock (Trees and Labor) – 75% of the actual cost not to exceed ~~\$105/acre~~\$95 for no-cost planting stock or ~~\$300/acre~~\$280 for purchased planting stock, based on a per seedling rate of 435 trees per acre, per acre.

A) Selected tree species and seed sources to be planted must be in accordance with the Plan.

B) Plantings must be made in accordance with the Plan. Trees must be firmly planted at the proper depth. Tree planting machines, augers or hand tools may be used.

C) At least 90% of the conifer stock must be not less than 3/32 inch in caliper at 1 inch above the root collar (nursery soil line). At least

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90% of the hardwood stock shall be no less than 7/32 inch caliper at 1 inch above the root collar ~~(nursery soil line)~~. In addition to ~~thesethese~~ standards ~~above~~, all hardwood stock purchased from private nurseries shall be ordered from the 12-18 inch category or larger as described in the nursery's catalog or other written description.

D) Seedling seed source must be within 200 miles north or south of planting site, unless otherwise specified in the Plan.

E)D) Spacing requirements ~~are as follows~~:

- i) Plant seedlings 6 to 12 feet apart in rows 6 to 12 feet apart. Plant at least 435 and no more than 700 trees per acre.
- ii) Interplantings within wooded areas are to be spaced 6 feet apart or more in openings ~~thatwhich~~ receive partial or full direct sunlight.
- iii) Variations in these spacing and seedling density standards may be made to enhance an existing forest area or riparian area in accordance with written recommendations approved by the ~~IDNR District~~ Forester. Cost ~~share~~ for planting of fewer thanless or more than 435 trees per acre will be prorated using 435 trees as the basis.

E)E) Stocking and replanting requirements:

- i) A minimum stocking level of 70% must be maintained for the planted area. The minimum level cannot drop below 300 trees per acre. Natural regeneration of acceptable species may be used to supplement the planted trees if approved by the IDNR Forester. At least 300 of the planted trees, per acre, must be maintained throughout the practice lifespan.
- ii) Cost-share assistance for replanting, subject to legislative approval, shall-will be available where losses are due to natural causes, such as ~~heat~~, drought, flood, hail,

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degradation, and similar occurrences~~occurrences~~, if 70% of a stand is not obtained, or if a stand deteriorates to less than 70% within the first 2~~two~~ growing seasons.

iii) Cost-share assistance for replanting will not be authorized for planting failures due to measures within the control of the timber grower, such as poor maintenance, lack of weed control, etc.

- 3) Tree Planting Containerized Stock (Trees and Labor) – 75% of the actual cost not to exceed \$315/acre for approved stock based on a minimum rate of 28 trees per acre.
- A) Planting of containerized stock may be used in addition to natural regeneration when approved by the IDNR Forester as part of a Plan.
- B) This practice is limited to areas that will naturally regenerate to soft mast species within 3 years. A seed source for natural regeneration for light seeded species, such as cottonwood, ash or maple, must be within 200 feet of planting or, in areas where frequent flooding occurs each 1 to 3 years, planting sites must have an upstream floodplain that is dominated by species such as cottonwood, ash and maple. A combined minimum of 300 trees per acre must be present 3 years following planting. Containerized trees must be hard mast producing, such as oak, black walnut, hickory and pecan.
- C) Selected tree species to be planted must be in accordance with the Plan. Trees may be planted by hand using an auger that is larger in diameter than the container.
- D) Containerized trees must be hard mast producing, no less than 2 gallon in size, have a height of no less than 3 feet, and have a caliper no less than $\frac{3}{8}$ inch at 1 inch above root collar.
- E) Tree seed source must be within 200 miles north or south of planting site, unless otherwise specified in the Plan.

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- F) Plant trees a minimum of 40 feet apart in rows 40 feet apart.
- G) A minimum of 70% survival of planted stock must be maintained.
- 4)3) Direct Seeding (Seed and Labor) – 75% of the actual cost not to exceed \$100/acre for free or self-collected seed or \$250/acre for purchased seed stock. ~~Component~~
~~The purpose of this practice is to extend limited supplies of plant materials and thereby to increase forestation.~~
- A) Direct seeding may be used in lieu of seedling planting, when approved by the IDNR ~~District~~ Forester as part of a Plan.
- B) As references for standards use: Herman, R.D. Schmoker, B. Sloan, and T. Ward, 2003 Illinois Direct Seeding Handbook, A Reforestation Guide. Illinois EPA and USDA Natural Resources Conservation Service, Champaign IL. "Direct seeding of Southern Oaks – A PROGRESS REPORT", by Robert L. Johnson and Roger M. Krinard, Southern Hardwoods Laboratory, Stoneville, MS, Forest Service, USDA (1988); and the guidelines offered in Silvies of Forest Trees of the United States (1974), Agriculture Handbook 271, Forest Service, USDA, Washington, DC 20250. (No later editions or amendments are included.)
- C) Spacing Requirements:
- i) Plant seeds 1 to 2 feet apart in rows 6 to 12 feet apart. Plant at least 3,000 hard mast seeds per acre. Soft mast species may be planted in addition to or instead of hard mast species, depending on site conditions.
- ii) Variations in spacing and seed density standards may be made in accordance with written recommendations approved by the IDNR Forester. Cost share for planting of fewer or more than 3,000 seeds per acre will be prorated using 3,000 seeds as the basis. Natural regeneration may be used as a supplement to planting if prescribed in an approved Plan.

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D) Stocking and replanting requirements:

- i)E) This cost-share practice may be attempted a second time if, through no direct fault of the landowner (~~i.e., drought, flood, hail, depredation and similar occurrences, etc.~~), fewer than ~~500~~300 seedlings of acceptable growing stock per acre survive after ~~2~~one full growing ~~seasons~~season.
- ii)D) If, after 2 full growing seasons, there are fewer than ~~500~~300 seedlings of acceptable growing stock per acre, no further attempts to direct seed shall be made. However, tree planting must be done per subsection (c)(2).

E) Seed source must be within 200 miles north or south of planting site, unless otherwise specified in the Plan.E) Cost-share Rate and Specifications

- i) This practice shall pay ~~85% of the owner's cost not to exceed \$95 per acre for seed collected or purchased plus labor and machinery use.~~
- ii) ~~Seed shall be local source, within 25 miles of the seeding site. Or, if local seed is not available, seed shall be collected within an area described as 50 miles west of the Mississippi River, 50 miles north of the Illinois Wisconsin border, a north-south line extended along the eastern border of Ohio and 100 miles south of the Ohio River.~~

F)iii) Measures to protect seed from depredation must be prescribed in the Plan~~predator pilferage shall be required when predator pilferage is identified as a problem.~~G)iv) Site preparation measures must be~~are best~~ done before direct seeding. ~~Additional treatments to introduce adequate sunlight and to reduce competition may be needed.~~

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v) ~~Overstory removal may be required following establishment of seedlings—saplings.~~

5)4) Control of Undesirable Vegetation ~~With Herbicides or Mulching~~ – 75% of the actual cost not to exceed \$40 per acre with herbicides, \$60 per acre with mulch or weed control fabric.

- A) The practice is limited to plantings that conform to specifications cited in this Section ~~1536.30~~.
- B) Application of herbicides may be in either the liquid or granular form and may be pre-emergents or post-emergents or combinations of these types, as approved by the IDNR District Forester. Application may be made as pre-plant, post-plant or at time of planting. ~~If vegetation control is a component of the forestation practice, it must be completed to qualify for reimbursement for site preparation and planting.~~ Treated bands ~~for hardwoods~~ shall be 4 feet, spot treatments shall be at least 12 square feet. ~~For conifers minimum band width is 2 feet, and spots of 4 square feet.~~
- C) Organic mulches may be used in combination with herbicides or in lieu of herbicides, and must be used if required in the approved management Plan, ~~in order to receive~~ to qualify for site preparation and planting payments. Minimum per seedling mulched area is ~~412~~ square feet with an initial depth of 4 inches. Mulch should not be piled against the stem. Mulched areas must be pretreated by removing existing vegetation to expose mineral soil prior to applying the mulch. Weed control fabric (~~cloth~~) can be used if at least 9 square feet is used around each seedling.
- D) Herbicide ~~or mulching~~ applications must be made, if required in the Plan, ~~in order to receive and included on the practice cost share application, to qualify for~~ site preparation and planting payments.
- E) Treatments for control of undesirable vegetation may be cost-shared for a second and third application as prescribed in the Plan and approved by the IDNR District Forester.

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

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Section 1536.40 Fencing to Protect Forests and Plantations

- a) The practice is limited to building permanent fences needed to exclude livestock.
- b) ~~The distance between posts or live trees must not exceed 1 rod (16.5 feet).~~
Limited use of live trees is permitted, provided 2" x 4" nailing strips of durable wood are used between the wire and the tree.
- c) ~~Boundary fences and fences adjacent to roads are not eligible for cost share. No assistance will be given for boundary fences or fences adjacent to roads.~~
- d) Cost-Share Rates/~~Specifications~~Specification – The cost-share amounts vary by type of fence constructed; however, the rate will be 75% of actual cost not to exceed these limits:
- 1) A woven wire fence must consist of at least a ~~32~~26 inch woven wire with at least ~~two~~ strands of barbed wire on top. ~~The distance between posts or live trees must not exceed 17 feet – \$15~~\$12 per rod.
 - 2) A barbed wire fence must be at least ~~3~~three strands. ~~The distance between posts or live trees must not exceed 17 feet – \$12~~\$11 per rod.
 - ~~3) If other fence materials are used, all weather wood or native lumber highly resistant to decay may be substituted for barbed wire if required for certain domestic animals – \$12 per rod.~~
 - 4) ~~A suspension fence will consist of at least four strands of barbed wire with the distance between posts not to exceed 100 feet and sufficient wire spacers to prevent sagging – \$6 per rod.~~
 - ~~35) A high-tensile fence must will consist of at least ~~5~~6 strands of wire with the distance between posts not to exceed ~~30~~40 feet with sufficient droppers to maintain proper wire spacing – ~~\$12~~\$9 per rod.~~
 - 4) Any other materials used must be treated or naturally resistant to decay – \$12 per rod.

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

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Section 1536.50 Tending Forest Stands (Repealed)

~~Profitable production for timber, wildlife mast, or aesthetics can result from the application of proper methods of thinning or releasing of desirable crop trees and by cutting of designated vines attached to desirable crop trees. Thinning, vine removal and pruning are methods to increase growth rates of the best crop trees. Vines not on crop trees shall be retained for wildlife benefit.~~

- a) ~~Cost sharing will be approved for area one acre or larger.~~
- b) ~~Improvement measures shall be carried out in such a manner as to improve or protect the quality of the environment, especially wildlife habitat, as described in the Plan.~~
- e) ~~Cost Share Rates/Specifications~~
 - 1) ~~Thinning/Crop Tree Release—75% of actual cost not to exceed \$45 per acre.~~
 - A) ~~The District Forester must give prior approval of the practice area, the methods to be used based upon the density and condition of the trees, and the economic feasibility of the practice.~~
 - B) ~~Work shall be done by cutting, girdling, and herbicide treatment of the surplus, diseased, cull or weed trees and by cutting designated vines attached to desirable crop trees. Thinning should release desirable tree species so as to leave per acre an adequately stocked stand composed predominately of high ranked timber species, well distributed, as described in the Plan. Stocking guides and species rank shall be determined by use of the appropriate table in "Recommended Silviculture and Management Practices for Illinois Hardwood Forest Types", Illinois Technical Forestry Association (1972), Extension Forester, Illinois Cooperative Extension Service, University of Illinois, 110 Mumford Hall, Urbana, IL 61081 (no later editions or amendments are included).~~
 - C) ~~Croptree management practice guidelines will follow the recommendations provided by "Croptree Management in Eastern Hardwoods" (Circa 1993), NA TP 19 93, USDA Forest Service,~~

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~~Arlyin Perkey, Morgantown, WV (no later editions or amendments are included).~~

- ~~D) Herbicide treatment of stumps may be omitted when crop trees released are more than 20 feet tall. Herbicide treatment may also be omitted, if a double girdle is utilized. Double girdling shall be done only when stump sprouting will not be a serious problem. This method is described in Central Hardwood Notes, 6-10, August 1989 Northeastern Area, State and Private Forestry. USDA Forest Service. Both exceptions above must be approved in writing by the District Forester. All other treatment methods require use of approved herbicides.~~
 - ~~E) Harvesting practices and silvicultural systems as prescribed in the Plan must be followed.~~
 - ~~F) Cost Share assistance will not be given for any acre from which commercial products are being sold or traded in the process of carrying out the timber stand improvement practices.~~
- 2) ~~Pruning Crop Trees (side branch pruning) — 75% of actual cost not to exceed \$75 per acre.~~
- ~~A) The District Forester must give prior approval of the practice area. Crop trees must be marked or otherwise designated and the methods must be described in writing.~~
 - ~~B) In coniferous stands, the trees must have a minimum total height of 18 feet. All dead branches and all live branches up to one half the total height of the trees must be pruned. Pruning to a total height of 17 feet is required where the trees are tall enough to meet this requirement. Not more than 100 final coniferous crop trees per acre, well distributed throughout the stand will be considered in determining the cost share payment.~~
 - ~~C) In deciduous stands, pruning to total height of 17 feet is required where trees are tall enough to meet the requirement of 34 feet. Pruned trees shall retain 40% to 50% of total height as live crown. Deciduous stands must have attained a minimum height of 12 feet~~

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~~to effect a minimum pruning height of 6 feet. Not more than 100 well distributed desirable crop trees per acre shall be selected and fine hardwood (white and red oak, black walnut, etc.) species will be given prime consideration. In order to reduce the risk of decay, prune no live limbs over 3 inches in diameter.~~

- ~~D) All pruning must be as close to the stem as possible without disturbing the branch bark ridge and branch collar.~~
- ~~E) Corrective pruning to influence tree form may be required in the Plan; but such pruning shall not be cost shared unless undertaken along with side branch pruning.~~

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

Section 1536.51 Timber Stand Improvement

The purpose of Timber Stand Improvement (TSI) is to increase tree growth and quality, improve stand vigor and health, influence tree species composition, enhance diversity of native flora and improve wildlife habitat. Examples of TSI practices include pre-commercial thinning, crop tree management (CTM), weeding, cleaning, cull tree removal and vine treatment.

- a) Cost share is authorized for TSI based upon a silvicultural prescription approved by the IDNR Forester and developed upon stand level analyses that support the goals and objectives stated in the Plan.
- b) Improvement measures shall be carried out in a manner to improve or protect the quality of the environment, especially wildlife habitat, as described in the Plan.
- c) Cost-Share Rates/Specifications
 - 1) Timber Stand Improvement – 75% of actual cost not to exceed \$54 per acre.
 - 2) The IDNR Forester must give prior approval of the practice area, the methods to be used based upon the density and condition of the trees, and the economic feasibility of the practice.

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- 3) Work will be done by an approved method, including cutting, girdling and herbicide treatment of the designated surplus, diseased, cull or weed trees and by cutting vines attached to desirable crop trees. TSI practices should release desirable trees as described in the Plan and leave an adequately stocked stand composed predominately of high quality, well-distributed trees. Stocking guides and species selection shall be determined by use of the appropriate table in "Recommended Silviculture and Management Practices for Illinois Hardwood Forest Types", Illinois Technical Forestry Association (1972), Extension Forester, Illinois Cooperative Extension Service, University of Illinois, 110 Mumford Hall, Urbana IL 61081 (no later editions or amendments are included).
- 4) Crop tree management practice guidelines will follow the recommendations provided by "Croptree Management in Eastern Hardwoods" (Circa 1993), NA-TP-19-93, USDA Forest Service, Arlyin Perkey, Morgantown WV (no later editions or amendments are included).
- 5) Herbicide treatments are required in implementing this practice but may be omitted when double girdling is used and/or crop trees released are at least 20 feet in height.
- 6) Cost-share assistance will not be approved for any acre from which commercial products are sold or traded in the process of carrying out the timber stand improvement practices.

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

Section 1536.55 Pruning Crop Trees

The purpose of pruning is to improve the quality and quantity of high value crop trees.

- a) Pruning Crop Trees (corrective pruning to a single leader with side branch pruning) – 75% of actual cost not to exceed \$105 per acre.
- b) The IDNR Forester must give prior approval of the practice area. A minimum of 40 crop trees per acre must be marked or otherwise designated and the methods must be described in writing.

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- c) In coniferous stands, the trees must have a minimum total height of 18 feet. All dead branches and all live branches up to one-half the total height of the trees must be pruned. Pruning to a total height of 12 feet is required where the trees are tall enough to meet this requirement.
- d) In deciduous stands, pruning to total height of 17 feet is required where trees are tall enough to meet the requirement of 34 feet. Pruned trees shall retain 40% to 50% of total height as live crown. Deciduous stands must have attained a minimum height of 12 feet to affect a minimum pruning height of 6 feet. In order to reduce the risk of decay, prune no live limbs over 3 inches in diameter.
- e) All pruning must be as close to the stem as possible without disturbing the branch bark ridge and branch collar.
- f) Corrective pruning to influence tree form may be required in the Plan; but such pruning shall not be cost-shared unless undertaken along with side branch pruning.

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

Section 1536.60 Firebreaks to Protect Forests

The purpose of this practice is to provide a practical and low cost way of affording protection to forests from damage by wildfire and to facilitate the use of prescribed fire.

- a) ~~The lower branches of trees adjacent to firebreaks must be pruned to increase the effectiveness of the practice.~~
- b) ~~Cost Share Rates/Specifications~~
- a1) Firebreak ~~Construction~~construction – 75% of actual cost not to exceed \$1.50 per rod.
- b2) Firebreaks for the area shall be cleared to a minimum of 1 rod in width. (If erosion is a problem, place firebreaks on the contour, or construct the appropriate number of water bars to deflect flowing water.)
- c) Firebreaks can be established and maintained by one of the following methods:

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- 13) ~~A firebreak~~Firebreaks must be disc'd at least twice annually to keep vegetation from accumulating or as indicated in the Plan.
- 2) A cool season grass, clover or winter wheat cover crop should be established and maintained by mowing to a maximum height of 6". Mowing must be done to prevent an accumulation of dead clippings that could carry a fire.

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

Section 1536.65 Reducing Wildlife Damage

Wildlife damage control is necessary at times to protect the investment in tree planting, direct seeding, or natural regeneration.

- a) This practice is limited to situations ~~in which~~where the need for damage control is evident or highly probable based on wildlife population. Consultation with ~~IDNR~~DNR District Wildlife Biologists is advised.
- b) In addition to cost-share practices, other strategies to control wildlife damage must be included in the Plan and must be implemented with ~~this~~the cost-share practice.
- c) Strategies ~~shouldean~~ include: Legal hunting, providing alternate habitats, planting of species not favored by a given wildlife species, vegetation management~~eliminating mowing~~, or planting a companion species.
- 1) Tree ~~Shelters~~shelters – 75% of the actual cost not to exceed ~~\$225~~\$150 per acre. The recommendation in the Plan as approved by the ~~IDNR~~District Forester shall be followed. Requirements include:
- A) Tree shelters shall be evenly distributed throughout each acre.
- B) Shelters shall be maintained as installed for the life of the shelter or until they interfere with the growth of the tree. ~~Shelters may be moved to other seedlings only if the original trees have died.~~
- C) Durable rot resistant stakes must be used.

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- D) Nylon mesh caps or other approved barriers may be needed to prevent death of birds.
 - E) For protection from deer, 4 foot shelters meet minimum requirements.
 - F) 50 shelters per acre is the minimum.
 - G) [Cost share of fewer than 50 shelters per acre is authorized only in conjunction with planting of containerized trees as defined in Section 1536.30\(c\)\(3\). Cost share for fewer than 50 shelters per acre will be prorated using 50 shelters as the basis.](#)
- 2) Electric Fencing – 75% of the actual cost not to exceed \$0.50 per foot. The purpose is to repel deer from forestation or natural regeneration sites, as follows:
- A) VGR type fence wire; [\(stainless steel enclosed in plastic\)](#) is the preferred type. Other wire may be used, but must be marked with bright color at minimum intervals of 25 feet.
 - B) For maximum benefit, the fence must be charged throughout the year so as to affect deer behavior.
 - C) The service life of the fence shall be determined in the Plan or by separate written prescription.
 - D) The fence should be installed prior to planting or at the time of planting to influence deer behavior.
- 3) Repellants – 75% of the actual cost not to exceed \$15 per acre to protect forestation or natural regeneration sites.
- A) Either scent or taste repellants may be used; the Plan shall prescribe specific types.
 - B) [Label](#) directions on approved products must be followed. Renewal applications must be made in a timely manner, per the label.

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- C) The primary treatment shall be done by treatment of the central leader of the seedling.
- 4) ~~Bud or Growing Point Protectors — 75% of the actual cost not to exceed \$5 per acre. Such devices as mesh netting, tubes, or bud caps may be used to protect seedling plants. Installation of such devices shall be according to the manufacturer's recommendations and the written prescription in the Plan.~~

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

Section 1536.70 Site Preparation for Natural Regeneration

The purpose of this practice is to ~~create the environmental conditions favorable for the establishment, development and/or release of desirable regeneration~~establish a stand of high value forest species through natural regeneration for timber production purposes and to protect and improve the environment. For guidelines on species preference, refer to the ITFA Guide, cited previously, in Section 1536.25(e).

- a) ~~Cost share~~Cost-sharing is not authorized for areas of less than one acre.
- b) ~~Cost share~~Cost-sharing is authorized for planting seed or seedlings should natural regeneration failone additional regeneration treatment, by use of seed or seedlings on the area originally site prepared, if by uncontrollable circumstances, such as weather related problems, etc., natural regeneration fails to become established to the desired~~the required~~ stocking levellevel.
- c) This practice should not be prescribed more than 20 years prior to a scheduled harvest.
- de) Cost-Share Rates/Specifications~~Specification~~
- 1) Selective Tree/Shrub Removal – 75% of actual cost not to exceed:~~Site preparation for natural regeneration — 75% of actual cost not to exceed \$30, \$60, \$90, or \$180 per acre determined by the District Forester using the cost-share categories as described in Section 1536.30(e)(1)(B)(i) through (iv), as guidelines to determine an appropriate maximum cost-share amount.~~

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\$54 per acre to treat fewer than 150 stems per acre

\$75 per acre to treat 150 to 300 stems per acre

\$120 per acre to treat more than 300 stems per acre

- A) The purpose of this component is create light conditions necessary for the development or release of advance regeneration of desirable species that are intermediate or intolerant of shade.
- B) Work will be done by cutting, girdling and/or herbicide treatment of the trees/shrubs to be removed. Undesirable species must be treated with an appropriate herbicide to prevent resprouting.
- C) Cost-share may also be authorized for prescribed burning and/or soil scarification as prescribed in the Plan.
- D) The goal of this practice is to obtain a 40-70% stocking level of desirable dominant and codominant trees distributed uniformly while reducing the stocking of unwanted species. Lower stocking levels are most appropriate for poorer quality sites where competing vegetation is not as aggressive and advance regeneration is usually better established.
- E) All undesirable stems greater than 2" DBH should be eliminated in regeneration harvest openings or other areas greater than 0.2 acres. 20 square feet of basal area per acre can be retained in crop trees within the openings without interfering with regeneration development.

- 2) Soil Scarification – 75% of actual cost not to exceed \$75 per acreThe goal is to obtain a 60-80% stocking level whereby a minimum of 20% to 40% of the available light reaches the forest floor, and other site factors are modified to enhance regeneration, by means of: reduction or elimination of competing vegetation, including unmerchantable or undesirable trees and brush, discing or tillage, use of foliar, cut surface, injected herbicides, mechanical removal of shallow rooted species, prescribed burn, and other measures as prescribed in the Plan.

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- A) The purpose of this component is to expose mineral soil to enhance the establishment of oak regeneration.
 - B) Perform practice in the fall of an abundant acorn crop and prior to leaf drop.
 - C) A timber harvest, prescribed burn, or selective tree/shrub removal may be needed in addition to scarification to enhance the survival, growth and development of newly established seedlings.
- 3) Woodland Prescribed Burning – 75% of actual cost not to exceed \$50/acre. A complete written prescription, in the Plan or submitted as an addendum, must be approved by the District Forester prior to initiation of this practice. The prescription shall address the process outlined in "Regenerating Red Oaks" by Rod Jacobs, Silviculturalist, U.S. Forest Service, State and Private Forestry, St. Paul, Minnesota (1987) (no later editions or amendments are included). The prescription shall also address the "Elements of a Silvicultural Prescription" and the appropriate "Silvicultural Systems and Regeneration Methods" described in the "FORESTRY HANDBOOK" 2nd Edition, Edited by Karl F. Wenger, for the Society of American Foresters, 5400 Grosvenor Lane, Washington DC 20014 (1984) (no later editions or amendments are included).
- A) The objective of this practice is to reduce the density of the forest subcanopy and the thickness of the litter layer to stimulate oak regeneration.
 - B) Cost share may be authorized for up to 3 burns in the same area within a 10 year period, if prescribed in the Plan. A detailed prescribed burn plan must be prepared prior to any burning, in accordance with IDNR policy and procedures.
- 4) Creation of suitable soil conditions for establishment of seedlings of desired species is particularly crucial for oak species. A reasonable expectation of seed deposition on the area to be regenerated must be imminent and abundant before site preparation is performed.

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- 5) ~~This practice should not be done more than 20 years prior to a scheduled regeneration cut.~~

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

Section 1536.75 Forestry Best Management Practices

The purpose of this practice is to promote the use of best management practices (BMPs) and streamside management zones (SMZs) through the construction, establishment, maintenance, renovation and/or restoration of roads, trails, culverts, stream crossing structures and landing areas for the purpose of improving and protecting soil and water quality.

- a) Cost share is authorized for the establishment of grasses, legumes or temporary cereal crops on skid trails and log landings developed or used during timber harvesting. Rates include site preparation, seed cost, nutrient and fertility tests, and installation.
- b) Cost share is authorized for the construction and installation of water bars and diversions to mitigate the impacts of soil erosion on water quality from sedimentation due to water runoff from logging skid trails, haul roads and landing areas.
- c) Cost share is authorized for the construction and installation of rock fords, culverts and bridges that will be used as temporary or permanent crossings over streams, ravines and ditches during a logging operation in order to protect water quality.
- d) Practices will be implemented and completed according to Forestry Best Management Practices for Illinois (October 2000), which can be obtained from the IDNR Division of Forest Resources, One Natural Resources Way, Springfield IL 62702.
- 1) Critical Area Seeding – 75% of actual cost not to exceed \$50/acre.
- 2) Water Bars (mounded soil) – 75% of actual cost not exceed \$0.50/linear foot of structures.
- 3) Water Deflector & Open Top Culvert – 75% of actual cost not to exceed \$3/linear foot of structures.

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- 4) Culverts (steel, aluminum, polyurethane) – 75% of actual cost not to exceed:
 - 15" – \$16/linear ft.
 - 18" – \$19/linear ft.
 - 21" – \$22/linear ft.
 - 24" and greater – \$25/linear ft.
- 5) Skidder Bridges – 75% of actual cost not to exceed \$375 per job.
- 6) Rock Fords – 75% of actual cost not to exceed \$500.

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

Section 1536.77 Invasive and Exotic Species Control

The purpose of this practice is to eradicate or control the establishment and spread of non-native and invasive plants that may threaten forest regeneration, productivity, native plant diversity and wildlife habitat.

- a) Cost share is authorized for the control of species that are considered a long term biological threat to the successful establishment or maintenance of the forest flora through natural processes. Species eligible for cost-shared control are:
 - Ailanthus altissima, tree of heaven
 - Alliaria petiolatal, garlic mustard
 - Celastrus orbiculatus, round leaved bittersweet
 - Dioscorea batatas, Chinese Yam
 - Elaeagnus umbellata, Autumn olive
 - Lonicera spp, honeysuckle spp

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[Microtegium vimineum, Japanese grass](#)

[Morus alba, white mulberry](#)

[Pueraria loata, kudzu vine](#)

[Pyrus calleryana, Bradford pear](#)

[Rhamnus spp, buckthorn spp;](#)

[Robinia pseudoacacia, black locust;](#)

[Rosa multiflora, multiflora rose](#)

[Ulmus pumila, Siberian elm](#)

[Acer platanoides, Norway maple](#)

[Euonymus alata, winged euonymus](#)

[Euonymus fortunei, climbing euonymus](#)

[Berberis thunbergii, Japanese barberry](#)

[Ligustrum vulgare, common privet](#)

[Populus alba, white poplar](#)

[Rehsonia sinensis, Chinese wisteria](#)

[Rehsonia floribunda, Japanese wisteria](#)

[Quercus acutissima, Sawtooth Oak.](#)

- b) [Invasive Species Control – 75% of the actual cost not to exceed a variable amount ranging from \\$60 to \\$380 per acre, as determined by the Plan preparer and approved by the IDNR Forester.](#)

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1) Cost-share categories and variable cost-share payments are:

<u>Category</u>	<u>Variable Cost-Share Amounts Not to Exceed (Per Acre)</u>
<u>Level 1 – Prescribed burning or brush mowing may be used</u>	<u>\$30</u>
<u>Level 2 – Less than 25% of area occupied by target species</u>	<u>\$60</u>
<u>Level 3 – 25% to 50% of area occupied by target species</u>	<u>\$90</u>
<u>Level 4 – 50% to 75% of area occupied by target species</u>	<u>\$190</u>
<u>Level 5 – More than 75% of area occupied by target species</u>	<u>\$380</u>

2) Treatments may be undertaken mechanically or by herbicide application, cutting, pulling, burning or other means. Treatment options may be used alone or in combination. Cost share may be authorized for up to 3 re-treatments within a 10-year period, as outlined in the Plan.

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

Section 1536.80 Appeal

- a) Any ~~landowner and/or~~ timber grower whose Plan or practice is not approved by the ~~IDNR District~~ Forester may appeal to the Regional Review Committee pursuant to 17 Ill. Adm. Code 2530. The Regional Review Committee is composed of the Regional Administrator, ~~an IDNR a District~~ Forester from another district in the Region and the Forest Management Program Administrator.
- b) The appeal must be made in writing to the State Forester or designee within 30 days from the date that the Plan or practice was disapproved by writing to the address in Section 1536.90.

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- c) The Regional Review Committee will conduct a meeting to receive written and oral arguments of the applicant and to reconsider the Plan and cost-share practices.
- d) The Regional Review Committee will notify the applicant in writing within 30 days after the meeting date stating the reasons for which the original decision is upheld or reversed.

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

Section 1536.90 Information

Anyone wishing additional information concerning this Part, may contact the Administrator, Forest Management Programs.

[Illinois](#) Department of Natural Resources
Division of Forest Resources
[One Natural Resources Way](#)~~P.O. Box 19225~~
Springfield [IL 62702-1271](#), ~~Illinois 62794-9225~~

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

Section 1536.100 Penalty

Each participant in this State Cost-Share Program is responsible for complying with the terms and conditions ~~stated in~~ the agreement, and shall follow the provisions detailed in the Plan. Refund of all cost-share payments made will be required if the agreement is not followed and/or the practice is not maintained for its minimum lifespan. Each practice carries a 10 year life span starting on the date the practice was completed and approved by ~~the IDNR~~ District Forester. Refund checks should be made payable to the Illinois Department of Natural Resources. Participants who refuse voluntary repayment will be subject to liens filed against their property or withholding of State payments by the Comptroller of Illinois.

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

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- 1) Heading of the Part: Forest Management Plan
- 2) Code Citation: 17 Ill. Adm. Code 1537
- 3)

<u>Section Numbers:</u>	<u>Proposed Action:</u>
1537.1	Amendment
1537.2	Amendment
1537.5	Amendment
1537.6	New Section
1537.10	Amendment
1537.15	Amendment
1537.17	New Section
1537.18	New Section
1537.20	Amendment
1537.21	New Section
1537.24	New Section
1537.25	Repealed
1537.30	Amendment
1537.40	Repealed
1537.42	Amendment
1537.45	Amendment
1537.47	New Section
1537.50	Amendment
1537.55	Amendment
1537.57	New Section
1537.58	New Section
1537.60	Amendment
1537.65	Amendment
1537.70	Amendment
1537.71	New Section
1537.72	New Section
1537.75	Amendment
1537.80	Amendment
1537.85	Amendment
1537.90	Amendment
1537.EXHIBIT A	Amendment
1537.EXHIBIT B	Amendment

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- 4) Statutory Authority: Implementing and authorized by the Illinois Forestry Development Act [525 ILCS 15]
- 5) A Complete Description of the Subjects and Issues Involved: The existing Part does not fully address changes and developing issues that have increasingly become important to the program's intent. The proposed amendments to this Part provide a more comprehensive direction for management of the lands in the Forest Development Act Program and provide a clearer interpretation of the program's intent. Outdated regulations are being repealed and new regulations are being added: to incorporate documentation requirements, provisions for additional emphasis to be placed on soils, wetlands, threatened and endangered species, criteria for plan review and decertification and to clarify regulations.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: This rulemaking does not affect units of local government.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on the proposed rulemaking may be submitted in writing for a period of 45 days following publication of this Notice to:

William K. Richardson, General Counsel
Department of Natural Resources
One Natural Resources Way
Springfield IL 62702-1271

217/782-1809

- 13) Initial Regulatory Flexibility Analysis:

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- A) Types of small businesses, small municipalities and not for profit corporations affected: The purpose of the revisions to this Part is to guide plan developers in requirements of a Forest Management Plan that will be eligible to be approved and certified into the Forest Development Act Program. The document also guides and sets standards and need for the property in order to enroll into the Forest Development Act Cost Share Program (17 Ill. Adm. Code 1536) and be eligible to receive reimbursement of the practices outlined as needed in the Plan. These Plans are often completed by small business Forestry Consultants working for individual landowners.
- B) Reporting, bookkeeping or other procedures required for compliance: The landowners must keep records of the Forest Management Plan created through the guidance of this Part for long-term implementation of sustainable forest management activities and implementation. The Landowner must allow periodic inspection by Department personnel: to ensure completion and approval of the practice requirements and conduct periodic inspections to ensure practice maintenance and assurance the land covered under the plan and program stay consistent with those requirements set forth by the Part.
- C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: January 2009

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

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TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF NATURAL RESOURCES
SUBCHAPTER d: FORESTRYPART 1537
FOREST MANAGEMENT PLAN

Section	
1537.1	Definitions
1537.2	Forest Management Plan Development
1537.5	Eligibility
1537.6	Plan Cover Page
1537.10	Description of the Land to be Managed
1537.15	Map of the Area
1537.17	Goals and Objectives
1537.18	Soils Information
1537.20	Description of Forest Types to be Managed
1537.21	Description of Management Practices
1537.24	Timber Harvest Schedule and Forest Regeneration
1537.25	Harvest Schedule Projected 10 Years (Repealed)
1537.30	Reforestation and Afforestation
1537.35	Afforestation Plan (Repealed)
1537.40	Forest Regeneration Plan (Repealed)
1537.42	Recreational Use and Esthetics
1537.45	Soil and Water Conservation Goals
1537.47	Wetlands
1537.50	Forest Wildlife Habitat Enhancement
1537.55	Protection Measures
1537.57	Threatened and Endangered Species
1537.58	Special Sites
1537.60	Silviculture Practices Required, Sequence and Specification
1537.65	An Estimate of the Practice Costs
1537.70	Forest Management Plan Approval Approved
1537.71	Plan Review
1537.72	Decertification Process
1537.75	Appeals
1537.80	Annual Review Process
1537.85	Information
1537.90	Amended Plans

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EXHIBIT A ~~Suggested~~ Forest Management Plan Outline

EXHIBIT B Illinois Forestry Development Act Management Plan Certification

AUTHORITY: Implementing and authorized by the Illinois Forestry Development Act [525 ILCS 15].

SOURCE: Adopted and codified at 8 Ill. Reg. 8732, effective June 6, 1984; amended at 9 Ill. Reg. 14278, effective September 5, 1985; amended at 14 Ill. Reg. 18222, effective October 29, 1990; recodified by changing the agency name from Department of Conservation to Department of Natural Resources at 20 Ill. Reg. 9389; amended at 33 Ill. Reg. _____, effective _____.

Section 1537.1 Definitions

"Advance Regeneration" – seedlings and saplings established and growing in a forest understory.

"Afforestation" ~~– means~~ the establishment of forest trees by planting or seeding an area not previously forested ~~a tree crop on an area from which trees have always or long been absent.~~

"Basal Area" or "BA" – a measurement of the cross-sectional area of a tree, taken at breast height (4½ ft.); a term commonly used as a measure of forest density and expressed in square ft./ac. ~~means the area of the cross-section of a tree stem at breast height, and is used to express relative density of trees per acre.~~

"Contiguous" – continuing without interruption by a non-forestry land use.

"DBH" – the means diameter of a tree's trunk measured at breast height (DBH) defined as 4½ feet above the ground level on the uphill side.

~~"District Forester, Regional Administrator, Forest Management Program Manager" are employees of the Department of Natural Resources who are designated by position title per official position description and specification on file with the Department of Central Management Services.~~

"Forest" – a biological community whose dominant vegetation ~~means an area whose principal~~ crop is trees.

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"Forestry Best Management Practices" or "BMPs" – practical and economically achievable practices for preventing or reducing nonpoint source pollution.

"Forest Management Plan" or "Plan" – a written document prepared by a professional forester or natural resource manager to guide and direct the use and management of a forest property.

"IDNR Forester", "Regional Administrator" or "Forest Management Program Manager" – employees of the Department of Natural Resources who are designated by position title as identified in the official position description and specification on file with the Department of Central Management Services.

"Reforestation" ~~– means~~ the re-establishment of forest cover by natural or artificial means on areas recently or historically supporting forest cover ~~restocking with trees of forest land.~~

"Regeneration" ~~– means~~ the replacement of one forest stand by another as a result of natural seeding, sprouting, planting, harvesting or other methods; also young trees that will develop into the future forest ~~renewal of a tree crop by natural or artificial means.~~

"Silviculture" ~~– means~~ the art, science and practice of establishing, tending and regenerating forest stands ~~art of cultivating forest crops~~ for the production of goods and services; the theory and practice of controlling forest establishment, composition and growth.

"Similar Land Use" – farmland, pasture, prairie, wildlife food plot, water, wetlands, utility right-of-way or unpaved road/farm access lane. Similar lands does not include highway, public roads, lawn, home/building or other non-agricultural land uses.

"Special Sites" – sites offering unique archaeological, cultural, natural or historical value.

"Stand" ~~– means~~ a group of trees that, because of their similar age, condition, composition, past management history, and soil characteristics, are logically managed together as a single unit ~~community of trees possessing sufficient uniformity in regard to composition, density, age, spatial arrangement, or condition, thus forming a silvicultural or management entity.~~

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"Stocking" – a function of the number of trees, basal area and quadratic mean diameter per acre in a specific forest area compared to the optimal level to best achieve management objectives. Stocking may be expressed as a percentage or in relative terms as understocked, fully stocked or overstocked~~means subjective indication in a forest of the number of trees as compared to the desirable number for best results. (For example—In an upland forest with an average tree diameter of 3 inches, 38 square feet of basal area is acceptable. Where the trees average 18 inches, the acceptable level is 77 square feet, stocking guidelines are to be found in "Recommended Silvicultural and Management Practices for Illinois Hardwood Forest Types" (1972) Extension Forester, Illinois Cooperative Extension Service, University of Illinois, 110 Mumford Hall, Urbana, IL 61081 (No later editions or amendments are included)).~~

"Timber" means trees, standing or felled, and parts of treesthereof, excluding Christmas trees and producers of firewood.

"Timber Grower" means the owner, tenant or operator of land in this Statestate who has an interest in, or is entitled to receive any part of the proceeds from, the sale of timber grown in this State and includes persons exercising authority to sell timber.

"Timber Stand Improvement" or "(TSI)" – a combination of intermediate cultural treatments designed to improve the growth, condition and composition of the forest~~is a term comprising all intermediate cuttings or other silviculture treatments made to improve the composition, condition and increment of a timber stand.~~

Wetlands – those areas inundated or saturated by surface water or groundwater at a frequency and duration sufficient to support, and that under normal circumstances do support, a prevalence of vegetation typically adapted to life in saturated soil conditions.

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

Section 1537.2 Forest Management Plan Development

Landowners~~A landowner~~ or their representativeshis/her representative may develop a forest management plan and submit it to their local Illinois Department of Natural Resources

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~~(IDNRDNR) District Forester for review and approval in accordance with Sections 1537.70 through 1537.75. Plans submitted for IDNR approval must include those items listed under Sections 1537.6 through 1537.65. The Forest Management Plan will include those items listed under Section 1537.10 to 1537.65.~~ A suggested outline of the Planforest plan is shown in Exhibit A.

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

Section 1537.5 Eligibility

- a) A timber grower must own or operate at least 5 contiguous acres of land at least 100 feet wide that is systematically managed for the production of timber~~which timber is produced~~. No acre on which a permanent building is located shall be included in calculations of acreage for the purpose of determining eligibility. Once eligibility of the 5 contiguous acres is met, non-connected timber producing lands at least 100 feet wide may be added at the minimum size of one acre. These additional acres must be connected to a qualifying parcel through a 100 foot wide forested corridor or separated only by a similar land use. The timber grower must agree to implement an approved Plan and demonstrate progress in completing the objectives listed in this Part. Participants must allow periodic field inspection by the IDNR Forester to ensure federal and State forestry program compliance.
- b) An eligible property must be able to physically support timber growing and harvesting operations. Field windbreaks, commercial nut/fruit orchards, landscape nurseries, and Christmas tree farms are not eligible for program enrollment. The Illinois Forestry Development Act (FDA) creates a voluntary program.
- c) All eligible land within a county owned by the same individual, partnership or corporation shall be included in a single Plan and approved on one certification form. Plan amendments that increase acreage during the 10 year lifespan of a Plan shall be added to the original Plan Certification Form.

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

Section 1537.6 Plan Cover Page

All Plans must include a cover page with the following minimum information: landowner's and Plan preparer's full name, address, phone number, e-mail address (if available), date of Plan

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preparation and number of acres covered under the Plan.

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

Section 1537.10 Description of the Land to be Managed

The minimum legal description of the property to be managed ~~must~~will include quarter section, section, township, range and county . Plans must describe the relationship of the forest program property in context to the surrounding properties. A general property description should include a geographic location, how to access the property, significant features, management history, and restrictive easements and property index number or parcel number (if used by the County Assessor's Office).

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

Section 1537.15 Map of the Area

A map composed of an aerial photo (min. Scale: 1" = 600 feet, 8" = 1 mile, or 1:7920) that clearly and adequately depicts roads, property boundaries, stand unit, water, trails, and other significant features must be included with the Plan. Soil maps must be included with all Plans. Furthermore, all maps, photos and drawings must include landowner's name, county, legend, north arrow and scale. A map encompassing the area must accompany the written plan and indicate the stands where silvicultural treatments are required. The map will have a minimum scale of 8" to the mile, and shall be reproducible on black and white copiers.

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

Section 1537.17 Goals and Objectives

A list of landowner goals regarding management of the property must be included in the Plan and be compatible with the Illinois Forestry Development Act (FDA). The FDA program is designed for timber growers and, as such, requires the production of timber as one of the stated goals. Stand level objectives designed to achieve these goals must also be included. Objectives should be clear, time specific, achievable and expressed in terms that are easily measured.

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

Section 1537.18 Soils Information

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All Plans shall include a description of soil features. Information may be generalized over the property when soil conditions are uniform or addressed on a stand-by-stand basis. The description shall include the soil series, drainage, associated topography and other pertinent properties, particularly as they relate to management limitations or site productivity.

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

Section 1537.20 Description of Forest Types to be Managed

- a) A description is required ~~for each of the present~~ forest ~~stand withstands and~~ the conditions that created the existing stand structure. Minimum stand descriptions must include: forest cover/site/natural community, acreage, stand condition, species composition, size classes, basal area/acre, trees/acre (or stand tables), volume/acre (or stocking tables), stocking advance regeneration, whether the main canopy is even-aged or uneven-aged, timber quality, and timber production potential. All information presented should be adequately explained and interpreted, species composition, forest cover types and/or forest site types, and whether the main canopy stand is even-aged or all-aged.
- b) An inventory of the forest stands shall be conducted in accordance with the procedure outlined in the Illinois Forest Inventory Data Processing ~~system~~ System (IFIDP) or alternative inventory procedure ~~any other procedures which will be~~ approved by the Department, provided the criteria for accuracy are met. Criteria for accuracy are: provided the criteria for accuracy are met. The IFIDP procedure is filed in all Division of Forest Resource, DNR District Offices and available to the public for review. Trees from 2" DBH should be included in the inventory and accuracy should be + or - ±10% of the basal area/acre and ± 20% of the volume/area at the 66% confidence level. The IFIDP procedure and software are available in all IDNR Forestry offices for public review. All trees greater than or equal to 2-inch DBH must be included in the inventory. The inventory described is not required for stands less than 5 acres. Stand volumes should be clearly emphasized to the landowner, whether or not the data are sufficient for sale purposes.
- c) All inventory ~~Inventory~~ and field data must be delivered ~~with~~ to the Plan to the IDNR ~~District~~ Forester for review. The IDNR Forester ~~review~~ will determine if all of the ~~information~~ required inventory data are ~~for the plan is~~ present, complete, and meet ~~meets~~ accuracy requirements ~~(+ or - 10% of the basal area at the 66% confidence level).~~

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d) ~~Forest site types are described in "Recommended Silviculture and Management Practices for Illinois Hardwood Forest Types" (1972), Extension Forester, Illinois Cooperative Extension Service, University of Illinois, 110 Mumford Hall, Urbana, IL 61081 (no later editions or amendments are included); Illinois Technical Forestry Association and forest cover types as described in "Forest Cover Types of the United States and Canada", Society of American Foresters (1980) 5400 Grosvenor Lane, Washington, D.C., 20014 (no later editions or amendments are included). These references are filed with the Division of Forest Resources, Department of Natural Resources District Offices and with the State Library and available to the public for review.~~

de) Forest Cover – Types

Bald Cypress
Bald Cypress, Tupelo
Beech, Sugar Maple
Black Ash, American Elm, Red Maple
Black Locust
Black Oak
Black Willow
Bur Oak
Chestnut Oak
Cottonwood
Eastern Red Cedar
Northern Pin Oak
Northern Red Oak
Northern White Cedar
Overcup Oak
Pin Oak, Sweetgum
Post Oak, Blackjack Oak
River Birch, Sycamore
Sassafras, Persimmon
Silver Maple, American Elm
Sugar Berry, American Elm
Sugar Maple
Sugar Maple, Basswood
Swamp Chestnut Oak, Cherrybark ~~Oakeak~~
Sweetgum, Yellow Poplar

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Sweetgum, Willow Oak
Sycamore, Sweetgum, American Elm
Tamarack
Yellow Poplar
Yellow Poplar, White Oak, Northern Red Oak
Water Tupelo
White Oak
White Oak, Black Oak, Northern Red Oak
White Pine

[ef](#)) Forest Site – Types

Oak Hickory
Mixed Oak
Mixed Hardwoods
Mixed Soft Hardwoods
Mixed Hard Hardwoods
Mixed Bottomland Hardwoods
Sycamore, Cottonwood, Willow
Cypress

[f](#)) [Illinois Natural Community Classification Types](#)

[Upland Forest \(xeric, dry, dry-mesic, mesic, wet-mesic\)](#)
[Floodplain Forest \(mesic, wet-mesic, wet\)](#)
[Flatwoods \(northern, southern, sand\)](#)
[Sand Forest \(dry, dry-mesic, mesic\)](#)
[Savanna \(dry-mesic, mesic\)](#)
[Sand Savanna \(dry, dry-mesic\)](#)
[Barren \(dry, dry-mesic, mesic\)](#)
[Swamp](#)
[Forested Bog](#)
[Forested Fen](#)
[Seep](#)

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

[Section 1537.21 Description of Management Practices](#)

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The Plan must include detailed narrative descriptions of recommended and required silvicultural practices based on the stand specific objectives. Silvicultural treatments or prescriptions should be integrated and stand or site-specific. All information presented should be adequately explained and interpreted and should cover all practices to be accomplished over the next 10 years. The description must contain the purpose of the prescribed silvicultural treatment and the desired outcome as it relates to the timber grower's overall goals.

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

Section 1537.24 Timber Harvest Schedule and Forest Regeneration

- a) A timber harvest schedule shall be based on reliable forest inventory data and timber grower objectives. The schedule must include a description of the stands to be harvested and the estimated volume of timber to be harvested per acre, and the silvicultural harvest system must be recommended. Trees may be grown to biological maturity; however, a timber harvest must be scheduled when decline becomes evident. An unforeseen need to harvest due to salvage or sanitation reasons may be amended into the Plan. Damaged timber should be salvaged when practical. The Plan must include detailed strategies to assure successful regeneration of the forest stand post-harvest, as well as incorporating environmental concerns. Silvicultural practices designed to improve the status of desirable advance regeneration prior to a timber sale should be included when appropriate. A timber harvest projection must be made, whether or not a harvest is recommended, within the 10 year schedule of forestry practices.
- b) All harvest recommendations should ensure satisfactory stocking levels within 3 years after harvest. This may be accomplished by silvicultural treatments (timber stand improvement, prescribed burning, site preparation, tree planting, or combinations of these activities). All timber harvesting activities must adhere to the laws of Illinois and follow as much as practicable the Illinois Forestry Best Management Practices (BMPs). A copy of the BMPs (October 2002) may be obtained from the Department of Natural Resources, Division of Forest Resources, One Natural Resources Way, Springfield IL 62702. Harvest schedules are not required for reforestation areas or when a harvest is not recommended within the time frame of the 10 year management plan.

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

Section 1537.25 Harvest Schedule Projected 10 Years (Repealed)

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~~The projection shall be based on forest inventory and will include the description of the areas to be harvested and the estimated volume to be harvested per acre. Harvest schedules are not required for afforestation and reforestation areas or when a harvest is not recommended within 10 years. An unforeseen need for harvest due to salvage and sanitation reasons may be added in an amended plan.~~

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

Section 1537.30 Reforestation and Afforestation

This Section, if needed, must address landowner afforestation/reforestation objectives, site description, soil descriptions, site preparation, planting methods, vegetation control, pre and post care, species selection, species quantities, spacing and planting location. Natural regeneration may be used as an alternative or as a supplement to planting if approved by the IDNR Forester. Furthermore, all afforestation/reforestation plans must include all requirements outlined in Sections 1537.6 through 1537.65. FDA certification may be canceled in accordance with Section 1537.72 if the reforestation is not completed by the third planting season, unless delayed due to circumstances beyond the control of the landowner and documented to the IDNR Forester soil series, landowner objectives and be identified on the map. The open areas designated for planting and described in an approved plan will not be submitted to the Illinois Department of Revenue as provided by Section 1537.70 until the following provisions are met: the planting is completed or the designated open areas remain idle and are not used for the growing of non-forest crops, pasture or any other agriculture purposes.

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

Section 1537.40 Forest Regeneration (Repealed)

~~The forest management plan must prescribe an appropriate silvicultural system and include detailed strategies to assure regeneration of the forest. This can be accomplished by silvicultural treatments, timber stand improvement, site preparation, tree planting or combinations of the above activities.~~

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

Section 1537.42 Recreational Use and Esthetics

All Plans must address recreation and aesthetics consistent with the landowner's goals.

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~~Commercial campground use and other intensive uses are not permitted. Measures to protect soil and water values will be utilized for recreational use. Landowners are encouraged to manage their forest with concern for visual impacts, in a manner consistent with the size and scale of their forestry operation. These uses, when compatible with the intent of IFDA, shall be incorporated into the plan, depending upon the landowners goals and objectives. Such uses, as follows are encouraged: wildlife observation, sport hunting, fee hunting, hiking, photography and others. Campground use and other intensive uses are not permitted. Development of a hiking trail for recreational uses and esthetic appreciation or for other practical uses may be recommended and prescribed in the plan. Measures to protect soil and water values shall be utilized for trail development and maintenance.~~

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

Section 1537.45 Soil and Water Conservation Goals

~~All Plans must address air, soil and water quality issues. Timber growers must comply with all relevant federal, State, county and municipal laws and regulations. The ~~Plan~~ forest management plan shall include measures to reduce soil erosion to acceptable tolerance levels. Consideration of the soils, topography and adjacent riparian areas shall be made when choosing silvicultural treatments. The treatments chosen on all sites should be those that will stabilize or otherwise conserve the soil, particularly for harvest treatments. All management activities, including timber harvesting, must follow BMPs. The maintenance or improvement of Illinois' water quality must be inherent in the development of all Plans. Pesticide use must not exceed necessary levels and must be applied in accordance with State and federal laws. Prescribed fire should be applied according to recommendations in the Plan and only after all necessary permits have been obtained.~~

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

Section 1537.47 Wetlands

~~A statement describing the presence of identified wetlands on the property, the potential effect of various management activities on these wetlands, and the effort that will be made to protect them must be included in the Plan. If wetlands are present on the property, information on the ecological value of wetlands and applicable State and federal laws protecting them should be included in the Plan. Silvicultural treatments prescribed in wetlands must adhere to Illinois BMPs.~~

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

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Section 1537.50 Forest Wildlife Habitat Enhancement

~~Fish and Forest~~ wildlife concerns must be taken into consideration ~~regarding~~ the ~~development and~~ implementation of the ~~Plansilviculture practices~~. ~~The minimum requirements for wildlife is the maintenance of all the forest components from ground cover, shrubs through trees.~~ ~~Enhancement-Habitat enhancement~~ practices, if any, must be ~~recommended and~~ integrated ~~into~~ the ~~Planforest plan and the conservation practices initiated.~~ ~~Practices to enhance forest wildlife populations shall address the most limiting factors for wildlife populations.~~

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

Section 1537.55 Protection Measures

Procedures must be established to ~~detect and managedeal with~~ insect, disease, ~~invasive/exotic species~~ and ~~other~~ environmental ~~concernsproblems~~. Where wildfire is a danger, firebreaks or other protective measures must be integrated ~~into~~ the ~~Planforest plan~~. ~~Prescribed fire and grazing by domestic livestock is strictly prohibited.~~ ~~Provisions for salvage/sanitation logging must be included in the Plan as needed.~~

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

Section 1537.57 Threatened and Endangered Species

A review of the Illinois Department of Natural Resources Natural Heritage database, BIOTICS, for possible presence of State and federal threatened and endangered species (T&E) is required in all Plans. If present, measures to protect the species and their associated habitat must be included in the Plan. If none are found, this fact must be noted in the general property description or stand description.

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

Section 1537.58 Special Sites

The Illinois Natural Areas Inventory database should be reviewed to identify "recognized" natural areas that occur on or near the property. A description of any unique archaeological, cultural, natural or historical areas must be included in the Plan. If any special sites are identified, describe efforts that will be made to protect them. If none are found, this fact must be noted in the general property description or stand description.

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

Section 1537.60 Silviculture Practices Required, Sequence and Specification

All Plans must~~The plan will~~ include a detailed~~an~~ outline of the recommended and required~~and required~~ forestry/silvicultural practices, practice acreage, stand location and timeframe~~description of those practices, identification of the areas on the plan map and established timetables~~ for practice implementation. A table format is required~~installation~~.

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

Section 1537.65 An Estimate of the Practice Costs

Estimated costs must be included by practice. Cost-share rates must be listed for recommended and required forestry~~Costs will be estimated for the~~ practices. Eligible~~The~~ costs include~~may be~~ ~~the~~ landowner's labor and materials consumed or the fee paid to a contractor. Cost-share rates and reimbursement are~~The cost will be~~ subject to the not-to-exceed rates~~ceiling~~ established for the practice under 17 Ill. Adm. Code 1536.

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

Section 1537.70 Forest Management Plan Approval

The ~~Forest Management~~ Plan must be accepted by the landowner and approved by the ~~IDNR local District~~ Forester. Acceptance and approval must be documented on the Plan Certification Form (Exhibit B). Allow 45 days, after the receipt of the ~~Forest Management~~ Plan (and inventory data, if applicable), for approval ~~or disapproval~~ by the ~~IDNR District~~ Forester. The ~~IDNR District~~ Forester will notify the landowner and ~~Plan~~ preparer of the approval or the reasons that prevent the ~~Plan~~ from being approved. Upon approval, and if requested by the landowner, the Illinois Department of Revenue and the county ~~assessor~~ will be notified quarterly in accordance with Section 10-15020e(4) of the Property Tax Code [35 ILCS 200/10-150]~~Revenue Act of 1939 (Ill. Rev. Stat. 1989, ch. 120, par. 501e(1)). (See Exhibit B for certification of plan).~~

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

Section 1537.71 Plan Review

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- a) Plan reviews are required annually. IDNR is responsible for monitoring the implementation of the Plan by the timber grower to ensure performance and review accomplishments. The timber grower shall submit a written statement annually, upon request, indicating the present status of the forest and all progress in carrying out the required forest practices.
- b) If the Plan requires revision, it shall be updated to reflect the new needs and resubmitted for approval to the IDNR Forester.

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

Section 1537.72 Decertification Process

- a) If the landowner or property is found to be out of compliance for the reasons stated in subsection (b), the landowner may be put on probationary status. The landowner will be notified in writing regarding the specific problems relating to the probation and will be given up to 30 days to respond and one year to comply. With guidance and approval of the IDNR Forester, a new or modified schedule of management practices may be drafted and/or the landowner may request a reevaluation of the management goals and required practices. If the landowner is found to be out of compliance for the reasons stated in subsection (c), the landowner will automatically be decertified.
- b) Landowners will be placed on "probationary status" for the following reasons:
 - 1) failure to follow the requirements outlined in the Plan to the best of their ability;
 - 2) failure to exclude domestic livestock grazing and fire unless prescribed in the plan;
 - 3) failure to submit the written statement for a period of 2 consecutive cycles as required in Section 1537.71;
 - 4) failure to successfully afforest/reforest required planting sites by the third available planting season, unless delayed due to circumstances beyond the control of the landowner;

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- 5) failure to follow timber harvest recommendations and BMPs as required; or
 - 6) converting forest areas to other types of uses (real estate development or agricultural purposes) without first notifying the IDNR Forester.
- c) Landowners will be automatically decertified for the following reasons:
- 1) landowner requests to be removed from the FDA program;
 - 2) landowner no longer meets the minimum criteria or eligibility for certification;
 - 3) property is sold or transferred, unless the subsequent landowner is willing to assume the existing Plan;
 - 4) death of the landowner, unless the subsequent landowner is willing to assume the existing Plan;
 - 5) harvest of timber when it was not recommended in the Plan;
 - 6) selling additional trees beyond those marked or designated by the IDNR Forester unless approved ahead of time in writing; or
 - 7) landowner fails to respond to a letter of probation or to correct problems that initiated probationary status in the time allowed.
- d) Upon decertification of a Plan, the Illinois Department of Revenue and the county assessor will be notified quarterly in accordance with Section 10-150 of the Property Tax Code [35 ILCS 200/10-150]. If decertification occurs within the life span of cost-shared practices, monies received by landowners from federal and State cost-share programs will be subject to recapture pursuant to State and federal law.

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

Section 1537.75 Appeals

- a) Any landowner whose property is considered ineligible, whose initial certification

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~~is denied, whose~~ plan ~~is decertified~~ or ~~whose~~ practice is not approved by the ~~IDNR District~~ Forester may appeal to the Regional Review Committee pursuant to 17 Ill. Adm. Code 2530. The Regional Review Committee is composed of the Regional Administrator, ~~an IDNR District~~ Forester from another district in the Region and the Forest Management Program Manager.

- b) The appeal must be made in writing, within 30 days ~~after~~~~from~~ the date that the ~~Plan~~~~plan~~ ~~was decertified~~ or practice was not approved, to the Forest Management Program ~~Manager at the Administrator~~ address listed in Section 1537.85.

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

Section 1537.80 Annual Review Process

- a) Each subsequent year, during the quarter ~~when~~~~that~~ the ~~Plan~~~~plan~~ was initially approved, the landowner will be required to submit in writing a statement indicating the present status of the forest as it relates to the approved ~~Plan~~~~forest management plan~~ and the recommendations contained in it and seek continued approval of that ~~Plan~~~~plan~~.
- b) In the event that no modifications are required or requested, the ~~Plan~~~~plan~~ will be reapproved. If the ~~Plan~~~~plan~~ requires revisions, it will be updated to reflect these needs and resubmitted for approval to the ~~IDNR District~~ Forester.

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

Section 1537.85 Information

Anyone wishing additional information ~~concerning this Part~~ may contact the Department of Natural Resources at the following address:

~~Illinois~~ Department of Natural Resources
Division of Forest Resources
~~One Natural Resources Way 600 North Grand Avenue West~~
Springfield ~~IL 62702-1271, Illinois 62706~~

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

Section 1537.90 Amended Plans

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Plans may be amended to adjust acreage or management activities. Amended ~~Plans~~plans shall be ~~approved by the IDNR Forester, based upon the same standards as~~valid only until 10 years following the effective date of the original ~~Plan~~plan. Amended ~~Plans shall~~plans must be ~~valid for 10 years following the effective date of~~approved by the District Forester, based upon the ~~same standards as~~ the original ~~Plan~~plan.

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

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1. Stand/Unit # and acreage
2. Objectives should be clear, time specific, achievable and expressed in terms that are easily measured.
3. Stand Description
 - Soils and topography
 - Forest cover/site/natural community type
 - Even-aged vs. uneven-aged
 - Species composition
 - Advance regeneration
 - Tree size classes
 - Trees/acre, basal area/area and volume/acre
 - Stocking (e.g.: overstocked, understocked, fully stocked)
 - Timber production potential
 - Timber quality assessment (e.g.: poor, average, good, excellent)
 - Other items not adequately addressed under General Property Description
4. Stand Recommendations
 - Narrative description of recommended and required silvicultural treatments necessary to achieve stand objectives (Integrate recreation/aesthetics; fish/wildlife; air, soil and water quality; and other resource objectives and concerns into recommendations as needed.)

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Timber harvest schedule and forest regeneration (BMPs included)

Adequate forest regeneration must be addressed if a timber harvest is scheduled.

B. Afforestation/Reforestation (if applicable) Forest Land (Land at least 10-percent stocked by forest trees of any size)

1. Stand/Field # and acreage

2. Stand Objectives

3. Stand/Field Description

Land use history

Soils description

Existing vegetative cover

4. Stand Recommendations

Method

Site preparation

Tree species and quality

Spacing

Vegetation control

Post-planting care and management

5. Recreation and Aesthetics – All Forest Management Plans (Plans) must address recreation and aesthetics consistent with the landowner's goals. All management activities should take into account the visual impact (aesthetics) resulting from applied

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management activities. This may either be a separate section in the Plan, included under the general description of the property, or included under the stand description.~~Specific Information, Recommendations~~

A. ~~Open Land (Afforestation, Reforestation) if applicable~~

- ~~1. pre-planting recommendations (planting stock, site preparation)~~
- ~~2. spacing~~
- ~~3. species and numbers required~~
- ~~4. post-planting recommendations (care of the planted stock)~~

B. ~~Forest Land (Established Forest) if applicable~~

- ~~1. volume/acre~~
- ~~2. basal area/acre~~
- ~~3. stocking/acre~~
- ~~4. growth/acre~~
- ~~5. harvest schedule~~
- ~~6. silvicultural practices to meet forest need; planting, regeneration, species, structure and stocking~~

6. Air, Soil and Water Quality – All Plans must address air, soil and water quality issues and address existing issues when relevant. Illinois Forestry Best Management Practices (BMPs) may need to be addressed. This may either be a separate section in the Plan, included under the general description of the property, or included under the stand description.~~Conservation Goals—A statement of landowners goals and practices to maintain or reduce soil erosion to meet or exceed Department of Agriculture tolerable level.~~
7. Wetlands – A statement describing the presence of identified wetlands on the property, the potential effect of various management activities on these wetlands, and the effort that will be made to protect them must be included in the Plan. Silvicultural treatments prescribed in wetlands must adhere to BMPs as required in the Plan. This may either be a separate section in the Plan, included under the general description of the property, or included under the stand description.~~Forest Wildlife Habitat Enhancement—Install compatible practices that will enhance the wildlife habitat potential and meet the owner's objectives.~~
8. Fish and Wildlife – Fish and wildlife concerns must be taken into consideration

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- regarding the implementation of the Plan. Enhancement practices, if any, must be integrated in the Plan. This may either be a separate section in the plan, included under the general description of the property, or included under the stand description.~~Protection Measures—Procedures to deal with insect, disease and environmental problems. Where wildfire is a danger, firebreaks must be installed and maintained.~~
9. Forest Health and Protection Measures – Procedures must be established to detect and manage insect, disease, invasive/exotic species and other environmental concerns. This may either be a separate section in the Plan, included under the general description of the property, or included under the stand description.~~Financial—Discussion of specific costs involved in implementing open land and forestland recommendations.~~
 10. Threatened and Endangered Species – A statement regarding threatened and endangered species must be included in the Plan, whether or not threatened and endangered species were found. This may either be a separate section in the plan, included under the general description of the property, or included under the stand description.~~Outline of Silvicultural Practices Recommended and time schedule of practices.~~
 11. Special Sites – A description of any archaeological, cultural, natural, or historical areas must be included in the Plan, whether or not special sites were observed. This may either be a separate section in the Plan, included under the general description of the property, or included under the stand description.~~Other Considerations/Conclusions.~~
 12. Schedule of Forestry Practices – All Plans must include a detailed outline of the recommended and required silvicultural practices, acreage, stand location and time frame for practice implementation. A table format is required.
 13. Forestry Cost-share Rates – A statement detailing cost-share rates will be included for recommended and required practices.
 14. Other Considerations
 - Program benefits
 - Eligible for federal reforestation tax credit

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Continued technical assistance from IDNR

No cost planting stock from the State nurseries, pending availability; certain restrictions apply

Eligible for cost-share funds to implement recommended practices; cost share is not guaranteed for all practices

FDA acreage qualifies for the lowest possible tax assessment rate

Program restrictions:

Afforested/reforested areas must maintain 70% of the initial number of trees planted. The minimum level cannot drop below 300 trees per acre.

If property is decertified, repayment of all cost-share monies earned is required. This penalty also applies in the event land ownership changes and the new owner does not assume all obligations under the Plan.

Any planting stock obtained from the State nurseries cannot be removed from the property with the roots attached. This restriction is binding on any and all subsequent landowners.

All trees marked or designated for harvest or thinning by the IDNR Forester will be cut or treated without deviation from the marking.

Modifications to the Plan must be approved by the landowner and the IDNR Forester. Any changes must be submitted in writing and documented by amending the original Plan Certification Form indicating the change, with the appropriate dates and initials. The original Plan approval date does not change.

The landowner must return the review letter to retain participation in the FDA program.

Plan acreage must be protected from wildfire.

Livestock must be excluded from Plan acreage.

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15. Conclusion – Signing the Certification sheet initiates a partnership between the timber grower and the IDNR. Failure to adhere to this Plan may result in program decertification and repayment of all monies received from any State and federal cost-share programs. It is important to read and understand all the information in the Plan and attached appendices provided. Do not sign the Certification page until all questions and concerns have been resolved to your complete satisfaction. By accomplishing the objectives in your Plan, you will have demonstrated your commitment to the principles of land stewardship and sustainable forest management.
16. Maps of the Property
- Include north arrow and legend
- Label map with landowner name, county and scale
- Clearly depict property and stand boundaries, roads, trails, water bodies and other significant features
- Aerial photo with minimum scale 1" = 660' or 1:7920
17. Appendices – IDNR planting standards must be included with afforestation/reforestation Plans. Plan preparers are encouraged to include literature on timber harvesting, timber stand improvement, wildlife, BMPs, 17 Ill. Adm. Code 1536 & 1537, etc.

REFERENCES

American Forest Foundation. Measuring Sustainable Forestry: The New Standard for Tree Farm Certification. 2004-2008 Standards of Sustainability for Forest Certification on Private Lands.

Eyre, F. H. 1980. Forest Cover Types of the United States and Canada. Washington DC: Society of American Foresters.

Illinois Department of Natural Resources. 2000. Forestry Best Management Practices for Illinois. 63pp.

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[Massachusetts Forest Plan Program: Raising the Bar – Revising Massachusetts Forest Plan Plans.](#)

[Mississippi Forest Plan Program, State Plan 2002-2006, Mississippi Forestry Commission. 25pp.](#)

[Recommended Silviculture and Management Practices for Illinois Hardwood Forest Types. Illinois Technical Forestry Association, Inc. 1972. 46pp.](#)

[Russel, D. Ramsey Jr. and S. Stein. 2002. Planning for Forest Plan: A Desk Guide. FS-733.](#)

[White, J. and M. H. Madany. 1978. Classification of Natural Communities in Illinois. pp. 309-405 in J. White, ed., Illinois natural areas inventory technical report. Vol. 1. Survey methods and results. Illinois Natural Areas Inventory, Urbana.](#)

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

DEPARTMENT OF NATURAL RESOURCES

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Section 1537. EXHIBIT B ILLINOIS FORESTRY DEVELOPMENT ACT MANAGEMENT PLAN CERTIFICATION

FORESTRY MANAGEMENT PLAN CERTIFICATION FOR THE ILLINOIS FORESTRY DEVELOPMENT ACT (FDA)

NEW RENEWAL AMENDED CHANGE TRANSFER Date Date Date Date Date

CANCELED EXPLAIN:

LANDOWNER: PLAN # NO: Region District County Case File

ADDRESS: ACREAGE ACRES:

TOWN town STATE state ZIP zip

PROPERTY TAX NUMBER: *

#1. #2. #3. #4.

(Required only when plan will be used for preferential tax treatment)

LEGAL LOCATION: QUARTER SECTION TOWNSHIP RANGE COUNTY

LEGAL LOCATION: QUARTER SECTION TOWNSHIP RANGE COUNTY

LEGAL DESCRIPTION: * (Fractional Quarter, Quarter, Section, Township #, Range #, County, Principal Meridian)

I am the owner or legal agency of the property for which this Planplan has been prepared. The Planplan has been prepared in accordance with the Illinois Forestry Development Act [525 ILCS 15](Ill. Rev. Stat. 1989, ch. 96 1/2, par. 9101 et seq.) and meets my requirements. I will follow the Planrecommendations to the best of my ability. If any changes in ownership or conditions of the forest occur, I will notify the Department of Natural Resources, Division of Forest Resources in

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writing within 30 days.

An approved forest Plan guarantees an equalized assessed valuation of 1/6 of the cropland productivity index for the acreage enrolled in FDA if certification is forwarded to the Illinois Department of Revenue.

SHALL THIS CERTIFICATION BE FORWARDED TO THE ILLINOIS DEPARTMENT OF REVENUE FOR PREFERENTIAL TAX TREATMENT?

YES NO

(IDNR District Forester will forward if YES is checked)

IMPORTANT NOTICE: Approval of this Planplan does not guarantee that all scheduledprojected cultural practices will be approved for cost-share payments. Cost sharing is available on a first-come, first-served basis, as funds are available. Applications for cost-share assistance must be approved by the IDNR District Forester before practices are initiatedbegun.

PLAN DEVELOPED BY: _____ DATE: _____

LANDOWNER ACCEPTANCE: _____ DATE: _____

IDNR ILLINOIS DEPARTMENT OF NATURAL RESOURCES APPROVAL BY DISTRICT FORESTER APPROVAL:

DATE: _____

choose one or more

NEW PLAN AMENDED PLAN CANCEL PLAN

ADDRESS CHANGE OTHER (explain)

* attach additional sheets as needed

A MAP, MINIMUM SCALE 1":660', MUST BE ATTACHED TO ALL CERTIFICATIONS.

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

STATE BOARD OF EDUCATION
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rules@isbe.net

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

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

STATE BOARD OF EDUCATION

NOTICE OF PROPOSED AMENDMENT

TITLE 23: EDUCATION AND CULTURAL RESOURCES

SUBTITLE A: EDUCATION

CHAPTER I: STATE BOARD OF EDUCATION

SUBCHAPTER c: FINANCE

PART 145

TEMPORARY RELOCATION EXPENSES

Section

145.10	Definitions
145.20	General Requirements
145.30	Allowable Expenses
145.40	Documentation (Repealed)
145.50	Accounting Requirements
145.60	Determination of Loan and Grant Amounts
145.TABLE A	Accounting Entries (Repealed)

AUTHORITY: Implementing and authorized by Section 2-3.77 of the School Code [105 ILCS 5/2-3.77].

SOURCE: Adopted at 10 Ill. Reg. 15060, effective August 28, 1986; amended at 22 Ill. Reg. 19777, effective October 30, 1998; amended at 29 Ill. Reg. 10126, effective June 30, 2005; amended at 33 Ill. Reg. _____, effective _____.

Section 145.50 Accounting Requirements

When money appropriated for temporary relocation expenses is received by a school district, the money shall be deposited in the ~~fund~~[fund\(s\)](#) from which ~~those~~[such](#) expenses were or will be paid and shall be accounted for in accordance with the [applicable provisions of 23 Ill. Adm. Code 100 \(Requirements for Accounting, Budgeting, Financial Reporting, and Auditing\) Program Accounting Manual \(23 Ill. Adm. Code 110\)](#).

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

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- 1) Heading of the Part: School Construction Program
- 2) Code Citation: 23 Ill. Adm. Code 151
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
151.20	Amendment
151.50	Amendment
151.140	Amendment
- 4) Statutory Authority: 105 ILCS 230/5-55
- 5) A Complete Description of the Subjects and Issues Involved: This set of amendments represents technical updating only. The reference to Part 110 of ISBE's rules (Program Accounting Manual) needs to be updated because that Part has recently been repealed. Similarly, where the Fall Enrollment and Housing Report is mentioned by name, the enrollment count as of September 30 is being referenced instead. This reflects the elimination of the separate reporting requirement for school districts due to the advent of the Student Information System.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: This rulemaking will not create or enlarge a State mandate.
- 12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Written comments may be submitted within 45 days after the publication of this Notice to:

Sally Vogl
Agency Rules Coordinator
Illinois State Board of Education

STATE BOARD OF EDUCATION

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100 North First Street (S-493)
Springfield, Illinois 62777

217/782-5270

Comments may also be submitted via e-mail, addressed to:

rules@isbe.net

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

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

STATE BOARD OF EDUCATION

NOTICE OF PROPOSED AMENDMENTS

TITLE 23: EDUCATION AND CULTURAL RESOURCES

SUBTITLE A: EDUCATION

CHAPTER I: STATE BOARD OF EDUCATION

SUBCHAPTER c: FINANCE

PART 151

SCHOOL CONSTRUCTION PROGRAM

SUBPART A: SCHOOL CONSTRUCTION PROJECT GRANTS

Section

151.10	Purpose
151.20	Eligible Applicants
151.30	Application for School Construction Project Grant Entitlement
151.35	Application for School Construction Project Grant Entitlement – Districts With A Population Exceeding 500,000
151.40	Award of Construction Project Grant Entitlement
151.50	Priority Ranking of Construction Grant Entitlements
151.55	Needed Capacity for Unit Districts
151.60	Grant Index
151.70	Debt Service Grants (Repealed)

SUBPART B: SCHOOL MAINTENANCE PROJECT GRANTS

Section

151.100	Purpose; Eligible Applicants
151.110	Definitions
151.120	Application for School Maintenance Project Grants
151.130	Award of School Maintenance Project Grants – Applicants With a Population of 500,000 or Fewer
151.135	Award of School Maintenance Project Grants – School Districts With a Population Exceeding 500,000
151.140	Terms of the Grant

AUTHORITY: Implementing the School Construction Law [105 ILCS 230] and authorized by Section 5-55 of that Law.

SOURCE: Emergency rules adopted at 22 Ill. Reg. 2616, effective January 16, 1998, for a maximum of 150 days; emergency rules modified in response to JCAR objection at 22 Ill. Reg. 4500; emergency rules expired June 15, 1998; emergency rules adopted at 22 Ill. Reg. 6238, effective March 24, 1998, for a maximum of 150 days; emergency rules modified in response to

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JCAR objection at 22 Ill. Reg. 7703; emergency expired June 15, 1998; new Part adopted at 22 Ill. Reg. 12538, effective July 6, 1998; emergency amendment at 23 Ill. Reg. 11336, effective September 1, 1999, for a maximum of 150 days; amended at 24 Ill. Reg. 497, effective January 3, 2000; amended at 24 Ill. Reg. 5661, effective March 17, 2000; amended at 26 Ill. Reg. 886, effective January 15, 2002; amended at 32 Ill. Reg. 7410, effective April 22, 2008; amended at 33 Ill. Reg. _____, effective _____.

SUBPART A: SCHOOL CONSTRUCTION PROJECT GRANTS

Section 151.20 Eligible Applicants

School districts that meet the requirements of the School Construction Law and this Subpart are eligible to apply for school construction project grant entitlements. A district's eligibility for a school construction project grant under the minimum enrollment requirements of Section 5-25(a) of the School Construction Law shall be determined using the district's enrollment in prekindergarten through grade 12 as [of the last school day in September of the most recent school year shown on the district's most recent Fall Enrollment/Housing Report](#).

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

Section 151.50 Priority Ranking of Construction Grant Entitlements

Priority ranking of construction grant entitlements shall be done if the appropriation for any fiscal year is insufficient to fund grants for all approved grant entitlements. In this case, districts holding construction grant entitlements shall be eligible for construction grants to be awarded by the Capital Development Board in order of the priority ranking described in this Section.

- a) Districts holding grant entitlements shall be eligible for grant awards in the order of:
 - 1) the six levels of priority described in Section 5-30 of the School Construction Law; and
 - 2) the district's ranking within its level of priority, determined according to subsections (b) through (d) of this Section.

- b) A district's ranking within a level of priority shall be determined by multiplying the district's needed capacity as determined under subsection (c) of this Section by the ratio of the district's needed capacity to the district's enrollment as [of the last school day in September of the most recent school year recorded on the district's](#)

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~~most recent Fall Enrollment/Housing Report~~. The resulting figure shall constitute the district's ranking, with the largest figure having the highest ranking.

- c) Needed Capacity
- 1) For each priority other than priority five, the district's needed capacity shall be calculated by subtracting its currently available capacity as determined under subsection (d) of this Section from its current enrollment or its projected enrollment, whichever is greater.
 - A) Projected enrollment shall be calculated by multiplying the district's current enrollment by the ratio of the district's current enrollment to the district's enrollment two years before.
 - B) For purposes of calculating needed capacity, projected enrollment shall not include any increase in enrollment attributable to a change in the district's boundaries.
 - 2) For priority five, the district's needed capacity shall be the number of qualified individuals with disabilities who require a school construction project.
- d) Determination of Available Capacity

- 1) The enrollment capacity of each room or space currently subject to occupancy by students for instructional purposes in a district-owned, permanent building, or in a building leased by the district if the lease is at least ten years from expiration, shall be determined by dividing the net floor area (in square feet) of such room or space by the appropriate loading factor, as follows:

Type of Room or Space	Loading Factor
Prekindergarten Classroom	40
Kindergarten Classroom	40
Elementary General Classroom	35
Elementary Art Classroom	40
Elementary Music Classroom	30
Elementary Computer Classroom	35
Middle School General Classroom	35

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Middle School Art Classroom	40
Middle School Family and Consumer Sciences Classroom	50
Middle School Music Classroom	25
Middle School Computer Classroom	40
Middle School Science Laboratory	40
Middle School Science Laboratory/Classroom	50
Middle School Industrial Technology Laboratory/Shop Not Classified Elsewhere	40
High School General Classroom	30
High School Art Classroom	35
High School Music Classroom	25
High School Computer Classroom	40
High School Family and Consumer Sciences Classroom	60
High School Science Laboratory	35
High School Industrial Technology Laboratory/Shop	75
High School Laboratory Not Classified Elsewhere	35
Special Education Classroom	50

- 2) Buildings and additions with a functional age over one hundred years old shall be assigned an enrollment capacity of zero. The functional age of a building and each of its additions shall be individually determined by multiplying its actual age by one of the following condition factors, to be determined using the Building Condition Evaluation Form supplied by the State Board of Education:

Condition of Building or Addition	Condition Factor
Excellent	0.2
Satisfactory	0.4
Substandard	1.0
Poor	1.5
Very Poor	2.0

- 3) As used in this subsection (d), "permanent building" means a building mounted on a slab or a permanent foundation. A permanent foundation is a closed-perimeter formation consisting of materials such as concrete, mortared concrete block, or mortared brick extending into the ground below the frost line which may include but not be limited to cellars,

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basements, or crawlspaces but does not include the sole use of piers.

- 4) Available capacity shall be calculated by multiplying enrollment capacity as determined in subsections (d)(1) through (d)(3) of this Section by the following utilization factors:

A) elementary schools	0.9
B) middle or junior high schools	0.85
C) high schools	0.8

- e) A new order of priority ranking shall be established among the applicants for each fiscal year. If a district is not awarded a construction grant in a fiscal year for which it has received an entitlement, the district must update its application to establish its priority ranking for the following fiscal year.

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

SUBPART B: SCHOOL MAINTENANCE PROJECT GRANTS

Section 151.140 Terms of the Grant

- a) Grants shall be subject to the Illinois Grant Funds Recovery Act [30 ILCS 705]. Any grant funds not expended or legally obligated within two years after disbursement by the State shall be returned to the State Board of Education within 45 days.
- b) Grant funds may only be used for the project described in the approved application and shall be accounted for in compliance with applicable accounting rules set forth at 23 Ill. Adm. Code [100 \(Requirements for Accounting, Budgeting, Financial Reporting, and Auditing\)](#)~~110 (Program Accounting Manual)~~. The applicant must provide local matching funds in an amount equal to the grant. If actual project expenditures are less than expected so that the amount of the grant is greater than 50 percent of the total project expenditures, the applicant shall refund the amount of the grant that is in excess of 50 percent of actual project expenditures. The applicant shall file a final expenditure report with the State Board of Education that describes the use of the grant funds.
- c) The applicant shall comply with the School Construction Law, this Subpart and

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all other applicable laws and regulations in completing a project.

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

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- 1) Heading of the Part: Providers of Supplemental Educational Services
- 2) Code Citation: 23 Ill. Adm. Code 675
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
675.30	Amendment
675.50	Amendment
675.70	Amendment
675.90	Amendment
675.175	Amendment
675.210	Amendment
675.220	Amendment
675.230	Amendment
675.APPENDIX B	Amendment
675.APPENDIX C	Amendment
- 4) Statutory Authority: 105 ILCS 5/2-3.6
- 5) A Complete Description of the Subjects and Issues Involved: This set of amendments includes changes in various, chiefly unrelated provisions that are intended to respond to issues that have arisen recently in the implementation of supplemental educational services (SES).
 - In Section 675.30 (Code of Ethics), a statement is being added to make clear the applicability of these requirements to contractors and other entities acting in conjunction with providers, a prohibition on marketing directly to students is being added, and a provision is being added to emphasize districts' obligation to treat all providers equitably. In addition, the circumstances under which school district employees may be hired by providers is being clarified, resulting in fewer limitations on employees of a given district with respect to working for providers serving other school districts.
 - The basis for evaluating providers stated in Section 675.90 is being changed to replace district-specific status with a statewide status for each of the subjects in which a provider offers tutoring. It is felt that parents would be confused to find providers with contradictory status levels for effectiveness, as might very well happen if reporting were to continue on a district-by-district basis.

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- Since the U.S. Department of Education (USDE) has informed states that they must allow providers to be approved to tutor in science and that other subjects may be included in the future, specific references to reading and mathematics are being eliminated in favor of generic references to subjects. See especially Section 675.50.
- In Section 675.175, subsections (b) and (c) are being revised to account for delays that are outside districts' and providers' control that would cause them to miss relevant deadlines. A new subsection (d) will also provide a means by which districts can document their compliance with a requirement of NCLB when parents do not respond.
- Based on recent clarification from USDE, revisions in Sections 675.210 and 675.220 will allow for the inclusion of costs related to transportation.
- The structure of the assessment of parental satisfaction (Appendix B) is being changed from focusing on positive responses from parents to focusing on negative responses instead. This will continue to entail meeting the same standard but will avoid penalizing providers for low response rates by parents. Also in Appendix B, the criterion related to attendance is being restated to refer to providers' "average attendance" rather than to the "attendance rates", in order to state more clearly how this component of the evaluation is being implemented.

Miscellaneous other revisions will provide clarifications, remedy omissions, and state expressly practices that have been developed in response to particular circumstances.

- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objective: This rulemaking will not create or enlarge a State mandate.

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- 12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Written comments may be submitted within 45 days after the publication of this Notice to:

Sally Vogl
Agency Rules Coordinator
Illinois State Board of Education
100 North First Street (S-493)
Springfield, Illinois 62777

217/782-5270

Comments may also be submitted via e-mail, addressed to:

rules@isbe.net

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

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

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TITLE 23: EDUCATION AND CULTURAL RESOURCES

SUBTITLE A: EDUCATION

CHAPTER I: STATE BOARD OF EDUCATION

SUBCHAPTER 6: MISCELLANEOUS

PART 675

PROVIDERS OF SUPPLEMENTAL EDUCATIONAL SERVICES

SUBPART A: GENERAL PROVISIONS

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- 675.20 Definitions
- 675.30 Code of Ethics
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675.APPENDIX A Calculation of Effect Size

675.APPENDIX B Evaluation Rubric

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675.APPENDIX C Decision Matrix

AUTHORITY: Implementing Section 1116(e) of Public Law 107-110, the No Child Left Behind Act of 2001 (20 USC 6316(e)) (34 CFR 200.45 through 200.48), and authorized by Section 2-3.6 of the School Code [105 ILCS 5/2-3.6].

SOURCE: Emergency rules adopted at 29 Ill. Reg. 9516, effective June 17, 2005, for a maximum of 150 days; emergency expired November 13, 2005; adopted at 29 Ill. Reg. 19942, effective November 23, 2005; amended at 30 Ill. Reg. 14325, effective August 18, 2006; amended at 32 Ill. Reg. 4046, effective February 26, 2008; amended at 33 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROVISIONS

Section 675.30 Code of Ethics

The requirements of this Section shall apply not only to each provider but also to any subcontractor or other entity, whether paid or unpaid, who acts in conjunction with or on behalf of an approved provider for the purpose of performing any function related to a program of supplemental educational services, including, but not limited to, marketing the program, tutoring students, providing snacks, conducting assessments, and completing individual learning plans.

- a) Providers must accurately and completely describe services to consumers in terms that are easy to understand. Providers' statements regarding the number of hours of service offered in their programs must match the number of hours for which districts have contracted. That is, a provider shall not charge a district for a portion of the hours of service offered and indicate that the remaining hours of service are to be provided free of charge.
- b) Providers must create and use promotional materials and advertisements that are consistent with their approved applications and free from deception. Upon request, providers shall submit all promotional materials and advertisements related to the SES program to ISBE or the school districts in which they wish to serve.
- c) Providers must not misrepresent to anyone the location of a provider's program or the approval status of a program. If the location of services is contingent upon a minimum student enrollment or the approval of a district, the provider shall indicate the applicable contingencies in its marketing materials.

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- d) Providers must not publicly criticize or disparage other providers.
- e) Providers must not distribute a district enrollment form that has the selected provider's name pre-printed as part of the form. Providers must not distribute enrollment forms with directions for how to complete the forms.
- f) [Providers must not market their programs directly to students in the absence of those students' parents or guardians, except in the course of district-sponsored provider fairs, school assemblies, or other events permitted pursuant to this Part.](#)
- g) Providers must maintain a system of addressing consumer grievances and concerns and must immediately report any grievances to both the district and ISBE.
- h)g) Providers must not compensate district employees in exchange for access to facilities, to obtain student lists, or for any illegal purpose. Providers must not solicit or accept an exclusive arrangement with any district or school (including, but not limited to, an exclusive right to conduct in-school assemblies or other marketing activities).
- i)h) Except as otherwise provided in this subsection [\(i\)h\)](#), [employees of a particular district](#) ~~personnel~~ may be hired [by a provider serving that district](#) for instructional purposes only. District personnel hired for instructional purposes shall not recruit students to a provider's program, engage in marketing activities on behalf of a provider, distribute or collect enrollment forms, or otherwise promote or encourage students to enroll in a provider's program.
 - 1) District personnel without responsibility for or involvement in the district's administration of SES may be employed to perform solely clerical functions having no relationship to the marketing of a provider's program or the recruitment of students.
 - 2) Where a school district or a school is also a provider of SES, an individual may be employed as coordinator or site manager for the SES program it provides if the individual will have no other responsibilities apart from oversight and management of that SES program, which may include marketing and recruitment, subject to the following additional requirements.

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- A) The individual employed by the district for this purpose shall not present marketing or recruitment information on any occasion unless all other providers approved for the schools served are offered the same opportunity to present information or recruit students.
- B) The district shall ensure that the individual has no greater access to parents and students at provider fairs, school assemblies, and other, similar occasions than is afforded to all other providers. "Access" means the amount of speaking time available, the space used, and any other resources allocated to providers.
- C) The individual's duties related to the SES program for which the district is the provider shall be entirely distinct from those of any other district employee who performs oversight with respect to the provision of SES generally, such as serving as the district's liaison to all SES providers within a school or schools.

j)† Each restriction applicable to a school district employee under this Section shall apply equally to a member of any governmental or nonprofit organization formed to support or advise a particular school in which the provider seeks to offer services.

k)† Each parent of an eligible student who is hired by a provider must have a written job description and must be compensated on the same basis as all other employees of the provider who perform similar work. No parent may receive any commission or other benefit related to the enrollment of his or her child in a provider's program, nor may a parent be subject to any employment action by the provider on account of the parent's selection of an SES program for his or her child.

l)† Providers must not make payments or in-kind contributions to a district, exclusive of customary fees for facility utilization.

m)† Providers must not offer or advertise economic incentives or gratuities of any kind to parents or students to solicit them to select the provider for SES. Providers may not offer any incentives to potential students in the course of informational

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sessions, but may offer promotional materials of negligible value, such as pencils, balloons, or magnets.

- | [n\)m\)](#) During the provision of SES, providers may offer only nominal rewards to students for achievement of program milestones or objectives that cannot be attained through attendance alone, or for above-average attendance when given after the mid-point of the provider's program. Providers shall not spend more than \$50 per pupil on rewards, exclusive of rewards that consist of materials and equipment used directly in the provision of services.
- | [o\)n\)](#) Providers must not encourage or induce students or parents to switch providers once enrolled.
- | [p\)ø\)](#) Providers must not attempt to influence or bias parents when performing an evaluation of the provider's services and achievement of the objectives in the student's Individual Learning Plan.
- | [q\)þ\)](#) A provider shall not use information provided by parents of students served under this Part for any commercial purpose without securing the parent's prior written consent for the intended use of the specified information, except that a provider may use parental contact information to communicate about SES with the parents of students served by that specific provider in any prior year.
- | [r\)ç\)](#) School district personnel shall treat all providers of SES impartially. Whether or not the employing district or school is a provider, school personnel shall not:
 - 1) promote or disparage specific SES providers;
 - 2) distribute SES enrollment forms that include a pre-printed provider's name;
 - 3) obstruct parents in exercising their right to select an SES provider;
 - 4) seek to influence parents' choices among SES providers;
 - 5) alter or destroy registration forms submitted by parents without specific authorization from the parents; or

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- 6) encourage students to drop out of an SES program or switch providers once enrolled.

s) [Districts must ensure that school personnel give providers of SES access to school facilities using a fair, open, and objective process, on the same basis and terms as are available to other groups that seek access to school facilities.](#)

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

Section 675.50 Application Requirements

Each application for approval to provide SES in Illinois shall consist of the components described in this Section [and shall be submitted as specified by the State Superintendent.](#)

- a) A summary of services that indicates:
 - 1) the subject areas available (~~i.e., reading and/or mathematics~~);
 - 2) the grade levels served;
 - 3) the total program hours per student, provided that, for any program proposing fewer than 30 instructional hours per subject, the applicant must supply specific evidence that the program has resulted in increased student achievement in that subject, including verification from school district administrators in which the program has been previously provided;
 - 4) the proposed locations of service delivery;
 - 5) the minimum number of students required by the eligible applicant in order to offer SES to a district and an indication of any districts in which that minimum will apply to each site served rather than to the district in the aggregate;
 - 6) whether the eligible applicant can provide services to students of limited English proficiency and, if so, the languages in which the eligible applicant provides instruction and the maximum number of LEP students the eligible applicant can serve in each district;

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- 7) whether the eligible applicant can provide services to students with disabilities and, if so, the accommodations or modifications the eligible applicant can offer and the maximum number of students with disabilities the eligible applicant can serve in each district;
 - 8) the time of day and months during which SES will be offered;
 - 9) the ratio of instructors to children, as determined by the provider; and
 - 10) the districts the eligible applicant seeks to serve.
- b) A rationale for the eligible applicant's SES program, including:
- 1) Evidence that the program complies with Section 675.40 of this Part; and
 - 2) Evidence of effectiveness that complies with either subsection (b)(2)(A) or subsection (b)(2)(B) of this Section.
 - A) General Method
 - i) Evidence that the [curriculum and pedagogy program](#) proposed in the application ~~have~~[has](#) a positive impact on students' achievement in [the relevant subject area reading and/or math](#), particularly for low-income, underachieving students, as demonstrated by scores on the State assessment or on a nationally recognized assessment; and
 - ii) At least five but no more than ten letters of reference from previous clients (families, districts, or teachers) offering testimonial information on the positive impact of the program proposed in the application and including contact information, starting and ending dates of service provided, and school and district names for each reference.
 - B) Alternate Method
 - i) Evidence that the eligible applicant has a minimum of three years' experience serving youth in the community where the eligible applicant intends to offer SES, through

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activities such as tutoring, mentoring or other extracurricular programs;

- ii) Evidence that the curriculum and pedagogy to be used by the eligible applicant havehas been demonstrated to have a positive impact on students' achievement in the relevant subject area~~reading and/or math~~, particularly for low-income, underachieving students, as demonstrated by scores on the State assessment or on a nationally recognized assessment;
 - iii) At least five but no more than ten letters of reference from previous clients (families, districts, or teachers) offering testimonial information on the positive impact of the youth services provided by the eligible applicant and including contact information, starting and ending dates of service provided, and school and district names for each reference; and
 - iv) An agreement to limit services to no more than 200 children during the first two years of SES.
- c) The specific procedures to be used and frequency of reports of student progress to teachers, district staff, and parents/families (including a description of how information will be provided to parents and families in a format and language they can understand).
- d) A description of the qualifications of instructional staff, including such resumes and other information on qualifications as ISBE may require. If the applicant intends to assign tutors who reside outside the United States, the application shall identify their countries of residence and, for each of those countries, the national and either regional or local law enforcement authorities from which fingerprint-based checks of criminal history records will be obtained that will be comparable to those required under Section 10-21.9 of the School Code [105 ILCS 5/10-21.9]. Individuals residing in countries where checks of these types are not available shall not be assigned as tutors.
- e) Proof of liability insurance in amounts deemed sufficient by ISBE to protect the district and ISBE in light of the number of students to be served by the provider.

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- f) Evidence that the eligible applicant possesses a sound management structure.
- g) Evidence that the provider has adequate financial, organizational and technical resources to administer the proposed program. [This evidence shall include, but need not be limited to, completed federal tax returns \(or the equivalent for non-profit entities\) for the two most recent years and either an audit report or audited financial statements completed within two years prior to submission of the application.](#)
- h) Proof of legal authority to conduct business in Illinois.
- i) Information on the eligible applicant's estimated per-pupil program cost, calculated as set forth in Section 675.210 of this Part for a sample or hypothetical district for which the provider assumes cost factors to be representative. If the provider's costs will vary based on the number of students enrolled, costs must be provided for various enrollment ranges. Providers must specify the assumptions upon which occupancy costs are shown for services in district facilities.
- j) Such certifications, assurances, and/or additional information as ISBE may require in order to verify any information reported by the eligible applicant or otherwise to fulfill its duties with respect to the administration of SES.

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

Section 675.70 Reporting Requirement

- a) Each provider shall be required to use a tracking system for student enrollment and progress developed by ISBE. This tracking system shall also be used to determine the amount billable to the district for the provider's services.
- b) Within 60 days after a provider's conclusion of SES for the SES reporting period, the provider shall submit a report to [the State Superintendent](#)~~ISBE~~ including the information identified in this subsection (b), which shall be submitted as specified by the State Superintendent:
 - 1) information on the students served [who received at least 18 hours of services](#);

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- 2) details of any complaints received from teachers or parents and the resolution of those complaints; and
- 3) the percentage of the provider's Illinois students meeting the academic goals set out in their Individual Learning Plans.;
- c) On or before May 1 of each year, each approved provider shall submit the information identified in this subsection (c) as specified by the State Superintendent:
- 1)4) updates and revisions to any information set forth in the provider's approved application (including the submission of all information required by Section 675.50 of this Part not previously reported by the provider); and
- 2)5) an assurance that all other information set forth on the provider's approved application, as may be updated from time to time, remains true and correct.
- d)e) Upon the request of any district served by a provider, the provider shall, within 10 days after receipt of the district's request or after the provider's submission of the report to ISBE, whichever is later, furnish to the district the information specified in subsections (b)(2) and (3) of this Section as applicable to that district. However, a provider shall not be obligated to supply this information for any SES reporting period more than one year after the end of that period.
- e)d) The State Superintendent~~ISBE~~ may request additional information from a provider that may be necessary for the State Superintendent~~ISBE~~ to verify any information reported by the provider or otherwise to fulfill theirs duties of the State Board with respect to the administration of SES.
- f)e) Providers failing to submit timely and complete reports shall not be included on the list of eligible providers for the following SES reporting period.

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

Section 675.90 Evaluation of Providers' Performance, Providers' Status, Sanctions, and Removal

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- a) For each SES reporting period, ISBE shall evaluate each provider's performance in each district the provider serves based upon students' achievement, students' attendance, and parents' satisfaction. Separate evaluations shall be performed for each subject tutored by a provider ~~(i.e., reading and mathematics)~~. Achievement shall be measured by calculating an "effect size" in accordance with the provisions of Appendix A to this Part based upon the assessment results attained by students who have received at least 18 hours of instruction in the same provider's program. Attendance shall be measured by the information submitted to ISBE through its tracking system for students' enrollment and progress and by means of a survey administered by ISBE to all providers. Parental satisfaction shall be measured by a survey administered by ISBE to parents of students receiving services. Providers and school districts shall cooperate with ISBE to facilitate the administration of all surveys.
- b) For each of the criteria outlined in subsection (a) of this Section, ISBE will determine, based upon the evaluation rubric set forth in Appendix B to this Part, whether the provider's performance in each subject tutored falls into the category of "insufficient information", "below standards", "meets standards", or "above standards". Based on these determinations, ISBE will assign each provider the status of "good standing", "probationary status 1", or "probationary status 2", in accordance with the decision tree displayed in Appendix C to this Part. Each provider's status shall be determined on a Statewide basis for each subject tutored~~assigned separately with respect to each district served~~.
- c) If a provider's compliance with State or federal requirements or interactions with districts or parents indicate areas for improvement that are not serious enough to warrant corrective action under subsection (h) of this Section, the provider's status may also be assigned "with reservations". A provider assigned any status with reservations that fails to address the identified areas for improvement during the next SES reporting period shall be placed into corrective action in accordance with subsection (h) of this Section.
- d) A provider assigned the status of good standing shall not be required to take any action in response, other than addressing any reservations during the next SES reporting period.
- e) A provider assigned to probationary status 1 shall submit a remedial action plan describing the policies and practices the provider will immediately implement to return its status to good standing, including:

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- 1) specific, measurable steps to be taken;
 - 2) a timeline for these activities; and
 - 3) a budget for these activities.
- f) A provider assigned to probationary status 2 shall submit a reconstitution plan setting forth substantial changes the provider will immediately implement to return its status to good standing, including:
- 1) a fundamental revision to the program described in the provider's approved application;
 - 2) professional development activities for all the provider's instructional staff serving the district;
 - 3) a plan of outreach to promote effective parental involvement in the provider's program;
 - 4) for each aspect described pursuant to subsections (f)(1) through (3) of this Section:
 - A) the specific, measurable steps to be taken;
 - B) a timeline for these activities; and
 - C) a budget for these activities; and
 - 5) a process for monitoring progress and revising the plan as needed.
- g) A provider that receives three consecutive determinations of probationary status 1 or lower with respect to any particular district shall be removed from the State-approved list ~~for that district~~, except that a provider that receives two consecutive determinations of probationary status 2 shall be removed.
- h) The State Superintendent of Education may require corrective action of a provider if compliance issues are raised through ISBE's monitoring of the provider's program. Providers placed in corrective action under this subsection (h) shall,

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within 30 days after receiving notice to this effect, submit to the State Superintendent of Education for approval a corrective action plan detailing how the provider intends to improve the deficiencies in its program. A provider shall be removed from the State-approved list if it fails to meet the requirements of its corrective action plan by the end of the SES reporting period following the provider's placement into corrective action.

- i) The State Superintendent of Education may immediately suspend a provider's services if ISBE determines that a threat exists to the health or safety of students or if necessary to investigate or remedy concerns regarding compliance issues or illegal practices allegedly engaged in by the provider.
- j) The State Superintendent of Education may remove a provider from the State-approved list upon 30 days' written notice if the provider has engaged in illegal or deceptive practices, violated any assurance or aspect of its application to ISBE, violated any assurance or aspect of a plan submitted to ISBE in accordance with this Section, falsified any information on its application or other reports to ISBE, or otherwise violated State or federal law.
- k) Any corrective action or termination rights ISBE has pursuant to this Part may be exercised solely with respect to the provider's program in one or more schools or districts, if the performance issues are localized.

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

Section 675.175 Timetable for Implementation of the Program

The requirements of this Section shall pertain to a district's initial enrollment period for SES in each school year. Districts are strongly encouraged to undertake parental notification and student enrollment in advance of the timelines set forth in this Section. No provision of this Section shall be construed to limit a district's ability to offer multiple enrollment periods during the course of a school year. The deadline for each district's initial enrollment period shall be no later than 60 days after the first day of school or 60 days after the district's receipt of notification from ISBE as to its status, whichever occurs later.

- a) In any school year when the performance of a district's schools obligates the district to offer supplemental educational services, the district shall distribute to parents of eligible students a notification to this effect, accompanied by a selection form for use by the parents. Each district's notification and selection

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form must be approved by the State Superintendent of Education annually to ensure that it includes the material required by Section 1116(e)(2)(A) of NCLB, [is free of unrelated information](#), and, to the extent practicable, is written in language that will be understandable to parents.

- 1) No later than three weeks prior to the date on which the district plans to distribute its notification to parents, each district shall submit to the State Superintendent either:
 - A) the intended notification and the intended enrollment form, if separate; or
 - B) an assurance that its approved notification and enrollment form from the previous year will not be changed other than with respect to dates or available providers.
- 2) Within ~~four~~[two](#) weeks after receipt of a district's intended notification materials or assurance, the State Superintendent shall either approve the communication or specify areas of insufficiency that must be corrected before the notification can be released.
- 3) This notification shall be distributed in such a way as to reach parents no later than two weeks prior to the close of the district's initial enrollment period, and shall inform parents regarding all the approved providers that will be serving the schools attended by their respective students.
- 4) [Concurrently with distribution of the notification to parents required under this subsection \(a\), each district shall post on its website:](#)
 - A) [the number of students eligible for SES in each school year beginning with 2007-08;](#)
 - B) [the number of students who participated in SES in each school year beginning with 2007-08, provided that a student is considered to have participated if the district paid a provider for any services performed in connection with that student;](#)
 - C) [a list of the providers that are approved and have agreed to serve the district in the current school year; and](#)

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D) a list of the locations where each provider will offer services during the current school year.

- b) Prior to negotiating contracts with districts, each provider shall submit to ISBE, in the form specified by the State Superintendent, good-faith estimates of its per-pupil district program costs, as specified in Section 675.240 of this Part and based in each case on the approximate number of students expected to enroll in the provider's program. The State Superintendent shall make these estimates available to districts without delay. As soon as reasonably practicable, but in no event later than 45 days after the deadline for a district's initial enrollment period, the district shall submit to each provider a district-approved list of students whose parents have selected that provider, a fully executed contract, and any other information or approvals the provider may need from the district in order to comply with the requirements of this Part. The district may receive an extension of no more than 10 days time by establishing to the satisfaction of the State Superintendent that the delay is due to circumstances beyond the district's control. The district shall also use its best efforts to deliver a fully executed contract to each provider, based on the provider's estimated per-pupil district program cost, within this timeframe.
- c) No later than 30 days after the district's delivery to the provider of a student list and fully executed contract and any other materials needed pursuant to subsection (b) of this Section, each school district shall verify that each provider with which the district has executed a contract has begun the provision of tutoring to the students whose families chose that provider. If any provider has not begun to provide services, the provider may receive an extension of no more than 10 days time by establishing to the satisfaction of the State Superintendent that the delay is due to circumstances that are beyond the provider's control and will be alleviated within 10 days. Otherwise, at the end of the 30-day period, the district shall notify the parents of the affected students to this effect and offer the parents a one-week opportunity to choose another approved provider. In any such instance, the district shall conclude any needed contractual revisions within one further week and ensure that the new provider begins serving each affected student no later than two weeks after receiving the applicable contract and the list of students. The other provisions of this subsection (c) notwithstanding, a district that has collected indications of parents' second choices may assign students to the programs selected and notify parents that this has occurred.

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- d) Section 1116(e)(3)(A) of NCLB requires consultation by a district with a student's parents and the student's provider to develop a statement of specific achievement goals for the student, a statement regarding how the student's progress will be measured, and a timetable for improving the student's academic achievement in the subjects tutored. For any student with respect to whom this consultation has not occurred by the time the provision of tutoring is to begin pursuant to subsection (c) of this Section, the plans for the student shall stand as developed by the district and the provider, and the district shall maintain records demonstrating that district personnel made reasonable efforts to consult with a parent, such as through telephone contact, e-mail, home visits, or contact at school events.

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

SUBPART B: FINANCIAL REQUIREMENTS

Section 675.210 District Program Cost

- a) A provider's district program cost shall consist of amounts reported for each of the cost categories described in this subsection (a) that the provider seeks to charge to the district in accordance with its contract.
- 1) Direct program expenses caused directly by and related directly to the provision of SES within a district and costs attributable to fulfilling certain State mandates imposed by this Part (collectively, "direct program expenses"). Subcategories of direct program expenses include:
- A) Program staff salaries or wages, payroll taxes, and fringe benefits (limited to staff having direct contact with students who receive services);
- B) Program consultants having direct contact with students who receive services;
- C) Program-related materials, supplies (e.g., replacement copies of consumable curricular materials, such as workbooks), and equipment (items costing more than \$500 and having a useful life of more than one year must be capitalized and depreciated on a straight-line basis);

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- D) Costs related to the administration of student assessments;
 - E) Instructional Staff Training Services – Workshops and demonstrations designed to contribute to the professional competence of the instructional staff;
 - F) Snacks for program participants, provided that such snacks do not consist of confections, candy, potato chips, carbonated beverages, fruit drinks containing less than 50 percent pure fruit juice, tea, coffee, or other foods or beverages designated as "competitive foods" by the State Board of Education pursuant to 23 Ill. Adm. Code 305 (School Food Service);
 - G) Program Insurance – All liability, malpractice, personal injury, and other types of insurance not reported as property insurance or as employee benefits;
 - H) Rewards for student achievement provided in accordance with Section 675.30(m) of this Part;
 - I) Student retention activities;
 - J) Data entry related to State or local requirements for reporting on enrollment and attendance;
 - K) [Transportation of students to and from SES activities;](#)
 - L) [State cost reporting and auditing requirements;](#) and
 - ~~M)~~ Other (must be specified).
- 2) Occupancy expenses for facilities housing SES program activities. Subcategories of occupancy expenses include:
- A) Lease, rental, or property taxes (less any revenues received from portions of a building not used for SES programs);
 - B) Operations and maintenance of buildings and equipment (including janitorial, building and grounds, and other maintenance supplies,

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equipment maintenance, utilities, telecommunications, and property/building insurance);

- C) Housekeeping, maintenance, and security (including staff salaries, payroll taxes, and fringe benefits);
- D) Mortgage and installment interest;
- E) Operating interest; and
- F) Other (must be specified).

- 3) Curriculum development expenses – Activities designed to aid providers in [purchasing or preparing new curricular materials, refining or updating](#) ~~developing~~ the [existing](#) curriculum, preparing and utilizing special curriculum materials, and understanding and appreciating the various techniques that stimulate and motivate pupils, including:

- A) Salaries or wages, payroll taxes, and fringe benefits for staff engaged in curriculum development; and
- B) Other (must be specified).

- 4) Administrative and general expenses not directly attributable to the provision of SES within a district (other than costs reported for curriculum and training), including expenses for all staff, facilities, supplies, and equipment not used in direct connection with SES program activities (i.e., staff not having regular contact with SES students, and supplies and equipment not used during the delivery of SES at a particular site). Subcategories of administrative and general expenses include:

- A) Salaries or wages, payroll taxes, and fringe benefits for all executive, administrative, managerial, office, and clerical employees not having direct contact with students who receive services;
- B) Legal and accounting services and other administrative consultants;

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- C) Operations and maintenance of buildings and equipment – not assigned to program;
 - D) Materials, supplies, and equipment – not assigned to program;
 - E) Lease, rental, or property taxes for facilities not serving as a primary location for the delivery of SES (less any revenues from the rental of portions of the facility);
 - F) Corporate royalty fees;
 - G) Advertising and marketing expenses;
 - H) Meals and entertainment expenses;
 - I) Distributions to shareholders or retained earnings ; and
 - J) Other (must be specified).
- b) Multiple Districts Served
- If a provider serves multiple districts (either within or outside of Illinois), the provider's expenses in the categories outlined in subsections (a)(3) and (4) of this Section must be prorated, first in accordance with the percentage of time applicable to SES in general, and second in accordance with the percentage of students served within each district. (Example: a provider's program manager earns an annual salary of \$100,000 and spends 50 percent of her time managing the provider's SES programs throughout the nation and the remainder of her time performing educational consulting services for districts. The provider serves 5,000 students in its SES programs nationwide, 1,000 of whom are within an Illinois district. \$10,000 of her salary may be reported as an actual cost of providing SES within that district. ($\$100,000 \times .5 \times .2 = \$10,000$.) All of the foregoing allocations must be in accordance with the following cost principles, as applicable:
- 1) OMB Circulars (5 CFR 1310 (2005)) available at www.whitehouse.gov/omb/circulars/index.html:
 - A) OMB Circular A-87 (Cost Principles for State, Local and Indian Tribal Governments);

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- B) OMB Circular A-21 (Cost Principles for Educational Institutions);
 - C) OMB Circular A-122 (Cost Principles for Non-Profit Organizations).
- 2) Federal Acquisition Regulation (applicable to for-profit providers) (48 CFR 9904 (2005) available at www.access.gpo.gov/nara/cfr/waisidx_01/48cfr9904_01.html).

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

Section 675.220 Non-Reimbursable Expenses and Revenue Offsets

- a) The expenditures discussed in this subsection (a) shall be non-reimbursable costs and shall not be calculated or reported as part of a provider's district program cost.
 - 1) Expenses resulting from transactions with related organizations that are greater than the expense to the related organization. Providers may be required to submit evidence to substantiate or refute any claim of relatedness in determining allowable costs.
 - 2) Non-straight-line depreciation.
 - 3) Bad debt.
 - 4) Special benefits to owners, including owner and keyman life insurance, except insofar as required by lending institutions.
 - 5) Charity grants.
 - 6) Interest payments related to a provider's assets that are unrelated to an SES program.
 - 7) Costs incurred by owners for non-SES activities, including that portion of overhead that should be allocated to these activities.
 - 8) Printing expenses unrelated to the program.

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- 9) Lobbying activities.
- 10) ~~Transportation of students to and from SES activities.~~ 11) Meals provided to students enrolled in SES programs.
- ~~11)12)~~ 11) Confections, candy, potato chips, carbonated beverages, fruit drinks containing less than 50 percent pure fruit juice, tea, coffee, or other foods or beverages designated as "competitive foods" by the State Board of Education pursuant to 23 Ill. Adm. Code 305.
- ~~12)13)~~ 12) Fines and penalties.
- ~~13)14)~~ 13) Payments of principal on mortgages or loans.
- ~~14)15)~~ 14) Asset acquisition costs for items whose costs exceed \$500 and have a useful life of one year or more.
- ~~15)16)~~ 15) Legal expenses incurred for non-program activities or for litigation against governmental entities.
- ~~16)17)~~ 16) Severance pay.
- ~~17)18)~~ 17) Sales tax (in the case of not-for-profit organizations).
- ~~18)19)~~ 18) Income tax.
- ~~19)20)~~ 19) Costs of any kind prohibited by the Code of Ethics set forth in Section 675.30 of this Part.
- ~~20)21)~~ 20) Economic incentives or gratuities of any kind to parents.
- b) Any revenue received by the provider for the provision of SES from any source other than the district shall be offset against the provider's district program costs.

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

Section 675.230 Reports of Actual Costs

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- a) Each provider shall report to the State Board of Education, no later than September 30 following the end of the SES reporting period or 45 days after the end of the provider's fiscal year, whichever is later, and using a form provided by ISBE, the provider's district program cost for each district the provider served. The cost report shall also indicate the payments received or invoiced to the district for the SES reporting period, as well as the difference between these payments and the district program cost.
- 1) Each provider shall identify all transactions with related organizations and the actual cost of each transaction.
 - 2) For purposes of this subsection (a)(2), a student "served" is one with respect to whom a provider performed any service that was billed to a district. Each non-governmental provider serving more than 50 students within a district must engage an independent Licensed Certified Public Accountant (CPA) who is a member of the American Institute of Certified Public Accountants to perform agreed-upon procedures on its reported information. An agreed-upon procedures report must be submitted with the district program cost report required by this subsection (a). The agreed-upon procedures must include the following.
 - A) Obtain the general ledger trial balance as of the reporting date and agree or reconcile the balances in the trial balance to the cost report;
 - B) Inquire of members of management who have responsibility for financial and accounting matters concerning:
 - i) whether the cost report has been prepared using the accrual basis;
 - ii) the procedures for recording, classifying, and summarizing transactions and accumulating information;
 - iii) the method used to allocate curriculum development and administrative and general expenses to the district;

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- iv) known transactions with related organizations and whether the actual cost of such transactions was accurately reported; and
 - v) the provider's procedures for identifying non-reimbursable expenses;
- C) Identify and report on results from the following procedures:
- i) compare the actual average cost per pupil as shown on the cost report to the average cost per pupil shown in the contract with the district, and report on management's explanation for any differences greater than 10 percent; and
 - ii) compare current-year and prior-year cost results by report line item, and report on management's explanations for any differences in line item amounts that exceed 10 percent of the prior year's amounts, or if the total cost for the reporting period exceeds the total cost for the prior year by more than 5 percent;
- D) For providers serving more than 200 students in a district, select a sample of program and curriculum and training expenses for source document testing. The sample must be representative of the population and represent no less than 25 percent of the expenses for each category. As a part of testing procedures, perform the following:
- i) verify that the provider properly classified costs according to the categories and subcategories set forth in Section 675.210 of this Part, and report on sampled items that were not classified in accordance with that Section;
 - ii) verify that sampled items are not non-reimbursable as defined in Section 675.220 of this Part, and report on sampled items that are non-reimbursable as defined in that Section; and

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- iii) verify that curriculum development and administrative and general expenses have been allocated to the district in an accurate and consistent manner and in accordance with Section 675.210(b) of this Part, and report on allocations for any sampled items that are not in accordance with that Section; and
 - E) Report on whether, as determined by the procedures performed under subsection (a)(2)(D) of this Section, the sampled items contain errors, omissions, inconsistencies, or non-compliance with the cost reporting requirements set forth in this Section, and specify each material error, omission, or inconsistency.
- 3) An agreed-upon procedures report submitted pursuant to subsection (a)(2) of this Section shall indicate whether all elements of the provider's cost report comply with the requirements of this Subpart B. In addition to the specific items to be reported under subsection (a)(2) of this Section, the CPA shall also report on:
- A) any unreconciled differences between the general ledger trial balance and the cost report;
 - B) any cost report that was not prepared on the accrual basis;
 - C) any entries that are not supported by or do not agree with documentation provided by management;
 - D) any cost allocation methods that are not in accordance with the requirements set forth in Section 675.210(b) of this Part; and
 - E) any other material error, omission, inconsistency, or area of non-compliance that comes to the CPA's attention during the course of conducting the agreed-upon procedures required by subsection (a)(2) of this Section.
- b) Each provider shall report the number of students enrolled in the provider's program during each SES reporting period. If a student's services are terminated during the SES reporting period, the student shall be reported in accordance with the percentage of the program completed prior to termination of services. For

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example, a student who completed 60 percent of the provider's program prior to termination of services should be reported as .6 of a student on the provider's cost report.

- c) All reporting shall be provided on an accrual basis.

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

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Section 675.APPENDIX B Evaluation Rubric

Criterion	Insufficient Information	Below Standards	Meets Standards	Above Standards
Student Achievement (See Note 1)	There is insufficient information available to determine student achievement outcomes.	The effect size for students in the provider's program can be identified and does not demonstrate any gains that can be attributed to tutoring received from the provider.	The effect size for students in the provider's program can be identified and does demonstrate gains that can be attributed to tutoring received from the provider.	The effect size for students in the provider's program can be identified and is in the top one-third of those providers demonstrating gains that can be attributed to tutoring received from the provider.
Attendance (See Notes 2 and 3)	Not applicable. Providers that do not submit attendance data will not be included on the list of eligible providers for the following SES reporting period.	(1) The provider's <u>average attendance rate</u> is one full standard deviation below the <u>overall averagemean attendance-rate</u> ; and (2) The provider cannot demonstrate <u>satisfactorily, based on a survey and ISBE's verification of reported information</u> , that it has made dedicated efforts to encourage student attendance.	The provider's <u>average attendance rate</u> is between one full standard deviation below and one full standard deviation above the <u>overall averagemean attendance-rate</u> .	The provider's <u>average attendance rate</u> is one standard deviation or more above the <u>overall averagemean attendance rate</u> .

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<p>Parent Satisfaction</p>	<p>There is insufficient information available to determine parent satisfaction outcomes.</p>	<p>More than 25%Fewer than 75% of respondents indicate: (1) overall dissatisfactionsatisfaction with the provider; or (2) they were not consulted in the development of the student's individual learning plan.</p>	<p>More than 10% but no more than 25%75-89% of respondents indicate: (1) overall dissatisfactionsatisfaction with the provider; and (2) they were not consulted in the development of the student's individual learning plan.</p>	<p>No more than 10%90-100% of respondents indicate: (1) overall dissatisfactionsatisfaction with the provider; and (2) they were not consulted in the development of the student's individual learning plan.</p>
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Note 1: The evaluation shall be limited to students who have received at least 18 hours of instruction from a given provider.

Note 2: Calculated based on attendance rate for sessions scheduled by the provider.

Note 3: A "provider's average attendance" is calculated by dividing the total number of hours the provider served by the total number of students the provider served. The "overall average attendance" is calculated by dividing the sum of all the "provider's average attendances" by the total number of providers.~~"Mean attendance rate" means, for programs serving the Chicago Public Schools, the mean attendance rate for all programs serving that district. For programs in districts other than the Chicago Public Schools, "mean attendance rate" means the mean attendance rate for all programs in districts outside the Chicago Public Schools.~~

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

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Section 675.APPENDIX C Decision Matrix

Determination Based on Evaluation	Status*
<ul style="list-style-type: none"> • Student achievement: insufficient information, meets standards or above standards. • Attendance: insufficient information, meets standards or above standards. • Parent satisfaction: insufficient information, meets standards or above standards. 	Maintain or return to good standing.
<ul style="list-style-type: none"> • Student achievement: insufficient information, meets standards or above standards. • Either attendance or parent satisfaction below standards. 	Probationary status 1.
<ul style="list-style-type: none"> • Student achievement: below standards (regardless of attendance or parental satisfaction). 	Probationary status 2.

* Any status level may be assigned "with reservations" in accordance with Section 675.90(c) of this Part.

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

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- 1) Heading of the Part: Approval of Voting Systems
- 2) Code Citation: 26 Ill. Adm. Code 204
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
204.20	Amended
204.50	Amended
204.60	Amended
204.130	Amended
- 4) Statutory Authority: Implementing Section 23-15.1 and Articles 24A, 24B and 24C, and authorized by Section 1A-8(9) of the Election Code [10 ILCS 5/23-15.1, Art. 24A, Art. 24B, Art. 24C, 1A-8(9)]
- 5) A Complete Description of the Subjects and Issues Involved: This rulemaking is a consequence of Public Act 95-699 (SB 662). It relates to Sections 5/24A-16, 24B-16 and 24C-16. The Sections require the State Board of Elections to provide, by rule, a fee structure for equipment approvals. These fees will be for staff's review of the application, manuals and federal reports. Prior to Board approval, the vendor is still responsible for all other expenses incurred during SBEL testing.
- 6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None
- 7) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 8) Does this rulemaking contain an automatic repeal date? No
- 9) Does this rulemaking contain incorporations by reference? No
- 10) Are there any other proposed rulemakings pending on this Part? No
- 11) Statement of Statewide Policy Objectives: This proposed rulemaking does not affect units of local government.
- 12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Interested parties may submit comments in writing within 45 days after publication to:

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Steven Sandvoss
General Counsel
State Board of Elections
1020 S. Spring Street
Springfield, Illinois 62708

217/782-4141

- 13) Initial Regulatory Flexibility Analysis:
- A) Types of small businesses, small municipalities and not for profit corporations affected: None
 - B) Reporting, bookkeeping or other procedures required for compliance: None
 - C) Types of professional skills necessary for compliance: None
- 14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the 2 most recent agendas because: it was not anticipated.

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

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STATE BOARD OF ELECTIONS

TITLE 26: ELECTIONS

CHAPTER I: STATE BOARD OF ELECTIONS

PART 204

APPROVAL OF VOTING SYSTEMS

Section	
204.10	General Provisions
204.20	Definitions
204.30	Jurisdiction Profile
204.40	Criteria for Approval of Voting Systems
204.50	Application for Approval of Voting Systems
204.55	Provision of the Voting System Computer Code
204.60	Preliminary Determination and Review of the Proposed Voting Systems
204.70	Full Review Procedures
204.75	Review and Verification of Computer Code
204.80	Hearing to Consider Staff Review Report
204.90	Interim Approval of Voting Systems
204.100	Final Approval of Voting Systems
204.110	Refusal to Grant Approval of Voting Systems
204.120	Withdrawal of Approval of Voting Systems
204.130	Subsequent Modification of Voting Systems
204.140	Monitoring of Voting Systems
204.150	Voting Systems in Use on the Effective Date of this Part (Repealed)
204.160	Emergency Approval of a Voting System
204.170	Jurisdiction of Election Authority over Voting System's Personnel
204.180	Number of Voting Booths

AUTHORITY: Implementing Section 23-15.1 and Articles 24A, 24B and 24C, and authorized by Section 1A-8(9) of the Election Code [10 ILCS 5/23-15.1, Art. 24A, Art. 24B, Art. 24C, 1A-8(9)].

SOURCE: Adopted at 2 Ill. Reg. 25, p. 70, effective July 3, 1978; codified at 6 Ill. Reg. 7216; amended at 9 Ill. Reg. 10733, effective July 1, 1985; amended at 11 Ill. Reg. 18655, effective October 30, 1987; amended at 15 Ill. Reg. 18144, effective December 9, 1991; amended at 23 Ill. Reg. 3943, effective March 19, 1999; amended at 29 Ill. Reg. 13734, effective August 25, 2005; emergency amendment at 29 Ill. Reg. 14070, effective September 10, 2005, for a maximum of 150 days; emergency expired February 6, 2006; emergency amendment at 29 Ill. Reg. 15057,

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effective September 27, 2005, for a maximum of 150 days; emergency expired February 23, 2006; amended at 33 Ill. Reg. _____, effective _____.

Section 204.20 Definitions

"Applicant" is any individual, public official, public body, trust, partnership, committee, association, corporation, vendor, user or any other organization or group of persons seeking to use or market any voting system or voting system component.

"Commercial Off the Shelf" or "COTS" is any commercial, readily available hardware devices (such as printers or personal computers) or software products (such as operating systems, programming language compilers, or database management systems).

"Computer Code" consists of, but is not limited to, ballot counting source code, table structures, modules (compiled source code), program narratives, installation instructions, operations instructions, data flows, deployment platforms, compatibility considerations for hardware, software and firmware, and any other documentation relevant to the structure and operation of the ballot counting system.

"Preliminary Review" shall consist of a full technical and procedural review of the proposed voting system component and of no more than three different and separate preaudited ballot counting tests created by the Board's staff. The purpose of the review and testing is to determine the proposed system's ability to adhere to ballot management procedures required by statute and rule and to tabulate ballots and report results as prescribed by the Election Code [10 ILCS 5].

"User" is any individual, public official, public body, trust, partnership, committee, association, corporation or any other organization or group of persons owning, using, or contracting for the purchase or use of any voting system or voting system component involved in the election process.

"Vendor" is any individual, trust, partnership, committee, association, corporation or any other organization or group of persons contracting to supply any voting system or voting system component involved in the election process.

"Voting System" or "Electronic Voting System" means that combination of

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equipment and programs used in the casting, examination and tabulation of ballots and the cumulation and reporting of results by electronic means.

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

Section 204.50 Application for Approval of Voting Systems

- a) In order to obtain Board approval of a voting system, a written application must be made to the Board. The application shall, at a minimum, contain the following:
- 1) A general description of the proposed system.
 - 2) The description, nomenclature, specifications and intended use or uses of all voting system components comprising the proposed voting system.
 - 3) A description of all contemplated and possible uses of the voting system software components.
 - 4) A description of support services provided for the proposed voting system.
 - 5) Applicant's primary address, telephone number and e-mail address and the names, addresses, e-mail addresses and telephone numbers of individuals and/or corporations who will be responsible for marketing the proposed voting system.
 - 6) The time period in which the applicant has actively engaged in marketing the proposed voting system.
 - 7) A complete list of election jurisdictions currently using the proposed voting system, including the size of the jurisdiction and the names and addresses of the election authorities.
 - 8) A complete list of jurisdictions currently contracting with the applicant for voting system components.
 - 9) A complete list of election jurisdictions in Illinois in which the applicant is seeking to market the proposed voting system.

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- 10) If known, a complete list of election jurisdictions in Illinois in which the applicant proposes to experimentally use the proposed voting system.

b) Application Fee

- 1) The non-refundable application fee shall be allocated pursuant to the following:

<u>A)</u>	<u>New system approval</u>	<u>\$750</u>
<u>B)</u>	<u>Software modification of a previously approved system</u>	<u>\$500</u>
<u>C)</u>	<u>Hardware modification of a previously approved system</u>	<u>\$250</u>
<u>D)</u>	<u>Hardware modification limited to "Commercial Off the Shelf" hardware for a previously approved system such as printers and personal computers</u>	<u>\$100</u>

- 2) Failure to submit the application fee will cause the application to be incomplete and prevent the approval of the voting system or system modification. No State testing may begin prior to the Board's receipt of the fee and a complete application. Staff will notify the applicant in writing of the receipt of the application and the fee. Any incomplete application or incorrect fee will be returned to the applicant with a request for correction.

- cb) The Computer Code as defined in Section 204.20 shall be submitted as part of the completed application for approval.

- de) No vendor or user shall offer to sell, lease, loan, give or otherwise supply to any user or potential user any voting system or voting system component, and no user shall place in operation any voting system or voting system component, without first submitting to the Illinois State Board of Elections the application for approval identified in subsection (a). A completed application for approval shall be submitted not less than six months prior to any election in which a voting system or support component is proposed for use.

- ed) Failure to provide the application in accordance with subsection (cb) shall result in the denial of any application or request for emergency approval of an electronic

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voting system that might otherwise be appropriate under Section 204.160 of this Part.

- f) The reasonable expenses incurred, except those expenses related to escrow of submitted Computer Code, by the State Board of Elections in conducting the approval process of the voting system shall be borne by the applicant for approval of the voting system or system component. Expenses for which the applicant shall be liable shall be limited to goods and materials necessary for the review process, necessary travel in accord with State travel regulations (80 Ill. Adm. Code 2800), use of contract consultants, and the actual cost of any computer support. Expenses shall be documented and submitted to the applicant at the end of full review prior to interim approval as defined in Section 204.90, and within 10 days after the completion of any testing conducted between interim and final approval as defined in Section 204.100. Payment of the costs shall be made by the applicant within 10 days after receipt. The Board shall not grant interim approval or full approval of a voting system or system component until the applicant has fully satisfied the monetary obligation incurred by the Board during the review process. Reasonable expenses are those customary and usual charges for goods and services of value and quality acceptable in the computer science industry. Board staff shall determine in the first instance what expenses are reasonable, and an applicant who believes that the staff determination is incorrect may ask for review of the determination by the State Board of Elections.

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

Section 204.60 Preliminary Determination and Review of the Proposed Voting Systems

- a) Upon the Board's receipt of a completed application requesting approval of a voting system and the appropriate application fee, a preliminary determination shall be made as to whether the proposed voting system has the capability of fulfilling the criteria prescribed in Section 204.40 ~~of this Part~~.
- b) If the preliminary determination indicates that the proposed voting system appears to fulfill the criteria prescribed in Section 204.40 ~~of this Part~~, then the staff of the Board will conduct a preliminary review of the proposed voting system.
- c) Insofar as practical, the preliminary review of the proposed voting system will consist of the creation of a pre-audited ballot counting test by the Board's staff that will be delivered to the applicant. The applicant shall tabulate the ballots

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contained within the pre-audited ballot counting test and generate, at a minimum, individual precinct result total reports and cumulative result total reports ~~that~~^{which}, along with the pre-audited ballot counting test, will be delivered to the Board. The Board's staff shall review the reports submitted by the applicant and submit a preliminary review findings and conclusions report to the Board and the applicant.

- d) If the preliminary review report indicates that the proposed voting system appears to demonstrate the capability to fulfill the criteria prescribed in Section 204.40, the staff of the Board shall continue with the full review process to demonstrate satisfactory performance of the proposed voting system as prescribed in Section 204.70. A system fails preliminary review when it fails to fulfill the criteria of Section 204.40 by the conclusion of the third ballot counting test.
- e) If the preliminary review report indicates that the proposed system fails to demonstrate the capability to fulfill the criteria prescribed in Section 204.40, the staff of the Board shall cease any further review of the system. Any application for system approval offered by an applicant who has previously failed during the preliminary review or full review process shall not be considered by staff for a period of one year from the date of determination by the Board.

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

Section 204.130 Subsequent Modification of Voting Systems

Any modification or change in the description, nomenclature, specifications, characteristics or use of any voting system components that relates to the election process shall constitute a change in the approved voting system and shall require submission and approval of an application and the appropriate application fee, as prescribed in Section 204.50, and submission of the Computer Code for the modification or change. However, modifications or changes that normally occur as a result of the election process, which shall include but not be limited to object code programming, instruction manual revisions, and ballot printing, shall not constitute a modification or change in the approved system.

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

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NOTICE OF ADOPTED AMENDMENTS

- 1) Heading of the Part: Sale of Information
- 2) Code Citation: 92 Ill. Adm. Code 1002
- 3)

<u>Section Numbers:</u>	<u>Adopted Action:</u>
1002.10	Amendment
1002.20	Amendment
1002.30	Amendment
1002.40	Amendment
1002.42	Amendment
1002.45	Amendment
1002.60	Amendment
1002.70	Amendment
1002.90	Amendment
- 4) Statutory Authority: 625 ILCS 5/2-104(b) and 625 ILCS 5/2-123(p)
- 5) Effective Date of Amendments: January 30, 2009
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposed Published in the Illinois Register: June 20, 2008; 32 Ill. Reg. 8898
- 10) Has JCAR issued a Statement of Objection to this rulemaking? No
- 11) Differences between Proposal and Final Version: No substantive changes made between proposal and adoption. All technical changes recommended by JCAR were made.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes
- 13) Will this rulemaking replace any emergency rulemakings currently in effect? No
- 14) Are there any amendments pending on this Part? No

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- 15) Summary and Purpose of Amendments: This rulemaking serves to update the policies that govern the release and sale of information of data acquired by the Secretary of State in conjunction with issuing vehicle registrations and driver's licenses.
- 16) Information and questions regarding these adopted amendments shall be directed to:
- Secretary of State
Brenda Glahn, Assistant General Counsel
298 Howlett Building
Springfield, IL 62701
- 217/785-3094
- 17) Do these amendments 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:

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NOTICE OF ADOPTED AMENDMENTS

TITLE 92: TRANSPORTATION
CHAPTER II: SECRETARY OF STATEPART 1002
SALE OF INFORMATION

Section	
1002.10	Applicability
1002.20	Definitions
1002.30	Fees
1002.40	Requests
1002.42	Impermissible Use Uses of Personally Identifying Personal Information
1002.45	Request for an Individual's Driving, Registration, or Title Information
1002.50	Lists of Purchasers
1002.60	Access Agreement Contract
1002.70	Public Records
1002.80	Lists of Licenses
1002.90	Social Security Numbers

AUTHORITY: Implementing Section 2-123, and authorized by Sections 2-104, 2-107, and 2-123, of the Illinois Vehicle Title and Registration Law [625 ILCS 5/2-123, 2-104 and 2-107] and 18 USC 2721.

SOURCE: Emergency rules adopted at 7 Ill. Reg. 11760, effective September 14, 1983; adopted and codified at 8 Ill. Reg. 2522, effective February 11, 1984; amended at 16 Ill. Reg. 13088, effective August 11, 1992; amended at 18 Ill. Reg. 18118, effective December 9, 1994; amended at 21 Ill. Reg. 466, effective January 1, 1997; amended at 31 Ill. Reg. 11337, effective July 23, 2007; amended at 33 Ill. Reg. 3177, effective January 30, 2009.

Section 1002.10 Applicability

~~This Part applies~~[These Rules apply](#) to the sale and dissemination of information contained in the Office of the Secretary of State ~~that, which information~~ has been collected pursuant to the Illinois Vehicle Code [625 ILCS 5] for the issuance of ~~driver's~~[drivers](#) licenses, vehicle titles, and vehicle registrations [and pursuant to the Illinois Identification Card Act \[15 ILCS 335\] for the issuance of identification cards](#). This information is a public record; however, [Social Security Numbers](#)~~social security numbers~~ are not public information. Personally ~~identifying~~[identifiable](#) information shall not be released to requestors unless otherwise permitted by statute or this Part.

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(Source: Amended at 33 Ill. Reg. 3177, effective January 30, 2009)

Section 1002.20 Definitions

"Access Agreement" – an agreement entered into under Section 1002.60 of this Part by the Secretary of State and a recipient of drivers, title, vehicle or identification card information covered by this Part.

"Attorney" – an individual who is licensed to practice law

"Automobile ~~Associated Businesses~~associated businesses" – shall include but not be limited to new or used vehicle dealerships, vehicle rental agencies, and tow truck operators

"Commercial Purchasers" – individuals and business entities who enter into a written agreement to buy all or a portion of the ~~drivers~~driver's, title, or vehicle list or individual records in bulk

"Commercial Solicitation Purposes" – the use of the drivers, vehicle or title list, or driving or identification card abstracts, to contact individuals for advertising, offering for sale, marketing or sale of products or services; or identifying potential employees, except for the United States armed forces

"Director" – the Director or Acting Director of either Driver Services or Vehicle Services, depending on the context

"Driver Services" – the Department of ~~Driver~~Drivers Services of the Office of the Secretary of State

"Drivers ~~List~~list" – the entire list or any part of the list~~thereof~~ of all ~~licensed~~licensed drivers licensed by the State of Illinois ~~that, the information contained on the list~~ includes the driver's name, address, weight, height, ~~gender~~sex, color of eyes, color of hair, and date of birth, county of residence, zip code, license, classification, license restriction codes, and license ~~issuance~~issue and expiration dates

"Driving ~~Abstract~~abstract" – a record kept by the Department of ~~Driver~~Drivers Services on each driver licensed by the State of Illinois, containing all information required by IVC Section 6-106(b) ~~of the Illinois Vehicle Code, and~~ all records of each driver's violations of the traffic laws, and administrative actions pertaining to

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driving privileges

~~"DUI listing" — a periodic listing of persons who have been convicted of Driving Under the Influence or have a statutory summary suspension or any suspension resulting from the receipt of the Sworn Report issued to a driver as the result of an alcohol or drug related traffic violation and/or revocation in effect on his/her driving record. The listing contains the person's name, driver's license number, address, and length of suspension and revocation~~

"Employers" – individuals or business entities ~~that, which~~ permit individuals to work, when requesting information concerning current or prospective employees

"Financial ~~Institutions~~institutions" – banks, savings and loans, and credit unions, but ~~shall~~ not ~~including~~include currency exchanges

"Government ~~Agencies~~agencies" – units of local, ~~state~~State, or federal governmental agencies or elected governmental officials, including, but not limited to, Representatives, Senators, Congressmen, park board members, county board members, and school districts

~~"Identification Card Abstract" – a record kept by the Department of Driver Services on each person issued an identification card by the Secretary of State, containing all information required by the Illinois Identification Card Act [15 ILCS 335]~~

~~"Illinois Vehicle Code", "Vehicle Code", or "IVC" – 625 ILCS 5~~

"Insurers" – any insurance agent or company as defined in Section 2(e) of the Illinois Insurance Code [215 ILCS 5] authorized by the laws of any state to transact the business of insurance, and ~~including~~shall include all employees of such agent or company

"Law Enforcement Officials" – police agencies, state's attorneys' offices or court officials

"News ~~Medium~~medium" – any newspaper or other periodical issued at regular intervals and having a general circulation; a news service; a radio station; a television station; a community antenna television service; and any person or corporation engaged in the making of news reels or other motion picture news for

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public showing

"Office" – the Office of the Secretary of State and not any particular department, address, or location

"Other ~~Business Entities~~business entities for ~~Purposes Consistent~~purposes consistent with the Illinois Vehicle Code" – licensed remitters when requesting title or registration information; public libraries, public educational institutions, and private educational institutions when requesting driving records; or registration or title information

"Personally ~~Identifying~~Identifiable Information" or "~~Personal Information~~" – for driving records, the information regarding the driver's name, address (excluding the 5 digit zip code), telephone number and, driver's license number, ~~weight, height, sex, color of eyes, color of hair, date of birth, restrictions, or endorsements and classification codes of the driver's license, county of residence, and zip code, Circuit Court County which imposed the conviction or County of venue for driver's license sanctions~~; for title or vehicle records, the information regarding the vehicle owner's name, address (excluding the 5 digit zip code), ~~county of residence~~, and telephone number, or registration owner's address (excluding the 5 digit zip code), ~~county of residence~~, and telephone number; for identification card records, the information regarding the identification card holder's name, address (excluding the 5 digit zip code), telephone number and identification card number

"~~Reporter~~Reporters" – any person regularly engaged in the business of collecting, writing or editing news for publication through a news medium; and includes any person who was a reporter at the time the information sought was procured or obtained

"Request" – the written application upon the designated form or an acceptable alternative for the obtaining of a drivers list, vehicle list, title list, or a driving or identification card abstract

"Secretary" – the Secretary of State of Illinois

"~~Section 2-123~~" – ~~Section 2-123 of the Illinois Vehicle Code [625 ILCS 5/2-123]~~

"Title ~~List~~list" – the list of all vehicles titled by the State of Illinois

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"Vehicle ~~List~~list" – the list of all vehicles by identification number, with the name and address of the owners, ~~that~~which are registered by the State of Illinois

"Vehicle Services" – the Department of Vehicle Services of the ~~Office~~office of the Secretary of State

(Source: Amended at 33 Ill. Reg. 3177, effective January 30, 2009)

Section 1002.30 Fees

Drivers, vehicle, and title information shall not be sold for commercial solicitation purposes.

- a) Fees for drivers lists:
 - 1) ~~The fee~~ for the sale of a drivers list pursuant to IVC ~~paragraph (a) of~~ Section 2-123 (a) is \$500.~~00~~.
 - 2) ~~The fee~~ for the sale of a drivers list pursuant to IVC ~~paragraph (b) of~~ Section 2-123 (b) is \$~~500~~200 plus \$~~50~~20 per 1,000 names, with a minimum cost of \$500.~~00~~.
- b) ~~Fees~~The fees for title and vehicle information provided to public entities pursuant to IVC Section 2-123(a) shall be as follows:
 - 1) for title lists or parts of a list~~thereof~~, \$600;
 - 2) for lists of recent title transactions, \$100;
 - 3) for passenger vehicle lists or parts of a list~~thereof~~, \$300;
 - 4) for miscellaneous vehicle lists or parts of a list~~thereof~~, \$200;
 - 5) for International Reciprocity Plan vehicle lists or parts of a list~~thereof~~, \$100;
 - 6) for computer searches of specific vehicle registration plate numbers, \$100.
- c) The fees for title and vehicle information provided to private entities pursuant to IVC Section 2-123(b) shall be as follows:

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- 1) for title lists or parts ~~of a list thereof~~, \$200 plus \$20 per 1,000 records, or the actual cost or \$600, whichever is greater;
 - 2) for lists of recent title transactions, \$200 plus \$20 per 1,000 records, or the actual cost, whichever is greater;
 - 3) for passenger vehicle lists or parts ~~of a list thereof~~, \$200 plus \$20 per 1,000 records, or the actual cost of \$300, whichever is greater;
 - 4) for International Reciprocity Plan vehicle lists or parts ~~of a list thereof~~, \$200 plus \$20 per 1,000 records or the actual cost thereof, whichever is greater;
 - 5) for computer searches of specific vehicle registration plate numbers, \$200 plus \$20 per 1,000 records, or the actual cost thereof, whichever is greater.
- d) The information sold pursuant to subsection (a) or (b) of this Section shall be provided on a computer processible medium as prescribed by the Secretary ~~on a computer processible medium as prescribed by the Secretary and furnished by the purchaser. Such information as requested will be provided on standard computer paper for an additional fee of 50 per page; the maximum number of records that may be so provided shall be 15,000 per request.~~
- e) The fees for additional copies of registration lists provided to public entities pursuant to IVC Section 2-123(d) shall be as follows:
- 1) for a complete list, \$80;
 - 2) for a partial list (up to one-half of the complete list), \$40.
- ~~f) The fees for registration lists provided pursuant to Section 2-123(e) shall be as follows:~~
- ~~1) for a complete list, \$400;~~
 - ~~2) for a partial list (up to one half of the complete list), \$200~~
- fg) The information sold pursuant to subsection (e) ~~or (f)~~ of this Section shall be provided on a computer processible medium as prescribed by the

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Secretary microfiche.

- gh) All fees, other than those paid by governmental agencies, shall be paid in advance of the delivery of any list to any purchaser.
- hi) Fees for information supplied by means of computer connections between the Secretary's computers and those of any other agency, corporation, or person may be paid on a daily or monthly basis for all information delivered during that day or month, and shall be determined by the Secretary and the agency or person to be the most economically feasible simplest way of billing billings.
- ij) No fees shall be charged from those local, state State, and federal Federal governmental government agencies that who obtain information from the Secretary to enforce criminal laws.
- jk) Computer terminal connections to the Secretary's computer may be provided to other State agencies. This service may be made available at no charge asse long as the requesting agency incurs all terminal costs and asse long as the service does not substantially increase costs or network traffic on the Secretary's computer.
- kl) Computer terminal connection may be allowed to non-governmental agencies provided that the expense of the equipment and communication cost seest are borne by the non-governmental agency. The allowance of computer terminal connections shall be contingent upon the best interests of the Office of the Secretary of State, which is based upon the volume of requests received, the cost-effectiveness of providing the information through computer terminal connections, as opposed to other methods, and other factors that which may impede the operations of the Office of the Secretary of State. Should This service will be suspended at any time, should the connection interfere with the Secretary's internal work schedules and processing, this service may be suspended at any time.

(Source: Amended at 33 Ill. Reg. 3177, effective January 30, 2009)

Section 1002.40 Requests

- a) Except as provided in subsection (c), all All requests for any type of information for sale pursuant to IVC Section 2-123 must be in writing, be signed before a notary by the person requesting the information, and include that person's address,

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the purpose of the request, the specific information or type of information sought, the name and address of any organization represented ~~and~~; the position of the requestor in the organization. This document shall be known as the Certified Statement of Use, and the identification of the requestor.

- b) Information obtained by means of a computer connection between the Secretary's computers and those of any organization shall be requested in writing, as set forth in subsection (a) including a certified statement of use, and a record shall be kept as required in subsection (a). ~~Throughout the term of the Access Agreement, the~~ requesting organization shall not deviate from the Certified Statement of Use, comply with the provisions of subsection (a) at the time of the original request and contract period.
- c) A request for an individual driving or identification card abstract must be in writing, signed by the person requesting the abstract, and include the requestor's address, driver's license or identification card number, purpose of the request, the name and address of any organization represented, and an affirmation that the information provided by the requestor is true and correct to the best of the requestor's knowledge. In addition, if the request is not made in person at a Secretary of State facility, the signature of the person making the request must be notarized. Personally identifying information will be released only if the request falls within IVC Section 2-123(f-5).

(Source: Amended at 33 Ill. Reg. 3177, effective January 30, 2009)

Section 1002.42 Impermissible Uses of Personally Identifying~~Personal~~ Information

The Secretary of State shall not sell personally identifying~~personal~~ information from the drivers, vehicle or title lists, or from a driving or identification card abstract for commercial solicitation purposes, as defined in this Part.

(Source: Amended at 33 Ill. Reg. 3177, effective January 30, 2009)

Section 1002.45 Request for an Individual's Driving, Registration, or Title Information

- a) If a request is made for an individual's driving or identification card abstract~~record~~, title, or registration information, the individual shall be notified by the Secretary of the request and the identity of the requestor. No information shall be released to the requestor until 10 days have elapsed from the date notice

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was mailed to the individual by the Secretary. No personally ~~identifying~~~~identifiable~~ information shall be released to a requestor, unless authorized by IVC Section 2-123 or this Part.

- b) The notification, 10-day waiting period, and non-disclosure of personally ~~identifying~~~~identifiable~~ information provisions shall not apply to requests made by law enforcement officials, ~~governmental~~~~government~~ agencies, financial institutions, attorneys, insurers, employers, automobile associated businesses, family members with ~~written~~~~expressed~~ consent, the individual ~~personally~~~~himself~~, or reporters or news media, or to other business entities for purposes consistent with the Illinois Vehicle Code, ~~and entities which register with the Illinois Department of Revenue in compliance with the Retail Occupation Tax Act (86 Ill. Adm. Code 270) when requesting information based upon an existing business relationship with an individual.~~ The exemption to the notification, 10-day waiting period, and non-disclosure of personally ~~identifying~~~~identifiable~~ information provisions shall apply to the aforementioned requestors or to an authorized agent of the requestor acting within the scope of ~~his or her~~~~their~~ employment, if such use is related to the operation of a motor vehicle or public safety.
- c) Requests made by the groups outlined in subsection (b) ~~of this Section~~ shall be exempt from the notification, 10-day waiting period, and non-disclosure of personally ~~identifying~~~~identifiable~~ information requirements only if the request is made for an official business purpose, which shall be documented by the requestor on the request form submitted to the Secretary.
- d) The notification, 10-day waiting period, and non-disclosure of personally ~~identifying~~~~identifiable~~ information outlined in subsection (a) ~~of this Section~~ shall not apply to bulk sale requests ~~which are~~ made through a computer connection, computer tapes or other data processing medium. Information disclosed pursuant to this Section shall not be used for commercial solicitation purposes.
- e) Personally ~~identifying~~~~identifiable~~ information shall be withheld from exempted entities listed in subsection (b) ~~above~~ if the individual about whom an inquiry is made submits a valid court order of protection to the Secretary. This non-disclosure shall apply for the duration of the court order; however, law enforcement officials and ~~governmental~~~~government~~ agencies shall always have access to this personally ~~identifying~~~~identifiable~~ information.

(Source: Amended at 33 Ill. Reg. 3177, effective January 30, 2009)

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Section 1002.60 Access Agreement~~Contract~~

All commercial or business purchasers of the drivers, vehicle, or title lists, or driving or identification card abstracts and all entities receiving drivers, vehicle or title lists or driving or identification card abstracts in bulk or via a computer connection, shall sign an Access Agreement~~a contract~~ with the Secretary. The Access Agreement~~contract~~ shall include disclosure of the commercial use, which shall not include commercial solicitation purposes, or disclosure of the permissible use of personal information, if applicable. The Access Agreement~~contract~~ shall contain those terms the Secretary deems necessary and appropriate to protect the integrity of the lists and abstracts, including, but not limited to, a requirement that the data~~list~~ not be used for criminal or immoral purposes, that violation of any terms of the Access Agreement~~contract~~ could result in the Secretary's denial of sale of the data~~lists~~ to the purchaser for a term of 5 years and the return of the data~~vehicles, titles or drivers list~~ to the Secretary. The redisclosure of the data~~information~~ is prohibited, except to the extent necessary to effectuate the purpose for which the original disclosure of the data~~information~~ was permitted. Any authorized recipient that resells or rediscloses personal data~~information~~ covered by this Part must keep, for a period of 5 years, records identifying each person or entity that receives information and the permitted purpose for which the data~~information~~ will be used. The purchaser must make these records available to the Secretary of State upon request.

(Source: Amended at 33 Ill. Reg. 3177, effective January 30, 2009)

Section 1002.70 Public Records

- a) Subject to the federal Driver's Privacy Protection Act (18 USC 2721 et seq.) and IVC Section 625-ILCS 5/2-123, the drivers lists, title lists and vehicle lists, driving or identification card abstracts and lists of purchasers of this data~~these lists~~, are public records and may be examined and purchased for the appropriate fees for a legitimate and lawful purpose and use.
- b) The Secretary may sell the lists in their entirety on the medium the Secretary deems most economical and efficient, or in any reasonable part, such as by county or counties, age group, zip code groups, make or model of car, restriction codes, license issuance~~issue~~ data, license expiration data, city, or other governmental or geographic division. No listing shall be prepared and sold by the Secretary to any person or organization for commercial solicitation purposes. Lists shall not be available as compiled by any type~~form~~ of driver's license sanction; i.e., suspension, revocation, cancellation, or denial. No list will be prepared and sold

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~~by the Secretary for any person or organization for commercial purposes if the request is for the Secretary to extract from a larger group certain persons or types of persons to be solicited by the requestor, when the requestor, by the purchase of the larger group of names, titles, or registrations, could extract the information sought.~~

(Source: Amended at 33 Ill. Reg. 3177, effective January 30, 2009)

Section 1002.90 Social Security Numbers

- a) Social Security Numbers of persons licensed to drive or issued an identification card by the State of Illinois shall not be disclosed to any person, public or private agency, corporation, or governmental body, except as permitted by IVC Section 2-123~~the Illinois Vehicle Code (Ill. Rev. Stat. 1981, ch. 95½, par. 2-123, as amended by P.A. 83-0148, effective August 29, 1983).~~
- b) Individual drivers or identification card holders may authorize the Secretary to release to designated persons or agencies the individual's Social Security Number. This authorization shall be in a written, notarized or affirmed statement delivered to the Director of the Department of Driver Services in Springfield.

(Source: Amended at 33 Ill. Reg. 3177, effective January 30, 2009)

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- 1) Heading of the Part: Education of Homeless Children and Youth State Grant Program
- 2) Code Citation: 23 Ill. Adm. Code 245
- 3)

<u>Section Numbers</u> :	<u>Adopted Action</u> :
245.10	New Section
245.20	New Section
245.30	New Section
245.40	New Section
245.50	New Section
- 4) Statutory Authority: 105 ILCS 5/2-3.6 and implementing 105 ILCS 45
- 5) Effective Date of Rules: January 27, 2009
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted rules, 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: September 22, 2008; 32 Ill. Reg. 16240
- 10) Has JCAR issued a Statement of Objection to these rules? No
- 11) Differences between proposal and final version:

Sections 245.20(a) and 245.20(b) now include regional offices of education as eligible to be both an applicant or serve as an administrative agent.

In Section 245.10(a), the modifier "high-quality" was added before "programs".

In Section 245.30(c)(2), the phrase "list of" was removed.

Section 245.60 was eliminated from the rulemaking.

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- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? All of the agreements issued by JCAR have been made in the rulemaking.
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? Yes
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Rules: The agency received \$3 million to fund homeless education programs for Fiscal Year 2009. This appropriation was being considered at the same time as HB 2210, which would have amended the Education for Homeless Children Act [105 ILCS 45] to establish a competitive grant program to "support school districts throughout this state in facilitating the enrollment, attendance and success of homeless children and youth". The program was to complement the federal McKinney-Vento Homeless Assistance Act by limiting allowable activities under the State grant to those authorized under the federal program. In FY 2009, the State received approximately \$3.2 million under the federal program.

HB 2210, which would have established the requirements for the grant program, failed to pass out of the General Assembly due to an amendment by the Senate that was procedural in nature rather than substantive to the program. For this reason, the rules incorporated the intent of the bill by focusing the State program on the goals and requirements of the federal McKinney-Vento Act. The rules set forth the eligible applicants, proposal procedures and content, and the criteria for review and approval of proposals. Grants will be made for a three-year period; funding in subsequent years will be contingent upon a sufficient appropriation and satisfactory progress of the grantee in the preceding grant period.

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

Gina Hopper
Grants and Programs Division
Illinois State Board of Education
100 North First Street, N-242
Springfield, Illinois 62777-0001

217/524-4832

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

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NOTICE OF ADOPTED RULES

TITLE 23: EDUCATION AND CULTURAL RESOURCES

SUBTITLE A: EDUCATION

CHAPTER I: STATE BOARD OF EDUCATION

SUBCHAPTER f: INSTRUCTION FOR SPECIFIC STUDENT POPULATIONS

PART 245

EDUCATION OF HOMELESS CHILDREN AND YOUTH STATE GRANT PROGRAM

Section

245.10	Purpose and Applicability
245.20	Eligible Applicants
245.30	Application Procedures and Content
245.40	Proposal Review, Approval and Grant Award
245.50	Application Content and Approval for Continuation Programs

AUTHORITY: Implementing the Education for Homeless Children Act [105 ILCS 45] and authorized by Section 2-3.6 of the School Code [105 ILCS 5/2-3.6].

SOURCE: Old Part repealed at 29 Ill. Reg. 18462, effective October 31, 2005; new Part adopted by emergency rulemaking at 32 Ill. Reg. 16264, effective September 22, 2008, for a maximum of 150 days; new Part adopted at 33 Ill. Reg. 3190, effective January 27, 2009.

Section 245.10 Purpose and Applicability

- a) This Part establishes the procedure and criteria for approval by the State Board of Education of high-quality programs to facilitate the enrollment, attendance, and educational achievement of homeless children and youth.
- b) It is the intention of the Education of Homeless Children and Youth State Grant Program to supplement, but operate independently of, the programs funded under Subtitle B, Title VII of the federal McKinney-Vento Homeless Assistance Act (42 USC 11431 et seq.).
- c) Services provided under the grant program shall not replace the regular academic program of the school.

Section 245.20 Eligible Applicants

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- a) Proposals for grant awards under this Part may be submitted only by public school districts, public university laboratory schools approved by the State Board of Education pursuant to Section 18-8.05(K) of the School Code [105 ILCS 5/18-8.05(K)], charter schools, and regional offices of education.
- b) Each RFP shall state whether joint applications for funds may be submitted by any combination of eligible applicants, as described in subsection (a) of this Section, subject to the conditions stated in subsections (b)(1), (b)(2) and (b)(3) of this Section.
 - 1) If a joint application is submitted, then an administrative agent shall be designated from among the participating eligible applicants or a regional office of education.
 - 2) The superintendent from each of the participating school districts and the official authorized to submit a proposal on behalf of any other eligible entity as defined in subsection (a) of this Section shall sign the joint application.
 - 3) An eligible applicant shall only participate in one proposal for a State-funded homeless education program.

Section 245.30 Application Procedures and Content

- a) When an appropriation is made for the State-funded homeless education program, the State Superintendent of Education shall issue a Request for Proposals (RFP) specifying the information that applicants shall include in their proposals, informing applicants of any bidders' conferences, and requiring that proposals be submitted no later than the date specified in the RFP. The RFP shall provide at least 30 calendar days in which to submit proposals.
- b) It is the intention of the State Board of Education to approve Education of Homeless Children and Youth State Grant programs for a three-year period. Funding in each subsequent year is subject to a sufficient appropriation for the program and satisfactory progress of the grantee in the previous grant period. (See Section 245.50 of this Part.)
- c) Each RFP shall indicate the descriptive information that initial applicants will be required to provide about their proposed programs. For the purposes of this Part,

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initial applicants are those that did not receive funding under this Part in the year previous to an application or that are completing the last year in a three-year funding cycle. The proposal description shall include:

- 1) evidence of the applicant's need for assistance under this Part, to include the process used to determine the need; demographic and other statistical information; and the barriers to school enrollment, attendance and success faced by homeless children and youth to be served;
 - 2) the activities and services to be provided, which shall be limited to those set forth under Section 723(d) of the McKinney-Vento Homeless Education Assistance Improvements Act of 2001, and how the proposed activities and services will meet the needs of homeless children and youth who will be served by the program;
 - 3) how the applicant will ensure effective coordination with other providers that serve homeless families; and
 - 4) the data to be collected and methods to be used to determine the success of the program in ensuring that homeless children and youth receive the supports and services necessary for them to meet the Illinois State Goals for Learning (see 23 Ill. Adm. Code 1.Appendix D).
- d) The RFP shall require completion of a budget summary and payment schedule as well as a budget breakdown, i.e., a detailed explanation of each line item of expenditure.
 - e) Each RFP shall include such certifications, assurances and program-specific terms of the grant, as the State Board of Education may require, to be signed by the applicant that is a party to the application and submitted with the proposal.
 - f) Applicants may be requested to clarify various aspects of their proposals. The contents of the approved proposal shall be incorporated into a grant agreement to be signed by the State Superintendent of Education or designee and the superintendent of the school district or, in the case of other eligible applicants, by the authorized official.

Section 245.40 Proposal Review, Approval and Grant Award

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- a) Proposals submitted for funding to establish a State-funded homeless education program shall be evaluated in accordance with the following criteria.
- 1) There is sufficient need for the program, as evidenced by the number or proportion of students identified as eligible for program services. Convincing evidence is presented of the applicant's inability to adequately meet the needs of its homeless children and youth without the additional assistance provided pursuant to this Part. (25 points)
 - 2) The proposed activities and other services to be provided have a strong potential for helping the applicant design and continue programs that enable homeless children and youth to achieve stability and integration within the regular education programs in order to reach the same challenging State content and student performance standards to which all children and youth are held, including preparation for self-sufficiency. The proposed activities and services address effective mechanisms for involving parents or guardians of homeless children and youth in the education of their children. (35 points)
 - 3) The proposal demonstrates that effective coordination with private, non-profit entities, social services agencies and others serving homeless children and youth and their families will occur, as necessary, so that the applicant is able to provide services that are appropriate and comprehensive. (15 points)
 - 4) The proposed evaluation process is designed to assess the effectiveness of the program's activities and services in relation to the program's goals and objectives and likely to produce data that can be used to improve the program. (15 points)
 - 5) The proposed budget is consistent with the proposal's activities and appears to be cost-effective. (10 points)
- b) Priority consideration may be given to proposals with specific areas of emphasis, as identified by the State Superintendent of Education in a particular RFP.
- c) The State Superintendent of Education shall determine the amount of individual grant awards. The final award amounts shall be based upon:

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- 1) the total amount of funds available for the Education of Homeless Children and Youth State Grant Program; and
- 2) the resources requested in the top-ranked proposals, as identified pursuant to subsections (a) and (b) of this Section.

Section 245.50 Application Content and Approval for Continuation Programs

The requirements of this Section shall apply to those applicants seeking funding to continue State-funded homeless education programs beyond the initial grant period.

- a) In order to continue to operate an Education of Homeless Children and Youth State Grant program, a grantee each year shall submit an application for continuation. The application shall include at least the following:
 - 1) an overview of the program, addressing the activities and services proposed for the renewal period;
 - 2) budget information for the year in which the application is being made; and
 - 3) the certifications, assurances and program-specific terms of the grant referred to in Section 245.30(e) of this Part applicable to the renewal period.
- b) An Education of Homeless Children and Youth State Grant program shall be approved for continuation provided that:
 - 1) a need continues to exist for the program, as evidenced by proposed numbers of homeless children and youth to be served whose needs are not currently being met;
 - 2) the activities and services proposed will be effective in facilitating the enrollment, attendance, and educational success of homeless children and youth;
 - 3) the proposed budget is cost-effective, as evidenced by the cost of proposed services in relation to the numbers to be served and the services to be provided; and

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- 4) in the year previous to the continuation application, the applicant complied with the terms and conditions of any grant it received pursuant to this Part.

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- 1) Heading of the Part: Regional Offices of Education and Intermediate Services
- 2) Code Citation: 23 Ill. Adm. Code 525
- 3)

<u>Section Numbers</u> :	<u>Adopted Action</u> :
525.130	Amendment
525.160	Amendment
- 4) Statutory Authority: 105 ILCS 5/2-3.62, 3A-16 and 3A-17
- 5) Effective Date of Amendments: January 27, 2009
- 6) Does this rulemaking contain an automatic repeal date? No
- 7) Does this rulemaking contain incorporations by reference? No
- 8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.
- 9) Notice of Proposal Published in Illinois Register: October 3, 2008; 32 Ill. Reg. 16248
- 10) Has JCAR issued a Statement of Objection to these amendments? No
- 11) Differences between proposal and final version: Section 525.160(e) was amended to clarify that the rule applies to fees charged for professional development, technical assistance and other school improvement activities authorized under Section 2-3.62 of the School Code [105 ILCS 5/2-3.62] and is not limited only to charges for conferences and workshops.
- 12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? JCAR did not issue any agreements for this rulemaking.
- 13) Will this rulemaking replace any emergency rulemaking currently in effect? No
- 14) Are there any amendments pending on this Part? No
- 15) Summary and Purpose of Amendments: Beginning with Fiscal Year 2009, new Part 100 (Requirements for Accounting, Budgeting, Financial Reporting, and Auditing) has taken the place of long-standing Part 110 (Program Accounting Manual). Part 525 contains

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cross-references to Part 110, and thus, needs to be updated at this time. In addition, several other changes conform the rules to current agency procedures.

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

Patrick Murphy
Educator and School Development Division
Illinois State Board of Education
100 North First Street, E-310
Springfield, Illinois 62777-0001

217/782-2948

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

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NOTICE OF ADOPTED AMENDMENTS

TITLE 23: EDUCATION AND CULTURAL RESOURCES

SUBTITLE A: EDUCATION

CHAPTER I: STATE BOARD OF EDUCATION

SUBCHAPTER 0: MISCELLANEOUS

PART 525

REGIONAL OFFICES OF EDUCATION AND INTERMEDIATE SERVICES

Section

525.10	Advisory Boards for Regional Offices of Education
525.20	Purpose (Repealed)
525.30	Membership and Selection (Repealed)
525.40	Duties (Repealed)
525.50	Intermediate Service Centers in Cook County Outside the City of Chicago
525.60	City of Chicago Intermediate Service Center
525.100	Role of Chief Administrator
525.110	Programs and Services to be Provided
525.120	Regional Improvement Plan
525.130	Annual Application
525.140	Program Evaluation Standards and Procedures
525.150	Allocation of Funds
525.160	Fiscal Procedures

AUTHORITY: Implementing and authorized by Sections 2-3.62, 3A-16, and 3A-17 of the School Code [105 ILCS 5/2-3.62, 3A-16, and 3A-17].

SOURCE: Adopted at 18 Ill. Reg. 17447, effective November 28, 1994; amended at 21 Ill. Reg. 2172, effective January 29, 1997; amended at 28 Ill. Reg. 15487, effective November 22, 2004; amended at 33 Ill. Reg. 3198, effective January 27, 2009.

Section 525.130 Annual Application

Each Regional Office of Education and Chicago Intermediate Service Center shall submit an annual application. The application shall include the following:

- a) A letter of transmittal which identifies the Regional Office of Education and, in the case of the Chicago Intermediate Service Center Governing Board, shows that the Board has formally approved a motion granting authority to submit the application.

STATE BOARD OF EDUCATION

NOTICE OF ADOPTED AMENDMENTS

- b) A detailed annual plan for the services to be provided by the Regional Office of Education or Chicago Intermediate Service Center pursuant to Section 525.120 of this Part. This plan shall be aligned with the school improvement planning needs identified through surveys of school districts to be conducted by each Regional Office of Education when formulating the plan. Objectives along with specific activities shall be presented. Activity statements shall include:
- 1) an indication of each activity that responds to a need identified in the annual needs assessment as specified in Section 525.120(a)(2) of this Part;
 - 2) an indication of when each activity will be implemented and completed;
 - 3) an indication of who (e.g., Regional Office of Education or Intermediate Service Center staff, consultants) will conduct each activity;
 - 4) an indication of what each activity will accomplish; and
 - 5) evaluation criteria by which progress can be measured.
- c) Job descriptions for the professional and nonprofessional staff to be employed by the Regional Office of Education or Chicago Intermediate Service Center. If there will be part-time employees, the approximate percentage of time they will be assigned to activities shall be submitted. Resumes shall not be submitted.
- d) Services that may be subcontracted are those which the Regional Office of Education or Chicago Intermediate Service Center staff cannot provide.
- 1) The following information regarding subcontracts in excess of \$5,000 shall be provided to the State Board of Education prior to entering into any subcontract:
 - A) a statement of what is needed and why the staff cannot provide it;
 - B) name of the subcontractor;
 - C) the total subcontract amount;
 - D) a description of the goods and/or services to be distributed or

STATE BOARD OF EDUCATION

NOTICE OF ADOPTED AMENDMENTS

delivered;

- E) a detailed budget, including the beginning and ending dates for the proposed subcontract; and
 - F) a resume(s) if the subcontract includes professional services.
- 2) The State Superintendent of Education shall approve a subcontract when the evidence presented demonstrates that a need exists which the Regional Office of Education or Chicago Intermediate Service Center staff cannot meet and that the costs represent fair market value for the goods and/or services to be provided.
- e) Applications shall contain a budget indicating in detail each item of expenditure for the programs and services to be provided. The proposed budget shall be presented on a form provided by the State Board of Education. Expenditures shall be annually audited by ~~an independent auditor~~ [the Auditor General](#) pursuant to [Section 2-3.17a of the School Code \[105 ILCS 5/2-3.17a\]](#) and [rules of the Auditor General \(Code of Regulations; 74 Ill. Adm. Code 420.320\(c\)\)](#)~~23 Ill. Adm. Code 110.115~~.
 - f) Applications must be submitted in accordance with directions set forth by the State Superintendent within 45 days after written notice by the State Board of Education. The Regional Office of Education or Chicago Intermediate Service Center shall submit three ~~(3)~~ copies of the application to the State Superintendent, with one copy bearing the original signature of either the Regional Superintendent or Chairperson of the Governing Board, in the case of the Chicago Intermediate Service Center. No FAX copies will be accepted; however, electronic transmission may be allowed as directed by the State Superintendent of Education.
 - g) Applications shall be reviewed by State Board of Education staff. If an application does not meet the criteria set forth in Section 2-3.62 of the School Code and this Part, then State Board staff shall contact the applicant and request the submission of an amended application.
 - h) Upon determining that an application is in compliance with Section 2-3.62 of the School Code and this Part, the State Superintendent of Education shall approve the application and shall notify the Regional Superintendent or, in the case of the

STATE BOARD OF EDUCATION

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Chicago Intermediate Service Center, the Chairperson of the Governing Board and the Administrative Agent, of such approval.

(Source: Amended at 33 Ill. Reg. 3198, effective January 27, 2009)

Section 525.160 Fiscal Procedures

- a) The Regional Superintendent of Schools in each Regional Office of Education and the Administrative Agent for the Chicago Intermediate Service Center shall maintain accurate financial records. ~~The financial records shall be maintained in accordance with 23 Ill. Adm. Code 110 (Program Accounting Manual) as applicable.~~ The State Board of Education and its agents shall have full and complete access at all times during regular business hours to files, records and all other property maintained by the Regional Superintendent of Schools or Administrative Agent for programs and services provided pursuant to Section 525.110 of this Part.
- b) All purchases exceeding the amount specified in Section 10-20.21 of the School Code [105 ILCS 5/10-20.21] must be bid in accordance with that Section.
- c) The Regional Superintendent of Schools and the Administrative Agent of the Chicago Intermediate Service Center shall maintain an inventory of equipment ~~(using forms to be provided by the State Board of Education)~~ acquired with funds received directly from the State of Illinois.
- d) The Regional Superintendent of Schools in each Regional Office of Education and the Governing Board of the Chicago Intermediate Service Center shall establish travel regulations. The travel regulations shall include reimbursement rates, designation of reimbursable items, and other conditions deemed necessary.
- e) Registration ~~charges and other~~ fees for professional development, technical assistance, and other school improvement activities authorized under Section 2-3.62 of the School Code ~~conferences/workshops~~ are to be determined on a cost-recovery basis, ~~in accordance with 23 Ill. Adm. Code 110.115(f).~~ Excess funds resulting from registrations and other fees beyond the anticipated cost-recovery basis shall be deposited in a separate fund to be used solely to cover costs incurred due to less-than-anticipated registrations or to reduce the cost of similar activities.

STATE BOARD OF EDUCATION

NOTICE OF ADOPTED AMENDMENTS

- f) A maximum daily rate for consultants shall be established by the Regional Superintendents of Schools and the Governing Board of the Chicago Intermediate Service Center. The maximum daily rate for individual programs cannot exceed the rate the State Board of Education establishes in the annual application.
- ~~g) All unexpended or unobligated funds held by the Regional Office of Education or Chicago Intermediate Service Center at the end of each funding period shall be returned within 45 days to the State Board of Education.~~
- ~~g)h)~~ The Regional Superintendent, or the Administrative Agent to the Chicago Intermediate Service Center Governing Board, shall provide on a regular basis such fiscal and programmatic information (e.g., expenditures, revenues, contracts, staffing) as is necessary for the Advisory Board or Governing Board to perform its duties.

(Source: Amended at 33 Ill. Reg. 3198, effective January 27, 2009)

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

- 1) Heading of the Part: Standard Procurement
- 2) Code Citation: 44 Ill. Adm. Code 1
- 3) Section Number: 1.5037 Emergency Action:
New Section
- 4) Statutory Authority: Implementing Public Act 95-971 and authorized by The Illinois Procurement Code [30 ILCS 500]
- 5) Effective Date of Amendment: January 28, 2009
- 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: This rulemaking has no earlier effective date specified.
- 7) Date Filed with the Index Department: January 28, 2009
- 8) A copy of the emergency rulemaking, 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: Public Act 95-971 was effective January 1, 2009. This rule needs to be effective immediately so as to ensure prompt implementation of the Act.
- 10) A Complete Description of the Subjects and Issues Involved: This rulemaking provides supplemental information regarding registration requirements and requirements regarding the submission of bids/proposals and contracts, including timeframes for submission of registration certificates and the inclusion of contract certifications.
- 11) Are there any proposed rulemakings to this Part pending? No
- 12) Statement of Statewide Policy Objectives: This rulemaking will not create a State mandate for units of local government.
- 13) Information and questions regarding this emergency rulemaking shall be directed to:

Gina Wilson
Illinois Department of Central Management Services
720 Stratton Office Building

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

Springfield, Illinois 62706

217/785-1793

Or

Lynn Carter
Illinois Department of Central Management Services
Deputy General Counsel, Procurement
100 West Randolph Street, 4-607 JRTC
Chicago, Illinois 60601

312/814-1569

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

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

TITLE 44: GOVERNMENT CONTRACTS, PROCUREMENT
AND PROPERTY MANAGEMENT

SUBTITLE A: PROCUREMENT AND CONTRACT PROVISIONS

CHAPTER I: DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

PART 1

STANDARD PROCUREMENT

SUBPART A: GENERAL

Section

- 1.1 Title
- 1.5 Policy
- 1.8 Purpose and Implementation of This Part
- 1.10 Application
- 1.15 Definition of Terms Used in This Part
- 1.25 Property Rights
- 1.30 Constitutional Officers, and Legislative and Judicial Branches

SUBPART B: PROCUREMENT RULES

Section

- 1.525 Rules

SUBPART C: PROCUREMENT AUTHORITY

Section

- 1.1005 Exercise of Procurement Authority
- 1.1010 Appointment of State Purchasing Officer
- 1.1030 Associate Procurement Officers
- 1.1040 Central Procurement Authority of the CPO
- 1.1050 Procurement Authority of the SPO; Limitations
- 1.1060 Delegation
- 1.1070 Toll Highway Authority
- 1.1075 Department of Natural Resources
- 1.1080 Illinois Mathematics and Science Academy

SUBPART D: PUBLICIZING PROCUREMENT ACTIONS

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

Section

- 1.1510 Illinois Procurement Bulletin
- 1.1525 Bulletin Content
- 1.1550 Official State Newspaper
- 1.1560 Supplemental Notice
- 1.1570 Error in Notice
- 1.1580 Direct Solicitation
- 1.1590 Retention of Bulletin Information

SUBPART E: SOURCE SELECTION AND CONTRACT FORMATION

Section

- 1.2005 General Provisions
- 1.2010 Competitive Sealed Bidding
- 1.2012 Multi-Step Sealed Bidding
- 1.2015 Competitive Sealed Proposals
- 1.2020 Small Purchases
- 1.2025 Sole Economically Feasible Source Procurement
- 1.2030 Emergency Procurements
- 1.2035 Competitive Selection Procedures for Professional and Artistic Services
- 1.2036 Other Methods of Source Selection
- 1.2037 Tie Bids and Proposals
- 1.2038 Mistakes
- 1.2040 Cancellation of Solicitations; Rejection of Bids or Proposals

SUBPART F: SUPPLIERS, PREQUALIFICATION AND RESPONSIBILITY

Section

- 1.2043 Suppliers
- 1.2044 Vendor List/Required Use
- 1.2045 Prequalification
- 1.2046 Responsibility

SUBPART G: BID, PROPOSAL AND PERFORMANCE SECURITY

Section

- 1.2047 Security Requirements

SUBPART H: SPECIFICATIONS AND SAMPLES

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

Section
1.2050 Specifications and Samples

SUBPART I: CONTRACT TYPE

Section
1.2055 Types of Contracts

SUBPART J: DURATION OF CONTRACTS

Section
1.2060 Duration of Contracts – General

SUBPART K: CONTRACT MATTERS

Section
1.2560 Prevailing Wage
1.2570 Equal Employment Opportunity; Affirmative Action
1.2575 Subcontractors

SUBPART L: CONTRACT PRICING

Section
1.2800 All Costs Included

SUBPART M: CONSTRUCTION AND
CONSTRUCTION RELATED PROFESSIONAL SERVICES

Section
1.3005 Construction and Construction Related Professional Services

SUBPART N: REAL PROPERTY LEASES AND CAPITAL IMPROVEMENT LEASES

Section
1.4005 Real Property Leases and Capital Improvement Leases

SUBPART O: PREFERENCES

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

- Section
1.4505 Procurement Preferences
1.4510 Resident Bidder Preference
1.4530 Correctional Industries
1.4535 Sheltered Workshops for the Disabled
1.4540 Gas Mileage
1.4545 Small Business
1.4570 Contracting with Businesses Owned and Controlled by Minorities, Females and Persons with Disabilities
1.4575 Domestic Products

SUBPART P: ETHICS

- Section
1.5013 Conflicts of Interest
1.5015 Negotiations for Future Employment
1.5020 Exemptions
1.5030 Revolving Door
1.5035 Disclosure of Financial Interests and Potential Conflicts of Interest
[1.5037 Vendor Registration, Certification and Prohibition on Political Contributions](#)
[EMERGENCY](#)

SUBPART Q: CONCESSIONS

- Section
1.5310 Concessions

SUBPART R: COMPLAINTS, PROTESTS AND REMEDIES

- Section
1.5510 Complaints Against Vendors
1.5520 Suspension
1.5530 Resolution of Contract Controversies
1.5540 Violation of Law or Rule
1.5550 Protests

SUBPART S: SUPPLY MANAGEMENT AND DISPOSITIONS

Section

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

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1.6010 Supply Management and Dispositions

SUBPART T: GOVERNMENTAL JOINT PURCHASING

Section

1.6500 General
1.6510 No Agency Relationship
1.6520 Obligations of Participating Governmental Units
1.6530 Centralized Contracts – Estimated Quantities
1.6535 Centralized Contracts – Definite Quantities

SUBPART U: MISCELLANEOUS PROVISIONS OF GENERAL APPLICABILITY

Section

1.7000 Severability
1.7010 Government Furnished Property
1.7015 Inspections
1.7020 Records and Audits
1.7025 Written Determinations
1.7030 No Waiver of Sovereign Immunity

AUTHORITY: The Illinois Procurement Code [30 ILCS 500].

SOURCE: Adopted at 7 Ill. Reg. 100, effective December 17, 1982; amended at 7 Ill. Reg. 13481, effective October 4, 1983; amended at 7 Ill. Reg. 13844, effective October 12, 1983; codified at 8 Ill. Reg. 14941; Sections 1.2210, 1.2220, 1.2230, 1.2240 recodified to Section 1.2210 at 9 Ill. Reg. 6118; amended at 10 Ill. Reg. 923, effective January 2, 1986; amended at 10 Ill. Reg. 18707, effective October 22, 1986; amended at 11 Ill. Reg. 7225, effective April 6, 1987; amended at 11 Ill. Reg. 7595, effective April 14, 1987; amended at 13 Ill. Reg. 17804, effective November 7, 1989; emergency amendment at 16 Ill. Reg. 13118, effective August 7, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 600, effective January 5, 1993; amended at 17 Ill. Reg. 14576, effective August 27, 1993; amended at 20 Ill. Reg. 9015, effective July 1, 1996; old Part repealed by emergency rulemaking at 22 Ill. Reg. 12632, effective July 1, 1998, for a maximum of 150 days, and new Part adopted by emergency rulemaking at 22 Ill. Reg. 12726, effective July 1, 1998, for a maximum of 150 days; old Part repealed and new Part adopted at 22 Ill. Reg. 20875, effective November 25, 1998; emergency amendment at 23 Ill. Reg. 2812, effective February 16, 1999, for a maximum of 150 days; emergency expired on July 15, 1999; emergency amendment at 23 Ill. Reg. 5869, effective April 29, 1999, for a maximum of 150 days; amended at 23 Ill. Reg. 7075, effective June 7, 1999;

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

amended at 24 Ill. Reg. 1900, effective January 21, 2000; amended at 26 Ill. Reg. 13189, effective August 23, 2002; emergency amendment at 29 Ill. Reg. 20540, effective December 2, 2005, for a maximum of 150 days; emergency amendment repealed by emergency rulemaking at 30 Ill. Reg. 5673, effective March 7, 2006, for the balance of the 150 days; emergency expired August 3, 2006; amended at 30 Ill. Reg. 138, effective December 22, 2005; amended at 30 Ill. Reg. 13378, effective July 25, 2006; amended at 30 Ill. Reg. 17305, effective October 20, 2006; amended at 30 Ill. Reg. 18635, effective November 17, 2006; emergency amendment at 33 Ill. Reg. 3205, effective January 28, 2009, for a maximum of 150 days.

SUBPART P: ETHICS

Section 1.5037 Vendor Registration, Certification and Prohibition on Political Contributions
EMERGENCY

- a) Introduction
Illinois law (Public Act 95-971; 10 ILCS 5/9-35; and 30 ILCS 500/20-160 and 50-37) restricts political contributions by vendors and affiliated entities; requires registration with the State Board of Elections; requires a copy of the registration certificate to be submitted with or must accompany bids/proposals and contracts; and requires solicitation and contract certifications relative to the requirements of the law. These rules supplement requirements found in the Act and do not excuse compliance with any of those requirements.

- b) General Registration Requirements
 - 1) These requirements apply to contracts, bids and proposals that are subject to the Illinois Procurement Code:
 - A) This value is calculated on a calendar-year basis.
 - B) These requirements generally apply to a vendor whose existing state contracts have an aggregate value in excess of \$50,000, or whose aggregate value of bids/proposals for state contracts exceeds \$50,000, or whose aggregate combination of contracts and bids/proposals exceeds \$50,000.
 - C) Bids and proposals include pending and unsuccessful bids and proposals.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

- D) Bids/proposals referenced in this Section are those submitted in response to a competitive solicitation that is posted to the Illinois Procurement Bulletin on or after January 1, 2009 regardless of the value assigned to the procurement.
- 2) On a calendar-year basis, each vendor or potential vendor must keep track of the value of contracts and bids/proposals. Vendors must register with the State Board of Elections when the vendor determines that the value of the contracts and bids/proposals meets the threshold for registration.
- 3) The State Board of Elections maintains the official registration records. All requests for copies of a vendor's registration certificate or other registration information should be directed to the State Board of Elections. Requests made to a procuring agency or to the Chief Procurement Officer are subject to Freedom of Information Act disclosure restrictions.
- 4) An "executive employee" means:
- A) the President, Chairman of the Board, Chief Executive Officer and/or other individuals that fulfill equivalent duties as the President, Chairman of the Board, or Chief Executive Officer; and/or
- B) any employee whose compensation is determined directly, in whole or in part, by the award or payment of contracts by a State agency to the entity employing the employee, irrespective of the employee's title or status in the business entity. For the purposes of this subsection, compensation determined directly by award or payment of contracts means a payment over and above regular salary that would not be made if it were not for the award of the contract.
- c) Bids and Proposals
- 1) A copy of the registration certificate must be submitted with bids/proposals as set forth in this subsection (c).

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

- 2) For bids and proposals due January 1, 2009 through February 2, 2009, the registration certificate must be submitted with the bid/proposal or it may be submitted by the earlier of February 2, 2009 or the contract execution.
 - 3) For bids and proposals due February 3, 2009 through August 1, 2009, the registration certificate must be submitted with the bid/proposal, or it may accompany the bid/proposal, but if it accompanies the bid, it must be submitted within 5 working days of the bid/proposal opening. If the registration certificate is not timely submitted, the procuring agency shall reject the bid/proposal.
 - 4) The procuring agency shall not reject a bid/proposal if absence of the registration certificate is the result of delay or error by the state, but shall require the certificate before making an award.
- d) Contracts
A copy of the registration certificate must be in the procurement file as set forth in this subsection (d), unless the Vendor certifies it is not required to register.
- 1) Contracts entered into beginning January 1, 2009 through February 2, 2009 must include the contract certifications provided by law, and the file must include the registration certificate issued by the State Board of Elections.
 - 2) Vendors required to register that have contracts that were fully executed prior to January 1, 2009 and that are in effect on or after January 1, 2009 must register with the State Board of Elections by February 2, 2009.
 - 3) Vendors required to register that have contracts that were fully executed between January 1, 2009 and February 2, 2009 must register with the State Board of Elections by February 2, 2009 and must make the contract certifications required by law.
 - 4) For contract renewals and extensions, if the value of the renewal or extension by itself, or in combination with the contract being renewed/extended and other contracts and bids/proposals exceeds \$50,000, the vendor must provide the registration certificate and make the appropriate certification, it has not already done so.

DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

NOTICE OF EMERGENCY AMENDMENT

- 5) For indefinite quantity/estimated value contracts, a vendor who is otherwise not required to register shall register when the value of orders placed pursuant to an indefinite/estimated value contract plus all other contracts and bids/proposals exceeds \$50,000.
- 6) For contract amendments, if the value of the amendment, by itself or in combination with the contract being renewed plus other contracts and bids/proposals exceeds \$50,000, the vendor must provide the registration certificate and make the appropriate certification, if it has not already done so.
- 7) Any contracts mistakenly executed in violation of this Section must be amended to include the contract certifications, and the vendor must supply the registration certificate. If any violation by the vendor is not cured within 5 business days of receipt of notification of the violation, the contract is voidable by the state without penalty.
- 8) The contract certification required by Public Act 95-971 shall be included in or added to each contract that must be filed with the State Comptroller pursuant to Section 20-80 of the Illinois Procurement Code. Each contract that need not be filed with the State Comptroller pursuant to Section 20-80 of the Illinois Procurement Code, whether oral or written, shall be deemed to include the contract certification required by Public Act 95-971. Agencies may require written confirmation of the rule-imposed certification at any time.

(Source: Added by emergency rulemaking at 33 Ill. Reg. 3205, effective January 28, 2009, for a maximum of 150 days)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF WITHDRAWAL OF PROPOSED AMENDMENTS

- 1) Heading of the Part: Eligibility
- 2) Code Citation: 89 Ill. Adm. Code 682
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
682.200	Withdrawal
682.500	Withdrawal
- 4) Date Notice of Proposed Amendments Published in the Illinois Register: November 7, 2008; 32 Ill. Reg. 17296
- 5) Reason for the Withdrawal: The Department of Human Services has been informed of issues regarding the spousal impoverishment language of this rulemaking. Therefore, the Department has decided to withdraw this rulemaking to investigate the issues and revise the rulemaking, if necessary.

ILLINOIS RACING BOARD

NOTICE OF WITHDRAWAL OF PROPOSED RULES

- 1) Heading of the Part: Self-Exclusion List
- 2) Code Citation: 11 Ill. Adm. Code 453
- 3)

<u>Section Numbers</u> :	<u>Proposed Action</u> :
453.10	Withdrawal
453.20	Withdrawal
453.30	Withdrawal
453.40	Withdrawal
453.50	Withdrawal
453.60	Withdrawal
453.70	Withdrawal
453.80	Withdrawal
453.90	Withdrawal
453.100	Withdrawal
- 4) Date Notice of Proposed Rules Published in the Illinois Register: December 1, 2008; 32 Ill. Reg. 18289
- 5) Reason for the Withdrawal: After consultation with affected parties, the Board has agreed to pursue alternative rulemaking.

STATE BOARD OF ELECTIONS

NOTICE OF WITHDRAWAL OF PROPOSED AMENDMENT

- 1) Heading of the Part: Registration of Voters
- 2) Code Citation: 26 Ill. Adm. Code 216
- 3) Section Number: 216.50 Proposed Action:
Withdrawal
- 4) Date Notice of Proposed Amendment was Published in the Illinois Register: 32 Ill Reg. 9124; June 27, 2008
- 5) Reason for the Withdrawal: The SBEL Board lacks statutory authority to permit election authorities in counties having populations of 500,000 or more to cancel voters' registration based on an obituary listing, coupled with confirmation by the funeral director.

Under Section 100/5-40(e) of the IAPA, this rulemaking will expire following its one year adoption period on June 27, 2009. The SBEL would like to withdraw the rulemaking and seek legislation to implement the procedure as described in this rulemaking and resubmit the proposed amendatory language at a later date.

JOINT COMMITTEE ON ADMINISTRATIVE RULES
FEBRUARY AGENDA

JOINT COMMITTEE ON ADMINISTRATIVE RULES

SCHEDULED MEETING:

STRATTON OFFICE BUILDING
ROOM C-1
SPRINGFIELD, ILLINOIS
10:00 A.M.
FEBRUARY 18, 2009

NOTICES: The scheduled date and time for the JCAR meeting are subject to change. Due to *Register* submittal deadlines, the Agenda below may be incomplete. Other items not contained in this published Agenda are likely to be considered by the Committee at the meeting and items from the list can be postponed to future meetings.

If members of the public wish to express their views with respect to a rulemaking, they should submit written comments to the Office of the Joint Committee on Administrative Rules at the following address:

*Joint Committee on Administrative Rules
700 Stratton Office Building
Springfield, Illinois 62706
Email: jcar@ilga.gov
Phone: 217/785-2254*

RULEMAKINGS CURRENTLY BEFORE JCAR

PROPOSED RULEMAKINGS

Aging

1. Community Care Program (89 Ill. Adm. Code 240)
 - First Notice Published: 32 Ill. Reg. 7445 – 5/16/08
 - Expiration of Second Notice: 3/8/09

Central Management Services

2. Electronic Commerce Security Act (14 Ill. Adm. Code 105)
 - First Notice Published: 32 Ill. Reg. 12115 – 8/1/08

JOINT COMMITTEE ON ADMINISTRATIVE RULES
FEBRUARY AGENDA

-Expiration of Second Notice: 3/11/09

Education

3. Early Childhood Block Grant (23 Ill. Adm. Code 235)
 - First Notice Published: 32 Ill. Reg. 16236 – 10/3/08
 - Expiration of Second Notice: 2/20/09
4. Reading Improvement Program (23 Ill. Adm. Code 260)
 - First Notice Published: 32 Ill. Reg. 17408 – 11/7/08
 - Expiration of Second Notice: 3/14/09

Elevator Safety Review Board

5. Illinois Elevator Safety Rules (41 Ill. Adm. Code 1000)
 - First Notice Published: 32 Ill. Reg. 18465 – 12/5/08
 - Expiration of Second Notice: 3/12/09

Emergency Management Agency

6. Americans With Disabilities Act Grievance Procedure (4 Ill. Adm. Code 175)
 - First Notice Published: 32 Ill. Reg. 17875 – 11/21/08
 - Expiration of Second Notice: 3/6/09
7. Fees For Radioactive Material Licensees and Registrants (32 Ill. Adm. Code 331)
 - First Notice Published: 32 Ill. Reg. 17882 – 11/21/08
 - Expiration of Second Notice: 3/5/09
8. Particle Accelerators (32 Ill. Adm. Code 390)
 - First Notice Published: 32 Ill. Reg. 17910 – 11/21/08
 - Expiration of Second Notice: 3/5/09
9. Notices, Instructions and Reports to Workers; Inspections (32 Ill. Adm. Code 400)
 - First Notice Published: 32 Ill. Reg. 17917 – 11/21/08
 - Expiration of Second Notice: 3/5/09
10. Safe Operation of Nuclear Facility Boilers and Pressure Vessels (32 Ill. Adm. Code 505)
 - First Notice Published: 32 Ill. Reg. 13695 – 8/22/08
 - Expiration of Second Notice: 3/8/09

JOINT COMMITTEE ON ADMINISTRATIVE RULES
FEBRUARY AGENDA

Financial and Professional Regulation

11. Commission Accounting or Direct Premium (Repealer) (50 Ill. Adm. Code 912)
 - First Notice Published: 32 Ill. Reg. 16993 – 10/31/08
 - Expiration of Second Notice: 3/13/09
12. Anticipated Salvage and Subrogation Recoverable (Repealer) (50 Ill. Adm. Code 927)
 - First Notice Published: 32 Ill. Reg. 16997 – 10/31/08
 - Expiration of Second Notice: 3/13/09
13. Medical Practice Act of 1987 (68 Ill. Adm. Code 1285)
 - First Notice Published: 32 Ill. Reg. 4127 – 3/21/08
 - Expiration of Second Notice: 3/13/09

Healthcare and Family Services

14. Medical Payment (89 Ill. Adm. Code 140)
 - First Notice Published: 32 Ill. Reg. 14003 – 8/29/08
 - Expiration of Second Notice: 2/18/09
15. Practice in Administrative Hearings (89 Ill. Adm. Code 104)
 - First Notice Published: 32 Ill. Reg. 13751 – 8/22/08
 - Expiration of Second Notice: 2/18/09

Public Health

16. Child Health Examination Code (77 Ill. Adm. Code 665)
 - First Notice Published: 32 Ill. Reg. 8545 – 6/13/08
 - Expiration of Second Notice: 3/13/09

Racing Board

17. Substance Abuse (11 Ill. Adm. Code 508)
 - First Notice Published: 32 Ill. Reg. 17383 – 11/7/08
 - Expiration of Second Notice: 2/18/09
18. Starting (11 Ill. Adm. Code 1415)
 - First Notice Published: 32 Ill. Reg. 17390 – 11/7/08
 - Expiration of Second Notice: 2/18/09

JOINT COMMITTEE ON ADMINISTRATIVE RULES
FEBRUARY AGENDA

Revenue

19. Retailers' Occupation Tax (86 Ill. Adm. Code 130)
 - First Notice Published: 32 Ill. Reg. 15763 – 9/26/08
 - Expiration of Second Notice: 2/18/09
20. Retailers' Occupation Tax (86 Ill. Adm. Code 130)
 - First Notice Published: 32 Ill. Reg. 17654 – 11/14/08
 - Expiration of Second Notice: 2/18/09

Secretary of State

21. Illinois State Library Grant Programs (23 Ill. Adm. Code 3035)
 - First Notice Published: 32 Ill. Reg. 14707 – 9/12/08
 - Expiration of Second Notice: 3/1/09

State Fire Marshal

22. Storage, Transportation, Sale and Use of Petroleum and Other Regulated Substances (41 Ill. Adm. Code 170)
 - First Notice Published: 32 Ill. Reg. 14924 – 9/19/08
 - Expiration of Second Notice: 2/18/09
23. Policy and Procedures Manual For Fire Protection Personnel (41 Ill. Adm. Code 141)
 - First Notice Published: 32 Ill. Reg. 18485 – 12/5/08
 - Expiration of Second Notice: 3/12/09
24. Storage, Transportation, Sale and Use of Petroleum and Other Regulated Substances (41 Ill. Adm. Code 170)
 - First Notice Published: 32 Ill. Reg. 17019 – 10/31/08
 - Expiration of Second Notice: 3/8/09

Teachers' Retirement System

25. The Administration and Operation of the Teachers' Retirement System (80 Ill. Adm. Code 1650)
 - First Notice Published: 32 Ill. Reg. 16750 – 10/17/08
 - Expiration of Second Notice: 3/7/09

EMERGENCY RULEMAKINGS

JOINT COMMITTEE ON ADMINISTRATIVE RULES
FEBRUARY AGENDA

Elections

26. Campaign Financing (26 Ill. Adm. Code 100) (Emergency)
-Notice Published: 33 Ill. Reg. 332 – 1/9/09

Healthcare and Family Services

27. Illinois Cares Rx Program (89 Ill. Adm. Code 119) (Emergency)
-Notice Published: 33 Ill. Reg. 1220 – 1/16/09

Housing Development Authority

28. Homeowner Mortgage Revenue Bond Program (47 Ill. Adm. Code 260) (Emergency)
-Notice Published: 33 Ill. Reg. 1512 – 1/23/09

PEREMPTORY RULEMAKINGS

Agriculture

29. Meat and Poultry Inspection Act (8 Ill. Adm. Code 125) (Peremptory)
-Notice Published: 33 Ill. Reg. 1230 – 1/16/09

Healthcare and Family Services

30. Hospital Services (89 Ill. Adm. Code 148) (Peremptory)
-Notice Published: 33 Ill. Reg. 1538 – 1/23/09

ADOPTED RULEMAKING

Auditor General

31. Public Information, Rulemaking, Organization and Personnel (2 Ill. Adm. Code 600)
-Notice Published: 33 Ill. Reg. 1704 – 1/30/09

EXEMPT RULEMAKINGS

Pollution Control Board

32. Primary Drinking Water Standards (35 Ill. Adm. Code 611)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
FEBRUARY AGENDA

-Proposed Date: 9/26/08

-Adopted Date: 1/16/09

33. Hazardous Waste Management System: General (35 Ill. Adm. Code 720)
-Proposed Date: 9/26/08
-Adopted Date: 1/16/09
34. Identification and Listing of Hazardous Waste (35 Ill. Adm. Code 721)
-Proposed Date: 9/26/08
-Adopted Date: 1/16/09
35. Standards for Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities (35 Ill. Adm. Code 724)
-Proposed Date: 9/26/08
-Adopted Date: 1/16/09
36. Interim Status Standards for Owners and Operators of Hazardous Waste Treatment, Storage, and Disposal Facilities (35 Ill. Adm. Code 725)
-Proposed Date: 9/26/08
-Adopted Date: 1/16/09
37. Land Disposal Restrictions (35 Ill. Adm. Code 728)
-Proposed Date: 9/26/08
-Adopted Date: 1/16/09

AGENCY RESPONSES

Children and Family Services

38. Foster Parent Code (89 Ill. Adm. Code 340; 32 Ill. Reg. 8063)

State Board of Education

39. Secondary Agricultural Education Program (23 Ill. Adm. Code Subtitle A, Chapter I)

Workers' Compensation Commission

40. Miscellaneous (50 Ill. Adm. Code 7110; 32 Ill. Reg. 3213)

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of January 27, 2009 through February 2, 2009 and have been scheduled for review by the Committee at its February 18, 2009 or March 17, 2009 meetings. 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>
3/12/09	<u>Elevator Safety Review Board</u> , Illinois Elevator Safety Rules (41 Ill. Adm. Code 1000)	12/5/08 32 Ill. Reg. 18465	2/18/09
3/12/09	<u>State Fire Marshal</u> , Policy and Procedures Manual For Fire Protection Personnel (41 Ill. Adm. Code 141)	12/5/08 32 Ill. Reg. 18485	2/18/09
3/13/09	<u>Department of Financial and Professional Regulation</u> , Commission Accounting for Direct Premium (Repealer) (50 Ill. Adm. Code 912)	10/31/08 32 Ill. Reg. 16993	2/18/09
3/13/09	<u>Department of Financial and Professional Regulation</u> , Anticipated Salvage and Subrogation Recoverable (Repealer) (50 Ill. Adm. Code 927)	10/31/08 32 Ill. Reg. 16997	2/18/09
3/13/09	<u>Department of Public Health</u> , Child Health Examination Code (77 Ill. Adm. Code 665)	6/13/08 32 Ill. Reg. 8545	2/18/09
3/13/09	<u>Department of Financial and Professional Regulation</u> , Medical Practice Act of 1987 (68 Ill. Adm. Code 1285)	3/21/08 32 Ill. Reg. 4127	2/18/09

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

3/14/09	<u>State Board of Education</u> , Reading Improvement Program (23 Ill. Adm. Code 260)	11/7/08 32 Ill. Reg. 17408	2/18/09
3/18/09	<u>Environmental Protection Agency</u> , Testing Fees for Analytical Services (35 Ill. Adm. Code 691)	12/12/08 32 Ill. Reg. 18916	3/17/09

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

Pursuant to the provisions of 20 ILCS 1605/7.1, the Illinois Department of Revenue, Lottery Division, shall publish each January in the Illinois Register a list of all game-specific rules, play instructions, directives, operations manuals, brochures, or other game-specific publications issued by the Division during the previous year. Following is the list of game-specific materials published by the Lottery during calendar year 2008.

Standard Instant Game Rules

On-Line Game Rules

Mega Millions Game Rules

Millionaire Raffle Game Rules effective February 21, 2008 – March 17, 2008

Millionaire Raffle Game Rules effective October 3, 2008 – October 31, 2008

Green Ball Double Draw Promotion Official Rules and Procedures (December 2008)

Golden Tee® Closest to the Pin Tournament Promotion

Deal or No Deal™ Second Chance Promotion Official Rules & Procedures

Deal or No Deal™ Hollywood Trip Drawing Procedures

Deal or No Deal™ \$1 Million Drawing Procedures

Live Like a Chicago Bull for a Day Promotion Official Rules & Procedures

Boleto Gigante (Big Ticket) Promotion 2008 Official Rules & Procedures

Boleto Gigante (Big Ticket) Promotion 2008 Official Drawing Procedures

Big Ticket to Universal Orlando Resort Promotional Poster

Replay for Riches 2nd Chance Promotion Official Rules & Procedures

Replay for Riches Promotion Drawing Procedures

Replay for Riches Addendum to Official Rules & Procedures

On-Line Drawing Procedures Supplemental Instructions for Green Ball Double Draw

Instant Game Prize List

2008 Winning Numbers Lists (Pick 3, Pick 4, Little Lotto, Lotto, Mega Millions, Millionaire Raffle)

2008 Winning Numbers in Order Drawn (Little Lotto, Lotto, Mega Millions)

Lottery Financial History, Sales by Game/Where Your Dollar Goes

Official How to Play brochure (Mega Millions, Lotto, Little Lotto, Pick 3/Pick 4 and Instant)

Chances of Winning Lotto, Little Lotto or Mega Millions

Lotto and Little Lotto Subscription Forms

Record North American Jackpots

Top Big Game/Mega Millions Jackpots

Top Lotto Jackpots

Top Illinois Jackpots

Retailer Newsletter

Copies of the foregoing may be obtained by submitting a written request to:

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

Freedom of Information Officer
Illinois Department of Revenue
101 West Jefferson, MC 6-595
Springfield, Illinois 62702

PROCLAMATIONS

Executive Order No. 1
Governor Pat Quinn
January 30, 2009

WHEREAS, as Governor of the State of Illinois, I have no higher responsibility to the People than to take tangible and immediate steps to remedy what has become a "crisis of integrity"; and

WHEREAS, while serving as Lieutenant Governor, I created an advisory body of people on January 16, 2009, having the responsibility to conduct a thorough review of ethics in government, charged with proposing policy solutions by a date certain; and

WHEREAS, having assumed the Office of Governor, it is my express desire to reaffirm my profound commitment to ethics in government by reestablishing the Commission under the auspices of the Governor's Office, having the duties, and operating under the same terms and conditions set forth in the Executive Order of the Lieutenant Governor No. 1 of January 16, 2009, with the technical changes set forth herein;

THEREFORE, I, Patrick J. Quinn, Governor of Illinois, pursuant to the authority vested in me by Article V of the Constitution of Illinois of 1970, hereby order as follows:

I. CREATION

Pursuant to the terms of Executive Order No. 1 of the Lieutenant Governor of January 16, 2009, the Illinois Reform Commission was created. By the terms of this executive order, the Commission is hereby reconstituted as an independent advisory body having the duties set forth herein, with respect to the Office of Governor.

II. PURPOSE

The purpose of the Commission is to undertake a focused evaluation of both existing Illinois law and the operational practices of the State of Illinois from the perspective of ethics in government, proposing, as the Commission deems appropriate, amendments to existing law. In addition, the Commission shall:

- a. Propose, as it deems appropriate, new legislation on subject matters on which there is currently no governing law or insufficient governing law, as well as other policy or operational reforms; and
- b. Draft, to the extent feasible, proposed statutory language, new or amended administrative regulations, and other documents as the Commission deems

PROCLAMATIONS

appropriate, or outlines of any such documents, implementing the Commission's policy recommendations; and

- c. Submit, not later than April 26, 2009, an initial report outlining its findings and recommendations to the people of Illinois and to the Governor, and, not later than May 31, 2009, any supplementary reports the Commission deems appropriate; and
- d. Ensure, with the logistical assistance of the Office of the Governor, that the report and recommended reforms of the Commission are available to the public; and
- e. Conduct its business at regular meetings, open to the public, in accordance with the Illinois Open Meetings Act (5 ILCS 120/1 *et. seq.*) (*see supra* Section V).

III. MEMBERSHIP

- a. The Commission shall be composed of a Chairperson and Commissioners appointed pursuant to the terms of Executive Order No. 1 of the Lieutenant Governor of January 16, 2009.

IV. INDEPENDENCE

- a. The Commission shall function as an independent advisory body, with the discretion to arrange its affairs and proceedings in the manner it deems appropriate.
- b. The Commission may, at its discretion, appoint individuals to serve as staff persons.
- c. The Governor's Office shall, upon the request of the Chairperson, provide administrative and technical support to the operations of the Commission.

V. TRANSPARENCY

- a. In addition to whatever policies or procedures it may adopt, all operations of the Commission will be subject to the provisions of the Illinois Freedom of Information Act (5 ILCS 430/1 *et. seq.*) and the Illinois Open Meetings Act (5 ILCS 120/1 *et. seq.*). This section shall not be construed so as to preclude other statutes from applying to the Commission and its activities.

VI. EFFECTIVE DATE

PROCLAMATIONS

- a. This Order shall take effect immediately upon its execution.

Wherefore I, Pat Quinn, have affixed my signature to this Order on this, the Thirtieth Day of January, 2009.

Issued: January 30, 2009.

Filed: January 30, 2009

ILLINOIS ADMINISTRATIVE CODE Issue Index - With Effective Dates

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