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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 2014

Issue#	Rules Due Date	Date of Issue
1	December 23, 2013	January 3, 2014
2	December 30, 2013	January 10, 2013
3	January 6, 2014	January 17, 2014
4	January 13, 2014	January 24, 2014
5	January 21, 2014	January 31, 2014
6	January 27, 2014	February 7, 2014
7	February 3, 2014	February 14, 2014
8	February 10, 2014	February 21, 2014
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11	March 3, 2014	March 14, 2014
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14	March 24, 2014	April 4, 2014
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47	November 10, 2014	November 21, 2014
48	November 17, 2014	December 1, 2014
49	November 24, 2014	December 5, 2014
50	December 1, 2014	December 12, 2014
51	December 8, 2014	December 19, 2014
52	December 15, 2014	December 26, 2014

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Community Care Program

2) Code Citation: 89 Ill. Adm. Code 240

3)

Section Numbers:	Proposed Action:
240.120	Amend
240.237	New
240.741	New
240.945	Amend
240.1505	Amend
240.1543	New
240.1544	New
240.1600	Amend
240.1650	Amend
240.1955	Amend
240.1957	New

4) Statutory Authority: 20 ILCS 10/4.01(11) and 4.02

5) A Complete Description of the Subjects and Issues Involved: This rulemaking will add automated medication dispenser (AMD) service as a core service under the Community Care Program (CCP).

Table of Contents: Adds references for new sections.

Section 240.120: Adds AMD as a new service provided under the CCP.

Section 240.237: Describes the applicable service components required of prospective AMD service provider agencies.

Section 240.741: Establishes eligibility requirements regarding the need for AMD service.

Section 240.945: Updates terminology.

Section 240.1505: Updates terminology. Adds necessary cross-references for AMD service and required experience for prospective AMD service provider agencies in administrative requirements for provider certification.

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

Section 240.1543: Lists the minimum equipment specifications for AMD service.

Section 240.1544: Describes applicable administrative requirements for AMD providers.

Section 240.1600: Updates terminology. Clarifies on-site review process in provider agency certification.

Section 240.1650: Updates terminology. Adds applicable cross-references for AMD service in provisions addressing provider service violations.

Section 240.1955: Sets forth fixed unit rates of reimbursement for AMD and emergency home response services provided by the same provider. Describes rate-setting methodology.

Section 240.1957: Sets forth the fixed unit rates of reimbursement for AMD service. Describes rate-setting methodology.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? Yes

10) Are there any other proposed rulemakings pending on this Part? Yes

Section Number:	Proposed Action:	*Illinois Register* Citation:
240.1530	Amendment	37 Ill. Reg. 10738, July 19, 2013

11) Statement of Statewide Policy Objective: This rulemaking does not create or expand any State mandate.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may submit written comments on this proposed rulemaking within 45 days after the date of publication of this notice to:

Karen Alice Kloppe
Deputy General Counsel

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

Illinois Department on Aging
One Natural Resources Way, #100
Springfield, IL 62702-1271

217/785-3346

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Prospective service provider agencies for AMD service under the Community Care Program

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 2012

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

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

SOURCE: Emergency rules adopted at 4 Ill. Reg. 1, p. 67, effective December 20, 1979, for a maximum of 150 days; adopted at 4 Ill. Reg. 17, p. 151, effective April 25, 1980; amended at 4 Ill. Reg. 43, p. 86, effective October 15, 1980; emergency amendment at 5 Ill. Reg. 1900,

effective February 18, 1981, for a maximum of 150 days; amended at 5 Ill. Reg. 12090, effective October 26, 1981; emergency amendment at 6 Ill. Reg. 8455, effective July 6, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 14953, effective December 1, 1982; amended at 7 Ill. Reg. 8697, effective July 20, 1983; codified at 8 Ill. Reg. 2633; amended at 9 Ill. Reg. 1739, effective January 29, 1985; amended at 9 Ill. Reg. 10208, effective July 1, 1985; emergency amendment at 9 Ill. Reg. 14011, effective August 29, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 5076, effective March 15, 1986; recodified at 12 Ill. Reg. 7980; amended at 13 Ill. Reg. 11193, effective July 1, 1989; emergency amendment at 13 Ill. Reg. 13638, effective August 18, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 17327, effective November 1, 1989; amended at 14 Ill. Reg. 1233, effective January 12, 1990; amended at 14 Ill. Reg. 10732, effective July 1, 1990; emergency amendment at 15 Ill. Reg. 2838, effective February 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 10351, effective July 1, 1991; emergency amendment at 15 Ill. Reg. 14593, effective October 1, 1991, for a maximum of 150 days; emergency amendment at 15 Ill. Reg. 17398, effective November 15, 1991, for a maximum of 150 days; emergency amendment suspended at 16 Ill. Reg. 1744; emergency amendment modified in response to a suspension by the Joint Committee on Administrative Rules and reinstated at 16 Ill. Reg. 2943; amended at 15 Ill. Reg. 18568, effective December 13, 1991; emergency amendment at 16 Ill. Reg. 2630, effective February 1, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 2901, effective February 6, 1992, to expire June 30, 1992; emergency amendment at 16 Ill. Reg. 4069, effective February 28, 1992, to expire June 30, 1992; amended at 16 Ill. Reg. 11403, effective June 30, 1992; emergency amendment at 16 Ill. Reg. 11625, effective July 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 11731, effective June 30, 1992; emergency rule added at 16 Ill. Reg. 12615, effective July 23, 1992, for a maximum of 150 days; modified at 16 Ill. Reg. 16680; amended at 16 Ill. Reg. 14565, effective September 8, 1992; amended at 16 Ill. Reg. 18767, effective November 27, 1992; amended at 17 Ill. Reg. 224, effective December 29, 1992; amended at 17 Ill. Reg. 6090, effective April 7, 1993; amended at 18 Ill. Reg. 609, effective February 1, 1994; emergency amendment at 18 Ill. Reg. 5348, effective March 22, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 13375, effective August 19, 1994; amended at 19 Ill. Reg. 9085, effective July 1, 1995; emergency amendment at 19 Ill. Reg. 10186, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 12693, effective August 25, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16031, effective November 20, 1995; amended at 19 Ill. Reg. 16523, effective December 1, 1995; amended at 20 Ill. Reg. 1493, effective January 10, 1996; emergency amendment at 20 Ill. Reg. 5388, effective March 22, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 8995, effective July 1, 1996; amended at 20 Ill. Reg. 10597, effective August 1, 1996; amended at 21 Ill. Reg. 887, effective January 10, 1997; amended at 21 Ill. Reg. 6183, effective May 15, 1997; amended at 21 Ill. Reg. 12418, effective September 1, 1997; amended at 22 Ill. Reg. 3415, effective February 1, 1998; amended at 23 Ill. Reg. 2496, effective February 1, 1999; amended at 23 Ill. Reg. 5642, effective May 1, 1999; amended at 26

Ill. Reg. 9668, effective July 1, 2002; emergency amendment at 26 Ill. Reg. 10829, effective July 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 17358, effective November 25, 2002; emergency amendment at 28 Ill. Reg. 923, effective December 26, 2003, for a maximum of 150 days; amended at 28 Ill. Reg. 7611, effective May 21, 2004; emergency amendment at 30 Ill. Reg. 10117, effective June 1, 2006, for a maximum of 150 days; emergency amendment at 30 Ill. Reg. 11767, effective July 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 16281, effective September 29, 2006; amended at 30 Ill. Reg. 17756, effective October 26, 2006; amended at 32 Ill. Reg. 7588, effective May 5, 2008; emergency amendment at 32 Ill. Reg. 10940, effective July 1, 2008, for a maximum of 150 days; emergency expired November 27, 2008; amended at 32 Ill. Reg. 17929, effective November 10, 2008; amended at 32 Ill. Reg. 19912, effective December 12, 2008; amended at 33 Ill. Reg. 4830, effective March 23, 2009; amended at 34 Ill. Reg. 3448, effective March 8, 2010; emergency amendment at 34 Ill. Reg. 10854, effective July 15, 2010, for a maximum of 150 days; emergency expired December 11, 2010; emergency amendment at 34 Ill. Reg. 12224, effective August 4, 2010, for a maximum of 150 days; emergency expired December 31, 2010; amended at 35 Ill. Reg. 8919, effective June 2, 2011; emergency amendment at 35 Ill. Reg. 13936, effective July 28, 2011, for a maximum of 150 days; amended at 35 Ill. Reg. 20130, effective December 6, 2011; emergency amendment at 37 Ill. Reg. 11381, effective July 1, 2013, for a maximum of 150 days; emergency expired November 27, 2013; amended at 38 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL PROGRAM PROVISIONS

Section 240.120 Services Provided

a) The Community Care Program (CCP) provides necessary services designed to prevent premature and unnecessary institutionalization of individuals determined eligible to receive those services.

b) Services provided through the CCP are: in-home care~~homemaker~~, adult day care, emergency home response, automated medication dispenser, information and referral, comprehensive care coordination ~~case management~~, individual provider (closed caseload), alternative provider and services made available through special demonstration/research projects.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART B: SERVICE DEFINITIONS

Section 240.237 Automated Medication Dispenser Service

a) Service Description

1) Automated Medication Dispenser (AMD) service is defined as a portable, mechanical system for individual use that can be programmed to dispense or alert the participant to take non-liquid oral medications through auditory, visual or voice reminders; to provide notification of a missed medication dose; and to provide 24 hour technical assistance for the AMD service in the home. The service may include medication specific directions or reminders to take other types of medications such as liquid medications or injections based on individual need. The AMD unit is connected to a Department approved support center through a telephone line or wireless/cellular connection in the participant's home or temporary residence.

2) The purpose of the service is to provide eligible participants with medication reminders to foster timely and safe administration of a complex medication schedule, thereby promoting independence and safety of the participants in their own homes, as well as reducing the need for nursing home care.

3) The authorization to receive this service is determined by the care coordinator through a screening process set forth in Section 240.741, which requires the participant/authorized representative to designate a responsible party to manage the AMD unit and medications as set forth in Section 240.741.

4) This service does not include medication management, oversight or handling of the participant's medications.

5) Provision of this service is contingent upon it being approved by the federal government as a State Medicaid Waiver service.

b) Specific components of AMD service must include, at a minimum, the following:

1) an AMD unit provided to the participant with all connectors, parts and equipment necessary for installation, and adaptations for operation by individuals who have functional, hearing or visual impairments, or who exhibit language barriers.

2) delivery of the AMD unit to the participant and installation of the unit into a functioning telephone or wireless/cellular system in the participant's home within 48 hours after the referral when the participant is at imminent risk of institutionalization and within 15 calendar days from the date of the referral in all other instances.

A) This timeline can be extended if requested by the participant/authorized representative/responsible party.

B) This service shall not be subcontracted and shall be provided by trained employees who will identify themselves by picture identification and an identification number that can be verified by the participant.

C) Delivery and installation of the AMD unit may include coordination of emergency home response service (see Section 240.235) for a participant.

3) training for the participant/authorized representative/responsible party on the proper use of the AMD system at the time of installation and subsequently when needed.

4) provision of verbal and written instructions that are easy to understand in the following areas:

A) demonstration of the AMD unit and equipment, including, but not limited to:

i) activation, use and maintenance of the unit;

ii) programming the unit;

iii) filling the unit with medications;

iv) sanitization and proper handling of medications that could cause medication poisoning or cross-contaminate other medications;

v) message options;

vi) early dose features;

vii) locking features;

viii) volume control;

ix) manual requirements for operation;

x) voice, text, buttons and flashing light features;

xi) battery back-up systems in case of power failure;

xii) HIPAA-compliant (e.g., privacy-protected and secure) methods of communicating with the support center and web-based systems, including toll free help-lines and other language options, if needed;

xiii) options for pick-up or return of the AMD equipment when no longer used;

xiv) description of other troubleshooting interventions; and

xv) explanation of how ongoing training needs are met.

B) explanation of the AMD provider's services, including how the participant and family member or other individuals designated as a responsible party for the unit may communicate through a HIPAA-compliant (e.g., privacy-protected and secure) website, fax, or phone call to change the programming of medications, such as adding new medications, changing the schedule of medications or discontinuing medications.

C) explanation of the notification process for missed medication doses; agreed mode of notification; and access to participant-specific information through other modalities, such as a HIPAA-compliant (e.g., privacy-protected and secure) website, texts or phone calls or written reports.

D) provision of instructions on any testing or monitoring required to assure the proper functioning of the AMD equipment, including how to report a malfunction of the equipment.

E) provision of appropriate training adaptations for individuals who have functional, hearing or visual impairments, or who exhibit language barriers, i.e., instructions in large print, Braille, audible recordings or other languages to meet individual needs.

5) ensuring the participant/authorized representative reviews his or her responsible party designation at least every 6 months. Any changes in this selection/designation must be sent to the Care Coordination Unit (CCU) within 5 calendar days from the date of execution of the Responsible Party Identification Form. If there is a change in designation, the AMD provider must complete new training as required under subsection (b)(3) within 7 calendar days from the date of execution of the Responsible Party Identification Form.

6) obtaining the signature of the participant/authorized representative/responsible party to verify that the AMD equipment was delivered and installed and that instructions and demonstration were given and understood by the participant/authorized representative/responsible party, including acknowledgement of their responsibilities in managing medications, medication administration and oversight of medications and of the limited role of the Department in approving of and paying for the AMD service. A copy of this receipt and acknowledgment must be sent to and kept at the CCU.

7) ownership and operation of a support center to provide live monitoring on a continuous basis, notify participant/authorized representative/responsible party of missed medication doses and provide necessary technical support for fault conditions, including a language line that provides interpreter service for at least 140 languages and communication facilitated by a teletypewriter (TTY) communication device for the deaf, as appropriate.

8) ownership and operation of a back-up support center that provides all components specified in subsection (b)(7) and that operates on a separate power grid.

9) maintaining adequate local staffing levels of qualified personnel to conduct and provide necessary administrative activities, installation, in-home training, equipment monitoring, technical support, medication program changes and repair requests in a timely manner. An AMD provider must have a written training program for personnel and be able to demonstrate that its staff members are qualified and have passed background checks.

10) repairing or replacing the AMD equipment within 24 hours after receiving a malfunction report.

11) alerts to the participant/authorized representative/responsible party when electric power to the AMD equipment has been interrupted (e.g., unplugged) and the unit is operating on a standby power source.

12) notification to the CCU within 1 business day after activation of the AMD unit and working with the appropriate care coordinator to resolve service complaints from the participant/authorized representative/responsible party.

13) notification to the CCU within 2 calendar days if the AMD service cannot be initiated or must be terminated.

14) maintaining records in accordance with Section 240.1544 relating to participant referral and service statistics, including equipment delivery; unit activation and programming; participant/authorized representative/responsible party training; missed medication notifications and dispositions; other AMD equipment monitoring and test transmission activity; equipment malfunction, repair and replacement; power interruption alerts; notifications to the CCUs; billing and payment information; and personnel qualifications, training and background checks.

15) making available individual reports on missed medication doses, power and battery status, and other reporting features on an ongoing basis to the participant/authorized representative/responsible party and care coordinators via a HIPAA-compliant (e.g., privacy-protected and secure) website or other modality.

16) providing access to individual and aggregate reports, consumer satisfaction surveys, and AMD system performance measures on an ongoing basis to authorized persons through a HIPAA-compliant (e.g., privacy-protected and secure) website or other modality.

17) providing ad hoc reports to the Department upon request.

c) Units of Service

1) One unit of installation service is the one-time fee to the AMD provider for the activity associated with the installation of the AMD equipment in the participant's home and training of the participant/authorized representative/responsible party.

2) One unit of monthly service is the fixed unit rate of reimbursement, per month, for the provider agency activity associated with providing the AMD service to each participant.

(Source: Added at 38 Ill. Reg. _____, effective _____)

SUBPART G: NON-FINANCIAL REQUIREMENTS

Section 240.741 Prerequisites for Automated Medication Dispenser Service

a) Authorization for the AMD dispenser service is determined based on an individual's need for the service, including the applicant's/participant's medication, medical, cognitive and physical needs that indicate the potential to benefit from the AMD service.

b) To be authorized for the service, the applicant/participant must:

1) meet all of the following criteria:

A) take 5 or more long term prescription medications that are:

i) administered 2 or more different times per day; and

ii) complex or necessitate that the medication be taken at a set schedule to avoid complications;

B) have the potential to benefit from the service, understand the need to take medications, respond to alerts to take medication and is physically able to take medication independently from the AMD unit;

C) designate a responsible party to manage the AMD unit and medications as required under Section 240.741(d); and

D) commit to using the AMD unit appropriately; and

2) exhibit at least one of the following issues:

A) a history of non-adherence to treatment, medication or therapy regimens;

B) resides alone or lacks assistance from others to assist with regular medication administration;

C) impaired motor function that causes difficulty in handling medication receptacles and small pills;

D) attempts at using less costly alternatives (e.g., pill reminders, medication organizers with alarms and telephone reminders/prompts) have failed;

E) recent transition from a more restrictive care setting, such as a hospital or nursing facility; or

3) have two or more of the following diagnoses requiring medication therapy:

A) cognitive impairment;

B) diabetes;

C) congestive heart failure;

D) hypertension;

E) depression/mental illness; or

F) cancer.

c) Other criteria may be developed by the Department to assist in determining what is the most appropriate AMD system to meet the participant's needs.

d) The responsible party must complete and sign a form verifying that:

1) the AMD unit was installed;

2) he/she is responsible for the management of medications of the participant, including all prescribed medications, assuring the medications are administered according to physician orders; and manually filling the AMD unit, working with the AMD provider to program the dispenser for the initial medication schedule and subsequent changes.

3) the medications in the AMD unit are prescribed by a medical provider who has prescriptive authority under Illinois law;

4) he/she is willing to serve as a point of contact for the AMD provider and is committed to acting on any notifications of missed medication doses and other system issues;

5) he/she received and understood the instructions and demonstration given by the AMD provider for the AMD equipment; and

6) he/she understands how to access reports about the unit and medication regimen and contact the AMD provider when medication schedules are changed.

e) Whenever a responsible party can no longer meet these obligations, it is the responsibility of the participant/authorized representative to make a new designation, execute a new Responsible Party Information Form, and arrange for

another individual to be trained by the AMD provider. Notification of the change should be communicated with the AMD provider and the CCU before the change is made. A copy of the Responsible Party Information Form must be sent to and kept at the Care Coordination Unit.

f) A responsible party cannot be an individual or entity providing other services under the Community Care Program, such as an in-home service provider.

(Source: Added at 38 Ill. Reg. _____, effective _____)

SUBPART I: DISPOSITION OF DETERMINATION

Section 240.945 Notification

a) Any participant~~client~~ whose CCP services are being changed in the following manner shall be advised of the change by written notice: change of service type; reduced amount of service; increased monthly incurred expense prior to July 1, 2010; or termination.

1) The written notice shall be sent to a participant/authorized representative~~client~~ by certified mail, return receipt requested, or given ~~to the client~~ personally, in which case the participant/authorized representative~~individual~~ is to provide a signed and dated receipt for the notice. In the event of death of a participant~~client~~, regular mail is acceptable.

2) The notice shall clearly state the reason for the action being taken.

3) The participant/authorized representative~~client~~ shall be notified of the action being taken no later than 15 calendar days from the date of assessment~~redetermination~~ and the action shall be effective no sooner than 15 calendar days from the date of the notice if the action is adverse to the participant~~client~~ (see Section 240.160 for a definition of adverse action). This time frame does not apply to termination as a result of the non-cooperative act specified in Section 240.350(b)(1).

4) In the event of death of the participant~~client~~, the termination shall be effective the date of the notice. The ~~Case Action Notice~~ form shall be dated and mailed/hand-delivered on the same day.

b) A CCP participant's~~client's~~ services, as specified in subsection (a), may be changed or reduced at the request of the participant/authorized representative~~client~~ and not require the 15-calendar day notice period under the following circumstances:

1) the participant/authorized representative~~client~~ provides the CCU with a signed statement that the change or reduction is at his/her~~the client's~~ request;

2) the CCU, participant/authorized representative~~client~~ and provider~~vendor~~ mutually agree to the initiation of the change or reduction on the agreed upon date (which may be less than the required 15 calendar days from the date of the notice to the participant/authorized representative~~client~~);

3) a~~A~~ written notice is provided to the participant/authorized representative~~client~~ (either by certified mail, return receipt requested, or handed to the participant/authorized representative~~client~~, with a receipt provided by the participant/authorized representative~~client~~ for the notice) prior to the initiation of the change or reduction. The notice shall indicate the agreed upon effective date;

4) rights of appeal shall not be denied to a participant~~client~~ who has requested a change or reduction in CCP services; and

5) the CCU has documented all of the requirements of this subsection (b) and placed the participant's~~client's~~ statement in the case record~~client's file~~.

c) When an assessment or reassessment for services~~a redetermination of eligibility~~ requires an increase, or no change in service, ~~or no change in the amount of expense to be incurred by the client (if applicable),~~ the participant/authorized representative~~client~~ shall be notified in writing. The notice shall be mailed by regular mail to the participant/authorized representative~~client~~ within 15 calendar days from the date of the assessment or reassessment~~redetermination~~.

d) A copy of any notification mailed/hand-delivered to a participant/authorized representative~~client~~ shall be mailed/provided to the appropriate provider~~vendor~~ on the same date it is mailed/hand-delivered to the participant/authorized representative~~client~~.

DEPARTMENT ON AGING

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART O: PROVIDERS

Section 240.1505 Administrative Requirements for Certification

a) In order to qualify for certification as a provider of CCP services, a provider agency must, to the satisfaction of the Department, meet the following administrative requirements:

1) Serve an entire CCP geographic area.

A) Other than in Cook County, the geographic area will be the county.

B) In Cook County outside the City of Chicago, the geographic area will be the township.

C) Within the City of Chicago, the geographic area will be the following subareas, defined by Zip Code:

i) 60645, 60626, 60659, 60660, 60640

ii) 60625, 60631, 60630, 60646, 60656

iii) 60666, 60634, 60641, 60707, 60639, 60635

iv) 60613, 60614, 60618, 60647, 60657

v) 60601, 60602, 60603, 60604, 60605, 60661, 60606, 60607, 60610, 60611, 60622

vi) 60637, 60616, 60615, 60649, 60653

vii) 60629, 60632, 60623, 60609, 60638

viii) 60628, 60617, 60619, 60633, 60627, 60827

ix) 60620, 60652, 60636, 60643, 60621, 60655

x) 60608, 60612, 60624, 60644, 60651.

2) The Department reserves the right to adjust this geographic area requirement to assure that:

A) no geographic area remains unserved.

B) the following entities are not excluded from participation as service providers in the CCP:

i) entities serving limited- or non-English-speaking participants~~clients~~;

ii) providers that are, or are controlled by, a unit of local government and cannot operate outside the jurisdiction of that local government; and

iii) regional benevolent, charitable, social or religious organizations that have as their charter providing services to a specific population or geographic area smaller than a county, township or CCP subarea.

C) transportation to/from adult day service facilities can be completed in a reasonable period of time.

3) Submit a request for certification providing the information described in this Section and Sections 240.1600 and 240.1605, in the form and manner prescribed by the Department, including all required supporting compliance material or other information documenting its administrative and operational ability, and institute all necessary action based on the outcome of the Department's review.

4) Document the legal structure under which it is organized to do business as set forth in Section 240.1607(h).

5) Provide a list of the directors, officers or owners, as applicable to the legal structure of the provider agency.

6) Verify experience in providing service comparable to the CCP, as defined in Sections 240.210, 240.230, ~~and~~ 240.235 and 240.237, for which certification is requested, and that is consistent with the requirements set forth in this Part.

A) Required Experience

i) For prospective emergency home response service provider agencies: A minimum of 5 years experience in business operations providing emergency home response service.

ii) For prospective adult day service provider agencies: A minimum of 2 years experience in business operations providing adult day service.

iii) For prospective in-home service providers: A minimum of 3 years experience in business operations providing in-home service, one of which must be in Illinois.

iv) For prospective automated medication dispenser service provider agencies: a minimum of 5 years experience in business operation providing automated medication dispenser services.

B) The Department reserves the right to:

i) adjust the experience requirements specified in subsection (a)(6)(A)~~(a)(5)(A)~~ if the provider agency submits proof of current accreditation or certification by an appropriate national organization for the service for which Department certification is being requested.

- For in-home services, the following national accreditation organizations are acceptable:

  Accreditation Commission for Health Care (2005, no later amendments or editions included), 4700 Falls of Neuse Rd., Suite 280, Raleigh NC 27609;

Community Health Accreditation Program (2004, no later amendments or editions included), 1300 19th St., Suite 150, Washington DC 20036;

The Joint Commission (2009, no later amendments or editions included), One Renaissance Blvd., Oakbrook Terrace IL 60181.

- For adult day services, accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) (2009, no later amendments or editions included), CARF-CCAC, 1730 Rhode Island Ave. NW, Suite 209, Washington DC 20036 is acceptable.

- Consideration of other accreditation organizations may be requested in writing with supporting documentation regarding the particular competency requirements for another designation. If approved by the Department, additional accreditation organizations will be added to this subsection (a)(6)(B)(i).

ii) adjust the experience requirement (e.g., substituting management team experience for agency experience) when it is in the best interests of the CCP. The Department will continue to assure that any adjustment of the experience requirement will occur only when the health, safety and welfare of CCP participants~~clients~~ and the quality of services provided will not be adversely affected.

C) The Department will not adjust the experience requirement for any accredited provider agency that is not currently in operation and actually providing services.

7) Disclosure of information regarding past business practices of the provider agency and its affiliates, including the managers, directors or owners, relevant to the service applied for, involving, but not limited to, the following circumstances:

A) denial, suspension, revocation or termination for cause of a license or Provider Agreement, or any other enforcement action, such as civil court or criminal action;

B) termination of a Provider Agreement or surrender of a license before expiration or allowing a contract or a license to expire in lieu of enforcement action;

C) any federal or state Medicaid or Medicare sanctions or penalties relating to the operation of the agency, including, but not limited to, Medicaid abuse or fraud;

D) any federal or state civil or criminal felony convictions;

E) operation of an agency that has been decertified in any state under Medicare or Medicaid; or

F) citations for client abuse, neglect, injury, financial exploitation or inadequate care in any state.

8) Document its written policies and procedures in compliance with the applicable administrative standards imposed on provider agencies under the CCP, as set forth in Section 240.1510.

9) Document its ability to comply with all applicable responsibilities imposed on provider agencies under the CCP, as set forth in Section 240.1520, including proof of required insurance coverages.

10) Submit audited financial reports from the last complete business fiscal year.

11) Submit proof that it is fiscally sound, as that term is defined in Section 240.160, by verifying assets (e.g., audited financial statements with accompanying notes, bank statements, investment statements, and letters of credit from financial institutions) sufficient to cover 90 days of CCP operating expenses, as defined by the agency business plan.

12) Provide assurance that its business operations comply with the service, staffing and training requirements imposed on provider agencies under this Part.

13) Provide a minimum of 5 references ~~or letters of recommendation~~ from such entities as persons who have been served by the provider, nonprofit or business organizations or governmental bodies that have observed the operations and/or services of the provider, employees of the provider, an Area Agency on Aging, etc., attesting to the provider agency's qualifications relevant to providing CCP services. The references shall be from a diverse group of knowledgeable entities.

14) Comply with all applicable federal, State and local laws, regulations, rules, service standards and policies or procedures pertaining to the provider agency in its business operations and to the services provided under the CCP.

b) If a provider agency is not able or is unwilling to meet the administrative requirements in subsection (a), the Department shall deny its request for certification.

c) The Department reserves the right to accept documentation of Illinois Department of Public Health (DPH) home service licensure for applicable administrative requirements. (See 77 Ill. Adm. Code 245.Subpart B.)

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 240.1543 Minimum Equipment Specifications for Automated Medication Dispenser Service

a) All AMD equipment must be capable of portability to be temporarily transferred to another non-institutional residence in Illinois without additional activation fees.

b) AMD Unit Specifications

1) The AMD unit must be a portable, waterproof, mechanical system configured with:

A) all the cords and interfaces needed for installation;

B) an internal battery capable of operating as a power source for a minimum of 3 years;

C) a battery back-up that charges automatically when unit is powered and maintains a charge for at least 12 hours when the electric power to the AMD unit is interrupted;

D) a low battery charge signal;

E) components certified as appropriate by the Federal Communications Commission (FCC) under 47 CFR 15 and 68; and

F) appropriate Underwriters Laboratories (UL) safety standards (UL 60950 and 60950-1) certification for battery powered technology equipment.

2) The AMD unit must have the following operating features:

A) ability to be loaded, programmed and changed with addition and removal of prescriptions, including:

i) local or remote programming accessibility to the AMD unit according to specified times for medication administration, at least 4 times a day; and

ii) providing notification to the participant/authorized representative/responsible party at the programmed times;

B) ability to be filled with medications by the participant/authorized representative/responsible party, including:

i) holding at least 7 days' supply of prescription medications;

ii) holding 8 or more different medications in individual compartments;

iii) access to medication for an early dose option; and

iv) locking after the medication is loaded;

C) ability to alert the participant/authorized representative/responsible party when it is time to take medications at least every 5 to 10 minutes for at least 60 minutes until the dose is taken or the dose is locked, including:

i) using verbal, auditory or visual prompts such as flashing lights and audible tones or verbal instructions, which may also provide messages to take medication that cannot be stored in the machine (e.g., take medications with food; time to take insulin) based on participant's needs;

ii) dispensing medications at the correct time of day in the correct combinations and in the correct quantities; and

iii) easy adjustment of the volume on auditory or verbal features;

D) use of HIPAA-compliant (e.g., privacy-protected and secure) methods of communication with the participant/authorized representative/responsible party, including:

i) notification when battery is low or unit is jammed, or if participant has not taken the medication within 90 minutes after the prescribed time;

ii) contact by the unit or call center to the participant/authorized representative/responsible party to assure adherence or needed intervention; and

E) ability to transmit information and provide data to the participant/authorized representative/responsible party, the Department or its designees.

3) The activation device must be capable of conducting automatic battery testing and transmitting the results through the AMD unit to the support center on an ongoing basis.

4) If an AMD unit is a Class I medical device, the AMD unit is subject to the General Controls mandated by the Federal Food and Drug Administration, including provisions that relate to adulteration (21 USC 351); misbranding (21 USC 352); device registration and listing (21 USC 360); notification, including repair, replacement, or refund (21 USC 360h); records and reports (21 USC 360i); and restricted devices (21 USC 520(e)). In addition, the manufacturer of the device must fulfill requirements under 21 CFR 820.180 (Record keeping) and 820.198 (Complaint files). If an AMD unit has enhanced features, such as remote capability, it may be classified as a Class II medical device and must then meet applicable Special Controls under the FDA.

5) The AMD unit should have adaptations for operation by individuals who have functional, hearing or visual impairments, and language barriers at no extra cost to the participant.

c) Base Unit Specifications

1) The base unit must have:

A) an integrated unit that connects to either a rotary dial or touchtone telephone via a modular jack or wireless/cellular system that does not interfere with the normal use of the telephone or other devices using the telephone line, such as Emergency Home Response Service;

B) an Underwriters Laboratory (UL) approved plug as the connector to a standard residential electrical outlet for its power supply;

C) an easily identifiable "ready" light to verify whether the batteries on the base unit are charged;

D) a battery that automatically charges whenever the base unit is powered and that maintains a charge for at least 12 hours when the electric power to the base unit is interrupted;

E) transmission capability to signal the support center if the base unit battery fails or has a low charge, or electric power to the base unit is interrupted;

F) configuration that allows signaling services through more than one unit for more than one participant in a home; and

G) an easy method to control the volume of the unit.

2) The base unit must give both audible and visual technology and lighting cues to provide medication alerts.

3) The AMD unit must provide repeated alerts or messages until the medication is taken, or until the time limit on reminders is met, at which time the dose is transferred to a locked storage area and the participant/authorized representative/responsible party is notified of the missed medication dose.

d) Support Center Specifications

1) The AMD support center must have back-up monitoring capacity to take over all medication dispenser notification functions, monitoring and technical support functions.

2) The AMD back-up monitoring center must be at a location different from the primary center, on a different power grid system, and on a different telephone trunk line. It must have a back-up battery and electrical generating capacity, as well as telephone line and wireless/cellular system monitoring abilities. If the back-up center is in the same city as the support center, the AMD provider must provide assurances that back-up can be maintained in the event of a natural disaster.

3) All AMD support center and back-up center equipment, at a minimum, must:

A) monitor the AMD system for the receipt of incoming signals from installed and programmed AMD units in participants' homes, including missed medication doses, power interruptions and

outages, and test transmissions and fault conditions, on a continuous basis;

B) direct an appropriate response to the receipt of a signal immediately via texts/emails to the participant/authorized representative/responsible party and call the participant/authorized representative/responsible party within 90 minutes after missed medications and within 8 hours after power interruptions and outages;

C) provide technical support as required, 24 hours a day, 365 days a year;

D) identify each participant and simultaneously record all communication between the participant/authorized representative/responsible party and the support center, as applicable, for all signals, including missed medication doses, test transmissions and fault conditions;

E) display, print and archive the participant identifier, date, time, communication and response for each signal, test and fault condition, which must be maintained for at least a 3-year period of time for quality control and liability purposes;

F) have an uninterruptible power supply (UPS) back-up that will automatically take over system operation in the event electric power to the support center is interrupted, other type of malfunction occurs, or repairs are needed. The back-up power supply must be sufficient to operate the entire system for a minimum of 7 calendar days;

G) have separate and independent primary and back-up systems, computer servers, databases, and other components to provide an uninterruptible monitoring system in the event of equipment malfunction;

H) perform self-diagnostic testing for malfunctions in equipment in participant homes and at the support center, and for fault conditions in the primary and back-up operating systems and

power supply at the support center, that could interfere with receiving and responding to signals, such as non-operational AMD units, messages sent from the AMD unit to the participant/authorized representative/responsible party without confirmation of receipt, telephone line outages, power loss, etc.;

I) capability to centrally generate medication compliance data and reports as requested by the Department;

J) have quality management systems that include tracking and trending of data, response times and dispositions; and

K) maintain appropriate certification by the FCC under 47 CFR 15 and 68.

(Source: Added at 38 Ill. Reg. _____, effective _____)

Section 240.1544 Administrative Requirements for Automated Medication Dispenser Service Providers

a) In order to qualify for certification, an Automated Medication Dispenser (AMD) provider must, to the satisfaction of the Department:

1) meet the administrative requirements and minimum administrative standards under Sections 240.1505 and 240.1510;

2) meet the applicable responsibilities imposed on provider agencies under the Community Care Program (CCP) set forth in Section 240.1520;

3) meet the certification requirements under Sections 240.1600 or 240.1605;

4) provide assurance that its equipment and support center are in continual compliance with the business and technology requirements imposed on provider agencies under Section 240.1543;

5) provide assurance that its business operations comply with the service, staffing and training requirements under Section 240.237;

6) complete management training provided by the Department or its designee:

A) Training shall be completed by management staff (e.g., managers, supervisors, billing agents) of the AMD provider prior to the award of a CCP AMD contract from the Department;

B) At a minimum, the individual responsible for administration of the CCP AMD program at the provider agency shall complete this training;

C) The Department is authorized to charge a reasonable fee for this training to cover related administrative costs;

7) submit audited financial reports as requested from the last complete business fiscal year to prove it is fiscally sound as that term is defined in Section 240.160;

8) accept all correspondence from the Department and maintain adequate records for administration, audit, budgeting, evaluation, operation and planning efforts by the Department in offering the AMD service through the CCP, which shall include, but are not limited to:

A) records of all referrals, including the disposition of each referral;

B) participant records, which shall include, but are not limited to:

i) applicable forms required by the Department;

ii) dates and times of all AMD notifications and communications with the participant/authorized representative/responsible party;

iii) disposition of all participant/authorized representative/responsible party communications;

iv) dates and times of all equipment tests and system interruptions; and

C) administrative records, including but not limited to:

i) service statistics;

ii) complaint resolution;

iii) billing and payment information plus the underlying documentation to support the units of service submitted to the Department for reimbursement; and

9) comply with all applicable federal, State and local laws, regulations, rules, service standards and policies or procedures pertaining to the AMD provider in its business operations and to the services provided under the CCP.

b) If an AMD provider is not able to meet these administrative requirements, the Department shall deny its request for a certification of qualifications under Section 240.1600.

(Source: Added at 38 Ill. Reg. _____, effective _____)

SUBPART P: PROVIDER PROCUREMENT

Section 240.1600 Provider Agency Certification

a) All services provided to Community Care Program Participants~~clients~~ shall be delivered in accordance with Provider Agreements entered into between certified provider agencies and the Department.

b) For purposes of administrative efficiency, the Department may initiate the provider certification process for the CCP by a specific service, on a geographic basis, or in accordance with other criteria determined by the Department.

c) Initial Certification
Any willing and qualified provider agency (see the federal Medicaid waiver, this Part and 42 CFR 431.51 (2008)) interested in the opportunity to enter into a Provider Agreement with the Department for the provision of CCP services shall comply with the following certification procedures:

1) A provider agency requesting initial certification of qualifications shall submit, in a form and manner prescribed by the Department, material documenting the ability to comply with administrative requirements, service specifications and any other administrative or operational information required by the Department for the applicable service.

A) The Department or its designee will review the material submitted and, if necessary, will request additional information. The Department or its designee will conduct on-site reviews of a prospective provider agency for in-home service and adult day service under the CCP unless a performance review of the provider agency has already been completed by the Department or its designee within the prior 12 months. The Department reserves the right to conduct on-site reviews of a prospective provider agency for emergency home response service and automated medication dispenser service under the CCP.

B) If additional information is requested by the Department, the provider agency has 30 calendar days from the date of request to submit this information.

C) After 60 calendar days, the provider agency's request for certification of qualifications will be closed and all information must be resubmitted to the Department if the provider agency wants to continue to request certification.

2) Provider agencies will be notified in writing of the results of the certification request. Those provider agencies determined by the Department to be qualified will be certified for a period of no more than 3 years and afforded the opportunity to execute a Provider Agreement (generally for a 3-year period) for the applicable service.

d) Recertification
The Department, or its designee, shall conduct recertification of each provider agency with a valid Provider Agreement no less frequently than every 3 years to determine continued compliance with qualifications for the applicable service. The timing of recertification shall be based upon the timing of the initial certification (see subsection (b)) or of the most recent recertification.

1) The Department, or its designee, shall notify each provider agency, in writing, at least 30 calendar days prior to recertification to request the material required for the recertification. Any provider agency interested in renewing its Provider Agreement shall submit, in a form and manner prescribed by the Department, material documenting the continued ability to comply with the administrative requirements, service specifications, and any other administrative or operational information required by the Department for the applicable service.

2) Before recertifying a service provider, the Department will conduct a performance review under Section 240.1660.

3) Provider agencies will be notified in writing of the results of the recertification.

4) Those provider agencies determined by the Department to be qualified will be recertified for a period of no more than 3 years and afforded the opportunity to execute renewal of the Provider Agreement (generally for a 3-year period) for the applicable service.

e) Other initial certification or recertification considerations include, but are not limited to:

1) pending or current Departmental on-notice or contract action for failure to adhere to Provider Agreement requirements, including a history of non-compliance with the Provider Agreement;

2) notification from another governmental entity of similar contract actions or non-compliance findings;

3) financial insolvency, criminal indictment or conviction, or other legal issues that, in the opinion of the Department, would make the award of a Provider Agreement contrary to the best interest of the State;

4) complaints forwarded to the Department by the Attorney General's office, the Better Business Bureau or other consumer protection organizations; or

5) the current provider agency is not in good standing with the Department.

f) The Department may require completion of additional disclosure statements and/or background inquiries if there is reason to believe offenses have occurred since completion of previous disclosures and background inquiries.

g) The Director shall represent and act for the State in all matters pertaining to the Application for Certification process and Provider Agreements awarded. The Director receives all recommendations and has the ultimate decision making authority for issuing Provider Agreements. The Director reserves the right to allow the applicant to correct inadvertent, technical errors in the application when, in the Director's opinion, the best interest of the State will be served by the correction.

h) Any provider agency denied initial certification of qualifications or recertification for the provision of CCP services shall be afforded the opportunity to submit another request to the Department after a 60-day period of time from issuance of the determination or notification of a final decision or other action on an objection filed pursuant to Section 240.1645. The provider agency may also object to the decision in a form and manner prescribed by the Department in the written notification of denial (see Section 240.1645).

i) Provider Agreements will be entered with qualified provider agencies on a schedule determined by the Department, but no more frequently than semiannually after initial certification.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 240.1650 Classification, Identification and Receipt of Provider Service Violations

Failure to comply with the contract, proposal and Department rules shall be identified and classified by the Department.

a) In determining the classification assigned to each provider service violation, the Department shall consider the following:

1) the severity of the violation;

2) the danger posed by the violation to the health, safety or welfare of the participant~~client~~, based upon degree of participant~~client~~ impairment and availability of support sources;

3) the provider's efforts to correct violations;

4) the volume and scope of violations.

b) There are 3 classifications of violations: Type I, Type II and Type III.

1) Type I provider service violations are participant-centered~~client-centered~~ violations that pose an imminent risk to the health, safety or welfare of the Community Care Program (CCP) participant~~client~~, and represent situations in which failure to correct the violation could result in the participant's~~client's~~ potential hospitalization or nursing facility placement. Type I violations shall receive priority attention, requiring immediate (within 24 hours) correction to remove the risk environment. Permanent correction must be achieved within 60 calendar days.

2) Type II provider service violations are participant-centered~~client-centered~~ violations that pose a potentially serious risk to the participant~~client~~. These violations are to be corrected within 60 calendar days.

3) Type III provider service violations are administrative violations that pose a very low risk to the participant~~client~~. The timeframe for correction of Type III violations shall be 60 calendar days or as established in an approved work plan.

c) Provider service violations include, but are not limited to, violation of the following Community Care Program rules:

1) adult day service standard requirements, as specified in Section 240.1550 ~~of this Part~~;

2) adult day service and in-home provider staffing requirements, as specified in Sections 240.1530 and 240.1555~~ of this Part~~;

3) special services, as specified in Subpart J;

4) provider administrative minimum standards and responsibilities, as specified in Sections 240.1510, 240.1520, 240.1542, 240.1544 and 240.2020~~ of this Part~~;

5) service components, as specified in Sections 240.210, 240.230, 240.235, 240.237, 240.270 and 240.280 ~~of this Part~~;

6) adult day service and in-home provider staff qualification and responsibilities, as specified in Sections 240.1535 and 240.1560 ~~of this Part~~;

7) service provision requirements, as specified in Subpart B and Section 240.915 ~~of this Part~~;

8) emergency home response equipment, as specified in Section 240.1541 ~~of this Part~~;~~.~~

9) automated medication dispenser equipment, as specified in Section 240.1543.

d) The Department will be in receipt of reported violations through the following methods:

1) Performance reviews of contracted provider agencies, as specified in Section 240.1660 of this Part;

2) Service complaints/violations that are reported directly to the Department or to the Senior HelpLine of the Department or are referred to the Senior HelpLine by the Department/Case Coordination Unit or service provider/other; and/or

3) Reports from Department staff.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SUBPART S: PROVIDER RATES

Section 240.1955 Fixed Unit Rates of Reimbursement for Emergency Home Response Service

Emergency home response service (EHRS) providers executing a contractual agreement with the Department pursuant to Section 240.1600 shall be uniformly reimbursed for the provision of

EHRS at fixed unit rates of reimbursement established by the Department. The reimbursable units of EHRS shall be as follows:

a) Installation and Removal
The Department shall pay a one-time installation fee at a fixed unit reimbursement rate established by the Department for the installation of the base unit in the participant's~~client's~~ home. The Department shall not pay any fee for expenses incurred by the EHRS provider if service could not be provided due to either the participant's~~client's~~ absence or the participant's~~client's~~ refusal to admit the EHRS provider's employee into the home. The Department shall not pay any fee for removal of the base unit.

b) Monthly Service
The Department shall pay a monthly service fee per participant~~client~~ at a fixed unit reimbursement rate established by the Department for providing EHRS to participants~~clients~~. The Department shall not pay for the cost of maintaining telephone service for the participant~~client~~ or any associated charges or fees.

Rate for EHRS and Automated Medication Dispenser (AMD) Provided by the Same Provider:

1) For individual participant households, the Department shall pay a single installation fee and a single monthly service fee for EHRS and AMD when these services are installed and provided at the same time, by the same provider.

2) For dual participant households when both participants are utilizing EHRS and AMD services, the Department shall pay a single installation fee, an AMD monthly service fee per participant, and a shared EHRS monthly service fee when these services are installed and provided at the same time, by the same provider.

d) The rates will be reviewed annually, at a minimum, and adjustments may be made to conform to the appropriation, service requirements and/or changes in federal and State laws, regulations and/or rules affecting the service.

e) In establishing the rates of reimbursement, the Department may consider any of the following factors:

1) appropriation levels;

2) cost information provided by the providers; and/or

3) current market conditions and trend analyses.

f) Upon written notification from the Department of a change in the rates of reimbursement, an AMD provider may exercise its 30 calendar day termination rights if the EHRS provider no longer wishes to provide services thereafter at the new rates of reimbursement.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 240.1957 Fixed Unit Rates of Reimbursement for Automated Medication Dispenser Service

Automated Medication Dispenser (AMD) service providers executing a contractual agreement with the Department pursuant to Section 240.1600 shall be uniformly reimbursed for the provision of AMD units at fixed unit rates of reimbursement established by the Department. The reimbursable units of AMD service shall be as follows:

a) Installation, Initial Training and Removal
The Department shall pay a one-time installation fee at a fixed unit reimbursement rate established by the Department for the installation and initial training of the family/responsible party of the AMD unit in the participant's home. The Department shall not pay any fee for expenses incurred by the AMD provider if service could not be provided due to either the participant's absence or the participant's refusal to admit the AMD provider's employee into the home. The Department shall not pay any fee for removal of the AMD unit.

b) Monthly Service
The Department shall pay a monthly service fee per participant at a fixed unit reimbursement rate established by the Department for providing AMD service which includes maintaining administrative and technical support to program machines; providing 24 hour technical assistance and additional training; signal monitoring, troubleshooting, machine maintenance, repair and replacement; notifications to family/responsible party on missed medication doses and power outage; tracking and analyzing data; and providing reports as requested by the

Department. The Department will not pay for the cost of maintaining telephone service for the participant or any associated charges or fees.

c) Rate for AMD and Emergency Home Response Services (EHRS) Provided by the Same Provider:

1) For individual participant households, the Department shall pay a single installation fee and a single monthly service fee for AMD and EHRS when these services are installed and provided at the same time, by the same provider.

2) For dual participant households when both participants are utilizing AMD and EHRS, the Department shall pay a single installation fee, an AMD monthly service fee per participant, and a shared EHRS monthly service fee when these services are installed and provided at the same time, by the same provider.

d) The rates will be reviewed annually, at a minimum, and adjustments may be made to conform to the appropriation, service requirements and/or changes in federal and State laws, regulations and/or rules affecting the service.

e) In establishing the rates of reimbursement, the Department may consider any of the following factors:

1) appropriation levels;

2) cost information provided by the providers; and/or

3) current market conditions and trend analyses.

f) Upon written notification from the Department of a change in the rates of reimbursement, an AMD provider may exercise its 30 calendar day termination rights if the AMD provider no longer wishes to provide services thereafter at the new rates of reimbursement.

(Source: Added at 38 Ill. Reg. _____, effective _____)

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

1) Heading of the Part: Procedures for Gas, Electric, Water and Sanitary Sewer Utilities Governing Eligibility for Service, Deposits, Payment Practices and Discontinuance of Service

2) Code Citation: 83 Ill. Adm. Code 280

3)

Section Numbers:	Proposed Action:
280.10	Repeal
280.20	Repeal
280.30	Repeal
280.40	Repeal
280.50	Repeal
280.60	Repeal
280.70	Repeal
280.75	Repeal
280.76	Repeal
280.80	Repeal
280.90	Repeal
280.100	Repeal
280.105	Repeal
280.110	Repeal
280.120	Repeal
280.130	Repeal
280.135	Repeal
280.136	Repeal
280.138	Repeal
280.140	Repeal
280.150	Repeal
280.160	Repeal
280.170	Repeal
280.180	Repeal
280.190	Repeal
280.200	Repeal
280.APPENDIX A	Repeal
280.APPENDIX B	Repeal
280.APPENDIX C	Repeal
280.APPENDIX D	Repeal

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

4) Statutory Authority: Implementing the Small Business Utility Deposit Relief Act [220 ILCS 35] and Sections 8-101, 8-206, and 8-207 of the Public Utilities Act [220 ILCS 5/8-101, 8-206, and 8-207], and authorized by Section 8 of the Small Business Utility Deposit Relief Act [220 ILCS 35/8] and Sections 8-101, 8-207, and 10-101 of the Public Utilities Act [220 ILCS 5/8-101, 8-207, and 10-101].

5) A Complete Description of the Subjects and Issues Involved: The Commission is concurrently proposing the adoption of new rules at Part 280 to replace the current rules. The current rules are not reflective of changes in the utility industry pertaining to the provision of customer service practices and technical support systems, or of recent legislative changes.

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: The proposed repealer 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:

Comments should be filed, within 45 days after the date of this issue of the *Illinois Register*, in Docket No. 06-0703 with:

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

(217) 782-7434

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: This repealer will affect any subject jurisdictional entities that are also small businesses as defined in the Illinois Administrative Procedure Act. This repealer will not affect any small municipalities or not-for-profit corporations.

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

C) Types of professional skills necessary for compliance: Managerial and accounting skills

14) Regulatory Agenda on which this rulemaking was summarized: This repealer was not included on either of the two most recent agendas because: The Commission did not anticipate the need for this repealer at that time.

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

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

TITLE 83: PUBLIC UTILITIES
CHAPTER I: ILLINOIS COMMERCE COMMISSION
SUBCHAPTER b: PROVISIONS APPLICABLE TO
MORE THAN ONE KIND OF UTILITY

PART 280
PROCEDURES FOR GAS, ELECTRIC, WATER AND SANITARY SEWER
UTILITIES GOVERNING ELIGIBILITY FOR SERVICE, DEPOSITS,
PAYMENT PRACTICES AND DISCONTINUANCE OF SERVICE (REPEALED)

Section
280.10 Policy
280.20 Scope and Application
280.30 Saving Clause
280.40 Definitions
280.50 Applicants for Service
280.60 Present Customers
280.70 Deposits
280.75 Refunds
280.76 Refunds of Additional Charges
280.80 Estimated Bills
280.90 Past Due Bills and Late Payment Charges
280.100 Unbilled Service
280.105 Treatment of Illegal Taps
280.110 Deferred Payment Agreements
280.120 Budget Payment Plan
280.130 Discontinuance of Service
280.135 Discontinuance of Service During the Period of Time from December 1 Through and Including March 31
280.136 Energy Act of 1989 Participants Discontinuance Prohibition
280.138 Reconnection of Former Residential Utility Customers for the Heating Season
280.140 Discontinuance of Service to Accounts Affecting Master Metered Apartment Buildings
280.150 Service Reconnection Charge
280.160 Dispute Procedures
280.170 Commission Complaint Procedures
280.180 Public Notice of Commission Rules
280.190 Second Language Notices
280.200 Customer Information Booklet

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

280.APPENDIX A	Notice of Utility Shut Off
280.APPENDIX B	Requirements to Avoid Shut Off of Service in the Event of Illness
280.APPENDIX C	Public Notice
280.APPENDIX D	Insert to be Included with Each Notice of Disconnection Sent to Residential Gas and Electric Customers

AUTHORITY: Implementing the Small Business Utility Deposit Relief Act [220 ILCS 35] and Sections 8-101, 8-206, and 8-207 of the Public Utilities Act [220 ILCS 5/8-101, 8-206, and 8-207], and authorized by Section 8 of the Small Business Utility Deposit Relief Act [220 ILCS 35/8] and Sections 8-101, 8-207, and 10-101 of the Public Utilities Act [220 ILCS 5/8-101, 8-207, and 10-101].

SOURCE: Rule repealed, new rule adopted at 3 Ill. Reg. 1, p. 102, effective January 6, 1979; emergency amendment at 3 Ill. Reg. 46, p. 65, effective November 16, 1979, for a maximum of 150 days; amended at 4 Ill. Reg. 46, p. 1274, effective November 10, 1980; amended at 6 Ill. Reg. 10917, effective September 7, 1982; amended at 6 Ill. Reg. 13723, effective November 8, 1982; amended at 7 Ill. Reg. 9285, effective July 22, 1983; codified at 7 Ill. Reg. 13218; emergency amendment at 7 Ill. Reg. 14543, effective October 18, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 13221, effective November 1, 1983; emergency amendment at 7 Ill. Reg. 16667, effective December 1, 1983, for a maximum of 150 days; amended at 8 Ill. Reg. 3664, effective March 15, 1984; emergency amendment at 8 Ill. Reg. 17924, effective September 13, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 21222, effective October 15, 1984; amended at 9 Ill. Reg. 2268, effective February 8, 1985; amended at 16 Ill. Reg. 11023, effective July 1, 1992; amended at 17 Ill. Reg. 805, effective January 15, 1993; amended at 18 Ill. Reg. 6160, effective May 1, 1994; amended at 18 Ill. Reg. 17974, effective December 15, 1994; emergency amendment at 25 Ill. Reg. 16545, effective December 13, 2001 for a maximum of 150 days; amended at 26 Ill. Reg. 7032, effective May 1, 2002; amended at 27 Ill. Reg. 4527, effective April 1, 2003; emergency amendment at 27 Ill. Reg. 15156, effective September 15, 2003, for a maximum of 150 days; amended at 28 Ill. Reg. 2684, effective February 10, 2004; repealed at 38 Ill. Reg. _____, effective _____.

Section 280.10 Policy

The purpose of this Part is to establish fair and equitable procedures within the scope of this Part, taking into account the duty of the utility, customer, applicant and user to demonstrate good faith and fair dealing.

Section 280.20 Scope and Application

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

This Part shall apply to electric, gas, sanitary sewer and water utilities for the purposes of:

a) establishing procedures governing eligibility for service, deposits, and payment practices; and

b) establishing conditions under which service may be discontinued by utilities.

Section 280.30 Saving Clause

The adoption of this Part shall in no way preclude the Commission from altering or amending it, in whole or in part, or from requiring or authorizing rules containing other provisions whenever it shall be deemed in the public interest to do so. The rules specified herein shall not preclude the filing of an application by a utility for good cause shown seeking approval of rules which may be in contradiction of this Part. Furthermore, the rules specified herein shall not supersede nor void any rules heretofore filed by any utility until the Commission determines that the utility's present rule is in contradiction of this Part and that allowing the contradictory rule to remain in effect is not in the public interest.

Section 280.40 Definitions

"Applicant" – a person who applies for residential or non-residential utility service.

"Credit scoring system" has the same meaning set forth in 12 CFR 202.2 as of January 1, 2002, and no later amendments or editions are incorporated.

"Customer" – a person who has agreed with a utility to pay for gas, electric, water or sanitary sewer utility service.

"Master-metered apartment building" – a building of three or more rental dwelling units where any utility service is registered by a single meter for all the units.

"Nonresidential Service" – gas, electric, water or sanitary sewer utility service rendered which is not residential service.

"Person" – a natural person, corporation, real estate trust, partnership, association or other legal entity.

"Residential Service" – gas, electric, water or sanitary sewer utility service for household purposes furnished to a dwelling of two units or less which is billed under a residential rate; or gas, electric, water or sanitary sewer utility service for household purposes furnished to a dwelling unit or units which is billed under a residential rate and which is registered by a separate meter for each dwelling unit.

"Small business" – any Illinois based business which has 50 or less full-time employees in the State. [220 ILCS 35/2].

"User" – a person who receives gas, electric, water or sanitary sewer utility service.

"Utility Service" – gas, electric, water or sanitary sewer utility service provided to a customer at a specific location.

Section 280.50 Applicants for Service

a) If, after a review of its own past service records, a utility finds that an applicant for residential service has failed to pay for past due utility service for the same class of service furnished to him/her at the same or at another address, or if the credit score of the applicant for residential service does not meet or exceed the predetermined minimum credit score selected by the utility using a credit scoring system (see Section 280.40), a utility may refuse to provide service, unless the applicant, at the option of the utility, pays any past due bill and/or provides a deposit pursuant to Section 280.70 and/or enters into a deferred payment agreement pursuant to Section 280.110. A utility that elects to use a credit scoring system shall file a tariff describing its practice of using a credit scoring system. For purposes of this subsection, a utility may refuse to provide service if the applicant is liable for a past due bill for utility service pursuant to Section 15 of the Rights of Married Persons Act [750 ILCS 65/15], unless the applicant, at the option of the utility, pays any past due bill and/or provides a deposit pursuant to Section 280.70 and/or enters into a deferred payment agreement pursuant to Section 280.110.

b) If, after a review of its own past service records, a utility finds that an applicant for non-residential service has failed to pay for past due utility service for the same class of service furnished to him/her at the same or at another address, or if the applicant for non-residential service is unable to establish satisfactory credit references, a utility may refuse to provide service, unless the applicant, at the

option of the utility, pays any past due bill and/or provides a deposit pursuant to Section 280.70 and/or enters into a deferred payment agreement pursuant to Section 280.110.

c) A bill for one class of service (residential or non-residential) shall not be transferred to a bill for the other class of service, nor shall the bill for one form of utility service (such as gas) be transferred to a bill for another form of utility service (such as electric). Service shall not be denied for nonpayment of bills for merchandise or nonutility services.

d) If a utility takes applications for service by telephone from third parties or users who will not be the customers of the service, and if the utility does not verify the third party or user application with the customer, the utility shall not be entitled to collect from the customer of the service if the customer disclaims any responsibility for requesting the service; provided, however, that users will be responsible for paying for their use.

e) A utility shall not require a deposit based on a credit scoring system if the applicant for residential service is eligible for the Low Income Home Energy Assistance Program (LIHEAP) or provides proof of identity fraud.

f) A utility that elects to utilize a credit scoring program for applicants for residential service shall collect the following data and maintain such data for a period of five years following its collection:

1) the number of credit scores requested for applicants;

2) the number of applicants who received passing credit scores;

3) the number of applicants who received failing scores;

4) the number and total amount of deposits obtained from applicants subject to the credit scoring program;

5) the number of times a security deposit was waived for low-income applicants and for other applicants, with stated reasons for the waiver;

6) the number of disconnections of service for applicants who failed to pay the required deposit; and

7) the number of formal or informal complaints alleged by applicants regarding the use of credit scoring or the requirement to pay a deposit based on the credit scoring program.

Section 280.60 Present Customers

a) A utility may request a deposit pursuant to Section 280.70 herein from a present residential or present non-residential customer during the first twenty-four months that the customer receives utility service from the utility if the customer, during any twelve month period, pays late four times if billed monthly, two consecutive times or three times if billed bi-monthly or two times if billed quarterly or semi-annually, or if the customer's wires, pipes, meters or other service equipment have been tampered with and the customer enjoyed the benefit of the tampering.

b) A utility may request a deposit pursuant to Section 280.70 herein from a present residential customer after the first 24 months that the customer has received utility service if the customer's wires, pipes, meters or other service equipment have been tampered with and the customer enjoyed the benefit of the tampering.

c) A utility may request a deposit pursuant to Section 280.70 herein from a present non-residential customer after the first twenty-four months that the customer has received utility service if the customer, during any twelve-month period ending after the first twenty-four months of service, pays late six times if billed monthly, three times if billed bi-monthly or two times if billed quarterly or semi-annually, or if the customer's wires, pipes, meters or other service equipment have been tampered with and the customer enjoyed the benefit of the tampering.

d) A utility requesting a deposit for any of the reasons stated in this Section shall make such request within forty-five days after the event giving rise to the request takes place. In the event the customer's wires, pipes, meters or other service equipment have been tampered with and the customer enjoyed the benefit of the tampering the request for deposit must be made within forty-five days after the discovery of the tampering.

e) A present customer whose service is discontinued becomes an applicant for service subject to the provisions of Section 280.50 herein for purposes of reconnection of his/her service.

f) Present residential customers who are indebted to a utility for past due utility service shall have the opportunity to negotiate a deferred payment agreement pursuant to Section 280.110 herein to retire the debt. Present non-residential customers who are indebted to a utility for past due utility service may have the opportunity to negotiate a deferred payment agreement pursuant to Section 280.110 herein to retire the debt.

Section 280.70 Deposits

a) Applicants for Service – Conditions under which a utility may request a deposit from applicants for service are set out in Section 280.50.

b) Present Customers – Conditions under which a utility may request a deposit from present customers are set out in Section 280.60.

c) Amount

1) Deposits required of applicants for residential service, residential customers, applicants for non-residential service that are not "small businesses" (see Section 280.40), and non-residential customers that are not small businesses, shall be governed by the following:

A) In the case of gas utilities and electric utilities, no utility shall request a deposit from an applicant for residential service or from a residential customer *in excess of $^{1}/_{6}$ of the estimated annual charges for service for the applicant or customer computed at the net rate for that class of service.* [220 ILCS 35/3] In the case of gas utilities and electric utilities, no utility shall request a deposit from an applicant for non-residential service or from a non-residential customer in excess of ⅓ of the amount of the estimated annual charges for service for the applicant or customer computed at the net rate for that class of service. In the case of water utilities and sanitary sewer utilities, no utility shall request a deposit from an applicant or customer in excess of ⅓ of the estimated annual charges for service computed at the net rate for that class of service.

B) *A utility may request that a minimum of ⅓ of the amount of a requested deposit be paid within twelve days after the issue date of*

the request for deposit. At least two billing periods shall be allowed by gas utilities and electric utilities in which to pay the balance of the deposit. A period of 30 days shall be allowed by water utilities and sanitary sewer utilities in which to pay the balance of the deposit.

2) Deposits required of small business applicants and customers shall be governed by the following:

A) No utility subject to this Part shall request a deposit from a small business *in excess of $^{1}/_{6}$ of the estimated annual charge for service for that small business computed at the net rate for that class of service.*

B) *A utility may request a minimum amount equal to ⅓ of a requested deposit to be paid within 12 days after the issue date of a notice requesting such deposit. A utility may require the full payment of the remaining balance of the deposit to be paid by the applicant no sooner than 2 billing periods typically or routinely used by the utility.*

3) For all deposits, *the date by which the entire deposit must be paid must be plainly indicated on the deposit request. The amount of the deposit may be adjusted at the request of the customer, applicant or utility at any time when the character or degree of use of the service materially changes or when it is clearly established that the character or degree of use of the service will materially change in the immediate future.*

d) Refund of Deposits

1) Deposits plus interest shall be automatically refunded after being held for twelve months as follows:

A) if the twelve months during which the deposit was held are within the first 24 months that a customer has received utility service, the deposit plus interest shall be refunded only so long as the service has not been interrupted for nonpayment or so long as the customer has not paid late four times if billed monthly, two consecutive times or three times if billed bi-monthly or two times if billed

quarterly or semi-annually or so long as the customer's wires, pipes, meters or other service equipment have not been tampered with during the time the deposit was held which resulted in the customer enjoying the benefit of the tampering;

B) if the twelve months during which the deposit was held were subsequent to the first 24 months that a customer has received utility service, the deposit plus interest shall be refunded only so long as the service has not been interrupted for nonpayment or so long as the customer has not paid late six times during the past twelve months if billed monthly, or three times if billed bi-monthly or two times if billed quarterly or semi-annually or so long as the customer's wires, pipes, meters or other service equipment have not been tampered with during the time the deposit was held which resulted in the customer enjoying the benefit of the tampering.

C) deposits plus interest need not be refunded until the customer pays any past due bills for utility service.

2) Deposits plus interest shall be refunded upon the discontinuance of service for more than 30 days less the amount of unpaid bills, if any, for the service. A transfer of service from one premise to another within the area served by the utility need not be deemed a discontinuance of service by the utility if the character of service remains the same. When a deposit plus interest is applied to the liquidation of unpaid bills, the utility shall provide the customer with a statement (Cancellation Notice) showing the amount of the deposit, the amount of any accrued interest, the amount of the unpaid bills liquidated by the deposit plus interest and the balance remaining due either to the customer or to the utility.

3) All deposit refunds shall be by separate check and not by credit to the customer's account except where discontinuance of service is affected.

4) At the option of the utility, a deposit plus interest may be refunded, in whole or in part, at any time earlier than the times prescribed in this subsection (d).

e) Interest on Deposits

1) Interest shall be paid on all deposits held by the utility. The rate of interest will be the same as the rate existing for the average one-year yield on U.S. Treasury securities for the last full week in November. The interest rate will be rounded to the nearest .5%. In December of each year the Commission shall announce the rate of interest that shall be paid on all deposits held during all or part of the subsequent year.

2) At the end of every year of service, if the deposit plus interest is not refunded to the customer, the utility shall automatically refund the accrued interest on the deposit to the customer by crediting the customer's account and so stating this credit clearly on the customer's next regular bill.

f) Records of Deposits

1) A utility shall maintain records of deposits together with interest, which collectively will show all transactions pertaining to each deposit. A utility shall provide the applicant or customer with a Certificate of Deposit for any deposit received. The Certificate shall show the customer's name, service address, serial number, type of service, amount of deposit, rate of interest on deposit, date received, utility's name and a statement of the conditions under which the deposit will be refunded to the applicant or customer. Nothing is implied herein to require a utility to accept deposits from third parties on behalf of an applicant or customer.

2) When a deposit is refunded, the utility shall issue a Cancellation Notice carrying the same serial number as the Certificate of Deposit. When refunds are not deliverable, records shall be maintained to show a utility's efforts toward locating the applicant or customer and delivering such deposit.

AGENCY NOTE: As required by 1 Ill. Adm. Code 100.380, statutory language in this Section appears in distinguishing type. However, the Small Business Utility Deposit Relief Act, which is the statute quoted, applies only to deposits requested from "small businesses" as defined in Section 280.40. Therefore, the statutory language in this Section is statutorily mandated as to small businesses only, and not as to other customers or applicants.

Section 280.75 Refunds

a) In the event that *a customer pays a bill as submitted by a public utility and the billing is later found to be incorrect due to an error either in charging more than the published rate, in measuring the quantity or volume of service provided,* or in charging for the incorrect class of service, *the utility shall refund the overcharge with interest from the date of overpayment* by the customer.

b) The rate of interest shall be the rate as established by the Commission to be paid on deposits in Section 280.70(e)(1) of this Part.

c) The refund shall be accomplished either by a credit on a subsequent bill for service or by check if the account is final or if so requested by the customer.

Section 280.76 Refunds of Additional Charges

In the event that the Commission orders a public utility to refund incorrectly calculated additional charges made pursuant to Section 9-221 or Section 9-222 of the Public Utilities Act, the public utility shall pay interest on such refund at the rate established by the Commission to be paid on deposits in 83 Ill. Adm. Code 280.70(e)(1).

Section 280.80 Estimated Bills

a) All utilities shall make an actual meter reading at least every second billing period, and no utility may consecutively estimate a customer's service usage unless:

1) the procedure used by the utility to calculate estimated bills has been approved by the Commission; and

2) the word "estimate" appears prominently on the face of the bill, in a manner previously approved by the Commission.

b) Notwithstanding the provisions of subsection (a) of this Section, the utility may render an estimated bill for any billing period in which:

1) the utility has taken appropriate and reasonable measures to read the meter, including but not limited to, making an appointment with the customer, scheduling readings for times other than normal business hours, and/or providing postal cards on which the customer may record the reading and mail it to the utility; or

2) the customer has knowingly and willfully denied reasonable access to the utility's representative for the purpose of taking an actual reading of the meter; or

3) the customer has otherwise made an actual reading of the meter unnecessarily difficult; or

4) circumstances beyond the control of the utility make an actual reading of the meter extremely difficult.

Section 280.90 Past Due Bills and Late Payment Charges

a) A utility shall not consider a customer's bill, when paid in person, past due unless the payment is made after the due date printed on the bill. When a customer mails any payment in the net amount of a bill for service, and such payment is received at the utility's office not more than two full business days after the due date printed on the bill, the customer shall be deemed to have made timely payment. In determining whether a bill is past due, a utility may rely on the postmark of the payment, in which case, the payment shall be considered past due if the payment is postmarked after the due date printed on the bill.

b) Each utility shall choose one of the above methods for determining when a bill is past due and shall apply this method to all customers. For utilities which choose the postmark method, in instances where the postmark is illegible or absent, the customer's payment shall be deemed timely made if the payment is received at the utility's office not more than two full business days after the due date printed on the bill.

c) For residential service, the due date printed on the bill may not be less than twenty-one days after the date of the postmark on the bill, if mailed, or the date of delivery as shown on the bill if delivered by other means. For non-residential service, the due date printed on the bill may not be less than fourteen days after the date of the postmark on the bill, if mailed, or the date of delivery as shown on the bill if delivered by other means.

d) If a utility elects to assess a late payment charge and files a tariff in accordance with the rules set forth herein, such charge shall be set at an amount equal to 1 ½% per month on any amount, including amounts previously past due, for utility

service which is considered past due under this Section.

e) A utility shall waive the assessment of a late payment charge for residential customers one time per twelve month period if it bills on a monthly or bi-monthly basis, and for residential customers one time per twenty-four month period if it bills on a quarterly or semi-annual basis. The utility may assess a charge if the amount on which the late payment charge was waived remains unpaid 30 days following the due date. At its discretion, a utility may waive more than one late payment charge for residential customers. However, a utility is not obliged to waive any late payment charges for units of government.

f) A utility may not continue to assess a late payment charge on any final bill which has been outstanding for more than 12 months.

g) No utility shall assess a late payment charge bill for a budget or levelized payment plan or for any amount billed which is not for utility service.

h) No late payment charges shall be assessed on the amounts owing on units of Federal, State, County, and local government (including, but not limited to, townships, municipalities and school districts) until 45 days from the date of the issuance of the bill for utility service, except that the provisions of "An Act to require prompt payments by the State of Illinois for goods or services" (Ill. Rev. Stat. 1981, ch. 127, par. 132.401 et seq.), as amended, control in the situations to which that Act applies.

i) Nothing in this Section shall deny a utility the ability to disconnect service for nonpayment of a bill for utility service in accordance with the provisions of the utility's tariffs and this Part.

j) Preferred Payment Date – When an eligible residential customer who is billed on a monthly basis for utility service shows the company that he receives funds which comprise the primary source of his income during the 10 day period following the due date of one utility bill and the date of issuance of his next utility bill, the company will, upon the customer's request allow that customer to:

1) Enter into a levelized payment plan or budget billing arrangement with a preferred date agreed upon by both the company and the customer which shall not be more than 10 days subsequent to the customer's regular due date, or

2) Establish a preferred payment date on which to make payment for utility service, which shall not be more than 10 days subsequent to the customer's regular due date.

k) The company shall inform the customer that he may accept either option, based upon his own assessment of his personal finances and living situation.

l) Only those residential customers who fall into the following categories are eligible for a preferred payment date:

1) Persons receiving Aid to Families with Dependent Children (AFDC) or Aid to the Aged, Blind and Disabled (AABD) benefits from the Illinois Department of Public Aid.

2) Persons receiving benefits from General Assistance or Supplemental Security Income.

3) Persons receiving their primary source of income from Social Security benefits or Veterans Administrative benefits.

4) Persons receiving unemployment compensation.

m) If the customer fails to pay by the preferred payment date more than four times in a twelve month period, the original due date may be re-established and the company may decline to offer a preferred payment date to the customer for a period of twelve months.

Section 280.100 Unbilled Service

a) A utility may render a bill for services or commodities provided to:

1) A residential customer only if such bill is presented within one year from the date the services or commodities were supplied, or

2) A non-residential customer only if such bill is presented within two years from the date the services or commodities were supplied.

b) No customer shall be liable for unbilled or misbilled service after expiration of the

applicable period except in those instances to which 83 Ill. Adm. Code 500.240(a), 83 Ill. Adm. Code 410.260(c), or the following subsections of this Section apply.

c) Tampering

1) When there has been tampering with wires, pipes, meters or other service equipment and the customer has enjoyed the benefit of such tampering, the utility is not restricted to the above time limitations on unbilled service. When a utility applies this provision to bill for service which occurred outside the applicable time limitations, a customer may dispute the bill under the provisions of Sections 280.160 and 280.170 of this Part. The customer shall be responsible for all service usage, and the utility may bill the customer for all service usage during the period the tampering occurred. Customers may be billed for diverted service not used by that customer if that customer had knowledge of or consented to the diversion.

2) If a utility alleges that tampering has occurred, the utility shall have the burden of proving, by a preponderance of the evidence, that the customer's meter has been tampered with, that the customer has benefitted from the tampering and that the utility's rebilling is reasonable.

d) When past due bills occur following the issuance of a "make-up" bill for previously unbilled utility service resulting from two or more consecutive estimated bills, utility billing error, meter failure, or undetected leakage or undetected loss of service, except in situations where tampering is involved, and where the "make-up" bill exceeds the otherwise normal bill for such billing period by 50%, a utility shall review the bill with the customer, and shall offer to accept payments toward the liquidation of the amount over a normal bill over a period mutually agreed to by the utility and the customer. This period of time shall be at least as long as the period over which the excess amount accrued. Where the excess billing resulted from undetected leakage or loss of service, the period shall be extended so that the bill rendered will not be greater than a normal bill, plus 50%.

e) When a utility computer rejects a bill because it is abnormally high or low, and the utility chooses to delay billing by more than five days, the utility must nevertheless send the customer a statement at the regular billing period which shows that billing has been delayed and that an investigation is being conducted

by the utility.

Section 280.105 Treatment of Illegal Taps

a) Where within 30 days of receipt of a utility's bill a customer alleges that the level of consumption reflected in his utility bill is unreasonably high, it shall be the responsibility of the public utility furnishing natural or artificial gas, electricity, or water to that customer to investigate the allegation. If, as a result of such investigation, the public utility determines that a tap has been constructed on the pipes and/or wires of the customer, the utility shall attempt to notify the landlord or his agent and instruct that the tap should be removed immediately. However, this provision shall in no way prohibit a utility from disconnecting service if the utility determines that an unsafe condition exits. The utility shall also attempt to determine the identity of the party benefiting from such tapped service.

b) If the utility determines that the third party benefiting from the tapped service is not the landlord or his agent as described in Section 54(b) of the Public Utilities Act, the following procedures shall apply once the tap has been removed. The customer whose pipes and/or wires had been tapped by a third party shall be billed by the utility according to a domestic use and/or degree day analysis, whichever is appropriate.

c) If the utility identifies the third party and finds that he is currently a customer of the utility on another account, the utility is authorized to bill that third party's account for the excess usage which is not attributable to the customer whose line had been tapped plus all related expenses incurred by the utility. If the utility identifies the third party and finds that he is not a customer of the utility, the utility is authorized to bill that third party for the excess usage which is not attributable to the customer plus all related expenses incurred by the utility using the procedures established for the billing of unauthorized use of utility service. In cases where the utility cannot determine the identity of the party benefiting from the tap, the utility may assign the dollar amount representing the excess usage and expenses to its bad debt account.

d) In cases where the diversion of gas or electricity is the result of a construction error in the pipes and/or wires which are not the responsibility of the public utility, the accounts of the customers involved may be adjusted according to a domestic use and/or degree day analysis, whichever is appropriate.

e) In instances where the customer of record benefited from, cooperated in or acquiesced to the tap, the utility may collect from the customer of record for the service associated with the tap.

Section 280.110 Deferred Payment Agreements

a) Residential customers who are indebted to a utility for past due utility service shall have the opportunity to make arrangements with the utility to retire the debt by periodic payments referred to hereinafter as a deferred payment agreement unless this customer has failed to make payment under such a plan during the past twelve months. All applicants for service and non-residential customers who are indebted to a utility for past due utility service may have the opportunity, at the discretion of the utility (with the exception of those former customers eligible for reconnection under Section 280.130 herein), to make arrangements with the utility to retire the debt by periodic payments referred to hereinafter as a deferred payment agreement.

b) The terms and conditions of a reasonable deferred payment agreement and the utility's decision whether or not to offer an applicant for service a deferred payment agreement shall be determined by the utility after consideration of the following factors, based upon information available from current utility records or provided by the customer or applicant:

1) size of the past due account; and

2) customer or applicant's ability to pay; and

3) customer or applicant's payment history; and

4) reason for the outstanding indebtedness; and

5) any other relevant factors relating to the circumstances of the customer or applicant's service.

c) An applicant for residential service or a residential customer shall pay a maximum of ¼ of the amount past due and owing at the time of entering into the deferred payment agreement, and an applicant for non-residential service or a non-residential customer shall pay ⅓ of the amount past due and owing at the time of entering into the deferred payment agreement. The utility shall allow a minimum

of two months (or, in the case of a gas or electric utility, four months) from the date of said agreement and a maximum of twelve months for payment to be made under a deferred payment agreement. A gas or electric customer may be permitted to enter into a deferred payment agreement which extends over less than four months, if he so chooses. Late payments charges may be assessed against the amount owing which is the subject of a deferred payment agreement.

d) A deferred payment agreement shall be in writing, with a copy provided to the applicant or customer, and shall conform to the following requirements:

1) the applicant or customer shall be required to pay all future bills for utility service by the due date; and

2) the applicant or customer shall retire his/her debt according to the terms of the deferred payment agreement.

e) A gas or electric utility shall explain the rules concerning a deferred payment agreement as set forth in this Section by means of an insert which shall be enclosed with each notice of disconnection sent to a residential gas or electric customer. Such insert shall be in the form set forth in Appendix D of this Part or, if approved by this Commission, a variation thereof. This information shall also be provided to gas or electric customers or applicants who visit the company's business office in order to negotiate a deferred payment agreement.

f) Renegotiation
If the gas or electric customer's economic or financial circumstances change during the effective period of a deferred payment agreement, and not more than 14 days has elapsed since the customer defaulted on the deferred payment agreement, the company shall be obliged, if the customer so requests, to renegotiate the terms and conditions of the deferred payment agreement, taking into consideration the changed economic and financial circumstances substantiated by the customer. The reinstatement of a previously defaulted deferred payment agreement pursuant to the provisions of this Section set forth below shall not prevent the renegotiation of a deferred payment agreement. However, the utility shall be obliged to renegotiate any deferred payment agreement more than one time or to extend the payment period beyond the maximum of twelve months available at the time the company and the customer entered into the original deferred payment agreement.

g) Reinstatement

1) If a gas or electric customer defaults on a deferred payment agreement but has not yet had service discontinued by the gas or electric utility, the utility shall permit such customer to be reinstated on the deferred payment agreement if the customer pays in full the amounts which should have been paid up to that date pursuant to the original payment agreement (including any amounts for current usage which have become past due). A utility shall be obliged to permit such reinstatement only once during the course of a deferred payment agreement.

2) If an applicant or customer shall default upon any payment due under the deferred payment agreement, the utility shall have the right to discontinue service pursuant to Section 280.130 herein, subject to the renegotiation and reinstatement provisions contained in this Section.

Section 280.120 Budget Payment Plan

When the character of an applicant's or customer's consumption of service causes or is likely to cause a substantial fluctuation among his/her bills over an annual period, the utility shall offer to the applicant or customer a budget payment plan which equalizes his/her payments into monthly installments. An applicant's or customer's budget payment plan may be terminated by a utility if the applicant or customer fails to meet the payment requirements under the plan.

Section 280.130 Discontinuance of Service

a) Discontinuance

1) A utility may discontinue service when any customer fails to do any of the following:

A) make a deposit or increase a deposit pursuant to Section 280.70 herein;

B) pay a past due bill owed to the utility for the same class of service furnished at the same or at another location. For purposes of this subsection, a utility may discontinue service if the current customer is liable for a past due bill for utility service pursuant to Section 15 of the Rights of Married Persons Act [750 ILCS 65/15],

unless the customer, at the option of the utility, pays any past due bill and/or provides a deposit pursuant to Section 280.70 and/or enters into a deferred payment agreement pursuant to Section 280.110;

C) comply with an order of the Commission;

D) make payment in accordance with the terms of a deferred payment agreement;

E) comply with any rules of the utility on file with the Commission for which the utility is authorized by tariff to discontinue service for noncompliance on the part of the customer or user; or

F) provide utility representatives with access to the meter after receiving consecutively estimated bills for four billing periods if billed monthly or bi-monthly or two billing periods if billed quarterly or semi-annually and the utility thereafter makes a written request for access.

2) The utility can discontinue service only after it has mailed or delivered by other means a written notice of discontinuance substantially in the form of Appendix A. Any notice required to be delivered or mailed to a customer prior to discontinuance of service shall be delivered or mailed separately from any bill. Service shall not be discontinued until at least five days after delivery or eight days after the mailing of this notice.

b) In addition, a copy of said notice shall be mailed to a third party designated by the customer, should the customer make a written request to the utility for such third party notice.

c) Said notice shall remain effective for two consecutive twenty day periods, provided that during each such period a call is made at the customer's premises or billing address or telephone contact with the customer is made. If the utility does not discontinue service within the two consecutive twenty day periods, the utility shall not discontinue service until at least five days after delivery or eight days after mailing of a new notice of its intention to discontinue service to the customer.

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d) A utility shall attempt to advise the customer that service is being discontinued by directing its employee making the disconnection to contact the customer at the time service is being discontinued. When the utility is unable to discontinue service during a call made at the customer's premise, the utility shall attempt to leave a notice at the premise or billing address informing the customer that an attempt to discontinue service has been made and that his/her service continues to be subject to discontinuance.

e) The utility shall not make a practice of delivering more than two consecutive notices of discontinuance for past due bills without engaging in collection activity with the customer.

f) A utility shall not discontinue service at the meter subsequent to 2:00 P.M. unless the utility shall be prepared to reconnect the same day at the standard reconnection charge, if any. No utility shall discontinue service on a holiday or weekend day unless prepared to reconnect on that holiday or weekend day.

g) Utility service shall not be discontinued and shall be restored if discontinued where a customer has established, renegotiates, or is reinstated onto a deferred payment agreement pursuant to Section 280.110 and has not defaulted on such agreement.

h) Utility service shall not be discontinued and shall be restored if discontinued for the reason which is the subject of a dispute or complaint during the pendency of procedures under Section 280.160 and/or Section 280.170 where the customer has complied with such Sections.

i) Termination of gas and electric utility service to all residential users, including all tenants of apartment buildings, for nonpayment of bills where gas or electricity is used as the only source of space heating or to control or operate the only space heating equipment at the residence is prohibited:

1) on any day when the National Weather Service forecast for the following 24 hours covering the area of the utility in which the residence is located includes a forecast that the temperature will be 32 degrees Fahrenheit or below; or

2) on any day preceding a holiday or a weekend when such a forecast indicated that the temperature will be 32 degrees Fahrenheit or below

during the holiday or weekend.

j) Notwithstanding any of the foregoing provisions, discontinuance of service to residential customers is prohibited for up to sixty days when discontinuance of service will aggravate an existing serious illness of any person who is a permanent resident of the premise where service is rendered if the customer complies with the following requirements regarding such illness:

1) The illness must be certified to the utility by a registered physician or local board of health. The certification shall be in writing and shall include the name of the ill person, a statement that he/she is a resident of the premises in question, the name, business address, and telephone number of the certifying party, the nature of the illness, and the period of time during which termination will aggravate the illness;

2) Initial certification by the certifying party may be by telephone if written certification is forwarded to the utility within five days;

3) Initial certification shall prohibit discontinuance of service for thirty days. Certification may be renewed by the customer for an additional thirty days by providing another certificate to the utility. Failure to so renew the certificate shall entitle the utility to initiate discontinuance procedures;

4) The customer must enter into an agreement for the retirement of the unpaid balance of the account within the first thirty days and keep the current account paid during the period that the unpaid balance is to be retired. Notice of discontinuance of service sent to residential customers must include a notice substantially in the form of Appendix B herein; and

5) In the event service is terminated within fourteen days prior to certification of illness by or for a qualifying resident, service shall be restored to that residence if a proper certification is thereafter made in accordance with the foregoing provisions.

k) Nothing in this Section or this Part shall be construed to prevent discontinuance of service for reasons of safety, health, or cooperation with civil authorities.

Section 280.135 Discontinuance of Service During the Period of Time from December 1 Through and Including March 31

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a) Notwithstanding any other provision of this Part, no electric or gas public utility shall disconnect service to any residential customer or master-metered apartment building for nonpayment of a bill or deposit where gas or electricity is used as the primary source of space heating or is used to control or operate the primary source of space heating equipment at the premise during the period of time from December 1 through and including March 31 of the immediately succeeding calendar year, unless:

1) The utility:

A) has offered the customer a deferred payment arrangement allowing for payment of past due amounts over a period of not less than four months not to extend beyond the following November and the option to enter into a levelized payment plan for the payment of future bills. The maximum down payment requirements shall not exceed 10 percent of the amount past due and owing at the time of entering into the agreement.

B) names, addresses and telephone numbers of governmental and private agencies which may provide assistance to customers of public utilities in paying their utility bills; the utility must obtain the approval of an agency before placing the name of that agency on any list which will be used to provide such information to customers;

2) The customer has refused or failed to enter into a deferred payment arrangement as described in subsection (a)(1)(A) above; and

3) All notice requirements as provided by law and this Part have been met.

b) Prior to termination of service for any residential customer or master-metered apartment building during the period from December 1 through and including March 31 of the immediately succeeding calendar year, all electric and gas public utilities shall, in addition to all other notices:

1) Notify the customer or an adult (as defined in the Probate Act of 1975, Ill. Rev. Stat. 1981, ch. 110½, par. 11-1) residing at the customer's premise either by telephone, a personal visit to the customer's premise or by First

Class mail, informing the customer that:

A) the customer's account is in arrears and the customer's service is subject to termination for nonpayment of a bill;

B) the customer can avoid disconnection of service by entering into a deferred payment agreement to pay past due amounts over a period not to extend beyond the following November and the customer has the option to enter into a levelized payment plan for the payment of future bills;

C) the customer may apply for any available assistance to aid in the payment of utility bills from any governmental or private agencies from the list of such agencies provided to the customer by the utility,

provided, however, that a public utility shall be required to make only one such contact with the customer during any such period from December 1 through and including March 31 of the immediately succeeding calendar year.

2) Each public utility shall maintain records which shall include, but not necessarily be limited to, the manner by which the customer was notified and the time, date and manner by which any prior but unsuccessful attempts to contact were made. These records shall also describe the terms of the deferred payment arrangements offered to the customer and those entered into by the utility and customers. These records shall indicate the total amount past due, the down payment, the amount remaining to be paid and the number of months allowed to pay the outstanding balance. No public utility shall be required to retain records pertaining to unsuccessful attempts to contact or deferred payment arrangements rejected by the customer after such customer has entered into a deferred payment arrangement with such utility.

c) No public utility shall disconnect service for nonpayment of a bill until the lapse of six business days after making the notification required by subsection (b)(1) of this Section so as to allow the customer an opportunity to:

1) Enter into a deferred payment arrangement and the option to enter into a

levelized payment plan for the payment of future bills.

2) Contact a governmental or private agency that may provide assistance to customers for the payment of public utility bills.

d) Any residential customer who enters into a deferred payment arrangement pursuant to this Section, and subsequently, during that period of time set forth in subsection (a) of this Section, becomes subject to termination, shall be given notice as required by law and this Part prior to termination of service.

e) During that time period set forth in subsection (a) of this Section, a utility shall not require a down payment for a deposit from a residential customer, pursuant to Section 280.60 of this Part, in excess of twenty percent of the total deposit requested. An additional four months shall be allowed to pay the remainder of the deposit. This provision shall not apply to master-metered apartment buildings or other non-residential customers.

f) During that period of time set forth in subsection (a) of this Section, the provisions of Section 280.110 of this Part which allow a utility to refuse to offer a deferred payment agreement to a residential customer who has defaulted on such an agreement within the past twelve months are suspended. However, no utility shall be required to enter into more than one deferred payment arrangement under this Part with any residential customer or master-metered apartment building during the period from December 1 through and including March 31 of the immediately succeeding calendar year.

g) In order to enable customers to take advantage of energy assistance programs, customers who can demonstrate that their applications for a local, state or federal energy assistance program have been approved may request that the amount they will be entitled to receive as a regular energy assistance payment be deducted and set aside from the amount past due on which they make deferred payment arrangements. Payment on the set-aside amount will be credited when the energy assistance voucher or check is received, according to the utility's common business practice.

h) In no event shall any utility send a Final Notice to any customer who has entered into a current Deferred Payment Agreement and has not defaulted on that Deferred Payment Agreement, unless the Final Notice pertains to a deposit request.

i) Each utility will include with each disconnection notice sent during the period from December 1 through and including March 31 of the immediately succeeding calendar year to a residential customer an insert explaining the above provisions and providing a telephone number of the utility company which the customer may call to receive further information.

j)

1) Each utility shall file with the Commission prior to December 1 of each year a plan detailing the implementation of this rule. This plan shall contain, but not be limited to:

A) a description of the methods to be used to notify residential customers as defined in this Part, including the forms of written and oral notices which shall be required to include all the information contained in subsection (b) of this Section;

B) a listing of the names, addresses and telephone numbers of governmental and private agencies which may provide assistance to residential customers in paying their utility bills;

C) the program of employee education and information which shall be used by the company in the implementation of this Section;

D) a description of methods to be utilized to inform residential customers of those governmental and private agencies and current and planned methods of cooperation with those agencies to identify the customers who qualify for assistance in paying their utility bills.

2) A utility which has a plan on file with the Commission need not resubmit a new plan each year. However, any alteration of the plan on file must be submitted and approved prior to December 1 of any year.

3) All plans are subject to review and approval by the Commission which may direct a utility to alter its plan to comply with this Part.

Section 280.136 Energy Act of 1989 Participants Discontinuance Prohibition

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Notwithstanding any other provision of this Part*, no electric or gas public utility shall disconnect service to any residential customer who is a participant under Section 6 of the Energy Assistance Act of 1989* [305 ILCS 20/6] *for nonpayment of a bill or deposit where gas or electricity is used as the primary source of space heating or is used to control or operate the primary source of space heating equipment at the premises during the period of time from December 1 through and including March 31 of the immediately succeeding calendar year.* [220 ILCS 5/8-206(k)]

Section 280.138 Reconnection of Former Residential Utility Customers for the Heating Season

a) *Any former residential customer whose gas or electric service was used to provide or control the primary source of space heating in the dwelling and whose service is disconnected for non-payment of a bill or a deposit from December 1 of the prior winter's heating season through April 1 of the current heating season shall be eligible for reconnection and a deferred payment arrangement under the provisions of this Section, subject to the following limitations:*

b) *A utility shall not be required to reconnect service to and enter into a deferred payment arrangement with a former customer under the provisions of this Section:*

1) *except between November 1 and April 1 of the current heating season for former customers who do not have applications pending for the program described in Section 6 of the Energy Assistance Act of 1989* (Ill. Rev. Stat. 1991, ch. 111⅔, par. 1406), *and except between October 1 and April 1 of the current heating season for all former customers who do have applications pending for the program described in Section 6 of the Energy Assistance Act of 1989 and who provide proof of application to the utility.*

2) *in two consecutive years;*

3) *unless that former customer has paid at least 33⅓ percent of the amount billed for utility service rendered by that utility subsequent to December 1 of the prior year; or*

4) *in any instance where the utility can show there has been tampering with the utility's wires, pipes, meters (including locking devices), or other service equipment and further shows that the former customer enjoyed the benefit of utility service obtained in the aforesaid manner.*

c) *The terms and conditions of any deferred payment arrangements established by the utility and a former customer shall take into consideration the following factors, based upon information available from current utility records or provided by the former customer:*

1) *the amount past due; and*

2) *the former customer's ability to pay; and*

3) *the former customer's payment history; and*

4) *the reasons for the accumulation of the past due amounts; and*

5) *any other relevant factors relating to the former customer's circumstances.*

d) *After the former customer's eligibility has been established in accordance with the first paragraph of this Section, and, upon the establishment of a deferred payment agreement, the former customer shall pay ⅓ of the amount past due (including reconnecting charge, if any) and ⅓of any deposit required by the utility.*

e) Reconnection

1) *Upon the payment of ⅓of the amount past due and 1/3 of any deposit required by the utility, the former customer's service shall be reconnected as soon as possible. The company and the former customer shall agree to a payment schedule for the remaining balances which will reasonably allow the former customer to make the payments on the remainder of the deposit and the past due balance while paying current bills during the winter heating season.*

2) Notwithstanding the foregoing, *a former customer who demonstrates* to the utility, or to the Commission through a formal or informal complaint under Sections 280.160 or 280.170, *a financial inability to meet the requirement of ⅓ of the amount past due and ⅓ of any deposit requested by the utility, shall be reconnected upon paying a reasonable amount and upon entering into a deferred payment agreement* (Section 8-207 of the Public Utilities Act ("Act") (Ill. Rev. Stat. 1991, ch. 111⅔, par. 8-207).

A) In determining financial inability under this subsection, the following factors, among others, shall be considered:

i) the combined income and financial resources of all persons residing in the former customer's household,

ii) the combined living expense of the former customer's household,

iii) *the former customer's payment history, and*

iv) *the reasons for the accumulation of the past due amounts.*

B) For purposes of this subsection, a "reasonable amount" shall be deemed to be 20 percent of the amount past due and 20 percent of any deposit required by the utility.

3) *However, the utility is not obliged to make payment arrangements extending beyond the following November. The utility shall allow the former customer a minimum of four months in which to retire the past due balance and three months in which to pay the remainder of the deposit. The former customer shall also be informed that payment on the amounts past due and the deposit, if any, plus the current bills must be paid by the due date or the customer may face termination of service pursuant to Sections 280.130, 280.135 and 280.138 of this Part.*

f) *Any payment agreement made shall be in writing, with a copy provided to the former customer.* The renegotiation and reinstatement provisions contained in Section 280.110 and the Budget Payment Plan provision of Section 280.120 shall also apply to payment agreements made pursuant to this Section.

g) *Not later than September 15 of each year, every gas and electric utility shall conduct a survey of all former residential customers whose gas and/or electric service was used to provide or control the primary source of space heating in the dwelling and whose gas and/or electric service was terminated for nonpayment of a bill or deposit from December 1 of the previous year to September 15 of that year and where service at that premises has not been restored. Not later than October 1 of each year the utility shall notify each of these former customers that the gas and/or electric service will be restored by the company for the coming*

heating season if the former customer contacts the utility and makes arrangements to pay the past due balance and any deposit to the utility under the conditions set forth in this Section. A utility shall notify the former customer or an adult member of the household by personal visit, telephone contact or mailing of a letter by First Class mail to the last known address of that former customer. The utility shall keep records which would indicate the date, form and the results of such contact.

h) Not later than February 20 and May 20 of each year, *each gas and electric utility which has former customers affected by this Section shall file a report with the Commission providing* statistical data concerning numbers of disconnections and reconnections involving utility service and deposits, and data concerning the dollar amounts involved in such transactions. *The Commission shall notify each gas and electric utility prior to August 1 of each year concerning the information which is to be included in the report for the following heating season* (Section 8-207 of the Act).

i) *In no event shall any actions taken by a utility in compliance with this Section be deemed to abrogate or in any way interfere with the utility's rights to pursue the normal collection processes otherwise available to it.*

Section 280.140 Discontinuance of Service to Accounts Affecting Master Metered Apartment Buildings

"An Act providing remedies for lessees in relation to the failure of lessors to pay for utility services" (Ill. Rev. Stat. 1981, ch. 80, pars. 62 et seq.) governs procedures for discontinuance of service to accounts affecting master-metered apartment buildings. These procedures include measures to inform tenants of the pending discontinuance of their utility service and set out their remedies including their right to petition a court for appointment of a receiver to collect rents and remit a portion thereof to the utility for payment of utility bills.

Section 280.150 Service Reconnection Charge

When service has been discontinued pursuant to Section 280.130 herein, the utility may charge and collect the reconnection charge, if any, set forth in its rules, regulations or terms and conditions of service which are on file with the Commission. Such rules, as filed, shall provide for the automatic waiver of one service reconnection charge for each customer for each year. For gas utilities and electric utilities, such automatic waiver shall apply only to reconnection at the meter. For water utilities and sanitary sewer utilities, such automatic waiver shall apply to

reconnection at the meter or curb valve (buffalo box). Customers may be liable for the additional costs incurred in disconnecting and reconnecting service other than at the meter, or for water utilities and sanitary sewer utilities, other than at the curb valve.

Section 280.160 Dispute Procedures

a) A utility shall assign to one or more of its personnel in each of its offices where it transacts business with the public, the duty of hearing, in person, any dispute by an applicant, customer or user. Such personnel shall consider the complainant's allegations and shall explain the complainant's account and utility's contentions in connection therewith. Such personnel shall be authorized to act on behalf of the utility in resolving the complaint and shall be available during all business hours for the duty hereinbefore described.

b) Where any dispute between a utility and an applicant, customer or user cannot be resolved between the parties, each utility shall direct its personnel engaged in personal contact with the applicant, customer or user seeking such dispute resolution under the provisions of this Part, to inform him/her, if he/she expresses nonacceptance of the decision of such personnel, of his/her right to have the problem considered and acted upon by supervisory personnel of the utility. Each utility shall further direct such supervisory personnel to inform such an applicant, customer, or user who expresses nonacceptance of the decision of such supervisory personnel, of his/her right to have the problem reviewed by the Commission, and shall furnish him/her with the telephone number and address of the Consumer Assistance Section of the Illinois Commerce Commission.

c) When a customer disputes a particular bill, a utility shall not discontinue service for nonpayment so long as the customer

1) pays the undisputed portion of the bill or an amount equal to last year's bill at the location for the same period normalized for weather, whichever is greater; and

2) pays all future periodic bills by the due date; and

3) enters into bona fide discussions with the utility to settle the dispute with dispatch.

d) Only net rates shall be charged on any disputed bill paid within fourteen days of

resolution of the dispute if the complaint was filed before the bill became past due.

Section 280.170 Commission Complaint Procedures

a) Before the Commission may allow the filing of a formal complaint by an applicant, customer, user or utility, an informal complaint shall be filed with the Commission's Consumer Assistance Section.

b) The informal complaint

1) should be in writing but may be initiated by telephone or in person at the offices of the Commission; and

2) shall provide the following information to the Commission:

A) the name, address and telephone number of the applicant, customer, or user,

B) the name of the utility involved,

C) the nature of the complaint in a clear and concise manner,

D) the specific relief requested.

c) Upon receipt of the informal complaint, the Consumer Assistance Section shall:

1) advise the party complained of that a complaint has been filed against it; the party complained of must in turn respond to the Consumer Assistance Section within fourteen days; and

2) review and investigate the complaint; and

3) advise the parties of the results of the investigation within a reasonable time not to exceed fourteen days following receipt of the response from the party complained of concerning the complaint.

d) If the Consumer Assistance Section is unable to resolve the complaint to the satisfaction of the parties or if the party complained of fails to respond to the

Consumer Assistance Section within fourteen days, any party may file a formal complaint in accordance with the Commission's Rules of Practice. By agreement of the parties and the Consumer Assistance Section, these time limits may be extended.

e) Utility service shall not be discontinued for the reason which is the subject of the complaint during the pendency of any proceeding before the Commission pursuant to the provisions of this Section so long as the customer has complied with the provisions of Section 280.160.

Section 280.180 Public Notice of Commission Rules

All utilities shall post in two public and conspicuous places in each of their offices where they transact business with the public a notice not less than seven inches by ten inches in size, printed in black on a white background, substantially in the form shown on Appendix C herein.

Section 280.190 Second Language Notices

Where there is a demonstrated need for second language notices in the service area of any utility, notices as set out in Appendices A and B herein sent to customers located within the area should contain the following warning in the appropriate second language: Important – This notice affects your rights and obligations and should be translated immediately.

Section 280.200 Customer Information Booklet

A customer information booklet which contains a utility's credit and collection practices shall be provided by each utility to all applicants for service and shall be available to customers at all business offices.

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

Section 280.APPENDIX A Notice of Utility Shut Off

IMPORTANT! READ THIS IMMEDIATELY!

UTILITY NAME _____ CUSTOMER _____
ADDRESS _____
CITY, STATE, ZIP _____ ADDRESS _____
PHONE # _____
ACCOUNT # _____

YOUR _____(Utility)_____ SERVICE WILL BE SHUT OFF ON OR AFTER _____(Date)_____ . BECAUSE:

_____ YOU OWE $ _____ IN PAST DUE BILLS

_____ YOU OWE $ _____ FOR A DEPOSIT FOR TELEPHONE SERVICE

_____ OTHER _____(Specify)_____

IF YOU DO NOT WANT YOUR _____(Utility)_____ SERVICE SHUT OFF, YOU MUST PAY $ _____ BEFORE _____(Date)_____ .

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

*** _____(Utility name)_____ has employees on duty from _____ A.M. to _____ P.M. to answer your questions or listen to your complaints. If you do not understand why you owe this money, or if you think there has been a mistake, call _____(Utility Name)_____ at _____Phone #_____ , as soon as possible. If the person you talk to cannot help you, ask to talk to a supervisor. If the supervisor cannot help you, call the Consumer Affairs Division of the Illinois Commerce Commission at 312-793-2887 (Chicago) or 217-782-2024 (Springfield). Call before you are Discontinued!

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

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

(Printed on Red Paper)

Reverse Side (Printed on Red Paper)

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

Section 280.APPENDIX B Requirements to Avoid Shut Off of Service in the Event of Illness

IF ANYONE NOW LIVING IN YOU HOME IS VERY SICK, WE WILL NOT SHUT OFF (Utility) SERVICE.

WHAT YOU MUST DO:

YOU MUST CONTACT YOUR DOCTOR OR LOCAL BOARD OF HEALTH. THEY MUST CALL (Utility Name) AT (Phone) RIGHT AWAY. THEY ALSO MUST SEND A WRITTEN CERTIFICATION TO THE COMPANY WITHIN 5 DAYS WHICH CONTAINS THE FOLLOWING INFORMATION:

- Name of the sick person
- A statement that the person is a resident of the premises in question
- The name, business address, and telephone number of the certifying party
- The nature of the illness
- The period of time during which termination of utility services will aggravate the illness

HOW LONG IS THE CERTIFICATION GOOD FOR?

THE CERTIFICATION IS GOOD FOR ONE MONTH. IT CAN ALSO BE RENEWED FOR ONE MONTH IF THE DOCTOR OR BOARD OF HEALTH WRITES TO THE COMPANY AGAIN. IF THE CERTIFICATION IS NOT RENEWED, YOUR UTILITY SERVICE MAY BE SHUT OFF AFTER THE FIRST MONTH.

FOR MORE INFORMATION CALL (Utility Name) AT (Phone #) OR CALL:

CONSUMER AFFAIRS SECTION

ILLINOIS COMMERCE COMMISION

217-782-2024 (Springfield)

or

312-793-2887 (Chicago)

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

MORE INVORMATION ABOUT THIS CAN BE FOUND IN SECTION 280.130 OF 83 ILL. ADM. CODE 280. YOU CAN REVIEW A COPY OF PART 280 AT ANY LOCAL UTILITY BUSINESS OFFICE, OR REVIEW OR OBTAIN A COPY AT THE ILLINOIS COMMERCE COMMISSION, 527 EAST CAPITOL AVENUE, SPRINGFIELD, ILLINOIS 62706 OR 160 NORTH LASALLE STREET, CHICAGO, ILLINOIS 60601. PART 289 (formerly General Order 172) IS AVAILABLE IN ENGLISH OR SPANISH.

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

Section 280.APPENDIX C Public Notice

RULES PERTAINING TO ELIGIBILITY FOR SERVICE,
CUSTOMER DEPOSITS, PAYMENT PRACTICES
AND DISCONTINUANCE OF SERVICE

ILLINOIS COMMERCE COMMISSION
83 Ill. Adm. Code 280

Part 280, the rules and regulations of the Illinois Commerce Commission prescribing procedures governing eligibility for service, deposits, payment practices and discontinuance of service, is on file in this office and open to public inspection.

Copies of Part 280 in the Spanish language are also available for inspection.

Any employee will direct you to the place where you may inspect a copy of Part 280 and will direct you to personnel assigned the duty of providing information about Part 280.

Copies of Part 280 may also be reviewed and/or obtained at the Commission's offices at 160 North LaSalle Street, Chicago, Illinois or 527 East Capitol Avenue, Springfield, Illinois.

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

Section 280.APPENDIX D Insert to be Included with Each Notice of Disconnection Sent to Residential Gas and Electric Customers

IF YOU CANNOT PAY YOUR ENTIRE BILL NOW

READ THIS NOTICE ABOUT MAKING
ARRANGEMENTS TO PAY OVER TIME

What can I do if I cannot pay my entire bill now?

If you are a residential customer of a public utility and owe for past due service, you may have the opportunity to make an agreement with the company to pay over time and avoid disconnection of your utility service.

These agreements to pay over time are called "deferred payment agreements." A deferred payment agreement will allow you to make a down payment on the amount which you owe and make monthly payments to the utility over a period of time to pay off the past due balance.

How do the company and I decide how much I should pay each month on my Deferred Payment Agreement?

The terms and conditions of a deferred payment agreement shall be determined by the utility after considering the following factors, based upon information which the company has or which you provide to the company:

(1) size of the past due account,

(2) your ability to pay,

(3) your payment history with the utility,

(4) your reasons for having the past due bills, and

(5) any other relevant factors concerning your utility service.

Agreements made from April 1 through November 30

(1) The residential customer must pay 25% of the amount past due in order to enter into a deferred payment agreement.

(2) The utility must allow you a minimum of 4 months and a maximum of 12 months to pay the rest of your past due amount.

(3) At the same time you are making your monthly payments on the past due amount, you must pay all your regular bills for utility service on or before the due date.

(4) You may also enter a budget plan to even out your regular bills.

(5) You are entitled to enter a deferred payment agreement as long as you have not broken such an agreement in the past 12 months.

Agreements made from December 1 through March 31 (Special Winter Rules)

(1) The residential customer must pay 10%, of the amount past due in order to enter into a deferred payment agreement.

(2) The utility must allow you a minimum of 4 months to pay the rest of your past due amount, but the agreement should not last past the following November.

(3) At the same time you are making your monthly payments on the past due amount, you must pay all your regular bills for utility service on or before the due date.

(4) You may also enter a budget plan to even out your regular bills.

(5) You are entitled to enter one deferred payment arrangement each winter even if you have broken another deferred payment arrangement in the last 12 months.

How do I make a deferred payment arrangement?

A deferred payment arrangement may be made by visiting the company's business office or contacting the utility by telephone. If you visit the company's business office, the company may ask you to sign the deferred payment agreement. They must provide you with a copy of the agreement which you signed. If you make the deferred payment agreement by telephone, the company must send you a confirmation copy of the agreement.

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED REPEALER

What can I do if I can't keep my deferred payment arrangement?

Renegotiation.

If your economic or financial circumstances change substantially during the time of the deferred payment agreement, the company will be obliged to renegotiate the deferred payment agreement with you, taking into account the changed economic and financial circumstances proved by you.

(1) To qualify for renegotiation, you should contact the utility before the due date of the bill which you are unable to pay.

(2) The company is not obligated to renegotiate your deferred payment agreement with you if you contact them more than 14 days after the due date of the bill which you did not pay.

(3) The utility need only renegotiate a deferred payment arrangement once during the term of the agreement, and does not have to extend the payment period beyond one year from the date of the original agreement.

What can I do if I miss a payment?

Reinstatement.

If you do not make a payment on a current bill or an amount indicated in your deferred payment agreement, the company may discontinue your utility service after sending you a final notice prior to disconnection.

(1) However, if you pay the utility all the amounts owed to it up to that time under the deferred payment agreement, including current bills, the utility must reinstate you on your original deferred payment agreement.

(2) The utility is only obligated to reinstate you once during the time of your deferred payment agreement.

Call your utility company immediately.

You should call the utility immediately to attempt to work out a payment agreement on

your account. You should call the utility to see if something can be arranged even if you have broken an agreement.

Once your utility service has been disconnected, the utility is not obligated to give you a deferred payment arrangement unless you qualify for the Special Winter reconnection rules.

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

1) Heading of the Part: Procedures for Gas, Electric, Water and Sanitary Sewer Utilities Governing Eligibility for Service, Deposits, Billing, Payments, Refunds and Disconnection of Service

2) Code Citation: 83 Ill. Adm. Code 280

3)

Section Numbers:	Proposed Action:
280.5	New
280.10	New
280.15	New
280.20	New
280.30	New
280.35	New
280.40	New
280.45	New
280.50	New
280.60	New
280.65	New
280.70	New
280.80	New
280.90	New
280.100	New
280.110	New
280.120	New
280.125	New
280.130	New
280.135	New
280.140	New
280.150	New
280.160	New
280.170	New
280.180	New
280.190	New
280.200	New
280.205	New
280.210	New
280.220	New
280.230	New
280.240	New

280.250	New
280.260	New
280.APPENDIX A	New
280.APPENDIX B	New
280.APPENDIX C	New
280.APPENDIX D	New

4) Statutory Authority: Implementing the Small Business Utility Deposit Relief Act [220 ILCS 35] and Sections 8-101, 8-206, and 8-207 of the Public Utilities Act [220 ILCS 5/8-101, 8-206, and 8-207], and authorized by Section 8 of the Small Business Utility Deposit Relief Act [220 ILCS 35/8] and Sections 8-101, 8-207, and 10-101 of the Public Utilities Act [220 ILCS 5/8-101, 8-207, and 10-101]

5) A Complete Description of the Subjects and Issues Involved: Few changes have been made to Part 280 since its adoption in 1979. Currently, there is widespread interest in updating the rules, and the repeal of the current set of rules and the drafting and adoption of a new version will allow the updating to be done in a systematic manner. The new rules are intended to reflect changes in the utility industry pertaining to the provision of customer service practices and technical support systems, to ensure the adequacy of consumer protections, and to incorporate recent legislative changes.

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: The proposed rulemaking 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:

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

Comments should be filed, within 45 days after the date of this issue of the *Illinois Register*, in Docket No. 06-0703 with:

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

217/782-7434

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: This rulemaking will affect any subject jurisdictional entities that are also small businesses as defined in the Illinois Administrative Procedure Act. This rulemaking will not affect any small municipalities or not-for-profit corporations.

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

C) Types of professional skills necessary for compliance: Managerial and accounting skills

14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent agendas because: The Commission did not anticipate the need for this rulemaking at that time.

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

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

TITLE 83: PUBLIC UTILITIES
CHAPTER I: ILLINOIS COMMERCE COMMISSION
SUBCHAPTER b: PROVISIONS APPLICABLE TO MORE THAN ONE KIND OF UTILITY

PART 280
PROCEDURES FOR GAS, ELECTRIC, WATER AND SANITARY SEWER UTILITIES GOVERNING ELIGIBILITY FOR SERVICE, DEPOSITS, BILLING, PAYMENTS, REFUNDS AND DISCONNECTION OF SERVICE

SUBPART A: GENERAL

Section
280.5 Policy
280.10 Exemptions
280.15 Compliance
280.20 Definitions

SUBPART B: APPLICATIONS FOR UTILITY SERVICE

Section
280.30 Application
280.35 Revert to Landlord/Property Manager Agreements

SUBPART C: DEPOSITS

Section
280.40 Deposits
280.45 Deposits for Low Income Customers

SUBPART D: REGULAR BILLING

Section
280.50 Billing

SUBPART E: PAYMENT

Section
280.60 Payment

280.65 Late Payment Fee Waiver for Low Income Customers
280.70 Preferred Payment Date
280.80 Budget Payment Plan

SUBPART F: IRREGULAR BILLING

Section
280.90 Estimated Bills
280.100 Previously Unbilled Service

SUBPART G: REFUNDS AND CREDITS

Section
280.110 Refunds and Credits

SUBPART H: PAYMENT ARRANGEMENTS

Section
280.120 Deferred Payment Arrangements
280.125 Deferred Payment Arrangements for Low Income Customers

SUBPART I: DISCONNECTION

Section
280.130 Disconnection of Service
280.135 Winter Disconnection of Residential Heating Services, December 1 through March 31
280.140 Disconnection for Lack of Access to Multi-Meter Premises
280.150 Disconnection of Master-Metered Apartment Buildings

SUBPART J: MEDICAL CERTIFICATION

Section
280.160 Medical Certification

SUBPART K: RECONNECTION

Section
280.170 Timely Reconnection of Service

280.180 Reconnection of Former Residential Customers for the Heating Season

SUBPART L: UNAUTHORIZED SERVICE USAGE

Section
280.190 Treatment of Illegal Taps
280.200 Tampering
280.205 Non-Residential Tampering
280.210 Payment Avoidance by Location

SUBPART M: COMPLAINT PROCEDURES

Section
280.220 Utility Complaint Process
280.230 Commission Complaint Process

SUBPART N: INFORMATION

Section
280.240 Public Notice of Commission Rules
280.250 Second Language Requirements
280.260 Customer Information Packet

280.APPENDIX A Disconnection Notice
280.APPENDIX B Customer Rights
280.APPENDIX C Public Notice
280.APPENDIX D Disconnection Notice Insert for Residential Gas and Electric Customers

AUTHORITY: Implementing the Small Business Utility Deposit Relief Act [220 ILCS 35] and Sections 8-101, 8-206, and 8-207 of the Public Utilities Act [220 ILCS 5/8-101, 8-206, and 8-207], and authorized by Section 8 of the Small Business Utility Deposit Relief Act [220 ILCS 35/8] and Sections 8-101, 8-207, and 10-101 of the Public Utilities Act [220 ILCS 5/8-101, 8-207, and 10-101].

SOURCE: Rule repealed, new rule adopted at 3 Ill. Reg. 1, p. 102, effective January 6, 1979; emergency amendment at 3 Ill. Reg. 46, p. 65, effective November 16, 1979, for a maximum of 150 days; amended at 4 Ill. Reg. 46, p. 1274, effective November 10, 1980; amended at 6 Ill. Reg. 10917, effective September 7, 1982; amended at 6 Ill. Reg. 13723, effective November 8, 1982; amended at 7 Ill. Reg. 9285, effective July 22, 1983; codified at 7 Ill. Reg. 13218;

emergency amendment at 7 Ill. Reg. 14543, effective October 18, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 13221, effective November 1, 1983; emergency amendment at 7 Ill. Reg. 16667, effective December 1, 1983, for a maximum of 150 days; amended at 8 Ill. Reg. 3664, effective March 15, 1984; emergency amendment at 8 Ill. Reg. 17924, effective September 13, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 21222, effective October 15, 1984; amended at 9 Ill. Reg. 2268, effective February 8, 1985; amended at 16 Ill. Reg. 11023, effective July 1, 1992; amended at 17 Ill. Reg. 805, effective January 15, 1993; amended at 18 Ill. Reg. 6160, effective May 1, 1994; amended at 18 Ill. Reg. 17974, effective December 15, 1994; emergency amendment at 25 Ill. Reg. 16545, effective December 13, 2001 for a maximum of 150 days; amended at 26 Ill. Reg. 7032, effective May 1, 2002; amended at 27 Ill. Reg. 4527, effective April 1, 2003; emergency amendment at 27 Ill. Reg. 15156, effective September 15, 2003, for a maximum of 150 days; amended at 28 Ill. Reg. 2684, effective February 10, 2004; old Part repealed at 38 Ill. Reg. _____, and new Part adopted at 38 Ill. Reg. _____, effective _____.

SUBPART A: GENERAL

Section 280.5 Policy

The purpose of this rule is to ensure that essential utility services are provided to and maintained for the People of the State of Illinois under reasonable terms and conditions, and to establish fair and equitable procedures governing eligibility for service, deposits, billing, payments, refunds and disconnection for gas, electric, water and sanitary sewer utilities, that take into account the duty of the utility, customer, applicant and occupant to demonstrate good faith and fair dealing. The policies and procedures outlined in this rule shall take precedence over any inconsistent utility tariff, unless the conflicting tariff provision has been specifically approved by the Commission as a waiver or exemption from this rule, and shall be viewed as the minimum standards applicable to gas, electric, water and sanitary sewer utilities. Utilities that are subject to these rules shall have the ability to expand or supplement the customer rights guaranteed by these provisions as long as those policies are applied in a nondiscriminatory manner. The "nondiscriminatory manner" requirement shall not be construed or interpreted to require a utility making an accommodation to a customer in a hardship situation to make that same accommodation for all customers facing a similar hardship.

Section 280.10 Exemptions

Any entity may file a petition requesting modification of or exemption from any Section of this Part that applies to the entity. Upon a showing that the modification or exemption is economically and technically sound and will not compromise the service obligations of the entity

and will not result in a net harm to consumers overall, the Illinois Commerce Commission (Commission) may grant the modification or exemption. A petition for exemption or modification shall be filed pursuant to 83 Ill. Adm. Code 200 and shall include specific reasons and facts in support of the requested exemption or modification.

Section 280.15 Compliance

The Commission shall require implementation of each requirement as quickly as reasonably practicable, but in no event later than 18 months from the effective date of the rules. Within 60 days after the effective date, each utility shall submit for Commission approval an Implementation Plan that outlines the dates by which the utility expects to be in compliance with each new requirement. The utility shall submit updates to the Plan every 120 days after initial approval until full compliance is achieved. The updates must include a report on progress in implementing each requirement and shall be submitted to the Commission's Consumer Services Division for approval. The utility shall post and update an Implementation "Checklist" conspicuously on its website so that the public can be informed when the utility has brought itself into compliance with each new requirement of Part 280 as rewritten. The checklist shall be updated no less frequently than every 30 days until each requirement has been fully implemented. Each utility shall schedule implementation of the requirements of this rule in a balanced manner so that requirements that benefit utilities are not given priority over those that benefit consumers.

Section 280.20 Definitions

"Actual reading" means a direct meter reading taken by utility personnel or a meter service provider at the customer's location or by use of a remote reading device.

"Applicant" means a person seeking to establish new residential or non-residential utility service under the accepted application process and who is not a customer. Applicants agree to provide payment for utility services that will be rendered to them. Successful applicants immediately become customers.

"Budget Payment Plan" means a plan seeking to reduce fluctuations in the amount a customer must pay in each billing cycle. The customer agrees to pay an amount for each billing cycle that is based upon the amount the utility expects the customer to be billed for an entire year divided by the number of billing cycles in the year. The amount may be adjusted to accommodate changes in the usage pattern by the customer.

"Class of Service" means either residential service or non-residential service.

"Credit Scoring System" has the same meaning set forth in 12 CFR 202.2 as of January 1, 2002, and no later amendments or editions are incorporated. A utility that elects to use a credit scoring system shall file a tariff describing its practice of using the credit scoring system.

"Current" means the status of a customer's utility account when there are no past due amounts owing on the account for utility services, including amounts owing for deposits, deferred payment arrangements or medical payment arrangements.

"Customer" means a person receiving utility service after a successful application, and a person transferring utility service from one location to another within the conditions described under the definition of "Transfer of Service."

"Customer Provided Reading" means a meter reading submitted by a customer to a utility instead of an actual or an estimated reading for the purpose of generating a bill.

"Deferred Payment Arrangement" or "DPA" means a payment plan whereby a customer may retire a past due amount owed to a utility by paying installments towards the arrearage in addition to future bills.

"Deposit" means money provided by a customer and held by a utility as a guarantee towards payment for utility service.

"Illegal Tap" means a diversion of utility service whereby a party or parties other than the customer of record receives a portion of the customer's metered utility service without the customer's consent.

"Implementation Checklist" means a list of each new requirement imposed by this rewritten rule including but not limited to: a reference to the subpart of this rule which imposes the new requirement, a general description of the new requirement, the date by which the utility must be in compliance, a description of the old requirement currently in place (if applicable), and a utility phone number the customer can call with questions.

"Implementation Plan" means a plan each utility creates to detail when it expects to be in full compliance with each new requirement included in the implementation checklist. The plan includes the following: the date the new requirement will be fully implemented, the rationale for a delay of the requirement, a description of the work that must be completed for implementation including a timetable, steps that have or will be taken to achieve maximum reasonable compliance prior to the date full compliance is required, and the expected cost of the implementation.

"Low Income Customer" means a residential customer who has qualified under the income criteria of Section 6 of the Energy Assistance Act of 1989 [305 ILCS 20/6]. Qualification is effective for purposes of this rule when the Low Income Home Energy Assistance Program (LIHEAP) administrator notifies the customer's utility of the customer's low income status. Unless water and sewer utilities begin participation in a low income assistance program with the LIHEAP agencies, it shall be the individual customer's responsibility to notify and provide proof to the water and/or sewer utility of the customer's low income status under the income criteria of Section 6 of the Energy Assistance Act of 1989. Qualifications established on or after September 1 shall remain effective for purposes of this rule until December 31 of the following year. Qualifications established before September 1 shall remain effective until December 31 of that same year. The utility shall notify the customer no less than 30 days and no more than 90 days prior to the expiration of a customer's qualification.

"Medical Certificate" means written certification (though initial certification may be by phone) of medical necessity provided to the utility company by a doctor or the local board of health. If a customer or occupant in the home is very sick, a medical certificate will provide the following documentation to the utility company:

Name and contact information for the certifying party;

Service address and name of patient;

A statement that the patient resides at the premises in question; and

A statement that the disconnection of utility service will aggravate an existing medical emergency or create a medical emergency for the patient.

"Master-Metered Customer" means a non-residential customer for a building where a single meter measures the utility service provided to three or more dwelling units in the building instead of separate meters for each residential unit in the building.

"Medical Payment Arrangement" or "MPA" means a payment plan established after the use of a medical certificate whereby a customer may retire a past due amount owing to a utility by paying installments towards the arrearage in addition to future bills.

"Meter Service Provider" means every provider of metering service certified by the Illinois Commerce Commission under the provisions of 83 Ill. Adm. Code 460.

"Non-residential Customer" means any customer not on a residential rate.

"Occupant" means a person who is not a utility customer and who receives the benefit of utility services at a residential or non-residential service location.

"Past Due" means any amount unpaid for more than two days beyond the due date on a customer's utility account bill statement.

"Payment Avoidance by Location" or "PAL" means a pattern of action taken to avoid payment for utility service used by customers or occupants at a specific premises. Evidence proving a PAL allegation shall be the burden of the utility.

"Person" means any legal entity with the ability to become a utility customer, including but not limited to: individual persons, units of government, corporations, trusts, partnerships, associations, not-for profits, boards, organizations and institutions.

"Residential Customer" means a customer receiving service for household purposes, including service provided through a single meter to one or two dwelling units.

"Returned Payment" means any payment submitted for utility service for which the utility is unable to receive the funds submitted for payment, and where the parties have not mutually agreed to void or otherwise disregard the submitted payment.

"Small Business" *means an Illinois business with 50 or less full time employees in Illinois* [220 ILCS 35/2(b)].

"Tampering" means any unauthorized alteration of utility equipment or facilities by which a benefit is achieved for which the utility is not compensated. Tampering includes customer self-restoration of utility service. Proof of tampering shall be the burden of the utility.

"Transfer of Service" means terminating service at one location and activating service at another location by the same customer of record served by the same utility within 14 calendar days as long as there is no change in the rate class of the customer. A transfer of service shall not be deemed an application for service unless the utility has reason to believe that the person requesting the transfer of service is not the original customer. Outside any winter, temperature or other period defined by statute or rule restricting disconnection of service, a customer requesting a transfer of service but who has past due utility charges or deposit amounts that have not previously been disputed by the customer owing for more than 2 days past the due date may be denied the transfer unless the customer pays the past due utility charges or deposit or enters into a payment agreement on the amounts owing. It shall be the responsibility of the utility to advise the customer of any such outstanding amounts at the time the transfer of service is sought. Note that this definition shall not be construed to entitle the customer to rights to an additional deferred payment arrangement beyond those conferred by Section 280.120.

"Type of Service" means either gas, electric, water or sewer service.

"Written" or "Writing" means either a hard copy or electronic copy, unless it is specifically stated a hard copy must be placed in the U.S. Mail or delivered by other means. Where this Part requires information to be "written" or in "writing", an electronic record satisfies that requirement, so long as both utility and customer have agreed to electronic communications.

SUBPART B: APPLICATIONS FOR UTILITY SERVICE

Section 280.30 Application

a) Intent: A utility may use reasonable means to verify the identity of its customers. Applicants shall have the right to a reasonable application process designed to provide for persons to obtain utility services without delay, while also safeguarding utilities and other customers from potential harm associated with fraud or the uncollected debts of applicants.

b) Information Requirements: The utility shall make available a full description of the utility's application process, including all forms of acceptable identification, for review in the utility's tariff with the Commission, on the utility's website, and mail a printed version to applicants or customers who request a copy.

c) Methods:

1) The applicant shall have the option to choose from the available application methods offered by the utility.

2) Third party applications may be made only by persons who have been authorized to act on behalf of the applicant, and the utility must verify this authorization either by documentation or by direct contact with the applicant. If a utility fails to verify authorization, it shall not be entitled to collect for service, if the customer disclaims any responsibility for requesting the service; provided, however, that named customers who reside and receive mail at the service/billing address will be rebuttably presumed to have authorized the application if they do not contact the utility to contest billing within six months after service activation.

d) Application Content:

1) Positive identification (ID) of applicants may be required by up to two forms of ID. One form shall be a government issued photo ID including a state issued ID, U.S. or foreign government issued passport, and consular identification documents, as defined by the Consular Identification Document Act [5 ILCS 230]. Applicants may be asked to provide one other form of identification including but not limited to any of the following:

A) A second government issued photo ID;

B) Social Security number;

C) Driver's license number;

D) Birth certificate;

E) Immigration and/or naturalization documents;

F) Student identification;

G) Banking information;

H) Employment records;

I) Government benefits/compensation records;

J) Tax ID number;

K) Articles of incorporation; or

L) Business license.

2) The applicant shall have the opportunity to choose the second form of identification to provide from the available list. The utility may not oblige an applicant to provide one form of identification in favor of another, so long as one form is a government issued photo ID and the identification provided is valid and accurate.

3) If the applicant is non-residential, then the utility shall request information to determine if the applicant is a small business.

4) Service location and contact information required of applicants:

A) Service address for the premises;

B) Mailing address if different from the service address;

C) The applicant's preferred method of contact from the utility;

D) Telephone number if available;

E) E-mail address (optional); and

F) Contact information for property owner/manager if premises are rental (optional).

e) Requirements for Successful Application:

1) Information submitted must be accurate and verifiable; and

2) Any past due debts for utility services still owing to the utility by the applicant shall be identified and governed by the following provisions: the Applicant must

A) pay past due debt in full, and if otherwise required, enter into a payment plan for the deposit amount; or

B) At the utility's discretion, enter into a payment agreement to retire the debt; or

C) Make a down payment and agreement to retire the debt under the requirements of Section 280.180 Reconnection of Former Residential Customers for the Heating Season.

f) Applicable Past Due Debts:

1) Past due debts may only include debts for which the utility has retained summary data to support the validity of the debt. The utility shall make these records available to the applicant upon request. In addition, the utility shall provide, on request, a detailed description and the source of any other information supporting the debt. At a minimum, summary data supporting the debt shall include:

A) The service address or addresses where the debt accrued;

B) Meter readings and dates;

C) Usage and dates; and

D) Bill amounts and dates.

2) For purposes of determining whether or not an applicant may become a customer, past due debts shall not include charges owing for non-utility services and merchandise.

3) Past due debts shall not include utility charges owing for a different class (residential or non-residential) or type (gas, electric, water or sewer) of service.

4) Past due debts shall not include debts owing by persons other than the applicant, with the exception of debts owing as family expenses of married persons. Family expenses shall not include debts incurred at a location separate from the family by a spouse who abandons the family [750 ILCS 65/15].

5) This rule shall not prevent a utility from using past due debts for applications or collections if those past due debts accumulated before adoption of this rule and if the utility kept records to document the past due debts as were allowed at the time the debts were accumulated.

6) In instances where the utility decides not to offer a payment plan for past due debts, it must provide a written statement to the applicant that contains the rationale for its refusal

g) Disputed Past Due Debts: If the applicant disputes the validity of the past due debt and the utility sustains the charges, the utility shall provide the applicant with the contact information for the Commission's Consumer Services Division for an informal complaint.

h) Deposit Payment Requirement: The utility may require a deposit of an applicant for service under the criteria listed in Sections 280.40, Deposits, and Section 280.45, Deposits for Low Income Customers. The utility may require that the initial down payment of any applicable deposit be paid within a minimum of 12 days.

i) Timeline for Application Processing:

1) Approval or rejection of the application, including notification to the applicant, shall be accomplished within two business days after the date all the required information is received from the applicant.

2) Notification shall include the specific reasons for the rejection so that the applicant may have the opportunity to remedy the reasons for the rejection. If the utility is unable to contact the applicant for notification purposes by a method other than mailing, then written notification of the problems shall be sent to the mailing address provided by the applicant.

3) If the application meets the requirements of this Part or the applicant remedies any deficiencies, then the utility shall approve the application for service.

j) Timeline for Service Activation:

1) Electric, water, or sewer utilities: Absent any delays caused by construction or other equipment work required for service activation, an electric, water or sewer utility shall activate service for a successful applicant at the earliest possible date, but no more than four calendar days after the approval of the application, unless the applicant requests a later date of activation.

2) Gas utilities: Absent any delays caused by construction or other equipment work required for service activation, a gas utility shall activate service for a successful applicant at the earliest possible date, but no more than seven calendar days after the approval of the application, unless the applicant requests a later date of activation.

3) If a successful applicant for utility service seeks activation of service on a date beyond the timelines described in subsections (j)(1) and (2), then the utility shall activate the service either on the date specified by the applicant or within two business days after the requested date if the utility is unable to accommodate the requested date.

4) If, through no fault of the applicant, the utility delays activation of service for two or more calendar days beyond the number of days required pursuant to this subsection, then it shall issue a credit to the new customer's account equal to the monthly customer charge for that

customer pro-rated by the number of days of the delay beyond the requirements of this subsection.

5) Exception for lack of access: A utility shall not be obliged to conform to the time limits in this subsection if it is not allowed access to activate the service, provided however that the utility must record the date, time of day, utility personnel involved and the reason access was not gained. It shall retain the record for a period of two years. In addition, the utility's field representative making the visit to activate service shall leave a door tag at the premises. The door tag shall indicate when the utility representative was there and provide the contact information for the customer to reschedule.

6) Exception for damage or unsafe condition: A utility shall not be obliged to conform to the above time limits of this subsection if repair, construction or correction of an unsafe condition is required prior to activation of service.

7) Temporary exception for unforeseen circumstances: A utility that experiences temporary unanticipated overload of its ability to provide for the timely activation of service may, upon notice explaining the circumstances to the Commission's Consumer Services Division, temporarily forego the requirements of this Section so long as the utility can demonstrate that it is taking diligent action to remedy the overload.

8) In those instances in which the timelines are not met, the utility shall report this to the Commission's Consumer Services Division; and the utility shall report quarterly on the frequency of the temporary exceptions exercised.

k) Data Collection and Maintenance Requirements: A utility shall collect the following data on a monthly basis and maintain the data for a period of two years following its collection, making the data available to Commission Staff (Staff) within 30 days after a request from Staff:

1) The total number of residential applications taken by the utility;

2) The total number of non-residential applications taken by the utility;

3) The number of residential applications rejected by the utility; for purposes of this Section, applications for service that are not accepted by the utility because the application are incomplete, shall be considered rejected applications.

4) The number of non-residential applications rejected by the utility; and

5) The reason, by category under subsection (e), for the rejection of each application listed in subsections (k)(3) and (4).

Section 280.35 Revert to Landlord/Property Management Agreements

a) Intent: Describe the rights and duties of a utility and landlord/property manager with respect to discontinuance of service or assumption of billing responsibility and continuance of service when a tenant vacates a premises and the utility has no customer of record. Also to describe the process whereby a utility may, by prearrangement with a landlord/property manager, place the service for a premises on a going forward basis into the name of the landlord/property manager and continue service to the premises when a tenant who had utility service in the tenant's name leaves the premises.

b) Prearrangement to be in Writing: The utility and landlord/property manager shall agree in writing to prearrange the provisions of this Section. The utility shall provide an example of its prearrangement form in the utility's tariff and maintain a copy of the form on its website. So long as the utility is able to contact and gain the cooperation of the respective landlord/property manager for a premises, it shall annually update in writing the individual prearrangements with each landlord/property manager so as to ensure accuracy. Absent written prearrangement with a landlord/property manager, the utility shall not place service in the name of the landlord/property manager unless the landlord/property manager contacts the utility to apply for service.

c) Notice: Every time a utility places service into the responsibility of a landlord/property manager under prearrangement, the utility must within two business days notify the landlord/property manager that the service has been placed in the landlord/property manager's responsibility, and that the landlord/property manager will be billed on a forward basis for service provided to the premises until a new tenant successfully applies for service. Notice shall be provided separately from the bill statement and shall be made prior to the first bill

to the landlord/property manager. By agreement with the landlord/property manager, the utility may disregard the above notification provisions.

d) Tenant Bills: The utility shall not hold the landlord/property manager responsible for an amount owing to the utility by any tenant.

e) Accuracy of Billing: Prior to making the landlord/property manager responsible for service, if the meter has not been read by the utility within the past 60 days, the utility shall obtain an actual meter reading to ensure correct billing so long as the utility is provided access to the meter. If the utility is unable to obtain an actual meter reading, then the utility must allow the landlord/property manager to provide the utility with a customer reading.

f) Itemization of Transfer Balances: Where a landlord/property manager maintains multiple premises within a utility's service territory, the utility shall not transfer balances owing from one premises account to another until the landlord/property manager has failed to pay the final bill rendered for that premises or the landlord/property manager requests that the balance be transferred. When transferring final balances from one premises account to another, the utility shall indicate on the bill the location where the amount due originated.

SUBPART C: DEPOSITS

Section 280.40 Deposits

a) Intent: Customer deposits are used to secure against potential unpaid debts. Utility collection activities, when not otherwise restricted by regulations or laws, will limit the accumulation of unpaid debt so that deposits will continue to serve this protective purpose.

b) Notification of Demand for Deposit:

1) A utility shall make an initial notice of a deposit to an applicant or customer no later than 45 days after the applicant's application for service is approved or after the event that justifies the deposit. A deposit shall not be assessed until the initial notice is given.

2) The initial deposit notice shall be made in writing and shall disclose:

A) The reason for the deposit;

B) The amount of the deposit and how it is calculated;

C) The payment requirements and schedule of payments for the deposit;

D) The date by which the entire deposit must be paid;

E) That the amount of the deposit may be adjusted if the annual charges for the customer substantially change;

F) The refund policy for the deposit;

G) The interest policy for the deposit;

H) The deposit policy applicable to qualified low income customers and how qualification can be demonstrated; and

I) The availability and contact information for the Commission's Consumer Services Division in the event of a dispute that the utility has not resolved to the satisfaction of the applicant or customer.

c) Calculation of Deposit Amounts:

1) Residential and small business customer deposits shall not exceed 1/6 of the estimated annual charges for the service to that customer.

2) Non-residential, other than small business, customer deposits shall not exceed 1/3 of the estimated annual charges for service to that customer.

d) Applicant Deposits: the utility shall have the right to require a deposit of an applicant under the following conditions:

1) The applicant was previously disconnected for non-payment of bill amounts owing to the utility for the same class and type of service;

2) The applicant failed to pay a final bill owing to the utility for the same class and type of service;

3) The residential applicant's credit score fails to meet the minimum standard of the credit scoring system described in the utility's tariff;

4) The non-residential applicant fails to provide satisfactory credit references, including past utility service records or favorable history with other creditors. The utility shall file a tariff with the Commission describing its criteria for non-residential applicants to establish satisfactory credit for this purpose;

5) The utility has proof that the applicant previously benefitted from tampering as described in Section 280.200;

6) The utility has proof that the conditions described in Section 280.210 Payment Avoidance by Location (PAL) exist for the applicant.

e) Present Customer Deposits:

1) A present customer may be required to pay a deposit if both of the following conditions occur:

A) The customer has paid late four times in the past 12 months; and

B) The customer's account has an undisputed past due balance that has remained unpaid for over 30 days beyond the due date.

2) A present residential customer may avoid the requirement to pay a deposit under subsection (e)(1) by entering into and keeping current with a DPA for the unpaid balance, so long as the customer enters the DPA prior to the assessment of the deposit.

3) A present customer may be required to pay a deposit if the utility has proof that the customer benefitted from tampering.

4) A present large commercial or industrial customer may be required to pay a deposit for indications of financial insecurity in accordance with and as allowed by the terms and conditions of a utility's effective tariffs.

f) Deposit Payment: A utility may require payment of 1/3 of an applicable deposit by including that amount on the first bill statement sent to the customer after the issuance of the deposit. The remaining 2/3 of the deposit shall be paid in equal installment amounts included on the next two bill statements. However, a deposit assessed under the provisions of Section 280.210 may be collected in a single amount due prior to service activation.

g) Deposit Interest:

1) Interest shall be paid to the customer on all deposit amounts, including installments, held by the utility. The rate of interest will be the same as the rate existing for the average one year yield on U.S. Treasury Securities for the last full week in November. The interest rate will be rounded to the nearest 0.5%. In December each year, the Commission shall announce the rate of interest that shall be paid on all deposit amounts held during all or part of the subsequent year.

2) After 12 consecutive months of accumulated interest, when a customer is not entitled to a refund of the deposit, the utility shall automatically credit the customer's account with the interest only. The credit shall be itemized on the customer's next regular bill statement as "deposit interest".

h) Refund Conditions for Deposits:

1) The utility shall automatically refund the deposit plus accumulated interest once the customer completes 12 consecutive months of service with fewer than four late payments, no disconnections for non-payment, no tampering with the service, and the customer has no past due balance owing at the time of the deposit refund.

2) The utility shall automatically refund the deposit plus accumulated interest, less any unpaid utility service bill amount, when the customer voluntarily ends service and is not transferring service to another location. The refund shall be made at the time the final bill for service is issued.

3) The utility shall refund the deposit plus accumulated interest automatically, less any unpaid utility service bill amount, 30 days after disconnection of service for non-payment when the former customer has

not paid the full balance owing or otherwise made arrangements with the utility to have the service restored.

4) Nothing shall prevent the utility from refunding a deposit earlier than the above conditions.

i) Issuance of Deposit Refund:

1) For a current small business customer, the refund, less past due unpaid utility service amounts, shall be by separate payment issued to the customer. The refund or credit shall be issued within 30 days after the event that triggers it.

2) For all other current customers, the refund, less past due unpaid utility service amounts, shall be by separate payment issued to the customer, except when the customer requests a credit to the account instead of a refund payment. The refund or credit shall be issued within 30 days after the event that triggers it. The utility shall not be obliged to issue the refund by separate payment instead of a credit if the amount to be refunded does not exceed 125% of the customer's average monthly bill amount.

3) For any former customer, the refund, less unpaid utility service bill amounts, shall be by separate payment issued to the former customer. The refund shall be issued within 30 days after the event that triggers it.

j) Records of Deposits:

1) The utility shall maintain records of deposits together with interest that collectively will show all transactions pertaining to each deposit.

2) The utility shall indicate the amount of each deposit held on each customer bill.

3) When refunds are not deliverable, the utility shall maintain records showing the utility's efforts towards locating the former customer and delivering the deposit refund.

k) Data Collection and Maintenance Requirements: A utility that elects to utilize a credit scoring program for applicants for residential service shall collect and

maintain the following data for a period of five years following its collection, making the data available to Commission Staff within 30 days after a request from Staff:

1) The number of credit scores requested for applicants;

2) The number of applicants who received passing credit scores;

3) The number of applicants who received failing credit scores;

4) The number and total dollar amount of deposits obtained from applicants subject to the credit scoring program;

5) The number of times a security deposit was waived for a low income applicant and for all other applicants, with stated reasons for the waiver;

6) The number of disconnections of service because customers failed to pay the required deposit; and

7) The number of formal complaints and the number of informal complaints from applicants regarding the use of credit scoring or the requirement to pay a deposit based on the credit scoring program.

Section 280.45 Deposits for Low Income Customers

a) A low income customer or applicant may be required to pay a deposit if the following conditions exist:

1) The utility has proof that the applicant or customer benefitted from tampering.

2) The applicant was previously disconnected for non-payment of bill amounts owing to the utility for the same class and type of service.

b) With the exceptions listed below, all provisions of Section 280.40 shall apply equally to low income customers.

1) Credit scoring: A utility shall not assess a low income customer a deposit based upon credit scoring. Credit scoring deposits shall be returned to the customer upon certification as a low income customer.

2) Late payments and past due over 30 days: A utility shall not assess a low income customer a deposit under the provisions of Section 280.40(e)(1).

3) Unpaid final bill: A utility may assess a deposit for a low income applicant if the applicant failed to pay a final bill owing to the utility for the same class and type of service, and that final bill was greater than 20% of the average annual billing for the residential customers of the utility for the calendar year preceding the time of the application.

4) Payment: A utility may require payment of 1/5 of an applicable deposit within a minimum of 12 days after the issue date of a deposit notice to a low income applicant or customer, with the remaining 4/5 to be paid in equal installments over the next four billing cycles.

c) Deposits collected for any reason other than credit scoring prior to a customer's certification as a low income customer shall remain validly held by the utility until the customer meets the refund conditions found in Section 280.40.

SUBPART D: REGULAR BILLING

Section 280.50 Billing

a) Intent: To establish minimum billing content and billing disclosure requirements.

b) Billing Cycle:

1) Without prior authorization from the customer, a utility shall not bill a customer account for utility usage in advance.

2) The utility shall bill the customer monthly unless both the customer and the utility have agreed to bi-monthly or quarterly billing.

3) Bills to large, non-residential customers may be rendered more frequently than monthly when agreed to by the utility and customer. More frequent billing may be offered if the large, non residential customer is subject to

disconnection or payment of a deposit. The more frequent billing shall not extend more than six months, at which time monthly billing shall resume.

c) Bill Content: Bills rendered to a retail customer for service, regardless of bill delivery method, shall be itemized to clearly show at least the following:

1) Customer billing information:

A) Customer name;

B) Service address;

C) Mailing address if different from service address;

D) Account number;

E) The date the bill was generated and sent to the customer;

F) For accounts on a budget billing plan, the accrued debit or credit balance for the plan;

G) The total amount owing on a payment arrangement, including the installment amounts due and the number of installments remaining to satisfy the arrangement; and that a late payment may result in the termination of the payment arrangement.

H) The amount of any deposit either held or owing and the accumulated interest on the deposit; and

I) Electric and gas utilities shall provide a graphic comparison such as a bar chart or pie chart of the current usage and the customer's previous 12 months of historical usage;

2) Contact information:

A) The utility's toll free phone number and/or local phone number for customer inquiries and complaints;

B) The toll free telephone number for the Commission's Consumer Services Division, and a statement indicating that the customer must contact the utility first before seeking assistance from the Commission's Consumer Services Division; and

C) The name and contact information for any supplier or other third parties authorized by the Commission to appear on the bill and with which the customer has contracted;

3) Meter and rate classification information:

A) The meter identification number;

B) The previous and current meter readings and the corresponding dates of those readings;

C) The number of days in the billing period;

D) The energy, natural gas or water used;

E) The meter constant if applicable;

F) The type of services rendered;

G) A complete description of the service or rate classification under which the customer receives service;

H) The type of reading that was used in the bill calculation (actual, estimate or customer reading); and

I) For meters for which beginning and ending meter readings are used as billing determinants, the reading of the meter at the beginning and the reading of the meter at the end of the period for which the bill is rendered;

4) Bills not based on metered usage: In the event that a bill is not based on usage derived from meter readings, the bill must indicate the period of time for which the bill is rendered, the type of service rendered, and a

complete description of the service or rate classification under which the customer receives service;

5) Itemization of billing amounts: The following components of the bill and the total amount shall be itemized and listed vertically for ease of reading:

A) The monthly customer charge or any portion of the charge;

B) Any applicable demand charges;

C) Depending upon the type of utility service:

i) Electricity: The cost of energy detailed by the energy used and price per unit of each change in the unit price;

ii) Natural gas: The cost of gas determined by the number of therms used and the price per therm for each change in the unit price;

iii) Water: The volume of water used and the price per gallon or cubic foot and the price for each change in the unit price;

D) Depending upon the type of utility service:

i) Electricity: Any applicable cost of fuel adjustment;

ii) Natural gas: Any applicable cost of gas adjustment;

iii) Water: Any applicable cost of purchased water;

E) Any other applicable adjustments, including other charges not under categories of changes but relating to services, energy, gas, water, sewerage or other programs provided to customers;

F) State tax;

G) Municipal tax;

H) Infrastructure maintenance fee;

I) Transition charge;

J) Optional services listed separately;

6) The bill due date;

7) Definitions or explanations of any abbreviations and technical words used on the bill; and

8) Electric and gas utilities shall provide the average use per day for the period over which the bill is rendered and for the comparable period one year earlier, and an indication of the difference in temperatures between the two periods.

d) Bill Delivery:

1) Bills for utility service sent through the United States mail shall be in envelopes to ensure privacy. Bills that are too large for enclosure in envelopes may be packaged and sent in boxes.

2) If mailed bill envelopes are not postmarked, the utility shall maintain an alternative method of third party verification of the date of mailing. Records to verify each bill issuance or delivery shall be retained for period of two years.

3) Customers may choose to have bills delivered by electronic means. The utility must have written confirmation, which may include written electronic acceptance, from the customer regarding this choice. Customers choosing such service must retain the right to have all notices, including disconnection notices as provided for in Subpart I, by United States mail at any time.

4) If bills are delivered or made available to customers by means other than United States mail, the utility shall maintain a record to verify each bill delivery or issuance for a period of two years.

e) Due Dates:

1) Bills for residential customers shall be due a minimum of 21 days after the date they are sent to the customer, and bills for non-residential customers shall be due a minimum of 14 days after the date they are sent to the customer.

2) If a bill is mailed from a state or location that does not border Illinois or if payment is received at a state or location that does not border Illinois, then the due date shall be:

A) Residential customer: a minimum of 23 days after the date the bill is sent to the customer; or

B) Non-residential customer: a minimum of 16 days after the date the bill is sent to the customer.

3) If a bill is mailed from a state or location that does not border Illinois and is also received at a state or location that does not border Illinois, then the due date shall be:

A) Residential customer: a minimum of 25 days after the date the bill is sent to the customer; or

B) Non-residential customer: a minimum of 18 days after the date the bill is sent to the customer.

f) Bill Transfers: When a customer has the same class and type of utility service at more than one location with the same utility, the utility shall not transfer a balance owing from one premises account to another until the customer has failed to pay the final bill rendered for that premises or the customer requests that the final balance be transferred directly to the other premises account. When transferring final balances from one premises account to another, the utility shall indicate on the bill the location where the amount due originated.

g) Each utility shall have an example of its bill form in its tariffs on file with the Commission and on its website.

SUBPART E: PAYMENT

Section 280.60 Payment

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

a) Intent: To describe the methods of payment for utility service; recording of payment receipt; determining lateness of payment; allocation of payment amounts to the customer's account; and limitations on payment methods for accounts where returned payments have been made.

b) Method of Payment:

1) At a minimum, the utility shall provide detailed information about all methods of payments on the utility's website and in the customer information packet required in this Section.

2) The utility's bill to the customer shall advise the customer how to obtain information on the available payment methods. When contacted by a customer inquiring about making a payment, the utility's customer service personnel shall advise the customer of the available methods of payment, including the most expedient and least cost methods of available payment.

3) When a utility determines that it will no longer accept a specific alternative method of payment, it shall provide advance notice to the affected customers.

c) Late Payment:

1) Payment is late when it has not been received by the utility within two days after the due date on the bill.

2) The date a payment or payment instrument is presented to or arrives at the utility or its agent/vendor is the date of payment receipt.

3) A utility shall not wait until funds are transferred or posted to the utility bank account for purposes of determining payment receipt.

d) Late Fees:

1) If a utility elects to assess late fees, it shall file a tariff describing the late fees.

2) Late fees shall not exceed 1.5% per month assessed towards any undisputed amounts remaining unpaid for more than two days after the due date on a bill.

3) Late fees may be assessed on undisputed overdue budget installment amounts (not the accumulated uncollected budget plan payment balance) owing on a budget payment plan when there is an overall deficit credit balance in an account as an alternative to termination of participation in the plan for late payment.

4) A utility shall not continue to assess late fees on any final bill that has been outstanding for more than six months.

5) Late fees shall not be assessed on any amount billed which is not for utility service unless otherwise authorized by statute.

6) Late fees for units of State government shall be assessed according to the State Prompt Payment Act [30 ILCS 540]. No late payment charges shall be assessed on the amounts owing on units of county and local government (including, but not limited to, townships, municipalities and school districts) until 45 days after the date of the issuance of the bill for utility service.

e) Returned Payments:

1) Limiting: A utility shall not limit a customer from paying by any of the available methods acceptable to the utility unless the customer has provided one or more returned payments in the past 12 months, without an explanation from the customer's financial institution that the returned payment was not the customer's fault.

2) Notice: A utility shall notify a customer when it will no longer accept a form of payment from the customer as a result of returned payment.

Section 280.65 Late Payment Fee Waiver for Low Income Customers

a) Waiver: A low income customer shall not be assessed late payment fees while he/she is qualified as a low income customer.

b) New Qualification: When a customer is qualified as a low income customer, the utility shall not be obliged to waive late fees that were assessed prior to qualification.

c) Expiration of Qualification: If a customer is not re-qualified as a low income customer, then the utility may begin assessing late fees on past due amounts. However, late fees shall not be assessed retroactively on bills during the time period when the customer was qualified as a low income customer.

Section 280.70 Preferred Payment Date

a) Intent: An eligible residential customer who is billed monthly and who can demonstrate that his or her primary source of income is derived from a benefit that is received during the ten day period after the customer's regular due date shall be entitled to a preferred payment date to enable the customer to submit timely payments.

b) Notification: When a customer pays late two times in a 12 month period, the utility shall notify the customer of the availability of a preferred payment date. The utility shall make a record on the customer's account of the notification, and notification shall be made by any of the following methods:

1) Message included in the customer's bill;

2) Separate written communication; or

3) Verbal communication.

c) Eligibility: Residential customers shall be eligible for a preferred payment date if they are included in any one of the following:

1) Customers receiving Temporary Assistance for Needy Families (TANF) or Aid to the Aged, Blind and Disabled (AABD);

2) Customers receiving benefits from General Assistance or Supplemental Security Income;

3) Customers receiving income from Social Security benefits or Veterans benefits; or

4) Customers receiving unemployment compensation benefits.

d) Options: The utility shall inform an eligible customer of the following options from which the customer may choose:

1) Enter into a budget payment plan with a preferred payment date that is not more than ten days after the customer's regular billing date and is agreed upon by the customer and the company; or

2) Establish a preferred payment date that shall not be more than 10 days after the customer's regular billing date.

e) Removal: If the customer fails to pay on or before the preferred payment date more than four times in a 12 month period, the utility may remove the customer's account from the preferred payment date and return the customer to the regular bill due date. After the removal of a customer, the utility shall not be obliged to offer the preferred payment date to that same customer for a period of 12 months.

Section 280.80 Budget Payment Plan

a) Intent: To provide a process to equalize payments for utility service, based upon the customer's average bill instead of the actual fluctuating amount for each separate billing period.

b) Applicability: The requirements of this Section shall apply to residential customers and small business customers. Nothing shall prevent a utility from offering a budget payment plan to non-residential customers that are not small businesses.

c) Eligibility:

1) No past due amount owing: A customer whose account balance is current may enroll in a budget payment plan at any time of the year.

2) Past due: In order to establish eligibility for a budget payment plan, a customer owing a past due amount must either pay the entire past due amount or enter into a DPA with the utility to retire the past due debt.

d) Offering: The utility shall inform its customers of the availability of its budget payment plan and encourage its use.

e) Enrollment: Upon inquiry from the customer, the utility shall calculate and advise the customer what the projected budget payment plan amount will be for the customer's account. If the customer accepts the offer to enroll in budget billing, the utility shall begin the plan for that account.

f) Bill Itemization: In addition to the regular billing requirements of Section 280.50, the bill statement for an account enrolled in the budget payment plan shall contain separate line items for:

1) The budget payment amount; and

2) The amount of the accrued credit or shortfall.

g) Periodic Adjustments:

1) If the customer's usage and regular billing changes so that the budget payment plan will not be successful if left at its current level, then the utility shall review and adjust the budget payment plan amount.

2) If the budget payment plan amount must be altered, the utility shall notify the customer of the change in writing. Notification may be included with the bill statement or by separate delivery.

h) Reconciliation: Unless another time frame is requested by the customer in writing, utilities shall review each budget plan at least once between the 4th and the 7th month of the term of the plan to ensure that significant shortfalls or credits do not accrue. If a customer's budget payment plan shortfall or credit becomes so large as to necessitate a reconciliation, then the utility shall:

1) In the case of a shortfall, offer the customer the option to pay off the shortfall or have the budget amount adjusted to accommodate the shortfall; or

2) In the case of a credit, offer the customer the option of a refund or have the budget amount adjusted to accommodate the credit balance.

i) Late Payments: No late payments charge shall be assessed on a budget payment plan unless there is an overall deficit credit balance in an account when the late payment occurs. The late payment charge shall be computed on the late installment only, not on the accumulated deficit in the account.

j) Transfer of Service: When a customer on a budget payment plan informs the utility that the customer will be transferring service with that utility from the current location to a new location served by the same utility, the utility shall advise the customer what the projected budget payment plan amount will be at the new location and that the customer may choose to either remain on the budget payment plan at the new location or cancel the plan.

k) Cancellation:

1) A customer may cancel a budget payment plan at any time.

2) A utility may cancel a customer's budget payment plan when the customer either submits a payment that is less than the full budget payment plan amount or the customer's payment is 21 days in arrears. Late fees may be assessed on undisputed budget installment amounts owing on a budget payment plan as an alternative to termination of participation in the plan.

3) Any shortfall amount owing to the utility at the time of cancellation shall be included and payable as current charges on the next bill statement.

4) Any credit amount owing to the customer at the time of cancellation shall appear as a credit on the next bill statement. After the issuance of that bill statement, the provisions of Section 280.110 shall apply to the credit balance.

SUBPART F: IRREGULAR BILLING

Section 280.90 Estimated Bills

a) Intent: To describe the utility's responsibilities to obtain actual readings of the customer's meter, and describe the process by which a utility may issue an estimated bill to a customer when the utility is unable to obtain an actual reading or a customer reading.

b) Utility Meter Reading:

1) A utility shall perform an actual reading of a customer's meter at least every second billing period unless the utility's attempt to do so is prevented.

2) A utility shall perform an actual reading of a customer's meter every billing period if that meter is equipped with a remote reading device, unless the utility effort to do so is prevented.

3) When the utility's attempt to read the meter fails, it shall record the date, time of day, utility personnel involved, and the reason for the failure. The record shall be retained for a period of two years. In addition, its field representative making the visit to read the meter shall leave a door tag at the premises. The door tag shall indicate when the utility representative was there and provide the utility's contact information for the customer to set up an appointment with the utility to gain access to the meter. If the customer's meter is equipped with a remote reading device to obtain a reading without the presence of field personnel on the customer's property, then the utility may mail or use other means to deliver written notification (may include electronic written notification to customers who have elected electronic billing methods) of the failed reading to the customer in lieu of leaving a door hanger. The utility may contact a customer by telephone to provide notice of a failed reading, provided that written notification must be sent if the utility fails to reach the customer directly or successfully leave a voice message.

4) A reading provided by a remote reading system or device shall be considered an actual reading.

5) A reading provided by a Commission certified meter service provider in compliance with the utility's tariff shall be considered an actual reading.

6) If a utility issues two consecutive estimated bills to a customer, then the utility shall contact the customer to resolve the reason for the consecutive estimated bills, so that the utility may obtain an actual reading of the meter or a customer reading. If the utility is unable to contact the customer, it shall send a letter advising the customer of the utility's need for contact on

the matter. The utility shall make a record of each effort to contact the customer.

c) Customer Meter Reading:

1) A customer reading of the meter provided to the utility shall satisfy the actual reading requirement in subsection (b)(1). However, a utility shall not require a customer to provide customer readings when the customer can provide access to the meter for utility personnel.

2) After six consecutive months of customer provided readings, a utility shall take an actual reading of the meter in accordance with the provisions of subsections (b)(1) and (2).

d) Meter Readings for Beginning and Ending Service: Unless a utility has taken an actual reading of the meter within the past 60 days, it shall take an actual reading of the meter as prescribed in this subsection. The utility may satisfy the requirements of this subsection on the day before or the day after the beginning or ending date if that date falls upon a non-business day of the utility.

1) On the beginning date of service for a new customer, so long as the new customer has provided the utility with at least five days advance notice of the start date, and so long as the customer provides the utility with access to the meter;

2) On the ending date of service for a customer who is stopping service, so long as the customer has provided the utility with at least five days advance notice of the end date, and so long as the customer provides the utility with access to the meter.

e) Estimated Bill Formula: A utility's formula for estimating customer meter readings shall be filed in the utility's tariff.

f) Bill Labeling:

1) A bill based upon an estimated reading shall indicate that it is an estimated bill and that the meter reading figure is an estimated reading.

2) A bill based upon an actual reading shall indicate that the meter reading figure is an actual reading.

3) A bill based upon a customer reading shall indicate that the meter reading figure is a customer reading.

g) Unless the utility's attempt to access the meter has been prevented, as described under subsection (b), the utility shall not disconnect a customer for non-payment of two or more consecutively estimated bills until the utility takes an actual reading of the meter to verify the accuracy of the billing.

Section 280.100 Previously Unbilled Service

a) Intent: To provide for the billing and payment of previously unbilled service caused by errors in measuring or calculating a customer's bills.

b) Time Limits:

1) Bills for any utility service, including previously unbilled service, supplied to a residential customer shall be issued to the customer within 12 months after the provision of that service to the customer.

2) Bills for any utility service, including previously unbilled service, supplied to a non-residential customer shall be issued to the customer within 24 months after the provision of that service to the customer.

3) The time limits of subsections (b)(1) and (b)(2) shall not apply to previously unbilled service attributed to tampering, theft of service, fraud or when the customer prevents the utility's recorded efforts to obtain an accurate reading of the meter.

4) No utility shall intentionally delay billing beyond the normal bill cycle.

c) Itemization: Any amount attributed to previously unbilled service shall be labeled as such on the customer's bill and include the beginning and ending dates for the period during which the previously unbilled amount accrued.

d) Calculation: For previously unbilled service accrued over a period of time where the rates for service have varied, the utility shall issue the makeup billing amount calculated on a pro-rated basis to reflect the varying rates.

e) Payment:

1) If a utility issues a makeup bill for previously unbilled service, it shall offer the customer a special payment arrangement to retire the amount by periodic payments without interest or late fees over a time equal to the amount of time for the delay in billing.

2) The special payment arrangement does not exhaust a customer's right to a DPA or medical payment arrangement (MPA), provided however, that neither the special payment arrangement nor the DPA nor the MPA may be used simultaneously unless it is agreed to by both the utility and the customer.

3) Late fees may be assessed on any installment amount on the special payment arrangement that is unpaid after two days beyond the due date on the bill containing that installment.

SUBPART G: REFUNDS AND CREDITS

Section 280.110 Refunds and Credits

a) Intent: To describe the procedures for customers to receive credits and refunds for overpayments and overcharges for utility service.

b) Billing Time Period for Refunds and Credits due to Overcharges Resulting from Utility Error:

1) A utility shall issue a refund or credit to a customer's account for the full period of time during which an overcharge occurred, so long as either the utility or the customer has retained billing records that would allow determining a refund or credit.

2) A utility shall retain billing records and ledgers that would allow determining a refund or credit for a minimum of two years from the current date.

3) A utility shall not be obliged to issue to a customer a refund or credit that extends into a time period during which that customer was not the customer of record. Exceptions may be made when the utility issues a refund or credit as a result of a Commission order.

c) Overpayment without Utility Error:

1) If the overpayment is the result of the customer paying more than the amount due on the bill, then the overpayment shall be noted on the customer's next bill statement, itemized to indicate the credit balance.

2) If the customer requests that the money overpaid be refunded to him/her, then the utility shall be obliged to do so as long as the overpayment credit amount exceeds 25% of the customer's average monthly bill. The refund shall be made within 10 business days after the utility confirms that it has received the money involved with the overpayment.

3) These provisions of this subsection shall not apply to any overpayment that results from payment on the customer's account by a State or federal assistance agency. Any such overpayment or credit on the customer's account shall be handled in the manner specified by the State or federal agency.

d) Interest on Refunds and Credits: All refunds and credits due to utility billing error shall be accompanied with interest calculated at the rates set by the Commission for customer deposits. Interest shall accumulate starting 30 days after the date the actual money comprising the overpayment is held by the utility until the date the utility issues a refund or credit to the customer's account. Credit balances accumulated on active budget payment plans shall not be subject to interest under this subsection unless the budget payment plan is cancelled while a credit balance remains. Interest shall accumulate from the date of the budget payment plan cancellation until the credit is refunded or consumed by future billing.

e) Itemization of Overcharges: All credits and refunds resulting from overcharges shall be accompanied by an itemization describing the reason for the credit or refund to the customer.

f) Credit to Bill Statement or Direct Refund to Customer:

1) Regular billing: For active service or transfer of service accounts, the utility shall issue either a credit to the account or, if the customer requests it at any time, make a direct refund to the customer so long as the credit balance exceeds 25% of the customer's average monthly bill.

2) Final bills: When the credit amount exceeds the total amount due on a customer's final bill, the utility shall issue a direct refund to the customer.

3) Exemptions for refunds: A utility shall not be obliged to issue a refund to a customer for a credit balance accrued as the result of Commission approved billing programs or rates that specifically disallow the issuance of refunds, or where the customer owes the utility a past due amount for the same class and type of service at another location.

g) Time Limit to File Complaint:

1) Excessive or unjust charges: *All complaints for the recovery of damages shall be filed with the Commission within 2 years from the time the produce, commodity or service as to which complaint is made was furnished or performed.* [220 ILCS 5/9-252]

2) Refunds for overcharges: *When a customer pays a bill as submitted by a public utility and the billing is later found to be incorrect due to an error either in charging more than the published rate or in measuring the quantity or volume of service provided, the utility shall refund the overcharge with interest from the date of overpayment at the legal rate or at a rate prescribed by the Commission. Refunds and interest for such overcharges may be paid by the utility without the need for a hearing and order of the Commission. Any complaint relating to an incorrect billing must be filed with the Commission no more than 2 years after the date the customer first has knowledge of the incorrect billing.* [220 ILCS 5/9-252.1]

SUBPART H: PAYMENT ARRANGEMENTS

Section 280.120 Deferred Payment Arrangements

a) Intent: Payment arrangements shall be structured and administered to maximize the successful retirement of past due utility service amounts owing to the utility while allowing the customer to retain active utility service.

b) Eligibility:

1) Mandatory offering by the utility: A residential customer owing a past due amount for utility service shall be eligible for a deferred payment arrangement so long as the customer has not failed to complete a previous DPA in the past 12 months.

A) At any time a customer's account balance owing is brought to current status, the utility shall consider all previous DPAs completed.

B) A customer who is eligible for a DPA under this subsection shall remain fully eligible until utility service is disconnected.

2) Optional offering by the utility:

A) At the utility's discretion, an applicant owing a past due amount for utility service may enter a DPA to retire the debt.

B) At the utility's discretion, a non-residential customer owing a past due amount for utility service may enter a DPA to retire the debt.

C) At the utility's discretion, a residential customer owing a past due amount for service, but who is not automatically eligible for a DPA under subsection (b)(1) may enter into a DPA to retire the debt.

c) Amounts included in DPA: The DPA shall only include amounts owing for utility service for which the utility would otherwise be entitled to disconnect the customer's service after proper notice if the customer was not on the DPA. DPA default shall not occur as a result of failure to pay non-utility service charges.

d) Transfer: When a customer transfers service, an existing DPA established at the old premises shall transfer with the customer to the new premises. A utility may be allowed to start an entirely new DPA at the new premises to accommodate its

billing systems programming so long as the "new" DPA is identical to the previous DPA.

e) Bill Itemization:

1) Each bill rendered to a customer who has established a DPA with the utility and has not defaulted shall include the following information:

A) The total balance remaining on the DPA;

B) The amount of the installment; and

C) The number of remaining installments on the DPA.

D) A statement explaining that:

i) a late or partial payment may result in the cancellation of the DPA, causing the total deferred amount and current charges to become immediately due in full; and

ii) non-payment of the full amount due may result in disconnection.

2) If a DPA defaults and is not reinstated prior to the next bill statement, the utility shall notify the customer of the default by at least one of the following methods:

A) A message on the next bill statement, stating the amount required to reinstate the DPA if paid in full by a specific date and that a later payment may result in additional charges or the cancellation of the DPA ; or

B) A separate written notice stating the amount required to reinstate the DPA if paid in full by a certain date and that a later payment may result in additional charges or the cancellation of the DPA; or

C) A live phone call to the customer, provided that the utility shall make a record of the date, time of day and utility personnel involved in the phone call, and retain the record for a period of two

years. If the utility is unable to speak with the customer directly, then it shall provide either a message on the next bill statement or separate written notice of default in accordance with subsections (e)(2)(A) or (B).

f) Down Payment:

1) In order to initiate a DPA, the customer must pay a minimum of 25% of the past due amount for utility service.

2) By agreement with the customer, the utility may include current billing amounts with the past due amount as the total balance from which the 25% down payment may be calculated.

3) At the utility's discretion, the down payment amount may be decreased.

g) Length of DPA:

1) The amount of time negotiated with the customer for the completion of the DPA shall be set between 4 to 12 billing cycles, with the utility having the discretion to allow more than 12 billing cycles for completion of the DPA.

2) In determining the length of time to offer, the utility shall take into account the ability of the customer to successfully complete the DPA.

3) If a residential customer's household income will not allow the customer to successfully complete a DPA of any length, then the utility shall advise the customer of the availability of local assisting agencies.

h) Installments:

1) The installments shall be equal amounts, unless unequal amounts are established by agreement with the customer.

2) The installments shall be due at the same time as the regular bill due dates.

i) Default:

1) A utility may consider a DPA in default when a customer fails to pay the full amount of the installment and the current bill by the second day after the bill due date.

2) The utility may resume collection activity after a DPA defaults, including delivery of a disconnection notice and subsequent disconnection of the service unless the customer pays the full amount past due or pays the reinstatement amount and any applicable reinstatement fee in order to resume the DPA.

j) Reinstatement:

1) A utility is not obliged to reinstate a defaulted DPA once it has disconnected service to the customer for non-payment.

2) A customer may reinstate a previously defaulted DPA by paying the required amount of the DPA installments owing up to that date on the DPA, including all past due bills that were not included in the original DPA amount. The default notice shall state that DPA reinstatement is possible for a stated amount if paid in full by a certain date and that reinstatement subsequent to that date may include additional charges.

3) The utility shall not assess a reinstatement fee for the first reinstatement of a defaulted DPA.

4) For each subsequent default after the first, in addition to paying the amounts required under subsection (j)(1), the customer shall pay a reinstatement fee if the utility has filed a tariff establishing a reinstatement fee.

k) Renegotiation:

1) A customer whose financial conditions change during the course of a DPA shall be allowed to renegotiate the length of the DPA with the utility to ensure its successful completion.

2) One such renegotiation is allowed during the course of a DPA, so long as:

A) The customer is willing to discuss the customer's financial circumstances;

B) The customer has at least made the down payment on the original DPA; and

C) The DPA is not currently in default status.

3) Through renegotiation, the utility shall not be obliged to extend the term of the DPA any longer than 4 to 12 additional billing cycles beyond the original term of the DPA, provided however that the utility and customer may renegotiate the DPA for a longer term if both parties agree.

4) Renegotiation does not preclude a customer's right to reinstate a defaulted DPA prior to disconnection.

l) Overlapping Arrangements: Multiple arrangements of any type under this Section shall not be employed simultaneously without the consent of both the utility and the customer. However, the utility shall not maintain an otherwise defaulted arrangement to prevent a customer from using another type of payment arrangement for which the customer is eligible.

m) Eligibility for winter DPA: a customer's right to establish a winter DPA under Section 280.135 shall be unaffected by any default on a DPA under this Section.

Section 280.125 Deferred Payment Arrangements for Low Income Customers

a) Intent: To enable low income customers to better retain essential utility services, a low income customer shall be eligible for all the provisions described in Section 280.120, April 1 through November 30. In addition, a low income customer shall be entitled to the altered provisions described in this Section.

b) Down payment:

1) In order to initiate a DPA, a utility may require a maximum down payment of 20% towards the past due amounts for utility service.

2) By agreement with the customer, the utility may include current billing amounts with the past due amount as the total balance from which the 20% down payment may be calculated.

c) Length of DPA term:

1) The amount of time offered to a low income customer for the completion of a DPA shall be set by the utility for 6 to 12 billing cycles.

2) At its discretion, the utility may set the term for a period longer than 12 months.

d) Reinstatement Fee Waiver: A utility shall not assess a reinstatement fee for any reinstatement of a DPA by a low income customer.

e) Amended DPA:

1) A utility shall offer an amended DPA to a low income customer who is in default on a first DPA if the customer has made at least two consecutive full payments under the first DPA and the customer has not been in default on the first DPA for more than 90 days.

2) The amended DPA shall be for the same term or longer than the term of the first DPA.

3) As a condition of entering the amended DPA, the utility may require the customer to participate in the payment option described in Section 280.80.

SUBPART I: DISCONNECTION

Section 280.130 Disconnection of Service

a) Intent: To provide adequate notice and reason for disconnection; allow for the customer to remedy the problem and avoid disconnection; create an expectation to act upon notice by a utility when a customer does not remedy the problem; and set prohibitions and limits on disconnection under certain circumstances.

b) Allowable Reasons for Disconnection:

1) Non-payment of past due bill for the same class and type of utility service;

2) Non-payment of valid utility service deposit owing on account;

3) Non-payment of a deposit owing as result of utility evidence of a problem described in Section 280.210;

4) Failure to provide access in multi-meter premises to utility facilities after attempts by the utility to gain access as described in Section 280.140;

5) Failure to provide access to utility facilities after four attempts (two attempts if in order to meet regulatory requirements) by the utility to gain access to a single customer premises, provided that the utility must comply with the same notification and record keeping requirements of Section 280.140 (c)(1), (2) and (3);

6) Occupant usage without a valid customer of record;

7) Theft of service and/or tampering;

8) Non-compliance with any rules of the utility on file with the Commission for which the utility is authorized by tariff to disconnect service in the event of non-compliance;

9) Non-compliance with an order of the Commission;

10) Unsafe condition; or

11) Cooperation with civil authorities.

c) Non-deniable Charges: The following shall not constitute valid reasons for disconnection of regulated utility services:

1) Charges for non-utility services, unless otherwise authorized by Illinois statute;

2) Charges for another class (residential or non-residential) of utility service;

3) Charges for another type (gas, electric, water or sewer, unless water and sewer utility service are provided by the same utility) of utility service;

4) Charges for equipment or merchandise unless otherwise authorized by statute; or

5) Charges currently in dispute under Section 280.220 or Section 280.230.

d) Disconnection Notice Content: Utility disconnection notices shall conform with Appendices A, B and D of this Part, and shall include at least:

1) Date issued;

2) Effective date;

3) Reason for disconnection;

4) Options for the customer to prevent disconnection;

5) Contact information for the utility;

6) Contact information for the Commission's Consumer Services Division; and

7) Medical certification process and customer bill of rights in Appendix B.

e) Method of Disconnection Notice Delivery:

1) All utility disconnection notices shall be sent separately from any other mailing to the customer.

2) The notice shall be mailed through the United State Postal Service or hand delivered.

3) The utility shall record the date the notice is sent or delivered and retain that record for a period of two years.

4) If the utility and customer have agreed to electronic communications, a utility shall submit a duplicate notice to the customer electronically as

long as it has also mailed or hand delivered a paper version of the notice to the customer.

f) Third Party Notice: A customer may designate by written request to the utility that a third party will be sent or delivered a duplicate notice whenever a disconnection notice is sent or delivered to the customer. The utility will send or deliver any third party notice at the same time as the notice is sent or delivered to the customer.

g) Timing of Notice:

1) When notice shall be sent: A utility shall not send or deliver a disconnection notice until after one of the reasons described in subsection (b) occurs.

2) Effective date: The utility shall not disconnect service until at least 10 days after the sending or delivery of the notice to the customer.

3) Duration of notice: The notice shall remain effective for 45 days after it is sent or delivered.

4) Overlapping notices: A utility may send or deliver a new notice prior to the expiration of a previous notice. The customer shall be entitled to the remedies offered in the previous notice until the effective date of the new notice.

5) the customer's regular monthly bill shall not be considered a new disconnection notice or operate to extend the due date of a previously issued disconnection notice.

h) Exemptions to Notice Requirements: Disconnection notices substantially in the form of Appendix A to this Part shall be required prior to all disconnections of service, except in cases of:

1) Occupant usage without a customer of record, provided that the utility shall refer to subsection (i) below for special provisions related to occupant usage;

2) Theft of service and/or tampering;

3) Unsafe condition;

4) Cooperation with civil authorities;

5) Outages and maintenance work; or

6) The current customer has requested the service be disconnected.

i) Warning Letter Required instead of Appendix A Disconnection Notice for Occupant Usage without Valid Customer:

1) When the utility has left the service on at a premises and there is usage without a customer of record, it shall send or deliver a warning letter to the premises address, containing the utility's toll free contact information, advising that an applicant must contact the utility to become a new customer or the service will have to be disconnected on or after 10 days have elapsed.

2) If the utility has contact information for the landlord or property manager of the premises, then a duplicate warning letter shall be sent or delivered to that person at the same time as the warning letter to the premises.

3) If there is no response within 10 days after the sending of the warning letter, the utility shall have the right to disconnect the service.

4) The utility shall not be obliged to send a warning letter to a premises when it disconnects service within 10 days after the date that the current customer requests as the date the utility will shut off and end that customer's service.

j) Warning Call to Residential and Master-Metered Customers:

1) Unless the customer has no phone number on record, the utility shall provide a warning call to the customer a minimum of 48 hours prior to the scheduled disconnection.

2) The warning call may be live or automated, and it shall advise the customer of the utility's intent to disconnect the service. A second call

shall be required 24 hours prior to the schedule disconnection if the first call does not reach a person or an answering machine.

3) The warning call shall provide the customer with the toll free or local phone numbers that the customer may use to contact the utility to discuss the situation.

4) The utility shall make a record of the date, time of day, and its success or failure in reaching the customer on the warning call. It shall retain the record for a period of two years.

k) Obligation to Act:

1) When a utility has sent or hand delivered four consecutive disconnection notices to the same customer for the same un-remedied reason for disconnection under subsection (b), it shall not be entitled to send a fifth notice of disconnection for the same un-remedied reason unless its effort to disconnect the service has failed. Such failure shall include any temporary moratoriums that would prevent the utility from attempting to disconnect service during the effective period of the disconnection notice.

2) If the utility's effort to disconnect the service fails, the utility shall record the date, time of day, utility personnel involved and a description of the reason for the failure. It shall retain this record for a period of two years.

l) Time of Day and Day of the Week Prohibitions and Limits: Except for matters of safety, emergency maintenance and cooperation with civil authorities, a utility shall comply with the following prohibitions and limits upon disconnection:

1) Non-business hours prohibition: A utility shall not disconnect a customer within one hour before or at any time during which it does not have its customer service personnel available to handle the customer's contact.

2) Weekday afternoon limits: A utility shall not disconnect a customer after 4:00 PM on Monday through Thursday unless the utility is prepared to take the customer's payment and reconnect the customer that same day if the customer remedies the reason for the disconnection.

3) Friday limits: A utility shall not disconnect a residential customer after noon on Friday or a non-residential customer after 4:00 PM on Friday, unless it is prepared to take the customer's payment and reconnect the customer that same day if the customer remedies the reason for the disconnection.

4) Weekend limits: A utility shall not disconnect a customer on Saturday or Sunday unless it is prepared to take the customer's payment and reconnect the customer that same day if the customer remedies the reason for the disconnection.

5) Holiday limits: A utility shall not disconnect a customer on a State of Illinois or utility holiday, or after noon on any day preceding a State of Illinois or utility holiday, unless the utility is prepared to take the customer's payment and reconnect the customer that same day if the customer remedies the reason for the disconnection.

m) Medical Certification: A utility shall not disconnect service to a residence for 60 days upon receipt of a valid medical certificate for a resident of the household, so long as the account is eligible for medical certification under Section 280.160.

n) Temperature Prohibitions:

1) Cold weather: *Termination of gas and electric utility service to all residential users, including all tenants of apartment buildings where gas or electricity is used as the only source of space heating or to control or operate the only space heating equipment is prohibited*:

A) *On any day when the National Weather Service forecast for the following 24 hours covering the area of the utility in which the residence or master-metered apartment building is located includes a forecast that the temperature will be 32 degrees Fahrenheit or below; or*

B) *On any day preceding a holiday or weekend when* the National Weather Service forecast for the following 24 hours covering the area of the utility in which the residence or master-metered apartment building is located includes a *forecast that the*

temperature will be 32 degrees Fahrenheit or below at any time during the holiday or weekend. [220 ILCS 5/8-205(a)]

2) Hot weather: *If gas or electricity is used as the only source of space cooling or to control or operate the only space cooling equipment at a residence or master-metered apartment building, then a utility with over 100,000 residential customers may not terminate gas or electric utility service to the residential user, including all tenants of master-metered apartment buildings:*

A) *On any day when the National Weather Service forecast for the following 24 hours covering the area of the utility in which the residence or master-metered apartment building is located includes a forecast that the temperature will be 95 degrees Fahrenheit or above; or*

B) *On any day preceding a holiday or weekend when* the National Weather Service forecast for the following 24 hours covering the area of the utility in which the residence or master-metered apartment building is located includes a forecast *that the temperature will be 95 degrees Fahrenheit or above at any time during the holiday or weekend.* [220 ILCS 5/8-205(b)]

o) Energy Act of 1989 Participants (low income customers) Winter Disconnection Prohibition: *Notwithstanding any other provision of this* Part, *no electric or gas public utility shall disconnect service to any residential customer who is a participant under Section 6 of the Energy Assistance Act of 1989* [305 ILCS 20/6] *for nonpayment of a bill or deposit where gas or electricity is used to control or operate the primary source of space heating equipment at the premises during the period of time from December 1 and including March 31 of the immediately succeeding calendar year*. [220 ILCS 5/8-206(k)]

p) Electric Space-Heating Customer Winter Disconnection Prohibition: *A utility that served more than 100,000 electric customers in Illinois as of December 31, 2005 shall not terminate electric service to a residential space heating customer for non-payment from December 1 through March 31*. [220 ILCS 5/16-111.6]

q) Military Personnel on Active Duty Disconnection Prohibition: No company *shall for nonpayment stop gas or electricity from entering the residential premises that*

was the primary residence of a service member immediately before the service member was assigned to military service [220 ILCS 5/8-201.5(b)]

r) Service Member or Veteran Disconnection Prohibition: *No electric or gas public utility shall disconnect service to any residential customer who has notified the utility that he or she is a service member or veteran for nonpayment of a bill or deposit where gas or electricity it used as the primary source of space heating or is used to control or operate the primary source of space heating equipment at the premises during the period of time from December 1 through and including March 31 of the immediately succeeding calendar year*. [220 ILCS 5/8-206(l)]

Section 280.135 Winter Disconnection of Residential Heating Services, December 1 through March 31

a) *Notwithstanding any other provision of this* Part, *no electric or gas public utility shall disconnect service to any residential customer or master-metered apartment building for nonpayment of a bill or deposit where gas or electricity is used as the primary source of space heating equipment at the premises during the period of time from December 1 through and including March 31 of the immediately succeeding calendar year, unless:*

1) *The utility*:

A) *Has offered the customer a* winter *deferred payment arrangement* (winter DPA) *allowing for payment of past due amounts over a period of not less than four months not to extend beyond the following November and the option to enter into a budget payment plan for the payment of future bills. The maximum down payment requirements shall not exceed 10 percent of the amount past due and owing at the time of entering into the agreement; and*

B) *provides the customer with the names, addresses and telephone numbers of governmental and private agencies which may provide assistance to customers of public utilities in paying their utility bills; the utility must obtain the approval of an agency before placing the name of that agency on any list which be used to provide the information to customers;*

2) *The customer has refused or failed to enter into a* winter DPA *as described in* subsection (a)(1)(A); and

3) *All disconnection notice requirements as provided by law* and this Part *have been met* by the utility.

b) *Prior to termination of service for any residential customer or master-metered apartment building during the period from December 1 through and including March 31 of the immediately succeeding calendar year, all electric and gas public utilities shall, in addition to all other notices:*

1) *Notify the customer or an adult* (a person over the age of eighteen) *residing at the customer's premises either by telephone, a personal visit to the customer's premises or by first class mail, informing the customer that:*

A) *The customer's account is in arrears and the customer's service is subject to disconnection for nonpayment of a bill;*

B) *The customer can avoid disconnection of service by entering into a deferred payment agreement to pay past due amounts over a period not to extend beyond the following November and the customer has the option to enter into a budget payment plan for the payment of future bills; and*

C) *The customer may apply for any available assistance to aid in the payment of utility bills from any governmental or private agencies from the list of the agencies provided to the customer by the utility,*

2) A *public utility shall be required to make only one contact* required in subsection (b)(1) *with the customer during any period from December 1 through and including March 31 of the immediately succeeding calendar year.*

3) *Each public utility shall maintain records which shall include, but not necessarily be limited to, the manner by which the customer was notified and the time, date and manner by which any prior unsuccessful efforts to contact the customer were made. These records shall also describe the terms of the DPA offered to the customer and those entered into by the utility and the customer. These records shall indicate the total amount past*

due, the down payment, the amount remaining to be paid and the number of months allowed to pay the outstanding balance. No public utility shall be required to retain records pertaining to unsuccessful efforts to contact or DPAs rejected by the customer after the customer has entered into a DPA with the utility.

c) *No public utility shall disconnect service for nonpayment of a bill until the lapse of six business days after making the notification required in* subsection (b)(1) of this Section *so as to allow the customer an opportunity to:*

1) *Enter into a DPA and the option to enter into a budget payment plan for the payment of future bills; and*

2) *Contact a governmental or private agency that may provide assistance to customers for the payment of public utility bills.*

d) *Any residential customer who enters into a DPA pursuant to this Section, and subsequently, during that period of time set forth in* subsection (a) of this Section, *becomes subject to disconnection, shall be given notice as required by law and* this Part *prior to disconnection of service.*

e) *During that time period set forth in* subsection (a) of this Section, *a utility shall not require a down payment for a deposit from a residential customer*, pursuant to Section 280.40, *in excess of 20% of the total deposit requested. An additional four months shall be allowed to pay the remainder of the deposit. This provision shall not apply to master-metered apartment buildings or other non-residential customers.*

f) *During that period of time set forth* in subsection (a) of this Section, the provisions of Section 280.120 of this Part which allow a utility to refuse to offer a DPA to a residential customer who has defaulted on an agreement within the past 12 months are suspended. *However, no utility shall be required to enter into more than one DPA under* this Part *with any residential customer or master-metered apartment building during the period from December 1 through and including March 31 of the immediately succeeding calendar year.*

g) *In order to enable customers to take advantage of energy assistance programs, customers who can demonstrate that their applications for a local, state or federal energy assistance program have been approved may request that the*

amount they will be entitled to receive as a regular energy assistance payment be deducted and set aside from the amount past due on which they make DPAs. Payment on the set-aside amount will be credited when the energy assistance voucher or check is received, according to the utility's common business practice.

h) *In no event shall any utility send a disconnection notice to any customer who has entered into a current DPA and has not defaulted on that DPA, unless the disconnection notice pertains to a deposit request.*

i) *Each utility will include with each disconnection notice sent during the period from December 1 through and including March 31 of the immediately succeeding calendar year to a residential customer an insert explaining the above provisions and providing a telephone number of the utility company which the customer may call to receive further information.*

j) Filing with the Commission:

1) *Each utility shall file with the Commission prior to December 1 of each year a plan detailing the implementation of this Section. This plan shall contain, but not be limited to:*

A) *A description of the methods to be used to notify residential customers as defined in this Part, including the forms of written and oral notices which shall be required to include all the information contained in* subsection (b) of this Section;

B) *A listing of the names, addresses and telephone numbers of governmental and private agencies which may provide assistance to residential customers in paying their utility bills;*

C) *The program of employee education and information which shall be used by the company in the implementation of this Section; and*

D) *A description of methods to be utilized to inform residential customers of those governmental and private agencies and current and planned methods of cooperation with those agencies to identify the customers who qualify for assistance in paying their utility bills.*

2) *A utility that has a plan on file with the Commission need not resubmit a new plan each year. However, any alteration of the plan on file must be submitted prior to December 1 of any year.*

3) *All plans are subject to review and approval by the Commission which may direct a utility to alter its plan to comply with this* Part. [220 ILCS 5/8-206]

Section 280.140 Disconnection for Lack of Access to Multi-Meter Premises

a) Intent: To provide adequate notice and reason for disconnection of an entire multi-meter premises when a utility is unable to gain access to its facilities; allow for the property owner/manager and customers of the premises to remedy the problem and thereby avoid disconnection; and set prohibitions and limits on this form of disconnection.

b) Allowable Reasons for Disconnection of an Entire Multi-Meter Premises:

1) The customers and property owner/manager have failed two consecutive times to provide access to utility facilities in order to meet regulatory requirements, including, but not limited to, inside safety inspections and meter exchanges;

2) The customers and property owner/manager have failed three consecutive times to provide access to utility facilities for non-payment disconnections; or

3) The customers and property owner/manager have failed four consecutive times to provide access to utility facilities for meter readings.

c) Utility Actions Required prior to Disconnection of an Entire Multi-Meter Premises:

1) The utility must attempt to obtain contact information for the property owner/manager, independently or with the assistance of the affected customers

2) The utility must seek access by physical visit. For each failure to gain access, the utility must record the date, time of day, utility personnel involved, a detailed description of utility's efforts to gain access and the

reason for each failure to gain access. The utility shall retain the records for a period of two years;

3) For each effort to gain access, the utility must send or deliver warning letters to each affected customer and property owner/manager with at least ten days advance notice of the utility's intent to gain access and the need for the customer to contact the utility to set up an appointment to provide access;

4) After the final consecutive failure to provide access, according to the number of consecutive failures required in subsection (b), the utility must send or deliver a disconnection notice to each affected customer and the property owner/manager as required by Section 280.130;

5) At the same time the utility sends or delivers the notices required in subsection (c)(3), it must also post the building with a written notice of disconnection; and

6) If the utility seeks access to disconnect non-paying customers, the utility must send or deliver a disconnection notice for non-payment to the customers in the premises that it intends to disconnect for non-payment.

d) Inconvenience Compensation Credit:

1) An inconvenience compensation credit shall be issued by the utility to the accounts of customers who are not otherwise eligible for non-payment disconnection when those customers are disconnected as a result of the utility's disconnection of non-paying customers in the same premises.

2) The inconvenience compensation credit shall be four times the monthly "customer charge" or $60, whichever is greater.

e) Limitations on Non-payment Disconnections for Multi-meter Premises: All of the limits, prohibitions and protections to customers offered in Sections 280.130 and 280.135 shall apply equally to lack of access disconnections of multi-meter premises for non-payment.

f) Reconnection: If access is provided, the utility shall not disconnect a building unless it has the resources in place and is prepared to reconnect service on the

same day as the disconnection or the day access is provided for any customers of a multi-meter premises who were otherwise not eligible for non-payment disconnection.

g) Data Collection and Maintenance: The utility shall collect the following data on a monthly basis and maintain the data for a period of two years following its collection. The utility shall make the data available to Commission Staff within 30 days after a request from Staff:

1) In addition to the record keeping required under subsection (c)(2), the utility shall record the total number of "at-risk" buildings (i.e., any buildings the utility believes are currently eligible for disconnection or would be eligible for disconnection in 30 days);

2) The utility shall retain a record of the following information regarding a disconnection event:

A) Address of building or facility disconnected;

B) Number of units affected by the disconnection;

C) The duration of the building disconnection from the date of the disconnection to the date that the building was reconnected;

D) Cause for Multi-Unit Disconnection;

E) Compensation credit issued; and

F) Customer contacts received prior to and as a result of disconnection and their given reason for failure to provide access.

Section 280.150 Disconnection of Master-Metered Apartment Buildings

Reference to Governing Statute: The Rental Property Utility Service Act [765 ILCS 735] governs procedures for disconnection of service to accounts affecting master-metered apartment buildings when a landlord or property manager has not paid the utility bill for the master-metered account. These procedures include requirements for a utility to:

a) Inform tenants of the pending disconnection of their utility service; and

b) Set out their remedies including the right to petition a court for appointment of a receiver to collect rents and remit a portion thereof to the utility for payment of utility bills.

SUBPART J: MEDICAL CERTIFICATION

Section 280.160 Medical Certification

a) Intent: To temporarily prohibit disconnection of utility service to a residential customer for at least 60 days in cases of certified medical necessity; and to provide an opportunity for the customer to retire past due amounts by periodic installments under an automatic medical payment arrangement commencing after 30 days.

b) Certifying Parties: Certification may be made by either a licensed physician or a local board of health.

c) Method of Certification:

1) Initial certification by phone call is allowed.

2) Written (may be mailed, faxed or delivered electronically) certification must be provided within 7 days after an initial certification by phone call.

d) Certificate Content:

1) Name and contact information for the certifying party;

2) Service address and name of patient;

3) A statement that the patient resides at the premises in question; and

4) A statement that the disconnection of utility service will aggravate an existing medical emergency or create a medical emergency for the patient.

e) Certificate Timing:

1) Certificate presentation prior to disconnection entitles a customer to receive a medical payment arrangement term, as described under subsection (h)(1).

2) The certificate may be presented up to 14 days after disconnection, with utility discretion as to whether it shall accept a certificate more than 14 days after disconnection have passed. Certification presented after disconnection entitles a customer to receive a medical payment arrangement term, as described under subsection (h)(2).

f) Restoration:

1) When a valid medical certification is provided to the utility up to 14 days after disconnection, service shall be restored within one day after the provision of certification.

2) The utility shall not treat the disconnected customer as an applicant for service for purposes of restoration under a medical certificate.

g) Duration of Certificate: The certificate shall protect the account from disconnection for 60 days after the date of certification. If the customer was disconnected prior to certification, then the 60 day period shall not begin until the utility restores the customer's service.

h) Data Collection and Maintenance: The utility shall collect the following data on a monthly basis and maintain the data for a period of two years following its collection. The utility shall make the data available to Commission Staff within 30 days after a request from Staff:

1) The total number medical certificates requested, and in instances where a utility declines to issue a medical certificate, the reason for denial;

2) The total number of medical certificates issued by the utility;

3) The duration, including start and end dates of the medical certification period (whether the end date is based on payment by the customer or expiration of the 60-day period).

i) Medical Payment Arrangement

1) If valid medical certification is received prior to disconnection, then the first bill statement that will be due after 30 days after the certification date shall indicate:

A) An amount to pay that is equal to 1/12th of the total amount owing for utility services by the customer;

B) The remaining balance owing for utility services;

C) That the customer is on a medical payment arrangement; and

D) 11 remaining installments of equal amounts to be paid on future bills.

2) If valid medical certification is received after disconnection, then the first bill statement that will be due after 30 days after the certification date shall indicate:

A) An amount to pay that is equal to 1/4th of the total amount owing for utility services by the customer;

B) The remaining balance owing for utility services;

C) That the customer is on a medical payment arrangement; and

D) Nine remaining installments of equal amounts to be paid on future bills.

3) Valid medical certification shall entitle a customer to an MPA, regardless of the success or failure of previous payment plans of any sort.

j) New Certification of Previously Certified Accounts: Accounts that received a prior valid medical certificate shall be eligible for new certification any time after either:

1) The total account balance has been brought current; or

2) 12 months from the beginning date of the prior certification has passed.

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

SUBPART K: RECONNECTION

Section 280.170 Timely Reconnection of Service

a) Intent: To provide for the timely reconnection of disconnected customers after they have remedied the reasons for the disconnection or provided valid medical certification.

b) Timing: Once a disconnected customer remedies the reason for the disconnection or provides a valid medical certificate, the utility shall prioritize reconnection as indicated in this subsection. If the utility does not comply with the time limits in this subsection, it shall not bill the customer a reconnection charge. If, through no fault of the customer, the utility delays reconnection for two or more calendar days beyond the number of days required in this subsection, then it shall issue a credit to the customer's account equal to two non-prorated monthly customer charges for that customer. If a disconnection is made in error, the penalty shall be an amount equal to three non-prorated monthly customer charges, in addition to any reconnection fees made for non-timely reconnection.

1) A customer account where a valid medical certificate has been provided shall receive first priority and be reconnected within one business day after the certification.

2) A customer disconnected in error shall be reconnected within one business day.

3) A disconnected electric, water or sewer customer who remedies the reason for the disconnection, and is not required by the utility to provide information as a new applicant for service, shall be reconnected within four calendar days.

4) A disconnected natural gas customer who remedies the reason for the disconnection, and is not required by the utility to provide information as a new applicant for service, shall be reconnected within seven calendar days.

c) Exception for Lack of Access: A utility shall not be obliged to conform to the above time limits in subsection (b) if it is not allowed access to reconnect the

service; provided, however, that the utility must record the date, time of day, utility personnel involved and the reason access was not gained. It shall retain the record for a period of two years.

d) Exception for Disconnection not at the Meter or not at the Normal Place of Disconnection: A utility shall not be obliged to conform to the above time limits in subsection (b) if it was forced to by lack of access to disconnect the service at a location other than the meter or at a place other than the normal place of disconnection if the utility does not normally disconnect service at the meter.

e) Exception for Damage or Unsafe Condition: A utility shall not be obliged to conform to the above time limits of subsection (b) if repair, construction or correction of an unsafe condition is required prior to reconnection of service.

f) Temporary Exception for Unforeseen Circumstances: A utility that experiences temporary unanticipated, and unforeseeable overload of its ability to provide for the timely reconnection of disconnected customers may, upon approval granted by the Commission's Consumer Services Division, temporarily forego the requirements of this Section so long as the utility can demonstrate that it is taking diligent action to remedy the overload.

g) If service was shut off in error, the utility shall not bill the customer a reconnection charge.

Section 280.180 Reconnection of Former Residential Customers for the Heating Season

a) *Any former residential customer whose gas or electric service was used to provide or control the primary source of space heating in the dwelling and whose service is disconnected for non-payment of a bill or a deposit from December 1 of the prior winter's heating season through April 1 of the current heating season shall be eligible for reconnection and a deferred payment arrangement under the provisions of this Section.* Under this Section, a former residential customer shall also include a former customer who has moved to a new location after the service at the customer's former premises was disconnected. However, it shall be the responsibility of the former customer to notify the utility of his or her need for service at the new premises, and a utility shall not be obliged to search for former customers who have moved for the purpose of subsection (g).

b) Limitations: *A utility shall not be required to reconnect service to and enter into a deferred payment arrangement with a former customer under the provisions of this Section:*

1) *Except between November 1 and April 1 of the current heating season for former customers who do not have applications pending for the program described in Section 6 of the Energy Assistance Act* [305 ILCS 20/6], *and except between October 1 and April 1 of the current heating season for all former customers who do have applications pending for the program described in Section 6 of the Energy Assistance Act and who provide proof of application with the utility.*

2) *In two consecutive years;*

3) *Unless that former customer has paid at least 33 1/3 percent of the amount billed for utility service rendered by that utility subsequent to December 1 of the prior year.* A former customer who did not pay the required amount prior to disconnection may establish eligibility by paying the required amount when seeking reconnection under this Section. In addition to calculating the 33 1/3 percent the former customer must pay to establish eligibility, the utility shall calculate the amount the customer must pay to enter into a payment agreement. For purpose of simplification, the utility shall inform the customer of the total amount needed for reconnection, including amounts required under subsections (b)(3), (b)(4), (d) and (e). The utility shall accept multiple sources of payment, including but not limited to energy assistance program payments, for purposes of satisfying this requirement.

4) Until the customer pays the charges associated with the tampering, *in any instance where the utility can show that there has been tampering with the utility's wires, pipes, meters (including locking devices), or other service equipment and further shows that the former customer enjoyed the benefit of utility service in the aforesaid manner.*

c) DPA: *The terms and conditions of any deferred payment arrangements established by the utility and a former customer shall take into consideration the following factors, based upon information available from current utility records or provided by the former customer:*

1) *The amount past due;*

2) *The former customer's ability to pay;*

3) *The former customer's payment history;*

4) *The reasons for the accumulation of the past due amounts; and*

5) *Any other relevant factors relating to the former customer's circumstances.*

d) *After the former customer's eligibility has been established in accordance with* subsections (a) and (b) of this Section, *and, upon the establishment of a deferred payment agreement, the former customer shall pay 1/3 of the amount past due (including reconnection charge, if any) and 1/3 of any deposit required by the utility.*

e) Reconnection:

1) *Upon payment of the 1/3 of the amount past due and 1/3 of any deposit required by the utility, the former customer's service shall be reconnected as soon as possible. The company and the former customer shall agree to a payment schedule for the remaining balances which will reasonably allow the former customer to make the payments on the remainder of the deposit and the past due balance while paying current bills during the winter heating season.*

2) Notwithstanding the foregoing, a former customer who demonstrates to the utility, or to the Commission through formal or informal complaint under Sections 280.220 or 280.230, a financial inability to meet the requirement of the 1/3 of the amount past due and 1/3 of any deposit requested by the utility, shall be reconnected upon paying a reasonable amount and upon entering into a deferred payment agreement

A) In determining financial inability under this subsection, the following factors, among others, shall be considered:

i) The combined income and financial resources of all persons residing in the former customer's household;

ii) The combined living expense of the former customer's household;

iii) The former customer's payment history;

iv) The reasons for the accumulation of past due amounts; and

v) A low income customer as defined by this Part shall automatically qualify for financial inability under this subsection.

B) For purposes of this subsection, a "reasonable amount" shall be 20 percent of the amount past due and 20 percent of any deposit required by the utility.

3) *However, the utility is not obliged to make payment arrangements extending beyond the following November. The utility shall allow the former customer a minimum of four months in which to retire the past due balance and a minimum of three months in which to pay the remainder of the deposit. The former customer shall also be informed that payment on the amounts past due and the deposit, if any, plus the current bills must be paid by the due date or the customer may be subject to disconnection of service.*

f) *Any payment agreement made shall be in writing, with a copy provided to the former customer. The renegotiation and reinstatement provisions* contained in Sections 280.120 and 280.125 and the budget payment plan provisions of Section 280.80 shall also apply to payment agreements made pursuant to this Section.

g) Survey and Notice to Affected Customers:

1) *Not later than September 15 of each year, every gas and electric utility shall conduct a survey of all former residential customers whose gas and/or electric service was used to provide or control the primary source of space heating in the dwelling and whose gas and/or electric services was terminated for non-payment of a bill or deposit from December 1 of the previous year to September 15 of that year and where service at that premises has not been restored.*

2) *Not later than October 1 of each year the utility shall notify each of these former customers that the gas and/or electric service will be restored by the company for the coming heating season if the former customer contacts the utility and makes arrangements to pay the past due balance and any deposit to the utility under the conditions set forth in this Section.*

3) *A utility shall notify the former customer or an adult member of the household by personal visit, telephone contact or mailing of a letter by first class mail to the last known address of that former customer. The utility shall keep records which would indicate the date, form and results of the contact.*

4) Any former customer who meets the eligibility requirements under subsections (a) and (b) shall be eligible for reconnection under this Section, regardless of whether or not the utility identified the former customer in the survey requirements of this subsection and regardless of whether or not that former customer received notification under this subsection.

h) Not later than November 20 and May 20 of each year, each gas and electric utility which has former customers affected by this Section shall file a report with the Commission providing statistical data concerning numbers of disconnections and reconnections involving utility service and deposits, and data concerning the dollar amounts involved in these transactions. *The Commission shall notify each gas and electric utility prior to August 1 of each year concerning the information which is to be included in the report* for the following heating season.

i) *In no event shall any actions taken by a utility in compliance with this Section be deemed to abrogate or in any way interfere with the utility's rights to pursue the normal collection processes otherwise available to it.* [220 ILCS 5/8-207]

SUBPART L: UNAUTHORIZED SERVICE USAGE

Section 280.190 Treatment of Illegal Taps

a) Intent: To require the utility to investigate high bills resulting from an abnormal or unexplained increase in consumption alleged by a customer. The utility shall investigate the allegation, to the extent customer-owned facilities are readily

visible or accessible, to determine the reason and whether the consumption is caused by an illegal tap or diversion of service.

b) Utility Investigation: Where within 30 days after receipt of a utility's bill a customer alleges that the level of consumption is unreasonably high, the public utility furnishing natural gas, electricity or water to that customer shall investigate the allegation.

c) Notice of Investigation Results: If, as a result of the investigation, the public utility determines that a tap has been constructed on the pipes and/or wires of the customer, the utility shall attempt to notify the landlord, property owner or his or her agent and instruct that the tap should be removed immediately. The customer shall also be provided with notice of the investigation results.

d) Disconnection of Service: This Section shall in no way prohibit a utility from disconnecting service if the utility determines that an unsafe condition exists.

e) Utility Determination of Benefitting Party: The utility shall also attempt to determine the identity of the party benefitting from the tapped service. The following procedures shall apply once the tap has been removed:

1) The customer whose pipes and/or wires had been tapped by a third party shall be billed by the utility according to the newly established usage pattern and/or degree day analysis, whichever is appropriate.

2) If the utility identifies the third party and finds that the third party is currently a customer of the utility on another account, the utility is authorized to bill that third party's account for the excess usage which is not attributable to the customer whose line had been tapped plus all related expenses incurred by the utility.

3) If the utility identifies the third party and finds that the third party is not a customer of the utility, the utility is authorized to bill that third party for the excess usage which is not attributable to the customer whose line had been tapped plus all related expenses incurred by the utility using the procedures established for the billing of unauthorized use of utility service.

4) In cases when the utility cannot determine the identity of the party benefitting from the tap, the utility may assign the dollar amount representing the excess usage and expenses to its bad debt account.

f) Construction Error: When the diversion of gas, electricity or water is the result of a construction error in the pipes and/or wires that is not the responsibility of the public utility, the accounts of the customers involved may be adjusted according to the newly established usage pattern and/or degree day analysis, whichever is appropriate.

g) When the customer of record benefitted from, cooperated in or acquiesced to the tap, the utility may collect all related expenses from the customer of record for the services associated with the tap.

Section 280.200 Tampering

a) Intent: Tampering with utility wires, pipes, meters or other service equipment is prohibited. The intent of this Section is to describe the process by which the utility shall bill the customer for the unauthorized usage when the utility has proof that the customer benefitted from tampering.

b) Proof: The utility has the burden of proving by a preponderance of evidence that tampering has occurred with the utility's wires, pipes, meters or other service equipment, that the customer has benefitted from the tampering, and that the utility's billing is reasonable.

c) Investigation: When the utility has reason to suspect that tampering has occurred, it shall investigate without delay.

d) Notice to Customer: Once the utility has full proof of the tampering, it shall report to the customer the details of the investigation.

e) Remedy: As soon as the condition becomes known to the utility, it shall take steps to correct the condition and issue a corrected bill without delay. Pursuant to any tariffed meter tampering charge, before assessing the charge, the utility shall review the situation to determine if the person benefitting from the tampering was responsible either directly or indirectly for the tampering.

f) Timing: If tampering evidence extends to previous customers of record, then the current customer shall not have to pay for the portions of the unauthorized usage that are attributable to the previous customers.

g) Record Keeping: The utility shall document and record the evidence that proves the tampering, and it shall save the full evidence proving the tampering for a minimum of three years from the date that the customer is issued a corrected bill for the tampering.

Section 280.205 Non-Residential Tampering

a) Intent: The provisions of Section 280.200 shall apply in cases of non-residential tampering. In addition, this Section shall provide the utility with immediate relief from further unauthorized usage of service by a non-residential customer.

b) Disconnection: When the utility has evidence proving the unauthorized use of non-residential service, it may disconnect service to the tampering customer until:

1) The utility or the customer removes the facilities that allow the customer to use service without paying for it. If the utility must remove the facilities, the customer shall pay the costs associated with the work; and

2) The customer pays for the unauthorized usage. The utility shall determine the amount of unauthorized usage and provide a bill to the customer without delay.

Section 280.210 Payment Avoidance by Location

a) Intent: With the understanding that a utility and its customers must deal in good faith with each other, this Section defines the process by which a utility may protect itself and its ratepayers from persons seeking to use a pattern of action to avoid payment for service used at a specific service location.

b) Conditions: Payment avoidance by location (PAL) applies only when all the following conditions occur:

1) a utility receives a new application for service at a service location;

2) a former customer who was disconnected for non-payment at the same service location still resides at the service location; and

3) the utility has proof that the new applicant for service also occupied the service location during the time the previous customer's debt accrued.

c) Exemption: Payment avoidance by location shall not include new owners and/or new tenants at a service location.

d) Notification of PAL: When a utility can demonstrate with evidence that a pattern of payment avoidance is occurring by a person or persons at a location, in order to invoke the protections of this Section, it shall provide the following notice:

1) The utility shall notify the person of the PAL allegation using the same method of contact by which that person contacted the utility.

2) The utility shall notify the person of the PAL allegation in writing. The written notification may be sent electronically if agreed upon by the utility and the person receiving the notification.

3) The notice shall be sent no later than two business days after the utility's decision to invoke the protections available to it under this Section.

4) The notice shall contain a detailed description of the problem and the facts and evidence that the utility has to support the PAL allegation.

5) The notice shall contain an explanation of the steps that the person must take in order to dispute or remedy the problem.

6) The notice shall contain the toll free number and contact information for the utility and the toll free number and contact information for the Commission's Consumer Services Division.

7) A duplicate copy of the notice shall be sent to the Commission's Consumer Services Division at the same time it is sent to the person.

e) Deposit: When a utility has proof that PAL is occurring, it may require the applicant to provide a deposit under the following conditions:

1) A deposit required under this Section shall be equal to 1/3 of the estimated annual charges for the premises.

2) The utility may require payment of the deposit in full prior to service.

3) The deposit shall earn interest as described in Section 280.40.

4) The deposit plus interest shall be refunded as described in Section 280.40.

f) Burden of Proof: It shall be the sole responsibility of the utility to prove with evidence that PAL has occurred. The person accused of PAL shall have the right to the full evidence possessed by the utility and the opportunity to present information to refute the allegations.

g) Data Collection and Maintenance: A utility that includes this Section as part of its practices shall collect the following data on a monthly basis and maintain the data for a period of two years following its collection. The utility shall make the data available to Commission Staff within 30 days after a request from Staff:

1) The total number of instances where the utility alleged that PAL occurred;

2) The total number of PAL instances where the utility denied service;

3) The total number of PAL instances where the utility required a deposit to begin service;

4) The total number of PAL instances where the person successfully refuted the utility's evidence of PAL;

5) The total number of PAL instances where the utility discovered that its evidence was inaccurate; and

6) The total number of PAL instances where the person remedied the problem by payment of the arrearage accrued for disconnection of the previous customer.

SUBPART M: COMPLAINT PROCEDURES

Section 280.220 Utility Complaint Process

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

a) Intent: To provide utilities and customers with the ability to resolve complaints or appeal complaints that cannot be resolved directly between the parties.

b) Customer Contact: The customer must contact the utility and attempt to resolve the complaint directly with the utility before proceeding to the Commission's informal complaint process. The customer and the utility shall cooperate to resolve the complaint.

c) Methods of Contact: The utility shall maintain local and/or toll free telephone numbers; a mailing address to receive customer complaints and correspondence; and, where the utility has the capability, a means of receiving electronically submitted complaints.

d) Availability: The utility shall maintain regular business hours and staffing to answer all customer inquiries and complaints.

e) Complaint Response Timeline: The utility shall respond to complaints within 14 days after their receipt, with exceptions where both the customer and the utility agree to an extension or where the utility can demonstrate to the customer that more time is required by circumstances beyond its control.

f) Customer Payment During Complaint: If the complaint involves a dispute over the amount billed:

1) The customer shall pay the undisputed portion of the bill or an amount equal to last year's bill at the location for the same period normalized for weather;

2) The utility shall confirm the disputed portion and the amount to be paid by the customer; and

3) The utility shall note and set aside the disputed amount in its records for the account.

g) Late Fees:

1) No late fees may be assessed on any amount in dispute while the complaint remains unresolved.

2) No late fees may be assessed on a previously disputed amount so long as the customer pays the previously disputed amount within 14 days after the resolution of the complaint and so long as the complaint was made to the utility before the disputed amount became past due.

h) Third Party Services and Billing: If the customer's complaint involves a service or good provided by a party other than the utility and the third party uses the utility for billing purposes, then the utility shall make a record in its files of the complaint and advise the customer how to contact the third party. The utility shall refrain from applying a customer's payment towards any amount in dispute with a third party on the bill until the complaint involving that portion of the bill has been resolved.

i) Appeal to Supervisor:

1) If the customer requests a referral to a supervisor, the utility personnel shall note the account and make the referral the same day.

2) The supervisory personnel must respond to the customer without delay, and priority shall be given:

A) First to customer accounts that are disconnected or where a health or safety concern has been raised by the customer;

B) Second to customer accounts in jeopardy of disconnection; and

C) Third to all other supervisory referrals.

j) All customer complaints must be assigned a complaint number which shall be retained by the utility for a period of two years.

k) Prohibition Against Disconnection: The utility shall not disconnect a customer's utility service during the pendency of a complaint for any amount or reason that is the subject of the complaint. However, nothing shall prevent the utility from disconnecting service for reasons of safety or cooperation with civil authorities.

l) Appeal to Commission Complaint Process: Once a final answer is provided to the customer, and, if the customer indicates non-acceptance of the response:

1) The utility shall advise the customer of the right to appeal the utility's answer to the Commission's Consumer Services Division for an informal complaint;

2) The utility shall provide the customer with the contact information for the Commission's Consumer Services Division; and

3) In the case of a pending disconnection, the utility shall refrain from disconnection for at least three business days to allow the customer to contact the Commission's Consumer Services Division.

Section 280.230 Commission Complaint Process

a) Intent: To provide utilities and customers with a process through the Commission's Consumer Services Division which allows the parties to settle a dispute without litigation; or appeal an ongoing conflict that cannot be resolved informally to the Commission's formal complaint process.

b) Intake of complaints by the Commission's Consumer Services Division:

1) Telephone or in person: The Consumer Services Division shall perform a customer interview and draft an informal complaint, including a description of the dispute and the relief sought. Telephone or in person informal complaints may also be taken from the customer's designated representative.

2) Writing: The customer or the customer's designated representative may submit informal complaints in writing either electronically or through traditional mail or fax (if available) to the Consumer Services Division.

c) Presentation of the Complaint to the Utility:

1) Except as noted below, the complaint shall be submitted by the Consumer Services Division to the utility in writing and shall contain as much of the following information as is available: the customer's name, service address, mailing address if different from service address, phone number, account number, any alternative contact information, a description of the complaint, and the relief being sought by the customer.

2) If all the parties agree, the written informal complaint process may be waived, and the Consumer Services Division may work to resolve the complaint by immediate direct contact between the parties as the time the customer initiates the informal complaint.

d) Timeline to Answer:

1) The utility shall answer the informal complaint within 14 days.

2) The Consumer Services Division shall mark as "urgent" those informal complaints that should be handled by the responding party on a priority basis.

e) Extensions: By contact with the Consumer Services Division prior to the lapse of the 14 day response period, the utility may seek to extend the timeline for a response. Consumer Services Division Staff shall decide whether or not to grant the extension.

f) Utility Answer to the Informal Complaint:

1) Except where the parties agree to a non-written response, the utility's answer to the Consumer Services Division shall be made in writing and shall contain:

A) A detailed description of the utility's position on the complaint, including the reasons for taking the position;

B) If applicable, a reference to the section of the tariff, rule or law that supports the utility's position;

C) A description of any interaction between the utility and the customer in answering the informal complaint.

D) The amount of any adjustments to the customer's bill;

E) The results of any tests performed on the equipment serving the customer; and

F) Any additional information requested by the Commission Staff.

2) Review of answer with customer: After receipt of the utility response, the Consumer Services Division shall have 14 days to contact the consumer to review the results of the informal complaint.

3) Ongoing dialog/negotiations: Upon agreement of the customer and the utility, further discussion may occur between the parties after the response to the informal complaint.

g) Prohibition on Disconnection: The utility shall refrain from disconnecting a customer during an informal or formal complaint for any amount or reason that is the subject of the informal or formal complaint. However, nothing shall prevent the utility from disconnecting service for reasons of safety or cooperation with civil authorities.

h) Right to Appeal:

1) Except in situations where to do so would cause the statute of limitations for filing a formal complaint to expire, any customer with a dispute arising under the jurisdiction of this Part shall first use the informal complaint process before proceeding with a formal complaint.

2) If the customer expresses non-acceptance of the response to the informal complaint, and further dialog cannot secure an agreement, then the Consumer Services Division shall advise the complainant of the right to escalate the informal complaint to the Commission's formal complaint process.

3) If the utility fails to respond to the informal complaint within 14 days, the customer may file a formal complaint in accordance with the Commission's Rules of Practice (83 Ill. Adm. Code 200).

4) Upon a customer's request for escalation to a formal complaint, the Consumer Services Division shall provide notice to the utility of the customer's intent to escalate the complaint.

5) Upon notice from Consumer Services Division of the customer's intent to file a formal complaint, the utility shall provide a minimum of 10 business

days for the customer to file the formal complaint without disconnection of service. Nothing, however, shall prevent the utility from disconnecting service for reasons of safety or compliance with civil authorities.

i) Timeline to File a Formal Complaint to Seek Refund:

1) Excessive or unjust charges: *All complaints for the recovery of damages shall be filed with the Commission within 2 years from the time the produce, commodity or service as to which complaint is made was furnished or performed.* [220 ILCS 5/9-252]

2) Refunds for overcharges: *When a customer pays a bill as submitted by a public utility and the billing is later found to be incorrect due to an error either in charging more than the published rate or in measuring the quantity or volume of service provided, the utility shall refund the overcharge with interest from the date of overpayment at the legal rate or at a rate prescribed by the Commission. Refunds and interest for such overcharges may be paid by the utility without the need for a hearing and order of the Commission. Any complaint relating to an incorrect billing must be filed with the Commission no more than 2 years after the date the customer first has knowledge of the incorrect billing.* [220 ILCS 5/9-252.1]

SUBPART N: INFORMATION

Section 280.240 Public Notice of Commission Rules

Each utility shall provide notice to customers of the availability of Commission rules. Notice substantially in the form shown in Appendix C shall be posted on any utility web site and written notice shall be provided to customers annually. Such notice to customers may be in the form of a bill message where customers will be provided the opportunity to obtain copies of the Commission's rules upon request or by accessing the utility's website.

Section 280.250 Second Language Requirements

Where there is a demonstrated need for second language notices in the service area of any utility, notices as set out in Appendices A and B sent to customers located within the area should contain the following warning in the appropriate second language: "Important – This notice affects your rights and obligations and should be translated immediately."

Section 280.260 Customer Information Packet

a) Intent: The utility shall develop customer information material and provide the material to customers without additional charge.

b) Content:

1) Description of the services provided; and

2) Customer rights and responsibilities under this Part, including at a minimum:

A) A brief description of billing information such as frequency of billing, due dates, and electronic billing and other billing options Billing and Paying for Service Procedures for billing;

B) A description of the estimated bill process;

C) Payment options, including Budget Payment Plan and Deferred Payment Arrangements;

D) Payment methods and locations;

E) Late fees;

F) Deposit requirements;

G) Disconnection and reconnection procedures;

H) Utility dispute procedures and escalation procedures if a dispute is not resolved;

I) Contact information for the utility;

K) Commission's Consumer Services Division's informal complaint procedures;

L) Contact information for the Commission's Consumer Services Division;

M) A statement that the Commission's rules apply to service standards and reliability;

N) Notice of the availability of the Commission's rules; and

O) That special rights are available to Low Income Customers, and how to qualify for Low Income Customer status.

c) Distribution:

1) Written copy sent or delivered to all new customers;

2) Written copy sent or delivered to customers upon request;

3) Material available on any utility web site; and

4) Notice that the material is available free of charge and instructions on obtaining material sent to all customers annually.

d) Filing with Commission: The material shall be kept current and a current copy shall be filed with the Manager of the Consumer Services Division. Any changes in the material shall be presented to the Manager of the Consumer Services Division at least 45 days prior to being made available to customers.

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

Section 280 Appendix A Disconnection Notice

Disconnection notices sent to customers shall be in red and substantially in the following form:

Issuance date:
Utility name
Utility contact information

Effective date:
Customer name and address
Customer account number

URGENT!
This is a DISCONNECTION NOTICE!

Your utility service is in danger of disconnection because (reason for notice here, including past due amounts for which the service may be disconnected)

In order to stop disconnection, you must (detailed description of what customer must do in order to avoid disconnection; in lieu of detailed steps, utility may offer contact info where customer can immediately access complaint handling utility personnel). If you have recently paid, please contact us to confirm that the service will not be disconnected.

You can be shut off on or after (effective date), and you can still be shut off until (date notice expires) or we send you a new notice to replace this one.

Residential customers have certain rights regarding this notice, including the right to a deferred payment arrangement and the potential to stop disconnection for 60 days and start a medical payment arrangement if a doctor of local board of health contacts us directly on behalf of a patient living in your household. Please see the reverse side of this notice for further details of your rights.

You will lose many of your rights if you wait to do something until after disconnection.

If you have questions or concerns about this notice, please contact us immediately at: (utility contact information).

If we are unable to assist you, you have a right to contact and review your rights with the government agency that regulates us:

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

The Illinois Commerce Commission's Consumer Services Division can be reached at

1-800-524-0795 (TTY 1-800-858-9277).

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

Section 280 Appendix B Customer Rights (Appearing on the reverse side of disconnection notices sent to residential customers)

Your rights and responsibilities regarding this notice:

Payment methods: (utility shall list available means or provide way to obtain available options).

Deferred Payment Arrangement (DPA): You may be eligible for a payment plan known as a DPA in order to prevent disconnection unless you failed to complete a previous DPA in the past 12 months. Please contact us at (contact info) to ask about payment options to avoid disconnection.

Reinstatement: You can reinstate a previous DPA that defaulted by catching up with all the payments that were due up to now. We may charge you a reinstatement fee unless this is your first time reinstating the DPA.

Renegotiation: If lose or change income, you may be able to renegotiate your DPA.

Financial Aid: Help with utility bills may be found in the Low Income Home Energy Assistance Program (LIHEAP). Along with the aid, LIHEAP qualification gives you extra rights. Contact LIHEAP at (current LIHEAP contact info). We may know of other additional aid available. To find out, contact us at (utility contact info).

Medical Certification: If you haven't used a medical certificate in the past 12 months or you paid off a previous medical certificate, a medical certificate from a doctor or local board of health can stop disconnection for 60 days or have service restored as long as they contact us within 14 days after shut off. The medical certificate must contain:

1) **Name and contact information for the doctor or board of health;**
2) **Your service address and the name of the patient;**
3) **A statement that the patient lives at the address; and**
4) **A statement that disconnection of utility service will aggravate an existing medical emergency or create a medical emergency for the patient.**

The doctor or local board of health can call us to certify, but they must provide a written medical certificate with the above information within 5 days after calling. The medical certificate also puts you on a **medical payment arrangement** to pay off the bill over time. **The term of the payment plan will be better if we receive the certificate before your service is disconnected.**

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

Active Duty Military: If someone living with you is on active U.S. military duty, State law offers certain protections for your electricity and natural gas. Please contact us if someone in your household is on active duty.

Deposits: We can demand a deposit from you if we shut you off or if you pay late 4 times and carry a past due balance older than 30 days at any time in a 12 month period. The deposit will be about twice the size of your average bill, and you can pay it in 3 installments. You can be disconnected for not paying a deposit.

Reconnection: If we shut you off, your service will be restored when you pay in full or take care of the problem if we shut you off for something other than a bill or deposit. You may be required to pay a reconnection fee.

Complaints: If you have a complaint or problem with us, do not wait until after we shut you off to try to take care of it! If you contact us to try to take care of a problem, we must try to work with you to resolve or explain the problem. If we can't help you, you can contact the Illinois Commerce Commission's Consumer Services Division at: 1-800-524-0795 (TTY 1-800-858-9277). Before calling the ICC, you must try to work things out with us first. Please call us at (Utility contact info).

Regulations: You can review the main set of rules that affect you at the http://www.ilga.gov/commission/jcar/admincode/083/08300280sections.html.

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

Section 280 Appendix C Public Notice

RULES PERTAINING TO ELLIGIBILITY FOR SERVICE,
DEPOSITS, BILLING, PAYMENT, REFUNDS
AND DISCONNECTION OF SERVICE

ILLINOIS COMMERCE COMMISSION
83 Ill. Adm. Code 280

Part 280, the rules and regulations of the Illinois Commerce Commission prescribing procedures governing eligibility for service, deposits, billing, payment, refunds and disconnection of service, is on file in this office open to public inspection.

Copies of Part 280 in the Spanish language are available for inspection at the offices and online.

Any employee will direct you to the place where you may inspect a copy of Part 280 and will direct you to personnel assigned the duty of providing information about Part 280.

Copies of Part 280 may also be reviewed and/or obtained at the Commission's offices at 160 North LaSalle Street, Suite C-800, Chicago, Illinois 60601 or 527 East Capitol Avenue, Springfield, Illinois 62701 or at
http://www.ilga.gov/commission/jcar/admincode/083/08300280sections.html.

ILLINOIS COMMERCE COMMISSION

NOTICE OF PROPOSED RULES

Section 280 Appendix D Disconnection Notice Insert for Residential Gas and Electric Customers

Disconnection notices sent to residential gas and electric customers shall include an insert in substantially the following form:

IF YOU CANNOT PAY YOUR ENTIRE BILL NOW

READ THIS NOTICE ABOUT MAKING
ARRANGEMENTS TO PAY OVER TIME

What can I do if I cannot pay my entire bill now?

If you are a residential customer of a public utility and owe for past due service, you may have the chance to make an arrangement with the company to pay over time and avoid disconnection of your utility service.

These arrangements to pay over time are called "deferred payment arrangements" or "**DPA**s." A DPA will allow you to make a down payment towards the amount you owe and then make monthly payments at the same time as your regular bill payments in order to pay off the past due balance. **You must contact the utility in order to see if you can make a DPA and protect your account from disconnection.**

How much will my down payment be?

From April 1 through November 30, the utility may require 25% of the amount past due, unless you have qualified for Low Income Home Energy Assistance (LIHEAP).

LIHEAP qualified customers may be required to pay 20% of the amount past due.

From December 1 through March 31, the utility may require 10% of the amount past due to put you on a special **Winter DPA**.

How will the utility and I figure out how much I will pay each month on the DPA?

The total number of installments that you will pay will dictate how much each equal installment will be. The utility will consider the following in choosing how many installments to allow you:

1. how much you owe,
2. your ability to pay,
3. your payment history with the utility,
4. the reasons the amount became past due,
5. if you are LIHEAP qualified, and
6. any other factors that relate to the situation.

From April 1 through November 30, the utility will allow from 4 to 12 months of installments, unless you are LIHEAP qualified.

From April 1 through November 30, LIHEAP qualified customers are allowed 6 to 12 months of installments.

From December 1 through March 31, the utility must allow between a minimum of 4 monthly installments and a maximum number of installments that should not last past the coming November on its Winter DPA program.

Do I have to pay my regular bills in addition to the installments?

Yes. The DPA will default if you don't pay on time or if you don't pay both the full amount of the installment and the full amount of the current bill. Your bill will tell you the total amount to pay each month in order to keep the DPA going.

Can I be on a Budget Payment Plan at the same time as the DPA?

Yes. In fact, by averaging the yearly cost of your bills, this may be a good way to help you plan how much you will likely have to pay each month. Ask us about our Budget Payment Plan.

What happens if my DPA defaults?

If you default either by paying late or failing to pay the full installment and current charges, then your account can be subject to disconnection again after we send you notice.

Can I get back on the DPA after default?

Yes. As long as you have not been disconnected, by paying the total amount of the installments and current charges that are due up to the current date, you can reinstate the DPA. **Reinstatement** puts you back on the arrangements you originally made. We may charge you a **reinstatement fee** if you have to reinstate the DPA more than once.

What if my economic situation changes and I cannot afford the original DPA?

Renegotiation allows you to extend your original DPA for a longer term. In order to renegotiate your DPA, you must:

1. not currently be in default on the DPA,
2. have made at least the down payment to get on the DPA, and
3. be willing to discuss the change in your economic situation with us.

How many DPAs can one account have?

As long as your service is still on, you qualify for a DPA any time after you either:

1. complete the last DPA you had, or
2. 12 months have passed since you failed to complete the last DPA you had.

From December 1 through March 31, if your service is used to heat or control the source of heat in your home, then you can get on a Winter DPA for a 10% down payment as long as your service is still on. Heating customers qualify for a Winter DPA whether they successfully completed their last DPA or not.

How soon should I call about a DPA?

Call right away. Do not wait. If your service is shut off, you may not be able to get back on without paying everything you owe us past due. Even if you think you may not qualify for a DPA, please call to see if something can be worked out.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Reimbursement for Nursing Costs for Geriatric Facilities

2) Code Citation: 89 Ill. Adm. Code 147

3)

Section Numbers:	Proposed Action:
147.5	Repeal
147.125	Repeal
147.150	Repeal
147.175	Repeal
147.200	Repeal
147.205	Repeal
147.310	New
147.315	New
147.320	New
147.325	New
147.330	New
147.335	New
147.340	New
147.345	New
147.346	New
147.355	Repeal
147. TABLE A	Repeal
147. TABLE B	Repeal

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and Public Act 98-0104

5) Complete Description of the Subjects and Issues Involved: The proposed rulemaking establishes a new nursing component reimbursement methodology based on Resource Utilization Group RUG-IV 48 methodology. This new methodology goes into effect on January 1, 2014 pursuant to PA 98-104, which requires the Department to implement a new nursing component reimbursement methodology based on Resource Utilization Group (RUG)-IV 48 methodology. Statutory authority requiring the Department to establish and implement this evidence-based payment methodology can also be found at PA 96-1530 and PA 97-689. Additionally, this rulemaking implements requirements of PA 97-689 and PA 98-104 which compel the Department to develop and submit in rule by January 1, 2014 a reimbursement methodology which reflects the unique service and resource needs of individuals scoring in the lowest four RUG-IV groups. This rule also defines best practice quality metrics the Department will adopt and measure.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

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: 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:

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue E., 3rd Floor
Springfield IL 62763-0002

217/782-1233
HFS.Rules@illinois.gov

The Department requests the submission of written comments within 45 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].

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Medicaid funded long term care facilities

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 2013

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 d: MEDICAL PROGRAMS

PART 147
REIMBURSEMENT FOR NURSING COSTS FOR GERIATRIC FACILITIES

Section	
147.5	Minimum Data Set-Mental Health (MDS-MH) Based Reimbursement System (Repealed)
147.15	Comprehensive Resident Assessment (Repealed)
147.25	Functional Needs and Restorative Care (Repealed)
147.50	Service Needs (Repealed)
147.75	Definitions (Repealed)
147.100	Reconsiderations (Repealed)
147.105	Midnight Census Report
147.125	Nursing Facility Resident Assessment Instrument (Repealed)
147.150	Minimum Data Set (MDS) Based Reimbursement System (Repealed)
147.175	Minimum Data Set (MDS) Integrity (Repealed)
147.200	Minimum Data Set (MDS) On-Site Review Documentation (Repealed)
147.205	Reimbursement for Ventilator Dependent Residents (Repealed)
147.250	Costs Associated with the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) (Repealed)
147.300	Payment to Nursing Facilities Serving Persons with Mental Illness
147.301	Sanctions for Noncompliance
147.305	Psychiatric Rehabilitation Service Requirements for Individuals With Mental Illness in Residential Facilities (Repealed)
147.310	Implementation of a Case Mix System~~Inspection of Care (IOC) Review Criteria for the Evaluation of Psychiatric Rehabilitation Services in Residential Facilities for Individuals with Mental Illness (Repealed)~~
147.315	Nursing Facility Resident Assessment Instrument~~Comprehensive Functional Assessments and Reassessments (Repealed)~~
147.320	Definitions~~Interdisciplinary Team (IDT) (Repealed)~~
147.325	Resident Reimbursement Classifications and Requirements~~Comprehensive Program Plan (CPP) (Repealed)~~
147.330	Resource Utilization Groups (RUGs) Case Mix Requirements~~Specialized Care – Administration of Psychopharmacologic Drugs (Repealed)~~
147.335	Enhanced Care Rates~~Specialized Care – Behavioral Emergencies (Repealed)~~
147.340	Minimum Date Set On-Site Reviews~~Discharge Planning (Repealed)~~

147.345 Quality Incentives~~Reimbursement for Program Costs in Nursing Facilities Providing Psychiatric Rehabilitation Services for Individuals with Mental Illness (Repealed)~~
147.346 Appeals of Nursing Rate Determination
147.350 Reimbursement for Additional Program Costs Associated with Providing Specialized Services for Individuals with Developmental Disabilities in Nursing Facilities
147.355 Reimbursement for Residents with Exceptional Needs (Repealed)
147.TABLE A Staff Time (in Minutes) and Allocation by Need Level (Repealed)
147.TABLE B MDS-MH Staff Time (in Minutes and Allocation by Need Level) (Repealed)
147.TABLE C Comprehensive Resident Assessment (Repealed)
147.TABLE D Functional Needs and Restorative Care (Repealed)
147.TABLE E Service (Repealed)
147.TABLE F Social Services (Repealed)
147.TABLE G Therapy Services (Repealed)
147.TABLE H Determinations (Repealed)
147.TABLE I Activities (Repealed)
147.TABLE J Signatures (Repealed)
147.TABLE K Rehabilitation Services (Repealed)
147.TABLE L Personal Information (Repealed)

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

SOURCE: Recodified from 89 Ill. Adm. Code 140.900 thru 140.912 and 140.Table H and 140.Table I at 12 Ill. Reg. 6956; amended at 13 Ill. Reg. 559, effective January 1, 1989; amended at 13 Ill. Reg. 7043, effective April 24, 1989; emergency amendment at 13 Ill. Reg. 10999, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 16796, effective October 13, 1989; amended at 14 Ill. Reg. 210, effective December 21, 1989; emergency amendment at 14 Ill. Reg. 6915, effective April 19, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 9523, effective June 4, 1990, for a maximum of 150 days; emergency expired November 1, 1990; emergency amendment at 14 Ill. Reg. 14203, effective August 16, 1990, for a maximum of 150 days; emergency expired January 13, 1991; emergency amendment at 14 Ill. Reg. 15578, effective September 11, 1990, for a maximum of 150 days; emergency expired February 8, 1991; amended at 14 Ill. Reg. 16669, effective September 27, 1990; amended at 15 Ill. Reg. 2715, effective January 30, 1991; amended at 15 Ill. Reg. 3058, effective February 5, 1991; amended at 15 Ill. Reg. 6238, effective April 18, 1991; amended at 15 Ill. Reg. 7162, effective April 30, 1991; amended at 15 Ill. Reg. 9001, effective June 17, 1991; amended at 15 Ill. Reg. 13390, effective August 28, 1991;

emergency amendment at 15 Ill. Reg. 16435, effective October 22, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 4035, effective March 4, 1992; amended at 16 Ill. Reg. 6479, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 13361, effective August 14, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 14233, effective August 31, 1992; amended at 16 Ill. Reg. 17332, effective November 6, 1992; amended at 17 Ill. Reg. 1128, effective January 12, 1993; amended at 17 Ill. Reg. 8486, effective June 1, 1993; amended at 17 Ill. Reg. 13498, effective August 6, 1993; emergency amendment at 17 Ill. Reg. 15189, effective September 2, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 2405, effective January 25, 1994; amended at 18 Ill. Reg. 4271, effective March 4, 1994; amended at 19 Ill. Reg. 7944, effective June 5, 1995; amended at 20 Ill. Reg. 6953, effective May 6, 1996; amended at 21 Ill. Reg. 12203, effective August 22, 1997; amended at 26 Ill. Reg. 3093, effective February 15, 2002; emergency amendment at 27 Ill. Reg. 10863, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18680, effective November 26, 2003; expedited correction at 28 Ill. Reg. 4992, effective November 26, 2003; emergency amendment at 29 Ill. Reg. 10266, effective July 1, 2005, for a maximum of 150 days; amended at 29 Ill. Reg. 18913, effective November 4, 2005; amended at 30 Ill. Reg. 15141, effective September 11, 2006; expedited correction at 31 Ill. Reg. 7409, effective September 11, 2006; amended at 31 Ill. Reg. 8654, effective June 11, 2007; emergency amendment at 32 Ill. Reg. 415, effective January 1, 2008, for a maximum of 150 days; emergency amendment suspended at 32 Ill. Reg. 3114, effective February 13, 2008; emergency suspension withdrawn in part at 32 Ill. Reg. 4399, effective February 26, 2008 and 32 Ill. Reg. 4402, effective March 11, 2008 and 32 Ill. Reg. 9765, effective June 17, 2008; amended at 32 Ill. Reg. 8614, effective May 29, 2008; amended at 33 Ill. Reg. 9337, effective July 1, 2009; emergency amendment at 33 Ill. Reg. 14350, effective October 1, 2009, for a maximum of 150 days; emergency amendment modified in response to the objection of the Joint Committee on Administrative Rules at 34 Ill. Reg. 1421, effective January 5, 2010, for the remainder of the 150 days; emergency expired February 27, 2010; amended at 34 Ill. Reg. 3786, effective March 14, 2010; amended at 35 Ill. Reg. 19514, effective December 1, 2011; amended at 36 Ill. Reg. 7077, effective April 27, 2012; emergency amendment at 38 Ill. Reg. 1205, effective January 1, 2014, for a maximum of 150 days; amended at 38 Ill. Reg. _____, effective _____.

Section 147.5 Minimum Data Set-Mental Health (MDS-MH) Based Reimbursement System (Repealed)

~~a) For Class I Institution for Mental Diseases (IMDs), until data can be collected and the payment methodology implemented using the Illinois Minimum Data Set-Mental Health (IL-MDS-MH), appropriate for the care needs of the IMD resident population, as described in Table B of this Part, the nursing component shall be the rate in effect on July 1, 2006. The payment methodology using the IL-MDS-MH shall be implemented on July 1, 2010.~~

~~b) To receive payment based on Table B, Class I IMDs shall obtain software that produces the Mental Health Assessment Protocols, outcome measures, and quality indicators, which are part of the MDS-MH system, and train staff to utilize this clinical information in resident treatment and care planning.~~

~~c) The nursing component of the rate shall be calculated annually and may be adjusted semi-annually. The determination of rates shall be based upon a composite of MDS-MH data collected from each eligible resident in accordance with Table B for those eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the six-month period preceding the rate period. Residents for whom MDS-MH resident identification information is missing or inaccurate, or for whom there is no current MDS-MH record for that period, shall be placed in the lowest MDS-MH acuity level for calculation purposes for that rate period. The nursing component of the rate may be adjusted on a semi-annual basis if any of the following conditions are met:~~

~~1) Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section exceeds total variable nursing time calculated for the previous rate period by more than five percent.~~

~~2) Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section exceeds:~~

~~A) total variable nursing time as calculated for the annual rate period by more than 10 percent;~~

~~B) total variable nursing time as recalculated and adjusted for the annual period by more than five percent.~~

~~3) Total variable nursing time for a rate period as calculated in subsection (d)(1) of this Section declines from the total variable nursing time as calculated for the annual period by more than five percent. No semi-annual nursing component rate reduction shall exceed five percent from the annual rate determination.~~

~~d) Per diem reimbursement rates for nursing care in nursing facilities consist of three elements: variable time reimbursement; fringe benefit reimbursement; and reimbursement for supplies, consultants, medical directors and nursing directors.~~

~~1) Variable Time Reimbursement. Variable nursing time is that time necessary to meet the major service needs of residents that vary due to their physical or mental conditions. Each need level or specific nursing service measured by the MDS-MH is associated with an amount of time and staff level (Table B). Reimbursement is developed by multiplying the time for each service by the wages of the type of staff performing the service, except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner:~~

~~A) The mean wages for the applicable staff levels (licensed staff, RNs, LPNs, certified nursing assistants (CNAs), social workers), as reported on the cost reports and determined by regional rate area, will be the mean wages.~~

~~B) Fringe benefits shall be calculated in accordance with Section 147.150(c)(1)(B).~~

~~C) The base wage shall be calculated in accordance with Section 147.150(c)(1)(C).~~

~~D) Special minimum wage factor shall be calculated in accordance with Section 147.150(c)(1)(D).~~

~~E) Beginning July 1, 2010, Class I IMDs shall be paid a rate based upon the sum of the following:~~

~~i) The facility MDS-MH system based rate multiplied by a ratio the numerator of which is the quotient obtained by dividing the funds appropriated specifically to pay for rates based upon the MDS-MH methodology by the total number of Medicaid patient days utilized by facilities covered by~~

~~the MDS-MH based system and the denominator of which is the difference between the weighted mean rate obtained by the MDS-MH methodology and the weighted mean rate direct care rate for IMDs in effect on July 1, 2006.~~

~~ii) The facility rate in effect on July 1, 2006, multiplied by one minus the ratio computed in subsection (d)(1)(E)(i).~~

~~2) Vacation, sick leave and holiday time shall be calculated in accordance with Section 147.150(c)(2).~~

~~3) Special supplies, consultants and the Director of Nursing shall be calculated in accordance with Section 147.150(c)(3).~~

~~e) Determination of Facility Rates~~
~~An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wages for each assessment item (see subsection(d)(1) of this Section), adding the amounts for vacation, sick and holiday time (see Section 147.150(c)(2)), and supplies, consultants, and the Director of Nursing (see Section 147.150(c)(3)). The average of the rates for eligible residents assessed will become the facility's per diem reimbursement rate for each eligible resident in the facility.~~

~~f) In order to code any item on the MDS-MH and receive subsequent reimbursement according to Table B, Class I IMDs shall follow all criteria and specific guidelines in the IL MDS-MH manual (Hirdes et al., RAI-MH Training Manual and Resource Guide 2.0, Toronto, Ontario Joint Policy and Planning Committee, 2003).~~

~~g) In order for services to qualify for reimbursement according to Table B, Class I IMDs shall maintain a minimum ratio for Psychiatric Rehabilitation Services Coordinator staff of one for every 20 residents.~~

~~h) The Department shall not pay for any new admissions to the Class I IMDs who are age 60 years or older or do not have a severe mental illness as determined by the State's mental health pre-admission screening program.~~

~~i) Service providers under Section L, Service Utilization/Treatments, of the MDS-MH shall be coded in column A when services are delivered by staff employed by~~

~~the facility. Column B shall be coded for services delivered by outside individuals not employed by the facility. The Medicaid rate shall reflect only those services delivered by staff that is employed by the facility.~~

~~j)~~ ~~The Medicaid rate determined by Table B for Class I IMDs shall be the combination of a nursing component and socio-development component.~~

~~k)~~ ~~The Department of Healthcare and Family Services and the Department of Human Services-Division of Mental Health shall have the right of entry and inspection to all Class I IMD facilities in order to assess resident mix, monitor data quality, develop service quality indicators, and conduct studies, such as staff time samples, in order to test and refine the payment method.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 147.125 Nursing Facility Resident Assessment Instrument (Repealed)

~~a)~~ ~~Except as specified in subsection (b) of this Section, all Medicaid certified nursing facilities shall comply with the provisions of the current federal Long Term Care Resident Assessment Instrument User's Manual, version 2. (Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2005), and the Resident Assessment Instrument-Mental Health Illinois version 2 (July 2003), adopted from Minimum Data Set-Mental Health version 2. This incorporation by reference includes no later amendments or editions.)~~

~~b)~~ ~~Nursing facilities shall, in addition, comply with the following requirements:~~

~~1)~~ ~~Complete a full Minimum Data Set (MDS) assessment, which includes required items A through R, in addition to any State required items, for each resident quarterly, regardless of the resident's payment source. Facilities are not required to complete and submit the MDS Quarterly Assessment Form. When completing the full MDS assessment for quarterly submittal to the Department, it is not necessary to also complete the Resident Assessment Protocols (RAPs) or Section T. RAPs and Section T are only required with the comprehensive assessment described in the current federal Long Term Care Resident Assessment Instrument User's Manual, which includes assessments completed at admission,

~~annually, for a significant change or for a significant correction of a prior MDS.~~

~~2) Transmit electronically to the State MDS database the MDS for all assessments within 31 days after the completion date of the assessment. Except for nursing facilities that are defined as Class I Institutions for Mental Diseases (IMDs) pursuant to 89 Ill. Adm. Code 145.30, the rate set will be based on the MDS received two quarters prior to the rate effective date and MDS not received within 31 days will be given a default rate.~~

~~e) While a new rate system referenced in Section 147.150 is under development, Medicaid-certified Class I IMDs shall electronically submit both the MDS pursuant to subsections (a) and (b) of this Section and the Illinois Minimum Data Set-Mental Health (IL MDS-MH) as specified by the Department at the following frequencies:~~

~~1) Complete a full IL MDS-MH within 14 days after admission for each resident, regardless of the resident's payment source.~~

~~2) Complete a full IL MDS-MH at 90 days after admission for each resident, regardless of the resident's payment source.~~

~~3) Complete a full IL MDS-MH at six months after admission for each resident, regardless of the resident's payment source, and every six months thereafter.~~

~~4) Transmit electronically to the Department's IL MDS-MH database, the IL MDS-MH for all required assessments within 31 days after the completion date of the assessment.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 147.150 Minimum Data Set (MDS) Based Reimbursement System (Repealed)

~~a) Public Act 94-0964 requires the Department to implement, effective January 1, 2007, a payment methodology for the nursing component of the rate paid to nursing facilities. Except for nursing facilities that are defined as Class I Institutions for Mental Diseases (IMDs) pursuant to 89 Ill. Adm. Code 145.30, reimbursement for the nursing component shall be calculated using the Minimum~~

~~Data Set (MDS). Increased reimbursement under this payment methodology shall be paid only if specific appropriation for this purpose is enacted by the General Assembly.~~

~~b) Except as referenced in subsection (c)(1)(E)(iv) of this Section, the nursing component of the rate shall be calculated and adjusted quarterly. The determination of rates shall be based upon a composite of MDS data collected from each eligible resident in accordance with Section 147.Table A for those eligible residents who are recorded in the Department's Medicaid Management Information System as of 30 days prior to the rate period as present in the facility on the last day of the second quarter preceding the rate period. Residents for whom MDS resident identification information is missing or inaccurate, or for whom there is no current MDS record for that quarter, shall be placed in the lowest MDS acuity level for calculation purposes for that quarter.~~

~~c) Per diem reimbursement rates for nursing care in nursing facilities consist of three elements: variable time reimbursement; fringe benefit reimbursement; and reimbursement for supplies, consultants, medical directors and nursing directors.~~

~~1) Variable Time Reimbursement.~~
~~Variable nursing time is that time necessary to meet the major service needs of residents that vary due to their physical or mental conditions. Each need level or specific nursing service measured by the Resident Assessment Instrument is associated with an amount of time and staff level (Section 147.Table A). Reimbursement is developed by multiplying the time for each service by the wages of the type of staff performing the service except for occupational therapy, physical therapy and speech therapy. If more than one level of staff are involved in delivering a service, reimbursement for that service will be weighted by the wage and number of minutes allocated to each staff type. In calculating a facility's rate, the figures used by the Department for wages will be determined in the following manner:~~

~~A) The mean wages for the applicable staff levels (RNs, LPNs, certified nursing assistants (CNAs), activity staff, social workers), as reported on the cost reports and determined by regional rate area, will be the mean wages.~~

~~B)~~ ~~Fringe benefits will be the average percentage of benefits to actual salaries of all nursing facilities based upon cost reports filed pursuant to 89 Ill. Adm. Code 140.543. Fringe benefits will be added to the mean wage.~~

~~C)~~ ~~The base wage, including fringe benefits, will then be updated for inflation from the time period for which the wage data are available to the midpoint of the rate year to recognize projected base wage changes.~~

~~D)~~ ~~Special minimum wage factor. The process used in subsection (c)(1)(A) of this Section to determine regional mean wages for RNs, LPNs and CNAs will include a minimum wage factor. For those facilities below 90% of the Statewide average, the wage is replaced by 90% of the Statewide average.~~

~~E)~~ ~~Beginning January 1, 2007, facilities shall be paid a rate based upon the sum of the following:~~

~~i)~~ ~~the facility MDS-based rate multiplied by the ratio the numerator of which is the quotient obtained by dividing the additional funds appropriated specifically to pay for rates based upon the MDS nursing component methodology above the December 31, 2006 funding by the total number of Medicaid patient days utilized by facilities covered by the MDS-based system and the denominator of which is the difference between the weighted mean rate obtained by the MDS-based methodology and the weighted mean rate in effect on December 31, 2006.~~

~~ii)~~ ~~the facility rate in effect on December 31, 2006, which is defined as the facility rate in effect on December 31, 2006 plus the exceptional care reimbursement per diem computed in 89 Ill. Adm. Code 140.569(a)(1), multiplied by one minus the ratio computed in Section 147.150(c)(1)(E)(i). The exceptional care reimbursement per diem effective January 1, 2007 computed in 89 Ill. Adm. Code 140.569 shall be included in the nursing component of the June 30, 2006 rate unless the total~~

~~variable nursing time for a rate quarter as calculated in subsection (c)(1) of this Section is more than a five percent drop from the total variable nursing time calculated for the June 30, 2006 rate quarter. Then the facility will receive for the rate period zero percent of the exceptional care reimbursement per diem computed in 89 Ill. Adm. Code 140.569.~~

~~iii) Until October 1, 2009, for facilities in which the number of ventilator care residents in any quarter has increased over the number used to compute the exceptional care per diem as specified in 89 Ill. Adm. Code 140.569(a)(1), the rate computed in subsections (c)(1)(E)(i) and (c)(1)(E)(ii) shall add the sum of total variable time reimbursement for the ventilator care add-on, vacation time, the average facility special patient need factors, and supply, consultant, and Director of Nursing factors for each resident receiving ventilator care in excess of the number used to compute the exceptional care per diem as specified in 89 Ill. Adm. Code 140.569(a)(1) divided by the total number of residents used to compute the MDS portion of the paid rate for that quarter. The resulting ventilator add-on shall be multiplied by one minus the ratio computed in Section 147.150(c)(1)(E)(i). This addition to the rate shall apply for each quarter regardless of the facility's eligibility for use of that quarter's MDS rate for computation of the paid facility rate as defined in subsection (b) of this Section.~~

~~iv) The calculations referenced in subsections (c)(1)(E)(i) and (ii) of this Section shall only change annually.~~

~~F) The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2007 is $60 million. The annual amount of new funds allocated for MDS reimbursement methodology beginning January 1, 2008 is $50 million. The annual amount of new funds for MDS reimbursement methodology beginning January 1, 2009 is $84 million. Subject to approval by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, the annual~~

~~amount of new funds for MDS reimbursement methodology, beginning May 1, 2011, is $222.5 million.~~

~~2) Vacation, Sick Leave and Holiday Time.~~
~~The time to be added for vacation, sick leave, and holidays will be determined by multiplying the total of variable time by 5%.~~

~~3) Special Supplies, Consultants and the Director of Nursing.~~
~~Reimbursement will be made for health care and program supplies, consultants required by the Department of Public Health (including the Medical Director), and the Director of Nursing by applying a factor to variable time and vacation, sick leave and holiday time. (A list of consultants required by the Department of Public Health can be found in 77 Ill. Adm. Code 300.830.)~~

~~A) Supplies will be updated for inflation using the General Services Inflator (see 89 Ill. Adm. Code 140.551). Health care and program salaries shall be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for supplies will be the Statewide mean of the ratio of total facility health care and programs supply costs to total facility health care and programs salaries.~~

~~B) The Director of Nursing and the consultants will be updated for inflation using the Nursing and Program Inflator (see 89 Ill. Adm. Code 140.552). A factor for the Director of Nursing and consultant costs shall be the Statewide mean of the ratio of all facilities' Director of Nursing and consultant costs to total facility health care and programs salaries.~~

~~C) These costs shall be updated pursuant to cost reports as referenced in 89 Ill. Adm. Code 153.125(f).~~

~~d) Determination of Facility Rates.~~
~~An amount for each resident will be calculated by multiplying the number of minutes from the assessment by the appropriate wages for each assessment item (see subsection (c)(1) of this Section), adding the amounts for vacation, sick and holiday time (see subsection (c)(2) of this Section), and supplies, consultants, and the Director of Nursing (see subsection (c)(3) of this Section). The average of the~~

~~rates for eligible residents assessed will become the facility's per diem reimbursement rate for each eligible resident in the facility.~~

~~e)~~ ~~A transition period from the payment methodology in effect on June 30, 2003 to the payment methodology in effect July 1, 2003 shall be provided for a period not exceeding December 31, 2006, as follows:~~

~~1)~~ ~~MDS-based rate adjustments under this Section shall not be effective until the attainment of a threshold. The threshold shall be attained at the earlier of either:~~

~~A)~~ ~~when all nursing facilities have established a rate (sum of all components) which is no less than the rate effective June 30, 2002, or~~

~~B)~~ ~~January 1, 2007.~~

~~2)~~ ~~For a facility that would receive a lower nursing component rate per resident day under the payment methodology effective July 1, 2003 than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be held at the level in effect on June 30, 2003 until a higher nursing component rate of reimbursement is achieved by that facility.~~

~~3)~~ ~~For a facility that would receive a higher nursing component rate per resident day under the payment methodology in effect on July 1, 2003 than the facility received June 30, 2003, the nursing component rate per resident day for the facility shall be adjusted based on the payment methodology in effect July 1, 2003.~~

~~4)~~ ~~Notwithstanding subsections (e)(2) and (3) of this Section, the nursing component rate per resident day for the facility shall be adjusted in accordance with subsection (e)(1)(E) of this Section.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 147.175 Minimum Data Set (MDS) Integrity (Repealed)

~~a) The Department shall conduct reviews to determine the accuracy of resident assessment information transmitted in the Minimum Data Set (MDS) that are relevant to the determination of reimbursement rates. Such reviews may, at the discretion of the Department, be conducted electronically or in the facility.~~

~~b) The Department shall quarterly select, at random, a number of facilities in which to conduct on-site reviews. The Department may select facilities for on-site review based upon facility characteristics, past performance, or the Department's experience. This may include, but is not limited to, analysis of case mix profile of nursing facilities in regard to frequency in distribution of the residents in identified reimbursement categories. In addition, the Department may use findings of the licensing and certification survey conducted by IDPH indicating the facility is not accurately assessing residents. It may also include resident assessments submitted by the provider that do not meet submission deadlines, facilities with a high percentage of corrections and facilities with high submission error rates.~~

~~c) Electronic review. The Department shall conduct quarterly an electronic review of MDS data for eligible individuals to identify facilities for on-site review.~~

~~d) On-site review. The Department shall conduct an on-site review of MDS data for eligible individuals.~~

~~1) On-site reviews may be conducted with respect to residents or facilities that are identified pursuant to subsection (b) or (c) of this Section. Such review may include, but shall not be limited to, the following:~~

~~A) Review of resident records and supporting documentation, as identified in Section 147.200, observation and interview, to determine the accuracy of data relevant to the determination of reimbursement rates.~~

~~B) Review and collection of information necessary to assess the need for a specific service or care area.~~

~~C) Review and collection of information from the facility that will establish the direct care staffing level. The amount of staff available in the facility shall be sufficient to carry out the number~~

~~and frequency of restorative programs identified for reimbursement.~~

~~2)~~ ~~The number of residents in any selected facility for whom information is reviewed may, at the sole discretion of the Department, be limited or expanded.~~

~~3)~~ ~~Upon the conclusion of any review, the Department shall conduct a meeting with facility management to discuss preliminary conclusions of the review. If facility management disagrees with those preliminary conclusions, facility management may, at that time, provide additional documentation to support their position.~~

~~e)~~ ~~Corrective action. Upon the conclusion of the review and the consideration of any subsequent supporting documentation provided by the facility, the Department shall notify the facility of its final conclusions, both with respect to accuracy of data and recalculation of the facility's reimbursement rate.~~

~~1)~~ ~~Data Accuracy~~

~~A)~~ ~~Final conclusions with respect to inaccurate data shall be referred to the Department of Public Health.~~

~~B)~~ ~~The Department, in collaboration with the Department of Public Health, shall make available additional training in the completion of resident assessments and the coding and transmission of MDS records.~~

~~2)~~ ~~Recalculation of Reimbursement Rate. The Department shall determine if reported MDS data or facility staffing data that were subsequently determined to be unverifiable would cause the direct care component of the facility's rate to be calculated differently when using the accurate data. No change in reimbursement required as a result of a review shall take effect before July 1, 2004. Prior to the record review of residents receiving skills training, the following components of this Part will be reviewed to ensure compliance:~~

~~A) Skills training shall be provided by staff that are paid by the facility and have been trained in leading skills groups by a Department approved trainer.~~

~~B) A private room shall be available with no other programs or activities going on at the same time. The environment shall be conducive to learning in terms of comfort, noise, and other distractions.~~

~~C) Schedules shall be presented that identify residents and reflect the facility's ability to provide the sessions in increments of a minimum of 30 minutes for each skills training (not including time to assemble and settle). The sessions shall be scheduled at least three times per week.~~

~~D) Training shall utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions.~~

~~3) In the event one or more of these components are not in place, the recalculated rate may be extrapolated to the entire population receiving this service.~~

~~4) When problems are noted in 30 percent of the population of residents receiving skills training during the record review, the recalculated rate may be extrapolated to the entire population receiving this service. When the recalculated rate has been extrapolated to the entire population, the facility shall obtain prior approval from the Department before future reimbursement for skills training is allowable. The Department shall have up to 90 days to determine this approval.~~

~~5) When problems are noted in 30 percent of coded responses to the sample population for other services areas, the review may be expanded to up to 100 percent for those service areas. The original sample population is defined as 20%, or no less than 10, of the eligible residents pursuant to Section 147.150(b).~~

~~6) In addition, the facilities with widespread problems in restorative and psychosocial adaptation may be subject to follow up reviews to ensure problems are corrected.~~

~~7) A facility's rate will be subject to change if the recalculation of the direct care component rate, as a result of using MDS data that are verifiable:~~

~~A) Increases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.~~

~~B) Decreases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.~~

~~C) Decreases the rate by more than ten percent in addition to the rate change specified in this subsection (e)(7). The direct care component of the rate shall be reduced, retroactive to the beginning of the rate period, by $1 for each whole percentage decrease in excess of two percent.~~

~~8) Any evidence or suspicion of deliberate falsification or misrepresentation of MDS data shall be referred to the Department's Inspector General and the Department of Public Health.~~

~~f) Appeals. Facilities disputing any rate change may submit an appeal request pursuant to 89 Ill. Adm. Code 140.830.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 147.200 Minimum Data Set (MDS) On-Site Review Documentation (Repealed)

~~a) Pursuant to Section 147.175, Department staff shall conduct on-site reviews of Minimum Data Set (MDS) data to determine the accuracy of resident information that is relevant to the determination of reimbursement rates.~~

~~1) Department staff shall request in writing the current charts of individual residents needed to begin the review process. Current charts and completed MDSs for the previous 15 months shall be provided to the~~

~~review team within an hour after this request. Additional documentation regarding reimbursement areas for the identified Assessment Reference Date (ARD) timeframe shall be provided to the review team within four hours after the initial request.~~

~~2)~~ ~~When further documentation is needed by the review team to validate an area, the team will identify the area of reimbursement requiring additional documentation and provide the facility with the opportunity to produce that information. The facility shall provide the team with the additional documentation within 24 hours after the initial request. All documentation that is to be considered for validation must be provided to the team prior to exit.~~

~~3)~~ ~~Pursuant to 89 Ill. Adm. Code 140.12(f), the facility shall provide Department staff with access to residents, professional and non-licensed direct care staff, facility assessors, clinical records and completed resident assessment instruments, as well as other documentation regarding residents' care needs and treatments.~~

~~4)~~ ~~Failure to provide timely access to records may result in suspension or termination of a facility's provider agreement in accordance with 89 Ill. Adm. Code 140.16(a)(4).~~

~~5)~~ ~~Some states may have regulations that require supportive documentation elsewhere in the record to substantiate the resident's status on particular MDS items used to calculate payment under the State's Medicaid system (RAI Manual, page 1-24). These additional documentation requirements shall be met for reimbursement.~~

~~6)~~ ~~The Department shall provide for a program of delegated utilization review and quality assurance. The Department may contract with medical peer review organizations to provide utilization review and quality assurance.~~

~~b)~~ ~~There shall be documentation in the resident's record to support an MDS-coded response indicating that the condition or activity was present or occurred during the observation or look back period. Directions provided by the RAI User's Manual (as described in Section 147.125) are the basis for all coding of the MDS.~~

~~Section S is reserved for additional State-defined items. All documentation requirements pertain to the MDS 2.0 and Section S items.~~

~~c) Each nursing facility shall ensure that MDS data for each resident accurately and completely describes the resident's condition, as documented in the resident's clinical records, maintained by the nursing facility, and the clinical records shall be current, accurate and in sufficient detail to support the reported resident data.~~

~~d) Documentation guidance has been compiled from the RAI Manual, instructions that are present on the MDS 2.0 form itself, RAI-MH, and Illinois additional documentation requirements. If later guidance is released by CMS that contradicts or augments guidance provided in this Section, the more current information from CMS becomes the acceptable standard. If additional ICD-9 codes are published, they will be reviewed for appropriateness.~~

~~e) Documentation from all disciplines and all portions of the resident's clinical record may be used to verify an MDS item response. All supporting documentation shall be found in the facility during an on-site visit.~~

~~f) All conditions or treatments shall have been present or occurred within the designated observation period. Documentation in the clinical record shall consistently support the item response and reflect care related to the symptom/problem. Documentation shall apply to the appropriate observation period and reflect the resident's status on all shifts. In addition, the problems that are identified by the MDS item responses that affect the resident's status shall be addressed on the care plan. Insufficient or inaccurate documentation may result in a determination that the MDS item response submitted could not be validated.~~

~~g) Disease Diagnoses. Throughout Table A, when a diagnosis is required, the following must be met:~~

~~1) Code only those diseases or infections that have a relationship to the resident's current ADL (Activities of Daily Living) status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death as directed in the RAI Manual.~~

~~2) The disease conditions require a physician-documented diagnosis in the clinical record. It is good clinical practice to have the resident's physician provide supporting documentation for any diagnosis.~~

~~3) Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.~~

~~h) Activities of Daily Living (ADL).~~

~~1) Facilities shall maintain documentation that supports the coding of Section G, Physical Functioning, and Structural Problems on the MDS during the look-back period. The documentation shall show the MDS coded level of resident self-performance and support has been met.~~

~~2) Documentation shall be dated within the look-back period and must contain information from all three shifts that clearly supports the level of self-performance and support needed.~~

~~3) When there is a widespread lack of supporting documentation as described in subsections (h)(1) and (2), the ADL scores for the residents lacking documentation will be reset to zero.~~

~~4) When there is an occasional absence of documentation for residents in the sample, ADL scores will be based on the observation and/or interview of the resident and facility staff at the time of the review. If the resident has been discharged and there is no documentation to support the ADL coding, ADL scores will be reset to one.~~

~~i) Restorative services are programs under the direction and supervision of a licensed nurse and are provided by nursing staff. The programs are designed to promote the resident's ability to adapt and adjust to living as independently and safely as possible. The focus is on achieving and/or maintaining optimal physical, mental, and psychosocial functioning. A program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated. Although therapists may participate in designing the initial program, members of nursing staff are still responsible for the overall coordination and supervision of restorative nursing programs. Staff completing the programs shall be communicating progress, maintenance, regression and other issues/concerns to the licensed nurse overseeing the programs. To qualify for reimbursement, the~~

~~provision of restorative programs shall meet the following criteria for each program identified for reimbursement:~~

~~1) When programs are designed using verbal cueing as the only intervention, documentation and/or observation must support the following:~~

~~A) Without such cueing the resident would be unable to complete the required ADL task.~~

~~B) The verbal interventions are aimed at providing the resident with instructions for completing the task in such a way that promotes the resident's safety and awareness.~~

~~C) Verbal interventions that are simply reminders to complete the task may not be the sole content of the program.~~

~~2) Documentation shall clearly define the resident's need for the program and the defined program shall correspond to the identified need of the resident. Observation and/or interview shall also support the need for the program.~~

~~3) The clinical record shall identify a restorative nursing plan of care to assist the resident in reaching and/or maintaining his or her highest level of functioning. Staff completing the programs shall be aware of the program and the resident's need for the program.~~

~~4) Documentation must support that the program was reevaluated and goals and interventions were revised as necessary to assist the resident in reaching and/or maintaining his or her highest level of functioning.~~

~~5) Documentation shall contain objective and measurable information so that progress, maintenance or regression can be recognized from one report to the next.~~

~~6) Goals shall be resident specific, realistic, and measurable. Goals shall be revised as necessary. Revisions shall be made based on the resident's response to the program.~~

~~7) The resident's ability to participate in the program shall be addressed.~~

~~8) Written evidence of measurable objectives and interventions shall be in the restorative plan of care and be individualized to the resident's problems and needs. There shall be evidence the objectives and interventions were reviewed quarterly and revised as necessary.~~

~~9) There shall be evidence of quarterly evaluation written by a licensed nurse in the clinical record. The evaluation must assess the resident's progress and participation in the program since the last evaluation. It shall contain specific information that includes the resident's response to the program (i.e., amount of assistance required, devices used, the distance, the progress made, how well the resident tolerated the program). An evaluation shall be documented on each restorative program the resident is receiving.~~

~~10) There shall be written evidence that staff carrying out the programs have been trained in techniques that promote resident involvement in the activity.~~

~~11) If volunteers or other staff were assigned to work with specific residents, there shall be written evidence of specific training in restorative techniques that promote the resident's involvement in the restorative program.~~

~~12) There shall be documentation to support that the programs are ongoing and administered as planned outside the look-back period, unless there is written justification in the clinical record that supports the need to discontinue the program. Observation and/or interviews must also support that the programs are ongoing and administered as planned.~~

~~13) If a restorative program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, duration and frequency as part of the care planning process. The results of this reassessment shall be documented in the record.~~

~~14) The actual number of minutes per day spent in a restorative program shall be documented for each resident and for each restorative program during the look-back period.~~

~~15) The Department designated endurance assessment must be completed quarterly on each resident receiving two or more restorative programs. A licensed nurse must complete this assessment.~~

~~16) A resident coded as totally dependent in an ADL function will only be reimbursed for one quarter for the following corresponding restorative programs: bed mobility, transfer, walking, dressing/grooming, and/or eating/swallowing.~~

~~17) A resident scoring and/or receiving hospice services shall not be eligible for the following restorative programs: bed mobility, transfer, walking, dressing/grooming, eating and/or other restoratives.~~

~~18) When multiple restoratives are coded in a facility, the staff levels must support the ability to deliver these programs based on the number and frequency of programs coded.~~

~~19) All restorative programs shall meet the specifications of the RAI Manual for the individual restoratives.~~

~~j) Passive Range of Motion (PROM).~~

~~1) The restorative program shall meet the definition of PROM as identified in the RAI Manual.~~

~~2) The PROM program shall address the functional limitations identified in section G4 of the MDS.~~

~~3) There shall be evidence that the program is planned and scheduled. PROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.~~

~~k) Active Range of Motion (AROM).~~

~~1) The restorative program meets the definition of AROM as identified in the RAI Manual.~~

~~2) The AROM programs shall address the functional limitations identified in section G4 of the MDS.~~

~~3) There shall be evidence that the program is planned and scheduled. AROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.~~

~~4) AROM does not include exercise groups with more than four residents assigned per supervising helper or caregiver.~~

~~l) Splint/Brace Assistance. A splint or brace is defined as an appliance for the fixation, union, or protection of an injured part of the body.~~

~~m) Dressing or Grooming Restorative. Grooming programs, including programs to help the resident learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff. These programs shall have goals, objectives, and documentation of progress and be related to the identified deficit.~~

~~n) Scheduled Toileting.~~

~~1) The program shall have documentation to support that all the requirements identified in the RAI Manual are met.~~

~~2) The description of the plan shall be documented, including: frequency, reason, and response to the program.~~

~~3) The plan shall be periodically evaluated and revised, as necessary, including documentation of the resident's response to the plan.~~

~~4) This does not include a "check and change" program or routine changing of the resident's incontinent briefs, pads or linens when wet, when there is no participation in the plan by the resident.~~

~~5) There shall be documentation to support the deficit in toileting and/or the episodes of incontinence.~~

~~6) A resident scoring S1 = 1 (meets Subpart S criteria) shall have a corresponding diagnosis of cerebral vascular accident (CVA) or multiple sclerosis to qualify for reimbursement in scheduled toileting.~~

~~o)~~ ~~Continence Care.~~

~~1)~~ ~~Documentation shall support that catheter care was administered during the look-back period.~~

~~2)~~ ~~The type and frequency of the care shall be documented.~~

~~3)~~ ~~Documentation shall support that the RAI requirements for a bladder retraining program were administered during the look-back period.~~

~~4)~~ ~~The resident's level of incontinence shall be documented during the look-back period to support the bladder retraining program.~~

~~5)~~ ~~Bladder scanners cannot be the sole content of the bladder retraining program.~~

~~p)~~ ~~Pressure Ulcer Prevention.~~

~~1)~~ ~~Documentation shall support the history of resolved ulcer in the identified timeframe and/or the use of the coded interventions during the identified timeframe.~~

~~2)~~ ~~Interventions and treatments shall meet the RAI definitions for coding.~~

~~3)~~ ~~Documentation shall support a specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.~~

~~4)~~ ~~There shall be documentation that the resident was assessed related to his or her risk for developing ulcers. A resident assessed to be at high risk shall have interventions identified in the plan of care.~~

~~q)~~ ~~Moderate Skin Care/Intensive Skin Care.~~

~~1)~~ ~~Interventions and treatments shall meet the RAI definitions for coding.~~

~~2)~~ ~~Documentation of ulcers shall include staging as the ulcers appear during the look-back period.~~

~~3) Documentation of ulcers shall include a detailed description that includes, but is not limited to, the stage of the ulcer, the size, the location, any interventions and treatments used during the look-back period.~~

~~4) Documentation of burns shall include, but is not limited to, the location, degree, extent, interventions and treatments during the look-back period.~~

~~5) Documentation of open lesions shall include, but is not limited to, location, size, depth, any drainage, interventions and treatments during the look-back period.~~

~~6) Documentation of surgical wounds shall include, but is not limited to, type, location, size, depth, interventions and treatment during the look-back period.~~

~~7) All treatments involving M5e, M5f, M5g, and M5h shall have a physician's order with the intervention and frequency.~~

~~8) Documentation to support that the intervention was delivered during the look-back period shall be included.~~

~~9) Documentation of infection of the foot shall contain a description of the area and the location.~~

~~10) Documentation shall support a specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.~~

~~11) Documentation for items coded in M4 shall include documentation of an intervention, treatment, and/or monitoring of the problem or condition identified.~~

~~r) IV Therapy.~~

~~1) Documentation shall include the date delivered, type of medication and method of administration.~~

~~2) Documentation shall support monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse as required in subsection (y) of this Section.~~

~~s) Injections. Documentation shall include the drug, route given and dates given.~~

~~t) Oxygen Therapy. Documentation shall include a physician's order and the method of administration and date given.~~

~~u) Chemotherapy. Documentation shall support the resident was monitored for response to the chemotherapy.~~

~~v) Dialysis. Documentation shall support the resident was monitored for response to the dialysis.~~

~~w) Blood Glucose Monitoring.~~

~~1) Documentation shall support that RAI criteria for coding a diagnosis was met, including a physician documented diagnosis.~~

~~2) Documentation shall support coding of a therapeutic diet being ordered and given to the resident.~~

~~3) Documentation shall support coding of a dietary supplement being ordered and given to the resident during the look-back period. There shall be evidence to support it was not part of a unit's daily routine for all residents.~~

~~4) Documentation shall support the coding that injections were given the entire seven days of the look-back period.~~

~~x) Infectious Disease.~~

~~1) Documentation shall support that the criteria defined in the RAI Manual for coding this subsection were met.~~

~~2) Documentation shall support the active diagnosis by the physician and shall include signs and symptoms of the illness.~~

~~3) Interventions and treatments shall be documented.~~

~~4) Documentation shall support that all RAI requirements for coding a Urinary Tract Infection (UTI) are met.~~

~~5) Administration of maintenance medication to prevent further acute episodes of UTI is not sufficient to code I2j.~~

~~y) Acute Medical Conditions.~~

~~1) Documentation shall support that the RAI requirements for coding these areas are met.~~

~~2) Documentation shall support monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse.~~

~~3) There shall be evidence that the physician has evaluated and identified the medically unstable or acute condition for which clinical monitoring is needed.~~

~~4) There shall be evidence of significant increase in licensed nursing monitoring.~~

~~5) There shall be evidence that the episode meets the definition of acute, which is usually of sudden onset and time-limited course.~~

~~z) Pain Management.~~

~~1) There shall be documentation to support the resident's pain experience during the look-back period and that interventions for pain were offered and/or given.~~

~~2) Residents shall be assessed in a consistent, uniform and standardized process to measure and assess pain.~~

~~aa) Discharge Planning.~~

~~1) Social services shall document monthly the resident's potential for discharge, specific steps being taken toward discharge, and the progress being made.~~

~~2) Social service documentation shall demonstrate realistic evaluation, planning, and follow-through.~~

~~3) Discharge plans shall address the current functional status of the resident, medical nursing needs, and the availability of family and/or community resources to meet the needs of the resident.~~

~~bb) Nutrition.~~

~~1) Documentation shall support coding of tube feeding during the look-back period.~~

~~2) Intake and output records and caloric count shall be documented to support the coding of K6.~~

~~3) Documentation of a planned weight change shall include a diet order and a documented purpose or goal that is to facilitate weight gain or loss.~~

~~4) Documentation of a dietary supplement shall include evidence that resident received the supplement and that it was ordered and given between meals.~~

~~cc) Hydration.~~

~~1) Documentation shall support that the resident passes two or fewer bowel movements per week, or strains more than one of four times when having a bowel movement during the look-back period to support the coding of H2b.~~

~~2) Documentation shall support that the resident received a diuretic medication during the look-back period to support the coding of O4e.~~

~~3) Documentation shall include frequency of episodes and accompanying symptoms to support the coding of vomiting.~~

~~4) Documentation shall include signs and symptoms, interventions and treatments used to support the coding of volume depletion, dehydration or hypovolemia.~~

~~5) There shall be documentation of temperature to support the coding of fever.~~

~~6) There shall be documentation to support the coding of internal bleeding that shall include the source, characteristics and description of the bleeding.~~

~~7) There shall be documentation that interventions were implemented related to the problem identified.~~

~~dd) Psychosocial Adaptation. Psychosocial adaptation is intended for residents who require a behavior symptom evaluation program or group therapy to assist them in dealing with a variety of mood or behavioral issues. The criteria for reimbursement in this area requires both an intervention program and the identification of mood or behavioral issues. Residents shall be assessed for mood and behavioral issues and interventions shall be implemented to assist the resident in dealing with the identified issues. To qualify for reimbursement in this area, the facility must meet the following criteria:~~

~~1) Criteria for a special behavior symptom evaluation program.~~

~~A) There must be documentation to support that the program is an ongoing and comprehensive evaluation of behavior symptoms.~~

~~B) Documentation must support the resident's need for the program.~~

~~C) The documentation must show that the purpose of the program is to attempt to understand the "meaning" behind the resident's identified mood or behavioral issues.~~

~~D) Interventions related to the identified issues must be documented in the care plan.~~

~~E) The care plan shall have interventions aimed at reducing the distressing symptoms.~~

~~2) Criteria for group therapy.~~

~~A) There is documentation the resident regularly attends sessions at least weekly.~~

~~B) Documentation supports that the therapy is aimed at helping reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve.~~

~~C) This area does not include group recreational or leisure activities.~~

~~D) The therapy and interventions are addressed in the care plan.~~

~~E) This must be a separate session and cannot be conducted as part of skills training.~~

~~3) Criteria for indicators of depression.~~

~~A) There must be documentation to support that identified indicators occurred during the look-back period.~~

~~B) The documentation shall support the frequency of the indicators as coded during the look-back period.~~

~~C) There shall be documentation to support that interventions were implemented to assist the resident in dealing with these issues.~~

~~4) Criteria for sense of initiative/involvement.~~

~~A) There is documentation to support the resident was not involved or did not appear at ease with others or activities during the look-back period.~~

~~B) There shall be evidence that interventions were implemented to assist the resident in dealing with these issues.~~

~~5) Criteria for unsettled relationships/past roles.~~

~~A) There is documentation to support the issues coded in this area during the look-back period.~~

~~B) There shall be evidence that interventions were implemented to assist the resident in dealing with the issues identified.~~

~~6) Criteria for behavioral symptoms.~~

~~A) There is documentation to support that the behaviors occurred during the look-back period and the interventions used.~~

~~B) Documentation should reflect the resident's status and response to interventions.~~

~~C) Documentation should include a description of the behavior exhibited and the dates it occurred, as well as staff response to the behaviors.~~

~~D) Documentation supporting that the behaviors coded meet the RAI definitions for the identified behavior.~~

~~E) The care plan identifies the behaviors and the interventions to the behaviors.~~

~~7) Criteria for delusions/hallucinations.~~

~~A) There is documentation to support that the delusions or hallucinations occurred during the look-back period.~~

~~B) Documentation contains a description of the delusion or hallucinations the resident was experiencing.~~

~~C) There is documentation to support the interventions used.~~

~~ee) Psychotropic Medication Monitoring.~~
~~Documentation shall support the facility followed the documentation guidelines as directed by 42 CFR 483.25(l), Unnecessary drugs (State Operations Manual F-tag F329).~~

~~ff) Psychiatric Services (Section S).~~

~~1) There shall be evidence the resident met IDPH Subpart S criteria during the look-back period.~~

~~2) There shall be evidence a pre-admission screening completed by a Department of Human Services-Division of Mental Health screening entity was completed on the resident that identifies the resident as having a serious mental illness (SMI).~~

~~3) Ancillary provider services are services that are provided by direct non-facility psychiatric service providers in order to meet 77 Ill. Adm. Code 300, Subpart S requirements.~~

~~4) Psychiatric rehabilitation services that are provided by non-facility providers or an outside entity shall meet the needs of the SMI resident as determined by the resident's individual treatment plan (ITP).~~

~~5) Facilities must ensure compliance with 77 Ill. Adm. Code 300.4050 when utilizing non-facility or outside ancillary providers.~~

~~6) Adjustments in the rate for utilization of ancillary providers shall be calculated based upon Department claims data for ancillary provider billing.~~

~~gg) Skills Training. Skills training is specific methods for assisting residents who need and can benefit from this training to address identified deficits and reach personal and clinical goals. To qualify for reimbursement, the provision of skills training shall meet all of the following criteria:~~

~~1) Skills and capabilities shall be assessed with the use of a standardized skills assessment, a cognitive assessment and an assessment of motivational potential. The assessment of motivational potential will assist in determining the type and size of the group in which a resident is capable of learning.~~

~~2) Addresses identified skill deficits related to goals noted in the treatment plan.~~

~~3) Skills training shall be provided by staff that are paid by the facility and have been trained in leading skills groups by a Department approved trainer.~~

~~4) Training shall be provided in a private room with no other programs or activities going on at the same time. The environment shall be conducive to learning in terms of comfort, noise, and other distractions.~~

~~5) Training shall be provided in groups no larger than ten, with reduced group size for residents requiring special attention due to cognitive, motivational or clinical issues, as determined by the skills assessment, cognition and motivational potential. Individual sessions can be provided as appropriate and shall be identified in the care plan.~~

~~6) Training shall utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions. (Published skills modules developed for the severe mentally ill (SMI) and Mental Illness/Substance Abuse (MISA) populations are available for use and as models.)~~

~~7) The curriculum shall address discrete sets of skill competencies, breaking skills down into smaller components or steps in relation to residents' learning needs.~~

~~8) The specific written content shall provide the rationale for learning, connecting skill acquisition to resident goals.~~

~~9) Training shall employ skill demonstration/modeling, auditory and visual presentation methods, role-playing and skill practice, immediate positive and corrective feedback, frequent repetition of new material, practice assignments between training sessions (homework), and brief review of material from each previous session.~~

~~10) There shall be opportunities for cued skill practice and generalization outside session as identified in the care plan and at least weekly documentation relative to skill acquisition.~~

~~11) Each training session shall be provided and attended in increments of a minimum of 30 minutes each (not counting time to assemble and settle) at~~

~~least three times per week. Occasional absences are allowable, with individual coverage of missed material as necessary. However, on-going 1:1 training shall not qualify under this area.~~

~~hh) Close or Constant Observations.~~

~~1) Coding of this item is intended only for interventions applied in response to the specific current significant need of an individual resident. This item shall not be coded for observation conducted as standard facility policy for all residents, such as for all new admissions, or as part of routine facility procedures, such as for all returns from hospital, or as a part of periodic resident headcounts.~~

~~2) There shall be documentation for the reason for use, confirmation that the procedure was performed as coded with staff initials at appropriate intervals, brief explanation of the resident's condition and reason for terminating the observation.~~

~~ii) Cognitive Impairment/Memory Assistance Services.~~

~~1) Documentation shall include a description of the resident's short-term memory problems.~~

~~2) A method of assessing and determining the short-term memory problem shall be documented.~~

~~3) Documentation shall include a description of the resident's ability to make everyday decisions about tasks or activities of daily living.~~

~~4) Documentation shall include a description of the resident's ability to make himself or herself understood.~~

~~jj) Dementia Care Unit.~~

~~1) Unit was Illinois Department of Public Health certified during look-back period.~~

~~2) Resident resided in the unit during the look-back period.~~

~~3) Activity programming is planned and provided seven days a week for an average of eight hours per day.~~

~~4) Required assessments were completed on the resident.~~

~~5) If the resident has a Cognitive Performance Scale (CPS) score of five, care planning shall address the resident's participation in the unit's activities.~~

~~6) If a particular resident does not participate in at least an average of four activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.~~

~~7) Documentation shall support staff's efforts to involve the resident.~~

~~kk) Exceptional Care Services.~~

~~1) Respiratory Services.~~

~~A) A respiratory therapist shall evaluate the status of the resident at least monthly if the resident has a tracheostomy.~~

~~B) Documentation of respiratory therapy being provided 15 minutes a day shall be present in the clinical record for the look-back period.~~

~~C) Documentation of a physician's orders for the treatments.~~

~~D) Respiratory therapy requires documentation in the record of the treatment and the times given by a qualified professional (respiratory therapist or trained nurse) as defined in the RAI Manual.~~

~~E) Documentation of suctioning includes type, frequency and results of suctioning.~~

~~F) Documentation of trach care includes type, frequency and description of the care provided.~~

~~2) Weaning From Ventilator.~~

~~Documentation shall be in place to support weaning from the ventilator.~~

~~3)~~ ~~Morbid Obesity.~~

~~A)~~ ~~A dietician's evaluation shall be completed with evidence of on-going consultation.~~

~~B)~~ ~~On-going monitoring of weight shall be evident.~~

~~C)~~ ~~The psychosocial needs related to weight issues shall be identified and addressed.~~

~~4)~~ ~~Complex Wounds.~~
~~Facilities are to follow documentation guidelines as directed by 42 CFR 483.25(c) (State Operations Manual F-tag F314). All documentation requirements listed in F314 shall be met.~~

~~5)~~ ~~Traumatic Brain Injury (TBI).~~

~~A)~~ ~~Documentation shall support that psychological therapy is being delivered by licensed mental health professionals, as described in the RAI Manual.~~

~~B)~~ ~~Documentation shall support a special symptom evaluation program as an ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms as described in the RAI Manual.~~

~~C)~~ ~~Documentation shall support evaluation by a licensed mental health specialist in the last 90 days. This shall include an assessment of a mood, behavioral disorder, or other mental health problems by a qualified clinical professional as described in the RAI Manual.~~

~~D)~~ ~~The care plan shall address the behaviors of the resident and the interventions used.~~

~~ll)~~ ~~Accident/Fall Prevention.~~

~~1) Documentation shall support that the resident has the risk factor identified on the MDS.~~

~~2) Documentation shall support that the resident has been assessed for fall risks.~~

~~3) If the resident is identified as high risk for falls, documentation shall support that interventions have been identified and implemented.~~

~~mm) Restraint Free.~~

~~1) There shall be documentation to support the previous use of a restraint and the resident response to the restraint.~~

~~2) There shall be evidence that the restraint was discontinued.~~

~~nn) Clarification and additional documentation requirements are as follows:~~

~~1) Defined actions such as further assessment or documentation, described in the RAI Manual as "good clinical practice", are required by the Department as supporting documentation. Clinical documentation that contributes to identification and communication of a resident's problems, needs and strengths, that monitors his or her condition on an on-going basis, and that records treatments and response to treatment is a matter of good clinical practice and is an expectation of trained and licensed health care professionals (RAI page 1–23).~~

~~2) The facility shall have in place policies and procedures to address specific care needs of the residents, written evidence of ongoing in-services for staff related to residents' specific care needs and all necessary durable medical equipment to sustain life and carry out the plan of care as designed by the physician. In the absence of these items, a referral will be made to the Illinois Department of Public Health.~~

~~3) No specific types of documentation or specific forms are mandated, but documentation shall be sufficient to support the codes recorded on the MDS. Treatments and services ordered and coded shall be documented as delivered in the clinical record.~~

~~4) When completing a significant change assessment, the guidelines provided in the RAI Manual shall be followed. This includes documenting "the initial identification of a significant change in terms of the resident's clinical status in the progress notes" as described in RAI page 2–7.~~

~~5) Documentation used to support coding must be signed or initialed and dated. Changes to documentation shall be done in accordance with professional standards of practice, which includes lining through the error, initialing and dating the changes made.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 147.205 Reimbursement for Ventilator Dependent Residents (Repealed)

~~a) Pursuant to Public Act 96-473, effective October 1, 2009, Department of Healthcare and Family Services (HFS) shall begin paying nursing facilities for ventilator dependent residents through a system separate from the Minimum Data Set (MDS) based reimbursement methodology. For purposes of this Section, ventilators are defined as any type of electrical or pneumatically powered closed mechanical system for residents who are, or who may become, unable to support their own respiration. It does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.~~

~~b) Payment shall be made for each individual resident receiving ventilator services through the Medicaid Management Information System (MMIS). The rate shall include the facility specific support, capital and nursing components plus the geographic area average ventilator minutes from the MDS and $150 supply cost.~~

~~c) Other services coded by a facility on the MDS for a ventilator dependent resident shall continue to be applied toward the nursing component of the nursing facility rate.~~

~~d) Staffing~~

~~1) A minimum of one RN on duty on the day shift, seven days per week (as required by the Department of Public Health (DPH) in 77 Ill. Adm. Code 300.1240 or 250.910(e) and 250.910(f)(1), as appropriate). Additional RN staff may be determined necessary by HFS, based on HFS' review of the ventilator services.~~

~~2) A minimum of the required number of LPN staff (as required by DPH in 77 Ill. Adm. Code 300.1230, 300.1240 or 250.910(e) and 250.910(f)(1), as appropriate), on duty, with an RN on call, if not on duty on the evening and night shifts, seven days per week.~~

~~3) A certified respiratory therapy technician or registered respiratory therapist shall be available at the facility or on call 24 hours a day.~~

~~4) A certified respiratory therapist shall evaluate and document the respiratory status of the ventilator resident on a weekly basis.~~

~~5) At least one of the full-time licensed nursing staff members must have successfully completed a course in the care of ventilator dependent individuals and the use of ventilators, conducted and documented by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one year experience in the care of ventilator dependent persons.~~

~~6) All staff caring for ventilator dependent residents must have documented in-service training in ventilator care prior to providing that care. In-service training must be conducted at least annually by a certified respiratory therapy technician or registered respiratory therapist or a qualified registered nurse who has at least one-year experience in the care of ventilator dependent persons. In-service training documentation shall include name and qualification of the in-service director, duration of presentation, content of presentation and signature and position description of all participants.~~

~~e) Physical Plant~~
~~The Provider shall have and maintain physical plant adaptations to accommodate the necessary equipment, such as, an emergency electrical backup system.~~

~~f) Notification to HFS~~
~~A provider shall notify HFS, in writing, when a ventilator dependent resident is admitted and discharged from the facility. Notification in either instance shall occur within five days after the admission or discharge. Discharge is defined as the resident leaving the facility with no intention of returning. It does not mean an admission to a hospital.~~

~~g) Accessibility~~
~~The provider must make accessible to HFS and/or DPH all provider, resident and other records necessary to determine that the needs of the resident are being met and to determine the appropriateness of ventilator services.~~

~~h) Pursuant to Section 5-5.4(4) of the Public Aid Code, payment for ventilator services has been incorporated into Section 147.355 that covers payment for exceptional need categories, including ventilator care, identified in that Section.~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 147.310 Implementation of a Case Mix System~~Inspection of Care (IOC) Review Criteria for the Evaluation of Psychiatric Rehabilitation Services in Residential Facilities for Individuals with Mental Illness (Repealed)~~

a) P.A. 98-0104 requires the Department to implement, effective January 1, 2014, an evidence-based payment methodology for the reimbursement of nursing services. The methodology shall take into consideration the needs of individual residents, as assessed and reported by the most current version of the nursing facility Minimum Data Set (MDS), adopted and in use by the federal government.

b) This Section establishes the method and criteria used to determine the resident reimbursement classification based upon the assessments of residents in nursing facilities. Resident reimbursement classification shall be established utilizing the 48-group, Resource Utilization Groups IV (RUG-IV) classification scheme and weights as published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). An Illinois specific default group is established in subsection (f)(3) of this Section and identified as AA1 with an assigned weight equal to the weight assigned to group PA1.

c) The pool of funds available for distribution by case mix shall be determined using the formula contained below. Base rate spending pool shall be:

1) The base year resident days which are calculated by multiplying the number of Medicaid residents in each nursing facility based on MDS comprehensive assessments for Medicaid residents on the last day of the quarter used to establish the base rate times 365 days.

2) Each facility's nursing component per diem in effect on July 1, 2012 shall be multiplied by the number determined in subsection (c)(1) of this Section.

3) Thirteen million is added to the result of subsection (c)(2) of this Section, to adjust for the exclusion of nursing facilities defined as Class I IMDs.

d) For each nursing facility with Medicaid residents as indicated by the MDS data defined in subsection (c)(1) of this Section, weighted days adjusted for case mix and regional wage adjustment shall be calculated. For each nursing facility this calculation is the product of:

1) Base year resident days as calculated in subsection (c)(1) of this Section.

2) The nursing facility's regional wage adjustor based on the Health Service Areas (HSA) groupings and adjustors in effect on April 30, 2012.

3) Facility weighted case mix which is the number of Medicaid residents as indicated by the MDS data defined in subsection (c)(1) of this Section multiplied by the associated case weight for the RUG-IV 48-group model using standard RUG-IV procedures for index maximization.

4) The sum of the products calculated for each nursing facility in subsections (d)(1) through (d)(3) of this Section shall be the base year case mix, rate adjusted weighted days.

e) The statewide RUG-IV nursing base per diem rate effective on January 1, 2014, shall be the quotient of subsection (c) of this Section divided by the sum calculated under subsection (d)(4) of this Section and is $83.49.

f) For services provided on or after:

1) January 1, 2014, the Department shall compute and pay a facility-specific nursing component of the per diem rate as the arithmetic mean of the resident-specific nursing components, as determined in subsection (d) of this Section, assigned to Medicaid-enrolled residents on record, as of 30 days prior to the beginning of the rate period, in the Department's Medicaid Management Information System (MMIS), or any successor

system, as present in the facility on the last day of the second quarter preceding the rate period. The RUG-IV nursing component per diem for a nursing facility shall be the product of the statewide RUG-IV nursing base per diem rate, the facility average case mix index to be calculated quarterly, and the regional wage adjustor. Transition rates for services provided between January 1, 2014 and December 31, 2014, shall be as follows:

A) The transition RUG-IV per diem nursing rate for nursing facilities whose rate calculated in this subsection is greater than the nursing component rate in effect July 1, 2012, shall be paid the sum of:

i) The nursing component rate in effect July 1, 2012; plus

ii) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012, multiplied by 0.88.

B) The transition RUG-IV per diem nursing rate for nursing facilities whose rate calculated in this subsection is less than the nursing component rate in effect July 1, 2012, shall be paid the sum of:

i) The nursing component rate in effect July 1, 2012; plus

ii) The difference of the RUG-IV nursing component per diem calculated for the current quarter minus the nursing component rate in effect July 1, 2012, multiplied by 0.13.

2) Subject to the requirement of P.A. 98-0104 that the Department submit a rule by January 1, 2014 that establishes a reimbursement methodology that is reflective of the intensity of care and services requirements of the low need residents in the lowest RUG-IV groups, the Department will calculate quarterly the value of a per diem increase of $1.00 multiplied by 365 divided by total facility resident days for each resident reporting in the low 4 RUG groups, PA1, PA2, BA1, or BA2, as of September 30, 2013. The value of this increase will be applied to the per diem rate of each nursing facility in which total resident occupancy is at least 70 percent Medicaid on a quarterly basis.

3) The Department shall determine the group to which a resident is assigned using the 48-group RUG-IV classification scheme with an index maximization approach. A resident for whom RUGs resident identification information is missing, or inaccurate, or for whom there is no current MDS record for that quarter, shall be assigned to default group AA1. A resident for whom an MDS assessment does not meet the CMS edit requirements as described in the Long Term Care Resident Assessment Instrument (RAI) Users Manual or for whom an MDS assessment has not been submitted within 14 calendar days after the time requirements in Section 147.315 shall be assigned to default group AA1.

4) The assessment used for the purpose of rate calculation shall be identified as an Omnibus Budget Reconciliation Act (OBRA) assessment on the MDS following the guidance in the RAI Manual.

5) The MDS used for the purpose of rate calculation shall be determined by the Assessment Reference Date (ARD) identified on the MDS assessment.

g) The Department shall provide each nursing facility with information that identifies the group to which each resident has been assigned.

(Source: Old Section 147.310 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.310 added at 38 Ill. Reg. _____, effective _____.

Section 147.315 Nursing Facility Resident Assessment Instrument~~Comprehensive Functional Assessments and Reassessments (Repealed)~~

a) A facility shall conduct and electronically submit a Minimum Data Set (MDS) assessment that conforms with the assessment schedule and guidance defined by Code of Federal Regulations, Title 42, section 483.20, and in the RAI Manual, published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), and subsequent updates when issued by CMS.

b) A facility shall complete the MDS Comprehensive Item Set form that includes all items Section A-Z, for each resident quarterly, regardless of the resident's payment source. The Comprehensive Item Set refers to the MDS items that are active on a particular assessment type or tracking form. While a Comprehensive Item Set is required for all assessments including quarterlies, a comprehensive

assessment is not required on a quarterly basis. A comprehensive assessment is defined as both the completion of a Comprehensive Item Set as well as completion of the Care Area Assessment (CAA) process and care planning. When completing the Comprehensive Item Set for the quarterly MDS, the CAA process is not required. The federal regulatory requirements at 42 CFR 483.20(d) requires nursing facilities to maintain all resident assessments completed within the previous 15 months in the resident's active clinical record.

c) A facility shall electronically transmit to the CMS database the following MDS assessments in the timeframes identified.

1) The Omnibus Budget Reconciliation Act (OBRA) regulations require nursing facilities that are Medicare or Medicaid certified to conduct initial and periodic assessments for all their residents. The MDS 3.0 is part of that assessment process and is required by CMS. The assessment that will be used for the purpose of rate calculations shall be identified as an OBRA assessment on the MDS following the guidance in the RAI Manual.

2) Admission, Annual, Significant Change in Status, and Significant Correction to Prior Comprehensive Assessments shall be completed and transmitted to the CMS database no later than 14 calendar days after the care plan completion date. The quarterly assessment shall identify the MDS was transmitted to the CMS database no later than 14 calendar days after the MDS completion date.

3) An MDS admission assessment and CAAs shall be completed by the 14th calendar day from the resident's admission date. This assessment shall include completion of the MDS Comprehensive Item Set as well as completion of the CAA process and care planning. Care plan completion date is 7 calendar days after the MDS/CAA completion date. Transmission date is within 14 calendar days after the care plan completion date.

4) An annual assessment shall have an assessment reference date (ARD) within 366 calendar days of the ARD identified on the last comprehensive assessment. This assessment shall include completion of the MDS Comprehensive Item Set as well as completion of the CAA process and care planning. The MDS/CAA completion date is the ARD plus 14 calendar days. The care plan completion date is MDS/CAA completion

date plus 7 calendar days. Transmission date is care plan date plus 14 calendar days.

5) A significant change assessment shall be completed within 14 calendar days after the identification of a significant change. This assessment shall include completion of the MDS Comprehensive Item Set as well as completion of the CAA process and care planning. The MDS/CAA completion date is 14 calendar days after the determination date plus 7 calendar days. Transmission date is care plan date plus 14 calendar days.

6) All quarterly assessments shall have an ARD within 92 calendar days after the previous OBRE assessment. This assessment includes the completion of the MDS Comprehensive Item Set, but does not include the completion of the CAA process and care planning. MDS completion date is ARD plus 14 calendar days. Transmission date is completion date plus 14 calendar days.

7) The significant correction to a prior comprehensive assessment or significant correction to a prior quarterly assessment shall be completed when the interdisciplinary team determines that a resident's prior assessment contains a significant error that has not been corrected by more recent assessments as required by the RAI Manual. Nursing facilities shall document the initial identification of a significant error in a prior assessment in the progress notes.

d) A facility shall comply with the following:

1) All staff completing any portion of the MDS shall enter their signatures, titles, section or portions of sections they completed and the date completed.

2) The signature attests that the information entered by them, to the best of their knowledge, most accurately reflects the resident's status during the timeframes identified.

3) Federal regulations require the RN assessment coordinator to sign and thereby certify that the assessment is completed.

4) When the electronic MDS record submitted to the state from the CMS database does not match the facility's copy of the MDS, the items on the MDS submitted will be used for purposes of validation.

5) It is the facility's responsibility to create an electronic transmission file that meets the requirements detailed in the current MDS Data Specification Manual. The facility shall submit MDS assessments under the appropriate authority and timely as defined in the RAI Manual. In addition, the facility is responsible to access the CMS database to receive and review validation reports. Records that are rejected or contain errors must be dealt with 30 days prior to the rate period and appropriately to avoid default rate.

(Source: Old Section 147.315 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.315 added at 38 Ill. Reg. _____, effective _____)

Section 147.320 Definitions~~Interdisciplinary Team (IDT) (Repealed)~~

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

"Active Disease Diagnosis" means a physician documented diagnosis (or by a nurse practitioner, physician assistance, or clinical nurse specialist if allowable under State licensure laws) that have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring or risk of death.

"Assessment Reference Date" means the last day of the Minimum Data Set (MDS) look-back period. The date sets the designated endpoint of the look-back period in the MDS process, and all MDS items refer back in time from that point. This period of time is also called the observation or assessment period.

"Case Mix" means a method of classifying care that is based on the intensity of care and services provided to the resident.

"Case Mix Index" means the weighting factors assigned to each RUG-IV classifications.

"Case Mix Reimbursement System" means a payment system that measures the intensity of care and services required for each resident, and translates these

measures into the amount of reimbursement given to the facility for care of a resident.

"Continuous Positive Airway Pressure" or "CPAP" means a respiratory support device that prevents the airways from closing by delivering slightly pressurized air through a mask continually or via electronic cycling throughout the breathing cycle. The mask enables the individual to support his or her own respirations by providing enough pressure when the individual inhales to keep his or her airway open.

"Department" means the Illinois Department of Healthcare and Family Services (HFS).

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or herself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

"Index Maximization" means a method to classify a resident who could be assigned to more than one category, to the category with the highest case mix index.

"Minimum Data Set" or "MDS" means the assessment instrument specified by the Centers for Medicare and Medicaid Services (CMMS) and designated by the "Department". A core set of screening, clinical, and functional status elements, including common definitions and coding categories, forms the foundation of a comprehensive assessment.

"Monitoring" means the ongoing collection and analysis of information (such as observations and diagnostic test results) and comparison to baseline and current data in order to ascertain the individual's response to treatment and care, including progress or lack of progress towards a goal. Monitoring can detect any improvements, complications or adverse consequences of the condition or of the treatments, and support decisions about adding, modifying, continuing or discontinuing any interventions.

"Nursing Monitoring" means clinical monitoring (e.g., serial blood pressure evaluations, medication management, etc.) by a licensed nurse.

"Resource Utilization Group" or "RUG" means the system for grouping a nursing facility's residents according to their clinical and functional status identified in MDS data supplied by a facility.

"Significant Error" means an error in an assessment where a resident's overall clinical status in not accurately represented and the error has not been corrected via submission of a more recent assessment.

"Ventilator or Respirator" means a type of electronically or pneumatically powered closed system mechanical ventilator support devices that ensures adequate ventilation in the resident who is, or who may become, unable to support his or her respirations.

(Source: Old Section 147.320 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.320 added at 38 Ill. Reg. _____, effective _____)

Section 147.325 Resident Reimbursement Classifications and Requirements ~~Comprehensive Program Plan (CPP) (Repealed)~~

a) Resident reimbursement classification shall be based on the Minimum Data Set (MDS), Version 3.0 assessment instrument mandated by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMMS) that nursing facilities are required to complete for all residents. When later guidance or clarifications are released by CMMS that contradicts or augments guidance provided in this Section, the more current information becomes the accepted standard and shall become effective as of the date required by CMMS. The Department shall establish resident classification according to the 48-group, Version IV or RUG-IV model. Resident classification shall be established based on the individual items identified on the MDS and shall be completed according to the RAI Manual.

b) Each resident shall be classified based on the information from the MDS submitted according to the categories as identified in Section 147.330 and as defined in the RAI Manual.

c) General Documentation Requirements

1) A facility shall maintain resident records on each resident in accordance with acceptable professional standards and practices.

2) Supportive documentation in the clinical record used to validate the MDS item responses shall be dated during the specified look-back period or other timeframe as identified in the RAI Manual. Records shall be retained for at least three years from the date of discharge.

3) Supportive documentation entries shall be dated and their authors identified by signature or initials. Signatures are required to authenticate all documentation utilized to support MDS item responses. At a minimum, the signature shall include the first initial, last name, and title/credentials. Any time a facility chooses to use initials in any part of the record for authentication of an entry, there shall also be corresponding full identification of the initials on the same form or on a signature legend. Initials may never be used where a signature is required by law (i.e., on the MDS). When electronic signatures are used, the facility shall have policies in place to identify those who are authorized to sign electronically and have safeguards in place to prevent unauthorized use of electronic signatures.

4) Each page or individual document in the clinical record shall contain the resident's identification information.

5) A multi-page supportive documentation form completed by one staff member may be signed and dated at the end of the form, provided that each page is identified with the resident's identification information and the dates are clearly indentified on the form.

6) Corrections/Obliterations/Errors/Mistaken Entries. At a minimum, there shall be one line through the incorrect information, the staff's initial, the date of correction was made, and the corrected information. Information that is deemed illegible by Department reviews will not be considered for validation purposes.

7) An error correction in the electronic record applies the same principles as for the paper clinical record. Some indication that a previous version of the entry exists shall be evident to the caregiver or other person viewing the entry.

8) Late entries shall be clearly labeled as a late entry and contain the current date, time and authorized signature. Amendments are a form of late entry. Amendments shall be clearly labeled as an addendum or amendment and include the current date, time and authorized signature.

9) Facilities shall have a written policy and procedures that states who is authorized to make amendments, late entries, and correct errors in the electronic health records (EHRs) and clearly dictate how these changes to the EHR are made.

10) Resident records shall be complete, accurately documented, readily accessible to Department staff, and systematically organized. At a minimum, the record shall contain sufficient information to identify the resident, a record of the resident's assessments, care plan, record of services provided, and progress notes.

11) Documentation from all disciplines and all portions of the resident's clinical record may be used to validate an MDS item response. All supporting documentation shall be produced by a facility during an onsite visit.

12) Documentation shall support all conditions or treatments were present or occurred within the look-back period ending on, and including the ARD period. The look-back period shall include observations and events through the end of the day (midnight) of the ARD. Documentation shall apply to the appropriate look-back period and reflect the resident's status on all shifts.

13) Documentation in the clinical record shall consistently support the item response and reflect care related to the symptom or problem. Documentation shall reflect the resident's status on all shifts.

14) Problems that are identified by the MDS item responses that affect the resident's status shall be addressed on the care plan when deemed appropriate by the interdisciplinary team (IDT) as identified in the RAI Manual.

15) Insufficient or inaccurate documentation may result in a determination that the MDS item submitted was not validated.

16) Documentation shall support that the services delivered were medically necessary.

17) Documentation shall support an individualized care plan was developed based on the MDS and other assessments and addressed the resident's strengths and needs. In addition, documentation, observation and/or interview shall support services were delivered as identified by the care plan.

18) Clinical documentation that contributes to identification and communication of a resident's problems, needs and strengths that monitors his or her condition on an ongoing basis and that records treatments and response to treatment is a matter of clinical practice and is an expectation of trained and licensed health care professional.

19) When there is a significant change in status assessment done, documentation shall include the identification of the significant change in status in the clinical record.

d) Disease Diagnosis Requirements

1) The disease condition shall require a physician-documented diagnosis in the clinical record during the 60 days prior to and including the ARD.

2) The diagnosis shall be determined to be active as defined in the RAI Manual during the 7-day look-back period. Conditions that have been resolved or no longer affect the resident's current functioning or care plan during the 7-day look-back period shall not be included.

3) Documentation shall support that the active diagnoses have a direct relationship to the resident's current functional status, cognitive status, mood or behavior, medical treatments, nursing monitoring, or risk of death during the look-back period.

4) There shall be specific documentation in the record by a physician stating the disease is active. Including a disease/diagnosis on the resident's clinical record problem list is not sufficient for determining active or

inactive status. In the absence of specific documentation that a disease is active, the following indicators may be used to confirm active disease.

A) Recent onset or acute exacerbation of the disease or condition indicated by a positive study, test or procedure, hospitalization for acute symptoms and/or recent change in therapy during the 7-day look-back period.

B) Symptoms and abnormal signs indicating ongoing or decompensating disease in the last 7-day look-back period.

C) Ongoing therapy with medication or other interventions to mange a condition that requires monitoring for therapeutic efficacy or to monitor potentially severe side effects in the 7-day look-back period. A medication indicates active disease if that medication is prescribed to manage an ongoing condition that requires monitoring or is prescribed to decrease active symptoms associated with a condition.

D) When documentation of conditions that are generally short term in nature (i.e., fever, septicemia, pneumonia, etc.) are noted over a long period of time by the facility staff, the physician may be interviewed to determine accuracy of the diagnosis. In addition, when questions regarding the validity of the diagnosis are found during review of the documentation the physician may be interviewed.

(Source: Old Section 147.325 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.325 added at 38 Ill. Reg. _____, effective _____)

Section 147.330 Resource Utilization Groups (RUGs) Case Mix Requirements~~Specialized Care – Administration of Psychopharmacologic Drugs (Repealed)~~

a) Activities of Daily Living (ADL)

1) Documentation shall support the ADL coded level as defined in the Resident Assessment Instrument (RAI) Manual.

2) Documentation of ADLs shall support the RAI requirement was met for coding Self Performance and Support during the look-back period. It is the responsibility of the person completing the assessment to consider all episodes of the activity that occurred over a 24-hour period during each day of the 7-day look-back period. There shall be signatures/initials of staff providing the ADL assistance and dates to authenticate the services were provided as coded during the look-back period. If using an ADL grid for supporting documentation, the key for self-performance and support provided shall be equivalent to definitions to the MDS key.

3) The ADL scores for residents lacking documentation shall be reset to zero.

b) Extensive Services. Documentation shall support that the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall support tracheostomy care was completed during the look-back period while a resident in the facility.

2) Documentation shall support the use of a ventilator or respirator during the look-back period while a resident in the facility. Documentation shall support the device was an electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is, or who may become, unable to support his or her own respiration. This does not include BiPAP or CPAP devices or a ventilator or respirator that is used only as a substitute for BiPAP or CPAP.

3) Documentation supports the need for and use of isolation during the look-back period while a resident is in the facility.

4) Documentation shall support the following conditions for "strict isolation" were met during the look-back period:

A) The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission;

B) Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect; and

C) The resident is in a room alone because of active infection and cannot have a roommate even if the roommate has a similar active infection that requires isolation. The resident must remain in his/her room. This requires that all services be brought to the resident (e.g., rehabilitation, activities, dining, etc.).

5) Treatment and/or procedures the resident received shall be care planned and reevaluated to ensure continued appropriateness.

6) Extensive services are defined as indicated in the following chart.

Category (Description)	ADL Score	End Splits or Special Requirements	IL RUG-IV GROUP
Extensive Services – At least one of the following:			
Tracheostomy Care while a resident (O0100E2)	≥ 2	Tracheostomy care and Ventilator/Respirator	ES3
Ventilator or Respirator while a resident (O0100F2)	≥ 2	Tracheostomy care OR Ventilator/Respirator	ES2
Infection Isolation while a resident O0100M2)	≥ 2	Infection Isolation: • Without trach • Without Ventilator /Respirator	ES1

c) Rehabilitation. Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) All RAI Manual requirements and definitions shall be met, including the qualifications for therapists.

2) Documentation shall support medically necessary therapies that occurred after admission or readmission to the facility that were:

A) Ordered by a physician based on a qualified therapist's (i.e., one who meets Medicare requirements) assessment and treatment plan;

B) Documented as delivered in the clinical record; and

C) Care planned and periodically evaluated to ensure the resident receives needed therapies and the current treatment plans are effective. Any service provided at the request of the resident or family that is not medically necessary shall not be included, even when performed by a therapist or a therapy assistant. It does not include the services performed when a facility elects to have licensed professionals perform repetitive exercises and other maintenance treatments or to supervise aides performing these maintenance services that are considered restorative care.

3) Documentation shall support the therapies were provided while the individual was living and being cared for at the long-term care facility. It does not include therapies that occurred while the person was an inpatient at a hospital or recuperative or rehabilitation center or other long-term care facility, or recipient of home care or community based services.

4) Documentation shall support the services were directly and specifically related to an active written treatment plan that is approved by the physician after any needed consultation with a qualified therapist and is based on an initial evaluation performed by a qualified therapist prior to the start of these services in the facility.

5) Documentation shall support the services were a level of complexity and sophistication, or the condition of the resident shall be of a nature that requires the judgment, knowledge, and skills of a therapist.

6) Documentation shall support the services were provided with expectation, based on the assessment of the resident's restoration potential made by the physician, that the condition of the patient will improve materially in a reasonable and generally predictable period of time, or the services shall be necessary for the establishment of a safe and effective maintenance program.

7) Documentation shall support the services are considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition.

8) Documentation shall support that services are medically necessary for the treatment of the resident's condition. This includes the requirement that the amount, frequency, and duration of the services shall be reasonable and they must be furnished by qualified personnel.

9) Documentation shall include the actual minutes of therapy. Minutes shall not be rounded to the nearest 5th minute and conversion of units to minutes or minutes to units is not acceptable.

10) Documentation shall identify the different modes of therapy (i.e., individual, concurrent, group) and the documentation shall support the criteria for the mode identified is met.

11) Documentation shall support that the restorative program include nursing interventions that promote the residents ability to adapt and adjust to living as independently and safely as possible. The program actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

12) Documentation shall include the following components for a restorative program is met:

A) There are measurable objectives/interventions established for the performance of the activity;

B) A licensed nurse shall evaluate and document the results of the evaluation related to the program on a quarterly basis.

C) Documentation includes the actual number of minutes the activity were performed and supports at least 15 minutes in a 24-hour period for a minimum of 6 days; and

D) Individuals who implement the program shall be trained in the interventions and supervised by a nurse.

13) Documentation shall support the requirements identified for coding ADL were met.

14) Rehabilitation is defined as indicated in the following chart.

Category (Description)	ADL Score	End Splits or Special Requirements	IL Rug-IV Group
At least 5 distinct calendar days (15 min per day minimum) in any combination of Speech, Occupational or Physical Therapy in the last 7 days. (O0400A4, O0400B4, O0400C4) AND 150 minutes or greater of any combination of Speech, Occupational or Physical Therapy in the last 7 days (O0400A1, O0400A2, O0400A3, O0400B1, O0400B2, O0400B3, O0400C1, O0400C2, O0400C3)	15-16	None	RAE
	11-14	None	RAD
	6-10	None	RAC
	2-5	None	RAB
	0-1	None	RAA
OR			
At least 3 distinct calendar days (15 min per day minimum) in any combination of Speech, Occupational, or Physical Therapy in the last 7 days (O0400A4, O0400B4, O0400C4) AND 45 minutes or greater in any combination of Speech, Occupational or Physical Therapy in the last 7 days (O0400A1, O0400A2, O0400A3, O0400B1, O0400B2, O0400B3, O0400C1, O0400C2, O0400C3) AND at least 2 nursing rehabilitation services.			

See description of Restorative in subsection (h)			

d) Special Care High-Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall support the requirements and criteria for coding an active disease diagnosis were met.

2) Documentation shall support the ADL scores met the requirements and criteria for coding.

3) Documentation shall include the date completed and the staff member completing the Mood interview when indicated. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date observed, a brief description of the symptoms, staff observing, and any interventions.

4) Documentation shall support a diagnosis of coma or persistent vegetative state.

5) Documentation shall support an active diagnosis of Septicemia. Interventions and/or treatments for the diagnosis shall be documented upon delivery.

6) Documentation shall support an active diagnosis of diabetes, and shall support insulin injections were given the entire 7 days of the look-back period and there were orders for insulin changes on 2 or more days during the look-back period.

7) Documentation shall support the active diagnosis of Quadriplegia.

8) Documentation shall support the active diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and/or asthma with shortness of breath while lying flat. Interventions and/or treatments for the condition shall be documented upon delivery.

9) Documentation to support fever shall include a recorded temperature of at least 2.4 degrees higher than the previous recorded baseline temperature and documentation shall support one of the following: pneumonia, vomiting, weight loss, and/or feeding tube with at least 51% of total calories or if 26-50% of the calories there is also fluid intake of 501cc or more per day. Interventions and/or treatments for the condition shall be documented upon delivery.

10) Documentation shall support the intervention of parenteral or IV feedings. Documentation shall support the intervention was administered for nutrition or hydration purposes.

11) Documentation of respiratory therapy shall include the following:

A) Physician orders that include a statement of frequency, duration, and scope of treatment;

B) The actual minutes the therapy was provided while a resident is in the facility;

C) Evidence that the services are provided by a qualified professional; and

D) Evidence that the services are directly and specifically related to an active written treatment plan that is based on an initial evaluation performed by qualified personnel.

12) Special Care High is defined as indicated in the following chart.

Category (Description)	ADL Score	End Splits or Special Requirements	IL RUG-IV Group
Special Care High (ADL Score of ≥ 2 or more and at least one of the following: Comatose (B0100) and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0110I1	15-16	Depression	HE2
	15-16	No Depression	HE1
	11-14	Depression	HD2
	11-14	No Depression	HD1

all = 4 or 8) Septicemia (I2100) Diabetes (I2900) with both of the following: • Insulin injections for all 7 days (N0350A = 7) • Insulin order changes on 2 or more days (N0350B ≥ 2) Quadriplegia (I5100) with ADL score ≥ 5(ADLs as above) Asthma or COPD (I6200) AND shortness of breath while lying flat (J1100C) Fever (J1550A) and one of the following: • Pneumonia (I2000) • Vomiting (J1550B) • Weight Loss (K0300 = 1 or 2) • Feeding Tube (K0510B1 or K0510B2) with at least 51% of total calories (K0710A3 = 3) OR 26% to 50% through parenteral/enteral intake (K0710A3 = 2) and fluid intake is 501cc or more per day (K0710B3 = 2) Parenteral/IV Feeding (K0510A1 or K0510A2) Respiratory Therapy for all 7 days (O0400D2 = 7) If a resident qualifies for Special Care High but the ADL score is a 1 or less, then the resident classifies as Clinically Complex	6-10 6-10 2-5 2-5	Depression No Depression Depression No Depression (Note: See description of depression indicators in subsection (k))	HC2 HC1 HB2 HB1

e) Special Care Low – Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall support the requirements and criteria for coding disease diagnosis were met. This includes an active diagnosis of Cerebral Palsy, Multiple Sclerosis, or Parkinson's.

2) Documentation shall support an active diagnosis of respiratory failure and the administration of oxygen therapy while a resident. Documentation shall include the date and method of delivery. Documentation shall support a need for the use of oxygen.

3) Documentation shall support the requirements and criteria for coding ADLs were met.

4) Documentation shall include the date, and staff completing the Mood interview. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date observed, a brief description of the symptom, any interventions implemented and identification of staff observing.

5) Documentation shall support the presence of a feeding tube and the proportion of calories received through the tube feeding.

6) Documentation shall support the presence of 2 or more Stage 2 pressure ulcers or any Stage 3 or 4 pressure ulcer as defined in the RAI Manual. Documentation shall include observation date, location, and measurement and description of the ulcer. Other factors related to the ulcer shall be noted including: condition of the tissue surrounding the area (color, temperature, etc.), exudates and drainage present, fever, presence of pain, absence or diminished pulses, and origin of the wound (such as pressure, injury or contributing factors) if known. Interventions and/or treatments for the ulcer shall be documented as delivered.

7) Documentation shall support the presence of 2 or more venous or arterial ulcers as defined in the RAI Manual. Documentation shall include observation date, location, and measurement and description of the ulcer.

Interventions and/or treatment for the ulcer shall be documented as delivered.

8) Documentation shall support the presence of a Stage 2 pressure ulcer and a venous or arterial ulcer. Documentation shall include observation date, location, and measurement and description of the ulcer. Interventions and/or treatments for the ulcer shall be documented as delivered.

9) Documentation shall support 2 or more of the following interventions when ulcers are noted: pressure relieving devices, turning and repositioning, nutrition and/or hydration, ulcer care, application of dressing and/or application of ointments. Documentation shall support the interventions identified were implemented during the look-back period.

10) Documentation and/or observation shall support the use of pressure relieving devices for the resident. This does not include egg crate cushions, doughnuts or rings.

11) Documentation for a turning and repositioning program shall include specific approaches for changing the resident's position and realigning the body and the frequency it is to be implemented. Documentation shall support the program was implemented and is monitored and reassessed to determine the effectiveness of the intervention.

12) Documentation shall support the nutrition and/or hydration interventions were delivered. These shall be based on an individual assessment of the resident's nutritional deficiencies and needs. Vitamins and mineral supplements shall only be coded on the MDS when noted through a thorough nutritional assessment.

13) Documentation for ulcer care shall support the care was delivered. Documentation shall include the date delivered, type of care delivered, and identification of the staff delivering the care.

14) Documentation shall support the application of non-surgical dressing and shall include date applied and identification of the staff delivering the care. This does not include application of a band-aid.

15) Documentation shall support the application of ointments or medications were actually applied to somewhere other than the feet. This includes only ointments or medications used to treat and/or prevent skin conditions. Documentation shall include name and description of the ointment used, date applied, and identification of the staff delivering the care.

16) Documentation of infections of the foot and/or presence of diabetic foot ulcers or open lesions to the foot shall include a description of the area.

17) Documentation shall support interventions and/or treatments for the problems noted were implemented. Documentation shall define the intervention and treatment, the date delivered and the identification of the staff delivering the care.

18) Documentation shall support the application of dressing to the feet was actually delivered. Documentation shall include the date applied and identification of the staff delivering the care.

19) Documentation shall support the reason for and the administration of radiation while a resident. Documentation shall include the date of administration and identification of the staff delivering the care.

20) Documentation shall support dialysis was administered while a resident. Documentation shall include type of dialysis, date delivered, and identification of the staff delivering the care.

21) Special Care Low is defined as indicated in the following chart.

Category (Description)	ADL Score	End Splits or Special Requirements	IL RUG-IV Group
Special Care Low-ADL score of 2 or more and at least one of the following:	15-16	Depression	LE2
Cerebral Palsy (I4400) with ADL score ≥ 5	15-16	No Depression	LE1
Multiple Sclerosis (I5200) with ADL score ≥ 5			
Parkinson's disease (I5300) with ADL score ≥ 5	11-14	Depression	LD2
Respiratory Failure (I6300) and oxygen therapy while a resident (O0100C2)	11-14	No Depression	LD1
Feeding Tube (K0510B1 or K0510B2) with at			

least 51% of total calories (K0710A3 = 3) OR 26% to 50% through parenteral/enteral intake (K0710A3 = 2) and fluid intake is 501cc or more per day (K0710B3 = 2)	6-10 6-10	Depression No Depression	LC2 LC1
2 or more Stage 2 pressure ulcers (M0300B1) with 2 or more skin treatments • Pressure relieving device for chair (M1200A) and/or bed (M1200B) • Turning/Repositioning (M1200C) • Nutrition or hydration intervention (M1200D) • Ulcer care (M1200E) • Application of dressing (M1200G) • Application of ointments (M1200H) Any Stage 3 or 4 pressure ulcer (M0300C1, D1, F1) with 2 or more skin treatments-See above list 2 or more venous/arterial ulcers (M1030) with 2 or more skin treatments-See above list One Stage 2 pressure ulcer (M0300B1) and one venous/arterial ulcer (M1030) with 2 or more skin treatments-See above list Foot infection (M1040A), Diabetic foot ulcer (M1040B) or other open lesion of foot (M1040C) with application of dressing to feet (M1200I) Radiation treatment while a resident (O0100B2) Dialysis treatment while a resident (O0100J2) If a resident qualifies for Special Care Low but the ADL score is 1 or less-then the resident classifies as Clinically Complex	2-5 2-5	Depression No Depression Note: See description of depression indicators	LB2 LB1

f) Clinically Complex – Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall support the requirements and criteria for coding disease diagnosis were met. This shall include documentation of an active diagnosis of pneumonia that includes current symptoms and any interventions.

2) Documentation shall also support an active diagnosis of hemiplegia or hemiparesis.

3) Documentation shall support the requirements and criteria for coding ADLs were met.

4) Documentation shall include the date completed, and staff completing the Mood interview when indicated. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date observed, brief description of the symptom, any interventions, and identification of staff observing.

5) Documentation shall support the presence of open lesions other than ulcers. The documentation shall include, but is not limited to, an entry noting the observation date, location, measurement and description of the lesion and any interventions. Documentation of interventions shall include at least one of the following: surgical wound care, application of non-surgical dressing to an area other than the feet and/or application of ointments to an area other than the feet. Documentation shall include all the types of interventions, dates delivered, and the staff delivering the interventions.

6) Documentation shall support the presence of a surgical wound. The documentation shall include an entry noting the observation date, origin of the wound, location, measurement and description, and any interventions. Documentation of interventions shall include at least one of the following: surgical wound care, application of non-surgical dressing to an area other than the feet and/or application of ointments to an area other than the feet. Documentation shall include the type of intervention, dates delivered, and the staff delivering the interventions.

7) Documentation shall support the presence of a burn. Documentation shall include an entry noting the observation date, location, measurement and description, and any interventions.

8) Documentation shall support the administration of a chemotherapy agent while a resident in the facility. Documentation shall include the name of the agent, date delivered and the staff delivering.

9) Documentation shall support the administration of oxygen while a resident in the facility. This shall include the date and method of delivery. Additionally, documentation shall support a need for the use of oxygen.

10) Documentation shall support the administration of an IV medication while a resident in the facility. The documentation shall include the name of the medication, date delivered, method of delivery, and identification of staff delivering.

11) Documentation shall support the resident received a transfusion while a resident was at the facility. Documentation shall include the date received, reason and identification of staff delivering the care.

12) Clinically Complex is defined as indicated in the following chart.

Category (Description)	ADL Score	End Splits or Special Requirements	IL RUG -IV Group
Clinically Complex-At least one of the following:	15-16	Depression	CE2
Pneumonia (I2000)	15-16	No Depression	CE1
Hemiplegia/hemiparesis (I4900) with ADL score ≥ 5	11-14	Depression	CD2
Surgical wounds (M1040E) or open lesion (M1040D) with any of the following selected skin treatments:	11-14	No Depression	CD1
• Surgical wound care (M1200F)	6-10	Depression	CC2
• Application of non-surgical dressing (M1200G) not to feet	6-10	No Depression	CC1
• Application of ointment (M1200H) not to feet	2-5	Depression	CB2
Burns (M1040F)	2-5	No Depression	CB1

Chemotherapy while a resident (O0100A2) Oxygen therapy while a resident (O0100C2) IV Medication while a resident (O0100H2) Transfusions while a resident (O0100I2) If a resident qualifies for Special Care High or Special Care Low, but the ADL score of 1 or 0, then the resident classifies in Clinically Complex CA1 or CA2	0-1 0-1	Depression No Depression	CA2 CA1

g) Behavioral Symptoms and Cognitive Performance – Documentation shall support the following requirements were met during the look-back period based on the MDS items identified.

1) Documentation shall include the date completed, and staff completing the Mood interview. Documentation shall demonstrate the presence and frequency of clinical mood indicators when staff assessment of mood is utilized. This shall include date observed, brief description of the symptom, any interventions and identification of staff observing.

2) Documentation shall include the date and staff completing the Brief Interview for Mental Status (BIMS).

3) Documentation shall support the occurrence of a hallucination and/or delusion that include the date observed, description, and name of staff observing.

4) Documentation shall include the date observed, staff observing, frequency, and description of resident's specific physical, verbal or other behavioral symptom. Documentation shall include any interventions and the resident's response.

5) Documentation shall include the date observed, staff observing, frequency and description of the behavior of rejection of care. Rejection of care shall

meet all of the coding requirements. Residents, who have made an informed choice about not wanting a particular treatment, procedure, etc., shall not be identified as "rejecting care". Documentation shall include any interventions and the resident's response.

6) Documentation shall include the date observed, staff observing, frequency and description of any wandering behavior. Documentation shall support a determination for the need for environmental modifications (door alarms, door barriers, etc.) that enhance resident safety and the resident's response to any interventions. Care plans shall address the impact of wandering on resident safety and disruption to others and shall focus on minimizing these issues.

7) Documentation shall identify how the coded behavior affected the resident, staff and/or others. Care plan interventions shall address the safety of the resident and others and be aimed at reducing distressing symptoms.

8) Documentation supports presence of a restorative program. This shall include, but is not limited to, the following: Documentation of the actual number of minutes the program was provided that equals 15 minutes, in a 24-hour period, a restorative care plan that contains measurable objectives, and goals that are specific, realistic and measurable. In addition, documentation shall support the programs are delivered 6-7 days a week, supervised by a licensed nurse, a quarterly evaluation is completed by a licensed nurse, and staff are trained in skilled techniques to promote the resident's involvement in the activity.

9) Behavioral Symptoms and Cognitive Performance is defined as indicated in the following chart.

Category (Description)	ADL Score	End Splits or Special Requirements	IL RUG-IV GROUP
Behavioral Symptoms and Cognitive Performance	2-5	2 or more Restorative Nursing Programs	BB2
BIMS score of 9 or less AND an ADL score of 5 or less	2-5	0-1 Restorative Nursing Programs	BB1
OR	0-1		BA2

Defined as Impaired Cognition by Cognitive Performance Scale AND an ADL score of 5 or less Hallucinations (E0100A) Delusions (E0100B) Physical Behavioral symptom directed toward others (E0200A = 2 or 3) Verbal behavioral symptom directed towards others (E0200B = 2 or 3) Other behavioral symptom not directed towards others (E0200C = 2 or 3) Rejection of care (E08002 or 3) Wandering (E0900 = 2 or 3)	0-1	2 or more Restorative Nursing Programs 0-1 Restorative Nursing Programs	BA1

h) Reduced Physical Function

1) Documentation shall support the ADL coded level.

2) Documentation shall support presence of a restorative program. This shall include, but is not limited to, documentation of the actual number of minutes the program was provided that equals 15 minutes, in a 24-hour period, 6-7 days a week, a restorative care plan that contains measureable objectives, and goals that are specific, realistic and measurable, documentation that supports the programs are supervised by a licensed nurse, a quarterly evaluation is completed by a licensed nurse and staff are trained in skilled techniques to promote the resident's involvement in the activity.

3) Reduced Physical Function is defined as indicated in the following chart.

Category (Description)	ADL Score	End Splits or Special Requirements	IL RUG-IV Group
Reduced Physical Function List of Restorative Programs	15-16	2 or more Restorative	PE2
Passive (O0500A = 6 or 7) or Active (O0500B = 6 or 7) ROM	15-16	0-1 Restorative	PE1

Splint or brace assistance (O0500C = 6 or 7)	11-14	2 or more Restorative	PD2
Bed Mobility (O0500D = 6 or 7)	11-14	0-1 Restorative	PD1
and/or walking training (O0500F = 6 or 7)	6-10	2 or more Restorative	PC2
Transfer training (O0500E = 6 or 7)	6-10	0-1 Restorative	PC1
Dressing and/or grooming training (O0500G = 6 or 7)	2-5	2 or more Restorative	PB2
Eating and/or swallowing training (O0500H = 6 or 7)	2-5	0-1 Restorative	PB1
Amputation/prostheses care (O0500I = 6 or 7)	0-1	2 or more Restorative	PA2
Communication training (O0500J = 6 or 7)	0-1	0-1 Restorative	PA1
No Clinical Conditions			
These programs count as one service even if both are provided			

i) Illinois Specific Classification – This is assigned to a resident for whom RUGs resident identification information is missing or inaccurate, or for whom there is no current MDS record for that quarter. In addition, a resident for whom an assessment is necessary to determine group classification is incomplete or has not been submitted within 14 calendar days of the time requirements in Section 147.315 shall be assigned the default group.

An assessment that is missing and/or submitted more than 14 days late from the due date	N/A		AA1

j) Additional Scoring Indicators

ADL	Self-Performance	Support	ADL Score
Bed Mobility (G0110A)	Coded -, 0, 1, 7, or 8	Any Number	0
Transfer (G0110B) Toilet Use (G0110I)	Coded 2	Any Number	1

	Coded 3 Coded 4 Coded 3 or 4	-,0, 1, or 2 -,0,1 , or 2 3	2 3 4
Eating (G0110H)	Coded -, 0, 1, 2, 7 or 8 Coded -, 0, 1, 2, 7 or 8 Coded 3 or 4 Coded 3 Coded 4	-, 0, 1 or 8 2 or 3 -, 0 or 1 2 or 3 2 or 3	0 2 2 3 4

k) Depression – Additional Scoring Indicator − The depression end split is determined by either the total severity score from the resident interview in Section D0200 (PHQ-9) or from the total severity score from the caregiver assessment of Mood D0500 (PHQ9-OV).

Resident	Staff	Description
D0200A	D0500A	Little interest or pleasure in doing things
D0200B	D0500B	Feeling down, depressed or hopeless
D0200C	D0500C	Trouble falling or staying asleep, sleeping too much
D0200D	D0500D	Feeling tired or having little energy
D0200E	D0500E	Poor appetite or overeating
D0200F	D0500F	Feeling bad or failure or let self or others down
D0200G	D0500G	Trouble concentrating on things
D0200H	D0500H	Moving or speaking slowly or being fidgety or restless
D0200I	D0500I	Thoughts of better off dead or hurting self
	D0500J	Short tempered, easily annoyed
Residents that were interviewed D0300 (Total Severity Score) ≥ 10 but not 99		
Staff Assessment-Interview not conducted D0600 (Total Severity Score) ≥ 10		

l) Restorative Nursing – Additional Scoring Indicators

Activities that are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's clinical record. These are nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. The concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. The program shall be performed for a total of at least 15 minutes during a 24 hour-period. Measurable objective and interventions shall be documented in the care plan. There shall be evidence of periodic evaluation by the licensed nurse. A registered nurse or licensed practical nurse shall supervise the activities. This does not include groups with more than 4 residents per supervising staff.

Restorative Nursing Programs-2 or more required to be provided 6 or more days a week

Passive Range of Motion (O0500A) and/or Active Range of Motion (O0500B)* These are exercises performed by the resident or staff that are individualized to the resident's needs, planned, monitored, and evaluated. Movement by a resident that is incidental to dressing, bathing, etc. does not count as part of a formal restorative program. Staff must be trained in the procedures.

Splint or Brace Assistance (O0500C) – This includes verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or there is a scheduled program of applying and removing a splint or brace. The resident's skin and circulation under the device should be assessed and the limb repositioned in correct alignment.

The following activities include repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse.

Bed Mobility Training (O0500D) and/or walking training (O0500F)* – Bed Mobility – Activities provided to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side and position self in bed. Walking – Activities provided to improve or maintain the resident's self-performance in walking, with or without assistive devices.

Transfer Training (O0500E) – Activities provided to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

Dressing and/or grooming training (O0500G) – Activities provided to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

Eating and/or swallowing training (O0500H) – Activities provided to improve or maintain the resident's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

Amputation/Prosthesis (O0500I) – Activities provided to improve or maintain the resident's self-performance in putting on and removing prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prostheses attaches to the body.

Communication training (O0500J) – Activities provided to improve or maintain the resident's self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

No count days required for current toileting program or trail (H0200C) and/or Bowel training program (H0500)* – This is a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing facility's policies and procedures and current standards of practice. The program is based on an assessment of the resident's unique voiding pattern. The individualized program requires notations of the resident's response to the program and subsequent evaluations as needed. It does not include simply tracking continence status, changing pads or wet garments, and random assistance with toileting or hygiene.

*Count as one service even if both are provided.

m) Cognitive Impairment – Additional Scoring Indicators
Cognitive impairment is determined by either the summary score from the resident interview in Section C0200-C0400 (BIMS) or from the calculation of Cognitive Performance Scale if the BIMS is not conducted.

Brief Interview for Mental Status (BIMS)
BIMS summary score (C0500 ≥ 9)

n) Cognitive Performance Scale – Additional Scoring Indicators

Cognitive Performance Scale is based off staff assessment. The RUG-IV Cognitive Performance Scale (CPS) is used to determine cognitive impairment. The resident is cognitively impaired if one of the three following conditions exists.
B0100 Coma (B0100 = 1) and completely ADL dependent or ADL did not occur (G0110A1, G0110B1, G0110H1, G0110I1 all = 4 or 8)

C1000 Severely impaired cognitive skills (C1000 = 3)

B0700, C0700, C1000 Two or more of the following impairment indicators are present:
B0700 > 0 Problem being understood
C0700 = 1 Short term memory problem
C1000 > 0 Cognitive skills problem
And
One or more of the following severe impairment indicators are present:
B0700 ≥ 2 Severe problem being understood

C1000 ≥ 2 Severe cognitive skills problem

(Source: Old Section 147.330 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.330 added at 38 Ill. Reg. _____, effective _____)

Section 147.335 Enhanced Care Rates~~Specialized Care – Behavioral Emergencies (Repealed)~~

An additional enhance rate is applied for certain categories of residents that are in need of more resources.

a) Ventilator Services – The following criteria shall be met to be eligible for enhanced rates.

1) Ventilators are defined as any type of electrical or pneumatically powered closed mechanical system for residents who are, or who may become, unable to support their own respiration. It does not include Continuous

Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BiPAP) devices. When ventilators are used to deliver CPAP or BiPAP they shall not be counted as ventilator services for enhanced rates.

2) Ventilators set to PEEP or CPAP to aid in weaning a resident from the ventilator are included. The weaning process shall be documented in the clinical record. Ventilators used to deliver CPAP or BiPAP services for the resident with Sleep Apnea are not included.

3) Nursing facility shall notify the Department using a Department designated form that includes a physician order sheet that identifies the need and delivery of ventilator services. A facility shall also use the designated form to notify the Department when a resident is no longer receiving ventilator services. In addition, a Section S item response of the MDS may be used.

4) The following criteria shall be met in order for a facility to qualify for ventilator care reimbursement.

A) A facility shall establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.

B) Facilities shall be equipped with technology that enables it to meet the respiratory therapy, mobility and comfort needs of its patients.

C) Clinical assessment of oxygenation and ventilation-arterial blood gases or other methods of monitoring carbon dioxide and oxygenation shall be available on-site for the management of residents. Documentation shall support clinical monitoring of oxygenation stability was completed at least twice a day.

D) Emergency and life support equipment, including mechanical ventilators, shall be connected to electrical outlets with back-up generator power in the event of a power failure.

E) Ventilators shall be equipped with internal batteries to provide a short term back-up system in case of a total loss of power.

F) An audible, redundant ventilator alarm system shall be required to alert staff of a ventilator malfunction, failure or resident disconnect. A back-up ventilator shall be available at all times.

G) Facilities licensed under the Nursing Home Care Act shall have a minimum of one RN on duty for 8 consecutive hours, 7 days per week, as required by 77 Ill. Adm. Code 300.1240. For facilities licensed under the Hospital Licensing Act, an RN shall be on duty at all times, as required by 77 Ill. Adm. Code 250.910. Additional RN staff may be determined necessary by the Department, based on the Department's review of the ventilator services.

H) Licensed nursing staff shall be on duty in sufficient numbers to meet the needs of residents as required by 77 Ill. Adm. Code 300.1230. For facilities licensed under the Nursing Home Care Act, the Department requires that an RN shall be on call, if not on duty, at all times.

I) No less than one licensed respiratory care practitioner licensed in Illinois shall be available at the facility or on call 24-hours a day to provide care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing as determined by the needs and number of the residents being served by a facility. The practitioner shall evaluate and document the respiratory status of a ventilator resident on no less than a weekly basis.

J) A pulmonologist, or physician experienced in the management of ventilator care, shall direct the care plan for ventilator residents on no less than a twice per week basis.

K) At least one of the full-time licensed nursing staff members shall have successfully completed a course in the care of ventilator dependent individuals and the use of the ventilators, conducted and documented by a licensed respiratory care practitioner or a qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals.

L) All staff caring for ventilator dependent residents shall have documented in-service training in ventilator care prior to providing such care. In-service training shall be conducted at least annually by a licensed respiratory care practitioner or qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals. Training shall include, but is not limited to, status and needs of the resident, infection control techniques, communicating with the ventilator resident, and assisting the resident with activities. In-service training documentation shall include name and title of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.

M) Documentation shall support the resident has a health condition that requires medical supervision 24-hours a day of licensed nursing care and specialized services or equipment.

N) The medical records shall contain physician's orders for respiratory care that includes, but is not limited to, diagnosis, ventilator settings, tracheostomy care and suctioning, when applicable.

O) Documentation shall support the resident receive tracheostomy care at least daily.

5) To be eligible to receive ventilator add-on, facilities shall also be required to implement the established written protocols on the following areas:

A) Pressure Ulcers. A facility shall have established policies and procedures on assessing, monitoring and prevention of pressure ulcers, including development of a method of monitoring the occurrence of pressure ulcers. Staff shall receive in-service training on those areas.

i) Documentation shall support the resident has been assessed quarterly for their risk for developing pressure ulcers.

ii) Documentation shall support that interventions for pressure ulcer prevention were implemented and include, but are not limited to, a turning and repositioning schedule, use of

pressuring reducing devices, hydration and nutritional interventions and daily skin checks.

B) Pain. A facility shall have established policies and procedures on assessing the occurrence of pain, including development of a method of monitoring the occurrence of pain. Staff shall receive in-service training on this area.

i) Documentation shall support the resident has been assessed quarterly for the presence of pain and the risk factors for developing pain.

ii) Documentation shall support an effective pain management regime is in place for the resident.

C) Immobility. A facility shall have established policies and procedures to assess the possible effects of immobility. These shall include, but not be limited to, range of motion techniques, contracture risk. Staff shall receive in-service training on this area.

i) Documentation shall support the resident's risk for contractures were assessed quarterly and interventions are in place to reduce the risk.

ii) Effects of immobility will be monitored and interventions implemented as needed.

D) Risk of infection. A facility shall have established policies and procedures on assessing risk for developing infection and prevention techniques. These shall include, but are not limited to proper hand washing techniques, aseptic technique in delivery care to a resident, and proper care of equipment and supplies. Staff shall receive in-service training on this area.

i) Documentation shall support the resident was given oral care every shift to reduce the risk of infection.

ii) Documentation shall support the facility has a method to monitor and track infections.

E) Social Isolation. A facility shall have a method of assessing a resident's risk for social isolation. Interventions shall be in place to involve a resident in activities when possible.

F) Ventilator Weaning. A facility shall have a method of routinely assessing a resident's weaning potential and interventions implemented as needed. Documentation shall support the weaning process and the use of mechanical ventilation for a portion of each day for stabilization.

G) Policies shall include monitoring expectations of the ventilator resident, routine maintenance of equipment and specific staff training related to ventilator settings and care.

H) In order to maintain quality standards and reduce cross contamination, the facility shall have a policy for cleaning and maintaining equipment.

6) Department staff shall conduct on-site visits on a random or targeted basis to ensure both facility and resident compliance with requirements. All records shall be accessible to determine that the needs of a resident are being met and to determine the appropriateness of ventilator services. In addition to the requirements of this subsection, Department review shall include, at a minimum, the following:

A) The tracking of Ventilator Associated Pneumonia;

B) Documentation to track hospitalizations, reason for hospitalizations, and interventions aimed at reducing hospitalizations for ventilator residents;

C) Ventilator weaning;

7) An enhanced payment shall be added to the rate determined by the methodology currently in place:

A) Payment shall be made for each individual resident receiving ventilator services;

B) The rate add-on for ventilator services is $174 per day.

b) Traumatic Brain Injury (TBI) – The following criteria shall be met to be eligible for enhanced rates.

1) A facility shall meet all the criteria set forth in this subsection for TBI care to a resident in order to receive the enhanced TBI reimbursement rate identified.

2) TBI is a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical, and psychosocial functions, with an associated diminished or altered state of consciousness.

3) The following criteria shall be met in order for a facility to qualify for TBI reimbursement.

A) The facility shall have written policies and procedures for care of the residents with TBI and behaviors that include, but are not limited to, monitoring for behaviors, identification and reduction of agitation, safe and effective interventions for behaviors, and assessment of risk factors for behaviors related to safety of residents, staff and staff shall be in-serviced on these policies.

B) The facility shall have staff to complete the required physical (PT), occupational (OT) or speech therapy (SP), as needed. Additionally, a facility shall have staffing sufficient to meet the behavior, physical and psychosocial needs of the resident.

C) Staff shall receive in-service for the care of a TBI resident and dealing with behavior issues identifying and reducing agitation, and rehabilitation for the TBI resident. In-service training shall be conducted at least annually. In-service documentation shall include name and title of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.

D) The facility environment shall be such that it is aimed at reducing distractions for the TBI resident during activities and therapies. This shall include, but not be limited to, avoiding overcrowding, loud noises, lack of privacy, seclusion and social isolation.

E) Care plans on all residents shall address the physical, behavioral and psychosocial needs of the TBI residents. Care plans shall be individualized to meet the resident's needs, and shall be revised as necessary.

F) The facility shall use the "Rancho Los Amigos Cognitive Scale" to determine the level of cognitive functioning. The assessment shall be completed quarterly by a trained rehabilitation registered nurse. Based on the level of functioning, and the services and interventions implemented, a resident will be placed in 1 of 3 tiers of payments. Tier 3 is the highest reimbursement. By completing a Department designated form, facilities will be responsible for notifying the Department of the applicable tier in which a resident is placed.

G) Documentation found elsewhere in the resident records shall support the scoring on the Rancho Los Amigos Scale as well as the delivery of coded interventions.

4) Admission Criteria

A) Documentation by a neurologist that the resident has a severe and extensive TBI diagnosis.

B) The diagnosis meets RAI Manual requirements for coding.

C) There shall be documentation the diagnosis has resulted in significant deficits and disabilities that required intense rehabilitation therapy. In addition, documentation from the neurologist shall identify the resident has the ability to benefit from rehabilitation and a potential for independent living.

D) Diagnostic testing shall support the presence of a severe and extensive TBI as a result of external force as defined in subsection (b)(2).

E) Documentation the resident was assessed using the Rancho Los Amigos Cognitive Scale and scored a Level IV-X. Residents scoring a Level I, II or III on the Rancho Los Amigos Cognitive Scale shall not be eligible for TBI reimbursement.

F) Documentation the resident is medically stable and has been assessed for potential behaviors and safety risk to self, staff and others.

5) Documentation supports the Tier I requirements are as follows:

A) Tier I shall not exceed 6 months.

B) The resident shall have previously scored in Tier II or Tier III.

C) The resident has received intensive rehabilitation and is preparing for discharge to the community. The resident shall receive intervention and training focusing on independent living skills, prevocational training and employment support. This includes, but is not limited to, community support options, substance abuse counseling, as appropriate, time management and goal setting.

D) Resident scores a Level VIII-X on the Rancho Los Amigos Cognitive Scale (Purposeful, Appropriate, and stand-by assistance to Modified Independence).

E) No behaviors or Behaviors present, but less than 4 days (E0200A-C<2 AND E0500A-C=0 AND E0800< 2 and E1000A+B=0). If behaviors are present, resident receives behavior management training to address the specific behaviors identified.

F) Cognitive- Brief Interview for Mental Status (BIMS) is 13-15 (Cognitively intact, C0500).

G) Activities of daily living (ADL) functioning. All ADL tasks shall be coded less than 3 (Section G).

H) An assessment shall be completed quarterly to identify the resident's needs and risk factors related to independent living. This assessment shall include, but is not limited to, physical development and mobility, communication skills, cognition level, food preparation and eating behaviors, personal hygiene and grooming, health and safety issues, social and behavioral issues, ADL potential with household chores, transportation, vocational skills and money management.

I) Discharge Potential. There is an active discharge plan in place (Q0400A=1) or referral has been made to the local contact agency (Q0600=1). There shall be weekly documentation by a licensed social worker related to discharge potential and progress. This shall include working with the resident on community resources and prevocational employment options.

J) The resident shall receive interventions and/or training related to their specific discharge needs.

6) Documentation supports the Tier II requirements are as follows:

A) Tier II shall not exceed 12 months.

B) Resident has reached a plateau in rehabilitation ability, but still requires services related to the TBI. Resident shall have previously scored in Tier III. The resident continues to receive restorative nursing services.

C) Resident scores a Level IV-VII on the Rancho Los Amigos Cognitive Scale (Confusion, may or may not be appropriate).

D) Cognition. BIMS is less than 13 (C0500) or Cognitive Skills for decision making are moderately to severely impaired (C1000=2 or 3).

E) Resident has behaviors (E0300=1 or E1000=1) and these behaviors impact resident (E0500A-C=1) or impact others (E0600A-C=1). Behaviors shall be tracked daily and interventions implemented. There shall be documentation of weekly meetings with interdisciplinary staff to discuss behaviors, effectiveness of interventions and to implement revisions as necessary.

F) ADL function (Section G) 3 or more ADL require limited or extensive assistance.

G) Resident is on 2 or more of the following restorative: Bed Mobility (O0500D=1), Transfer (O0500E=1), Walking (O0500F=1), Dressing/Grooming (O0500G=1), Eating (O0500H=1) or Communication (O0500J=1).

H) Resident receives either Psychological (O0400E2>1) or Recreational Therapy (O0400F2>1) at least 2 or more days a week. Documentation shall include a summary of the sessions, resident's progress and potential goals, and identify any revisions needed.

I) Documentation shall support one to one meeting with a licensed social worker at least twice a week to discuss potential needs, goals and any behavior issues.

J) Documentation of at least quarterly oversight of care plan by a neurologist.

K) Documentation the resident has received instruction and training at least twice per week that includes, but is not limited to, behavior modification, anger management, time management goal setting, life skills and social skills.

L) Behavioral rehabilitation assessment and evaluations shall be completed quarterly and shall include cognition, behaviors, interventions and outcomes.

M) Documentation shall support the residents requires intensive counseling, behavioral management and neuro-cognitive therapy. The resident behaves in such a manner as to indicate an inability,

without ongoing supervision and assistance of others, they would be unable to satisfy the need for nourishment, personal care, medical care, shelter, self-protection and safety.

7) Documentation supports the Tier III requirements are as follows:

A) Tier III shall not exceed 9 months.

B) The injury resulting in a TBI diagnosis must have occurred within the prior 6 months to score in Tier III.

C) Includes the acutely diagnosed resident with extensive deficits in physical functioning and identifies intensive rehabilitation needs.

D) Resident scores an IV-VII on the Rancho Los Amigos Cognitive Scale.

E) Cognition- BIMS is less than 13 (C0500) or Cognitive Skills for decision making are moderately to severely impaired (C1000=2 or 3).

F) Documentation shall support the facility is monitoring behaviors and has implemented interventions to identify the risk factors for behaviors and to reduce the occurrence of behaviors.

G) Resident receives Rehabilitation therapy (PT, OT or ST) at least 500 minutes per week and at least one rehabilitation discipline 5 days per week (O0400). The therapy shall meet the RAI Manual guidelines for coding. The resident shall continue to show the potential for improvement in the therapy programs.

H) The facility shall have trained rehabilitation staff on-site working with the resident on a daily basis. This shall include a trained rehabilitation nurse and rehabilitation aides. The resident requires a minimum of 6 to 8 hours per day of one-to-one support as a result of functional issues.

I) Documentation shall support there are weekly meetings of the interdisciplinary team to discuss the resident's rehabilitation progress and potential.

J) Resident receives Psychological Therapy (O0400E2>1) at least 2 days per week. Documentation shall include a summary of the sessions, resident's progress and potential goals, and identify any revisions needed.

K) There shall be documentation to support monthly oversight by a neurologist.

L) A comprehensive medical and neuro-psychological assessment is done upon admission and quarterly. It shall include, but is not limited to, the following:

i) Physical ability and mobility;

ii) Motor coordination;

iii) Hearing, vision and speech;

iv) Behavior and impulse control;

v) Social functionality;

vi) Cognition;

vii) Safety and medical needs; and

viii) Communication needs.

8) Rates of payment for each Tier are as follows:

A) The payment amount for Tier I is $265.17 per day.

B) The payment amount for Tier II is $486.49 per day.

C) The payment amount for Tier III is $767.46 per day.

(Source: Old Section 147.335 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.335 added at 38 Ill. Reg. _____, effective _____)

Section 147.340 Minimum Data Set On-Site Reviews~~Discharge Planning (Repealed)~~

a) The Department shall conduct reviews to determine the accuracy of the resident assessment information transmitted in the Minimum Data Set (MDS) that are relevant to the determination of reimbursement rates. The MDS data used by the Department to set the reimbursement rate will be used to conduct the validation reviews. Such reviews may, at the discretion of the Department, be conducted electronically or onsite in the facility.

b) The Department may select, at random, a number of facilities in which to conduct quarterly on-site reviews.

c) The Department may also select facilities for on-site review based upon facility characteristics, atypical patterns of scoring MDS items, non-submission or late submission of assessments, high percentage of significant corrections, previous history of review changes, or the Department's experience. The Department may also use the findings of the licensing and certification survey conducted by the Department of Public Health (DPH) indicating the facility is not accurately assessing residents.

d) In addition, the Department may conduct reviews if the Department determines that circumstances exist that could alter or affect the validity of case mix classifications of residents. These circumstances include, but are not limited to, the following:

1) Frequent changes in administration or management of the facility;

2) An unusually high percentage of residents in a specific case mix classification or high percentage of change in the number of residents in a specific case mix classification;

3) Frequent adjustments of case mix classification as result of reconsiderations, reviews, or significant corrections submitted;

4) A criminal indictment alleging fraud; and

5) Other similar factors that relate to a facility's ability to conduct accurate assessments.

e) The Department shall provide for a program of delegated utilization review and quality assurance. The Department may contract with medical peer review organizations to provide utilization review and quality assurance.

f) Electronic review. The Department shall conduct quarterly an electronic review of MDS data for eligible individuals to identify facilities for on-site review.

g) On-site review. The Department shall conduct an on-site review of MDS data for eligible individuals. The Department is authorized to conduct unannounced on-site reviews. On-site reviews may include, but shall not be limited to, the following:

1) Review of the resident records and supporting documentation.

2) Observation and interviews of residents, families and/or staff, to determine the accuracy of data relevant to the determination of reimbursement rates.

3) Review and collection of information necessary to assess the resident's need for a specific service or care area.

h) The Department shall select at least 20 percent, with a minimum of 10 assessments, of the assessments submitted. The number of residents in any selected facility for whom information is reviewed may, at the sole discretion of the Department, be limited or expanded.

i) If more than 25 percent of the RUG-IV classifications are changed as a result of the initial review, the review may be expanded to a second 25 percent, with a minimum of 10 assessments. If the total changes between the first and second sample exceed 40 percent, the Department may expand the review to all the remaining assessments.

j) If the facility qualifies for an expanded review, the Department may review the facility again within 6 months. If a facility has 2 expanded reviews within a 24-month period, that facility may be subject to reviews every 6 months for the next

18 months and a penalty may be applied as defined in subsection (s) of this Section.

k) Pursuant to 89 Ill. Adm. Code 140.12(f), the facility shall provide Department staff with access to residents, professional and non-licensed direct care staff, facility assessors, clinical records and completed resident assessment instruments, as well as other documentation regarding the residents' care needs and treatments. Failure to provide timely access to records may result in suspension or termination of a facility's provider agreement in accordance with 89 Ill. Adm. Code 140.116(a)(4).

l) Department staff shall request in writing the current charts of individual residents needed to begin the review process. Current charts and completed MDS for the previous 15 months shall be provided to review team within an hour after the request. Additional documentation regarding reimbursement areas for the identified Assessment Reference Date (ARD) timeframe shall be provided to the review team within 4 hours after the initial request. The team will request no more than 2 records per reviewer to begin the review process. If the facility chooses to have HFS staff review the electronic health record, at least 2 computer terminals with read-only access will be made available to the review team within one hour. Within 4 hours after the team's arrival and for the remainder of the review, the facility shall provide a computer terminal for each reviewer or hard copies shall be provided.

m) When further documentation is needed by the review team to validate an area, the team shall identify the MDS item requiring additional documentation and provide the facility with the opportunity to produce that information. The facility shall provide the team with additional documentation within 24 hours after the initial request.

n) Facilities shall ensure that clinical records, regardless of form, are easily and readily accessible to Department staff.

o) Throughout the review, the Department shall identify to the facility any preliminary conclusions regarding the MDS items/areas that could not be validated. If the facility disagrees with those preliminary conclusions they shall present the Department with any and all documentation to support their position. It is up to the facility to determine what documentation is needed to support both

the Resident Assessment Instrument (RAI) Manual and rule requirements regarding the MDS items identified.

p) All documentation that is to be considered for validation must be provided to the team prior to exit. All RAI Manual requirements and requirements identified in this subsection shall be presented to validate the identified area.

q) Corrective Action. Upon conclusion of the review and the consideration of any subsequent supporting documentation provided by the facility, the Department shall notify the facility of its final conclusions, both with respect to accuracy of data and recalculation of the facility's reimbursement rate. The Department shall reclassify a resident if the Department determines that the resident was incorrectly classified.

r) Data Accuracy. Final conclusions with respect to inaccurate data may be referred to the appropriate agencies, including, but not limited to, the Department's Office of Inspector General, Illinois State Police or Department of Public Health.

s) Recalculation of Reimbursement Rate. The Department shall determine if the reported MDS data that was subsequently determined to be unverifiable would cause the direct care component of the facility's rate to be calculated differently when using the accurate data.

t) A facility's rate shall be subject to change if the recalculation of the direct care component rate, as a result of using RUGs-IV data that is verifiable:

1) Decreases the rate by more than one percent. The rate is to be changed, retroactive to the beginning of the rate period, to the recalculated rate.

2) Decreases the rate by more than 10 percent in addition to the rate change specified in this subsection (t). The direct care component of the rate may be reduced, retroactive to the beginning of the rate period, by $1.00 for each whole percentage decrease in excess of 2 percent.

u) Based on the areas identified as reclassified, the nursing facility may request that the Department reconsider the assigned classification. The request for reconsideration shall be submitted in writing to the Department within 30 days after the date of the Department's notice to the facility. The request for reconsideration shall include the name and address of the facility, the name of

each resident in which reconsideration is requested, the reasons for the reconsideration for each resident, and the requested classification changes for each resident based on the MDS items coded. In addition, a facility may offer explanations as to how they feel the documentation presented during the review supports their request for reconsideration. However, all documentation used to validate an area shall be submitted to the Department prior to exit. Documentation presented after exit will not be considered when determining a recalculation request. If the facility fails to provide the required information with the reconsideration request, or the request is not timely, the request shall be denied.

v) Reconsideration by the Department shall be made by individuals not directly involved in that facility review. The reconsideration shall be based upon the initial assessment documentation and the reconsideration information sent to the Department by the facility. The Department shall have 120 days after the date of the request for reconsideration to make a determination and notify the facility in writing of the final decision.

(Source: Old Section 147.340 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.340 added at 38 Ill. Reg. _____, effective _____)

Section 147.345 Quality Incentives~~Reimbursement for Program Costs in Nursing Facilities Providing Psychiatric Rehabilitation Services for Individuals with Mental Illness (Repealed)~~

Effective January 1, 2015, the Department shall allocate an amount for quality incentive payments. To establish baselines for these measures, the information shall be submitted beginning January 1, 2014. These measures may be included as part of the on-site reimbursement review. To receive the quality incentive payments for these measures, a facility shall meet the following criteria.

a) The Department shall allocate an amount for staff retention. To receive the quality incentive payment for this measure, the facility's staff retention rate shall meet or exceed the threshold established and published by the Department based upon statewide averages and must be at least 80 percent.

1) Retention relates to the extent to which an employer retains its employees and may be measured as the proportion of employees with a specified length of service expressed as a percentage of overall workforce numbers.

2) The staff retentions shall reflect the percentage of individuals employed by the facility on the last day of the previous calculation period who are still employed by the facility on the last day of the following calculation period.

3) Staff retention shall be calculated on a semiannual basis.

A) The June 30 calculation will be based on the percentage of full-time (defined as 30 or more hours per week) direct care staff employed by the nursing facility on January 1 and still employed by the nursing facility on June 30. The deadline for reporting this information shall be July 31. Direct care staff is defined as certified nursing assistants.

B) The December 31 calculation shall be based on the percentage of full-time direct care staff employed by the nursing facility on July 1 and still employed by the nursing facility on December 31. The deadline for reporting this information shall be January 31.

4) The staff retention rate is calculated using full-time direct care staff employed in a facility.

5) Documentation in the employee's record shall support the retention rate submitted.

6) Facilities shall submit the required information to the Department in a format designated by the Department.

b) The Department shall allocate an amount for consistent assignments. To receive the quality incentive payment for this measure, the facility shall meet the threshold established and published by the Department based upon statewide averages.

1) Consistent assignments shall be calculated on a semiannual basis. The deadline for reporting this information shall be July 31 and January 31, respectively.

2) The facility shall have a written policy that requires consistent assignment of certified nursing assistants and it shall specify a goal of limiting the

number of certified nursing assistants that provide care to a resident to no more than 8 certified nursing assistants per resident during a 30-day period.

3) Documentation shall support that no less than 85 perecent of Long Term Care residents received their care from no more than 8 different certified nursing assistants during a 30-day period.

4) There shall be evidence the policy has been communicated, and understood, to the staff, residents and family of residents.

5) Facilities shall submit the required information to the Department in a format designated by the Department.

c) The Department shall establish a center for Psychiatric Rehabilitation in Long Term Services and Support to organize and coordinate the provision of training on serious mental illness, psychiatric rehabilitation services and evidence-based informed practices.

(Source: Old Section 147.345 repealed at 26 Ill. Reg. 3093, effective February 15, 2002; new Section 147.345 added at 38 Ill. Reg. _____, effective _____)

Section 147.346 Appeals of Nursing Rate Determination

a) Appeals must be submitted in writing to the Department no later than 30 days after the date of the Department's notice to the facility of the rate calculation resulting from the on-site review. The revised rate shall be processed into the payment system 30 days after the date of the Department's notice in order to allow time for submission of appeals.

b) The appeal shall contain clear and relevant supportive documentation. The facility must succinctly address the area being appealed. Additional documentation not presented to the HFS review team during the review, or at the time of exit, will not be considered in the appeal process.

c) The Department will rule on all appeals within 120 days after the date of appeal, except in rare instances where the Department may require additional information from the facility. In this case, the response period may be extended.

d) The appeal and supportive documentation will go through several stages of review within the Department to ensure fairness, objectivity and consistency with the appeal determination. The rate resulting from the appeal determination will become effective the first day of the applicable quarter.

(Source: Added at 38 Ill. Reg. _____, effective _____)

Section 147.355 Reimbursement for Residents with Exceptional Needs (Repealed)

~~a) Pursuant to Public Act 96-1530, effective January 1, 2012, the Department of Healthcare and Family Services (HFS) shall allocate at least $8 million of the funds collected from the assessment identified in 89 Ill. Adm. Code 140.84 to develop and make enhanced payments to nursing facilities for services provided to residents with exceptional needs. For purposes of this Section, an exceptional need means ventilator care, tracheotomy care, bariatric care, complex wound care and traumatic brain injury (TBI) care. The break-out of the spending will be $2 million each for ventilator care and TBI as scored under the Minimum Data Set (MDS) 3.0, and $4 million for tracheotomy care, bariatric care, complex wound care and TBI supply costs as scored under the MDS 2.0.~~

~~b) Ventilator Care~~

~~1) Ventilators are defined as any type of electrical or pneumatically powered closed mechanical system for residents who are, or who may become, unable to support their own respiration. It does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices.~~

~~2) In order for an applicable rate to be assigned to a ventilator dependent resident, a nursing facility shall notify the Department using a Department designated form that includes a physician order sheet that identifies the need and delivery of ventilator services. A facility shall also use the designated form to notify the Department when a resident is no longer receiving ventilator services. The following criteria shall be met in order for a facility to qualify for ventilator care reimbursement.~~

~~3) A facility shall establish admission criteria to ensure the medical stability of patients prior to transfer from an acute care setting.~~

~~4) Facilities shall be equipped with technology that enables them to meet the respiratory therapy, mobility and comfort needs of their patients.~~

~~5) Clinical assessment of oxygenation and ventilation-arterial blood gases or other methods of monitoring carbon dioxide and oxygenation shall be available on-site for the management of residents.~~

~~6) Emergency and life support equipment, including mechanical ventilators, shall be connected to electrical outlets with back-up generator power in the event of a power failure.~~

~~7) Ventilators shall be equipped with internal batteries to provide a short back-up system in case of a total loss of power.~~

~~8) An audible, redundant ventilator alarm systems shall be required to alert caregivers of a ventilator malfunction, failure or resident disconnect. A back-up ventilator shall be available at all times.~~

~~9) Staffing~~

~~A) A minimum of one RN on duty on the day shift, seven days per week (as required by the Department of Public Health (DPH) in 77 Ill. Adm. Code 300.1240 or 250.910(e) and (f)(1), as appropriate). Additional RN staff may be determined necessary by HFS, based on the HFS review of the ventilator services.~~

~~B) A minimum of the required number of LPN staff (as required by DPH in 77 Ill. Adm. Code 300.1230 and 300.1240 or 250.910(e) and (f)(1), as appropriate), on duty, with an RN on call, if not on duty on the evening and night shifts, seven days per week.~~

~~C) No less than one licensed respiratory care practitioner licensed in Illinois shall be available at the facility or on call 24 hours a day to provide care, monitor life support systems, administer medical gases and aerosol medications, and perform diagnostic testing as determined by the needs and number of the residents being served by a facility. The practitioner shall evaluate and document the respiratory status of a ventilator resident on no less than a weekly basis.~~

~~D)~~ ~~A pulmonologist, or physician experienced in the management of ventilator care, shall direct the plan of care for ventilator residents on no less than a biweekly basis.~~

~~E)~~ ~~At least one of the full-time licensed nursing staff members shall have successfully completed a course in the care of ventilator dependent individuals and the use of ventilators, conducted and documented by a licensed respiratory care practitioner or a qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals.~~

~~F)~~ ~~All staff caring for ventilator dependent residents shall have documented in-service training in ventilator care prior to providing that care. In-service training shall be conducted at least annually by a licensed respiratory care practitioner or qualified registered nurse who has at least one-year experience in the care of ventilator dependent individuals. Training shall include, but is not limited to, status and needs of the resident, infection control techniques, communicating with the ventilator resident, and assisting the resident with activities. In-service training documentation shall include name and qualification of the in-service director, duration of the presentation, content of presentation, and signature and position description of all participants.~~

~~10)~~ ~~Facilities shall be required to have established protocols on the following areas:~~

~~A)~~ ~~Pressure Ulcers. A facility shall have established policies and procedures on assessing, monitoring and prevention of pressure ulcers, including development of a method of monitoring the occurrence of pressure ulcers. Staff shall receive in-service training on those areas.~~

~~i)~~ ~~Documentation shall support that the resident has been assessed quarterly for his or her risk for developing pressure ulcers.~~

~~ii) Interventions for pressure ulcer prevention shall be in place that include, but are not limited to, a turning and repositioning schedule, use of pressure reducing devices, hydration and nutritional interventions and daily skin checks.~~

~~B) Pain. A facility shall have established policies and procedures on assessing the occurrence of pain, including development of a method of monitoring the occurrence of pain. Staff shall receive in-service training on this area.~~

~~i) Documentation shall support that resident has been assessed quarterly for the presence of pain and the risk factors for developing pain.~~

~~ii) Documentation shall support that an effective pain management regime is in place for the resident.~~

~~C) Immobility. A facility shall have established policies and procedures to assess the possible effects of immobility and risk for developing infections. These shall include, but not be limited to, range of motion techniques, contracture risk, proper hand washing techniques, aseptic technique in delivering care to a resident and proper care of the equipment and supplies. Staff shall receive in-service training on those areas.~~

~~i) Documentation shall support that the resident's risk for contractures were assessed quarterly and interventions are in place to reduce the risk.~~

~~ii) Documentation shall support that the resident was given oral care every shift to reduce the risk of infection.~~

~~D) Social Isolation. A facility shall have a method of assessing a resident's risk for social isolation. Intervention shall be in place to involve a resident in activities when possible.~~

~~E) Ventilator Weaning. A facility shall have a method or routinely assessing a resident's weaning potential and interventions shall be implemented as needed.~~

~~11) HFS staff shall conduct on-site visits on a random and targeted basis to ensure both facility and resident compliance with identified requirements. All records shall be accessible to determine that the needs of a resident are being met and to determine the appropriateness of ventilator services. In addition to the requirements of this subsection (b)(11), HFS review shall include, but not be limited to, the following:~~

~~A) Ventilator Associated Pneumonia;~~

~~B) Ventilator Weaning;~~

~~C) Length of Stay and Hospital Discharge;~~

~~D) Length of Stay and Discharge Destination; and~~

~~E) Length of Stay and Death.~~

~~12) The enhanced payment shall be added to the rate determined by MDS 2.0:~~

~~A) Payment shall be made for each individual resident receiving ventilator services;~~

~~B) A rate for ventilator services shall be set based on geographic area for all facilities within that area; and~~

~~C) The rate shall include the facility specific support, capital and nursing components plus the geographic area average ventilator minutes from the MDS and $174 supply costs.~~

~~c) TBI~~

~~1) Any facility meeting the criteria set forth in this subsection (c) for TBI care serving individuals shall receive the enhanced TBI reimbursement rate identified. This rate is in lieu of the rate received under MDS 2.0 reimbursement, and the TBI add-on shall no longer apply.~~

~~2) TBI is a nondegenerative, noncongenital insult to the brain from an external mechanical force, possibly leading to permanent or temporary impairment of cognitive, physical and psychosocial functions, with an associated diminished or altered state of consciousness.~~

~~3) The following criteria shall be met in order for a facility to qualify for TBI reimbursement:~~

~~A) The facility shall have policies and procedures for care of the residents with TBI and associated behaviors that include, but are not limited to, monitoring for behaviors, identification and reduction of agitation, safe and effective interventions for behaviors, and assessment of risk factors for behaviors related to safety of residents, staff and others.~~

~~B) The facility shall have staff to complete the required physical (PT), occupational (OT) or speech (ST) therapy, as needed. Additionally, a facility shall have staffing sufficient to meet the behavior, physical and psychosocial needs of the resident.~~

~~C) Staff caring for a TBI resident shall receive in-service training for the care of a TBI resident and dealing with behavior issues, identifying and reducing agitation, and rehabilitation for the TBI resident. In-service training shall be conducted at least annually. In-service documentation shall include name and qualifications of the in-service director, duration of the presentation, content of presentation, and signature and position description of each participants.~~

~~D) The facility environment shall be such that it is aimed at reducing distractions for the TBI resident during activities and therapies. This shall include, but not be limited to, avoiding overcrowding, loud noises, lack of privacy, seclusion and social isolation.~~

~~E) Care plans on all residents shall address the physical, behavioral and psychosocial needs of the TBI residents. Care plans shall be individualized to meet the resident's needs and shall be revised as necessary.~~

~~F) The facility shall use the Rancho Los Amigos Cognitive Scale (Rancho) to determine the level of cognitive functioning. The assessment shall be completed quarterly by a trained rehabilitation registered nurse. Based on the level of functioning, and the services and interventions implemented, a resident will fall into one of three tiers of payments, tier 3 being the highest reimbursement. By completing a Department designated form, facilities will be responsible for notifying the Department of the applicable tier into which a resident falls.~~

~~G) Documentation found elsewhere in the resident records shall support the scoring on the Rancho assessment, as well as the delivery of coded interventions.~~

~~4) Admission Criteria~~

~~A) Documentation by a neurologist that the resident has a TBI diagnosis on the MDS 3.0 (I5500=1) that meets the RAI requirements for coding. In addition, documentation from the neurologist shall identify that the resident has the ability to benefit from rehabilitation and a potential for independent living.~~

~~B) Documentation that the resident was assessed using the Rancho Los Amigos Cognitive Assessment and scored a Level IV-X. Residents scoring a Level I, II or III on the Rancho assessment shall not be eligible for TBI reimbursement.~~

~~C) Documentation that the resident is medically stable and has been assessed for potential behaviors and safety risk to self, staff and others.~~

~~5) Tier I requirements are as follows:~~

~~A) The payment amount is $264.17 per day, and shall not exceed six months.~~

~~B) The resident must have previously scored in Tier II or Tier III.~~

~~C)~~ ~~Includes residents who have received intensive rehabilitation and are preparing for discharge to the community. The resident shall receive instructions focusing on independent living skills, prevocational training and employment support.~~

~~D)~~ ~~Resident scores a Level VIII-X on the Rancho Los Amigos Cognitive Scale (Purposeful, Appropriate, and stand-by assistance to Modified Independence).~~

~~E)~~ ~~No behaviors or behaviors present, but less than 4 days (E0200A-C<2 AND E0500A-C=0 AND E0800=2 and E1000A+B=0 on the MDS 3.0).~~

~~F)~~ ~~Cognitive-Brief Interview for Mental Status (BIMS) is 13-15 (Cognitively intact, C0500 on MDS 3.0).~~

~~G)~~ ~~Activities of daily living (ADL) functioning. All ADL tasks shall be coded less than 3 (Section G on MDS 3.0).~~

~~H)~~ ~~An assessment shall be completed to identify the resident's needs and risk factors related to independent living. This assessment shall include, but is not limited to, physical development and mobility, communication skills, cognition level, food preparation and eating behaviors, personal hygiene/grooming, health/safety issues, social/behavioral issues, ADL potential with household chores, transportation, vocational skills and money management.~~

~~I)~~ ~~Discharge potential. There is an active discharge plan in place (Q0400A=1 on MDS 3.0) or referral has been made to the local contact agency (Q0600=1 on MDS 3.0). There shall be weekly documentation by a licensed social worker related to discharge potential and progress.~~

~~6)~~ ~~Tier II requirements are as follows:~~

~~A)~~ ~~The payment amount is $486.49 per day, and shall not exceed 12 months.~~

~~B) Includes residents who have reached a plateau in rehabilitation ability, but still require services related to the TBI. Resident must have previously scored in Tier III.~~

~~C) Resident scores a Level IV-VII on the Rancho Los Amigos Cognitive Scale (Confusion, may or may not be appropriate).~~

~~D) Cognition. BIMS is less than 13 (C0500 on MDS 3.0) or Cognitive Skills for decision making are moderately to severely impaired (C1000=2 or 3 on MDS 3.0).~~

~~E) Resident has behaviors (E0300=1 or E1000=1 on MDS 3.0) and these behaviors impact resident (E0500A-C=1) or impact others (E0600A-C=1). Behaviors shall be tracked daily and interventions implemented as needed. There shall be documentation of weekly meetings with interdisciplinary staff to discuss behaviors, effectiveness of interventions and implementation of revisions as necessary.~~

~~F) ADL function (Section G on MDS 3.0) 3 or more ADLs requires limited or extensive assistance.~~

~~G) Resident is on 2 or more of the following restoratives: Bed Mobility (O0500D=1 on MDS 3.0), Transfer (O0500E=1 on MDS 3.0), Walking (O0500F=1 on MDS 3.0), Dressing/Grooming (O0500G=1 on MDS 3.0), Eating (O0500H=1 on MDS 3.0) or Communication (O0500J=1 on MDS 3.0).~~

~~H) Resident receives either Psychological (O0400E2>1 on MDS 3.0) or Recreational Therapy (O0400F2>1 on MDS 3.0) at least two or more days a week.~~

~~I) Documentation shall support that a one-on-one meeting with a licensed social worker is held at least twice a week to discuss potential needs, goals and any behavior issues.~~

~~J) At least quarterly oversight of plan of care by a neurologist.~~

~~K)~~ ~~Documentation that the resident has received instruction and training that includes, but is not limited to, behavior modification, anger management, time management, goal setting, life skills and social skills.~~

~~7)~~ ~~Tier III requirements are as follows.~~

~~A)~~ ~~The payment amount is $767.46 per day and shall not exceed nine months.~~

~~B)~~ ~~The injury resulting in a TBI diagnosis must have occurred within the prior six months to score in Tier III.~~

~~C)~~ ~~Includes the acutely diagnosed resident with high rehabilitation needs.~~

~~D)~~ ~~Resident scores a Level IV-VII on the Rancho LOS Amigos Cognitive Scale.~~

~~E)~~ ~~Cognition-BIMS is less than 13 (C0500 on the MDS 3.0) or Cognitive Skills for decision making are moderately to severely impaired (C1000=2 or 3 on MDS 3.0).~~

~~F)~~ ~~Documentation shall support that the facility is monitoring behaviors and has implemented interventions to identify the risk factors for behaviors and to reduce the occurrence of behaviors.~~

~~G)~~ ~~Resident receives Rehabilitation Therapy (PT, OT or ST) at least 500 minutes per week and at least 1 rehab discipline 5 days/week (O400 on MDS 3.0). The therapy shall meet the RAI guidelines for coding.~~

~~H)~~ ~~The facility shall have trained rehab staff on site working with the resident on a daily basis. This shall include a trained rehab nurse and rehab aides.~~

~~I)~~ ~~Documentation shall support that there are weekly meetings of the interdisciplinary team to discuss the resident's rehab progress and potential.~~

~~J) Resident receives Psychological Therapy (O0400E2>1 on MDS 3.0) at least 2 days per week.~~

~~K) There shall be documentation to support monthly oversight by a neurologist.~~

~~d) Other Exceptional Need Services~~

~~1) Facilities scoring tracheotomy care, bariatric care, complex wound care and TBI on MDS 2.0 shall receive an additional add-on for supply costs associated with providing those services.~~

~~2) Following are the per diem add-ons for the four services identified in subsection (d)(1).~~

~~A) Tracheotomy Care – $8.80~~

~~B) Bariatric Care – $1.00~~

~~C) Complex Wound Care – $8.80~~

~~D) TBI – $8.80~~

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 147.TABLE A Staff Time (in Minutes) and Allocation by Need Level (Repealed)

~~a) Effective July 1, 2003, each Medicare and Medicaid certified nursing facility shall complete, and transmit quarterly to the Department, a full Minimum Data Set (MDS) for each resident who resides in a certified bed, regardless of payment source. A description of the MDS items referenced in the tables found following subsection (e) of this Table A are contained in the Long Term Care Resident Assessment Instrument User's Manual available from the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244 (December 2002).~~

~~b) Table A identifies MDS items that shall be used to calculate a profile on each Medicaid-eligible resident within each facility.~~

~~c) The profile for each Medicaid-eligible resident shall then be blended to determine the nursing component of the nursing facility's Medicaid rate.~~

~~d) Each MDS item in Table A includes a description of the item and the variable time referred to in Section 147.150(c)(1). The variable time assigned to each level represents the type of staff that should be delivering the service (unlicensed, licensed, social worker and activity) and the number of minutes allotted to that service item.~~

~~e) Following is a listing of the reimbursable MDS items found in Table A.~~

~~1) Base Social Work and Activity~~

~~2) Activities of Daily Living (ADL)~~

~~3) Restorative Programs~~

~~PROM/AROM~~

~~Splint/Brace~~

~~Bed Mobility~~

~~Mobility/Transfer~~

~~Walking~~

~~Dressing/Grooming~~

~~Eating~~

~~Prosthetic Care~~

~~Communication~~

~~Other Restorative~~

~~Scheduled Toileting~~

~~4) Medical Services~~

~~Continence Care~~

~~Catheter Care~~

~~Bladder Retraining~~

~~Pressure Ulcer Prevention~~

~~Moderate Skin Care Services~~

~~Intensive Skin Care Services~~

~~Ostomy Care~~

~~IV Therapy~~

~~Injections~~

~~Oxygen Therapy~~

~~Chemotherapy~~

~~Dialysis~~

~~Blood Glucose Monitoring~~

~~End Stage Care~~

~~Infectious Disease~~

~~Acute Medical Conditions~~

~~Pain Management~~

~~Discharge Planning~~

~~Nutrition~~

~~Hydration~~

~~5) Mental Health (MH) Services~~

~~Psychosocial Adaptation~~

~~Psychotropic Medication Monitoring~~

~~Psychiatric Services (Section S)~~

~~Skills Training~~

~~Close or Constant Observation~~

~~6) Dementia Services~~

~~Cognitive Impairment/Memory Assistance~~

~~Dementia Care Unit~~

~~7) Exceptional Care Services~~

~~Extensive Respiratory Services~~

~~Total Weaning From Ventilator~~

~~Morbid Obesity~~

~~Complex Wound Care~~

~~Traumatic Brain Injury (TBI)~~

~~8) Special Patient Need Factors:~~

~~Communication: add 1% of staff time accrued for ADLs through Exceptional Care Services~~

~~Vision Problems: add 2% of staff time accrued for ADLs through Exceptional Care Services~~

~~Accident/Fall Prevention: add 3% of staff time accrued for ADLs through Exceptional Care Services~~

~~Restraint Free Care: add 2% of staff time accrued for ADLs through Exceptional Care Services~~

~~Activities: add 2% of staff time accrued for ADLs through Exceptional Care Services~~

~~**MDS ITEMS AND ASSOCIATED STAFF TIMES**~~

~~Throughout Table A, where multiple levels are identified, only the highest level shall be scored.~~

~~**1) Base Social Work and Activity**~~

~~Level~~		~~Unlicensed~~	~~Licensed~~	~~Social Worker~~	~~Activity~~
~~I~~	~~All Clients~~	~~0~~	~~0~~	~~5~~	~~10~~

~~**2) Activities of Daily Living**~~

~~Documentation shall support the following for scoring Activities of Daily Living.~~

~~1) Coding of Section G, Physical Functioning, and Structural Problems on the MDS during the look-back period.~~

~~2) MDS coded level of resident self-performance and support has been met.~~

~~3) When there is a widespread lack of supporting documentation as described in subsections (1) and (2) of this item **(2)**, the ADL scores for the residents lacking documentation will be reset to zero.~~

~~4) When there is an occasional absence of documentation for residents in the sample, ADL scores will be based on the observation and/or interview of the resident and facility staff at the time of the review. If the resident has been discharged and there is no documentation to support the ADL coding, ADL scores will be reset to one.~~

~~Level~~	~~Composite Scores~~	~~Unlicensed~~	~~Licensed~~	~~Social Worker~~	~~Activity~~
~~I~~	~~Composite 7-8~~	~~50~~	~~7.5 RN~~ ~~7.5 LPN~~		
~~II~~	~~Composite 9-11~~	~~62~~	~~9.5 RN~~ ~~9.5 LPN~~		
~~III~~	~~Composite 12-14~~	~~69~~	~~10.5 RN~~ ~~10.5 LPN~~		
~~IV~~	~~Composite 15-29~~	~~85~~	~~12.5 RN~~ ~~12.5 LPN~~		

~~**ADL Scoring Chart for the above Composite Levels**~~

~~MDS values equal to "-" denote missing data.~~

~~ADL~~	~~MDS items~~	~~Description~~	~~Score~~
~~Bed Mobility~~	~~G1aA = - or~~ ~~G1aA = 0 or~~ ~~G1aA = 1.~~	~~Self-Performance = missing~~ ~~Self-Performance = independent~~ ~~Self-Performance = supervision~~	~~1~~
	~~G1aA = 2.~~	~~Self-Performance = limited assistance~~	~~3~~

	~~G1aA = 3 or~~ ~~G1aA = 4 or~~ ~~G1aA = 8 AND~~ ~~G1aB = - or~~ ~~G1aB = 0 or~~ ~~G1aB = 1 or~~ ~~G1aB = 2.~~ ~~G1aB = 3 or~~ ~~G1aB = 8.~~	~~Self-Performance = extensive assistance~~ ~~Self-Performance = total dependence~~ ~~Self-Performance = activity did not occur~~ ~~Support = missing~~ ~~Support = no set up or physical help~~ ~~Support = set up help only~~ ~~Support = 1 person assist~~ ~~Support = 2+ person physical assist~~ ~~Support = activity did not occur~~	~~4~~ ~~5~~
~~Transfer~~	~~G1bA = - or~~ ~~G1bA = 0 or~~ ~~G1bA = 1.~~ ~~G1bA = 2.~~ ~~G1bA = 3 or~~ ~~G1bA = 4 or~~ ~~G1bA = 8 AND~~ ~~G1bB = - or~~ ~~G1bB = 0 or~~ ~~G1bB = 1 or~~ ~~G1bB = 2.~~ ~~G1bB = 3 or~~ ~~G1bB = 8.~~	~~Self-Performance = missing~~ ~~Self-Performance = independent~~ ~~Self-Performance = supervision~~ ~~Self-Performance = limited assistance~~ ~~Self-Performance = extensive assistance~~ ~~Self-Performance = total dependence~~ ~~Self-Performance = activity did not occur~~ ~~Support = missing~~ ~~Support = no set up or physical help~~ ~~Support = set up help only~~ ~~Support = 1 person assist~~ ~~Support = 2+ person physical assist~~ ~~Support = activity did not occur~~	~~1~~ ~~3~~ ~~4~~ ~~5~~
~~Locomotion~~	~~G1eA = - or~~ ~~G1eA = 0 or~~ ~~G1eA = 1.~~ ~~G1eA = 2.~~	~~Self-Performance = missing~~ ~~Self-Performance = independent~~ ~~Self-Performance = supervision~~ ~~Self-Performance = limited assistance~~	~~1~~ ~~3~~

	~~G1eA = 3 or~~ ~~G1eA = 4 or~~ ~~G1eA = 8 AND~~ ~~G1eB = - or~~ ~~G1eB = 0 or~~ ~~G1eB = 1 or~~ ~~G1eB = 2.~~ ~~G1eB = 3 or~~ ~~G1eB = 8.~~	~~Self-Performance = extensive assistance~~ ~~Self-Performance = total dependence~~ ~~Self-Performance = activity did not occur~~ ~~Support = missing~~ ~~Support = no set up or physical help~~ ~~Support = set up help only~~ ~~Support = 1 person assist~~ ~~Support = 2+ person physical assist~~ ~~Support = activity did not occur~~	~~4~~ ~~5~~

~~Toilet~~	~~G1iA = - or~~ ~~G1iA = 0 or~~ ~~G1iA = 1.~~ ~~G1iA = 2.~~ ~~G1iA = 3 or~~ ~~G1iA = 4 or~~ ~~G1iA = 8 AND~~ ~~G1iB = - or~~ ~~G1iB = 0 or~~ ~~G1iB = 1 or~~ ~~G1iB = 2.~~ ~~G1iB = 3 or~~ ~~G1iB = 8.~~	~~Self-Performance = missing~~ ~~Self-Performance = independent~~ ~~Self-Performance = supervision~~ ~~Self-Performance = limited assistance~~ ~~Self-Performance = extensive assistance~~ ~~Self-Performance = total dependence~~ ~~Self-Performance = activity did not occur~~ ~~Support = missing~~ ~~Support = no set up or physical help~~ ~~Support = set up help only~~ ~~Support = 1 person assist~~ ~~Support = 2+ person physical assist~~ ~~Support = activity did not occur~~	~~1~~ ~~3~~ ~~4~~ ~~5~~

~~Dressing~~	~~G1gA = - or~~ ~~G1gA = 0 or~~ ~~G1gA = 1.~~ ~~G1gA = 2.~~ ~~G1gA = 3 or~~ ~~G1gA = 4 or~~ ~~G1gA = 8.~~	~~Self-Performance = missing~~ ~~Self-Performance = independent~~ ~~Self-Performance = supervision~~ ~~Self-Performance = limited assistance~~ ~~Self-Performance = extensive assistance~~ ~~Self-Performance = total dependence~~ ~~Self-Performance = activity did not occur~~	~~1~~ ~~2~~ ~~3~~

~~Hygiene~~	~~G1jA = - or~~ ~~G1jA = 0 or~~ ~~G1jA = 1.~~	~~Self-Performance = missing~~ ~~Self-Performance = independent~~ ~~Self-Performance = supervision~~	~~1~~
	~~G1jA = 2.~~	~~Self-Performance = limited assistance~~	~~2~~
	~~G1jA = 3 or~~ ~~G1jA = 4 or~~ ~~G1jA = 8.~~	~~Self-Performance = extensive assistance~~ ~~Self-Performance = total dependence~~ ~~Self-Performance = activity did not occur~~	~~3~~

~~Eating~~	~~G1hA = - or~~ ~~G1hA = 0 or~~ ~~G1hA = 1.~~	~~Self-Performance = missing~~ ~~Self-Performance = independent~~ ~~Self-Performance = supervision~~	~~1~~
	~~G1hA = 2.~~	~~Self-Performance = limited assistance~~	~~2~~
	~~G1hA = 3 or~~ ~~G1hA = 4 or~~ ~~G1hA = 8~~	~~Self-Performance = extensive assistance~~ ~~Self-Performance = total dependence~~ ~~Self-Performance = activity did not occur~~	~~3~~
	~~Or~~		
	~~K5a = 1 or~~ ~~K5b = 1 and~~ ~~Intake = 1~~	~~Parenteral/IV in last 7 days~~ ~~Tube feeding in last 7 days~~ ~~See below~~	
	~~Where~~		
	~~Intake = 1 if~~		
	~~K6a = 3 or~~	~~Parenteral/enteral intake 51-75% of total calories~~	
	~~K6a = 4~~	~~Parenteral/enteral intake 76-100% of total calories~~	
	~~Or Intake = 1 if~~		
	~~K6a = 2 and~~	~~Parenteral/enteral intake 26-50% of total calories~~	
	~~K6b = 2 or~~	~~Average fluid intake by IV or tube is 501-1000 cc/day~~	

	~~K6b = 3 or~~ ~~K6b = 4 or~~ ~~K6b = 5.~~	~~Average fluid intake by IV or tube is 1001-1500 cc/day~~ ~~Average fluid intake by IV or tube is 1501-2000 cc/day~~ ~~Average fluid intake by IV or tube is 2001 or more cc/day~~	

~~3)~~ ~~**Restorative Programs**~~

~~With the exception of amputation/prosthesis care and splint or brace assistance restoratives, the total number of restorative programs eligible for reimbursement shall be limited to four, with no more than three being a Level II restorative. Scheduled toileting shall be included in this limit. Splint or brace assistance and amputation/prosthesis care shall be reimbursed independently. A resident coded in I1t (CVA/stroke), I1v (hemiplegia/hemiparesis), I1w (Multiple Sclerosis), I1x (paraplegia) or I1cc (Traumatic Brain Injury) on the MDS and also coded as B4≤2 (cognitive skills for decision making) shall be limited to a total of six restoratives with no more than four being a Level II restorative. A Department designed assessment shall be required quarterly to assess the resident's endurance and the resident's ability to benefit from two or more restorative programs.~~

~~For the following restorative programs: bed mobility, mobility/transfer, walking, dressing/grooming, and eating, when the corresponding ADL is coded a "1" under self-performance on the current MDS, the previous MDS must have a code of greater than "1" to qualify for reimbursement.~~

~~If PROM is scored, AROM is reset to zero unless the resident has a diagnosis of CVA, hemiplegia/hemiparesis, multiple sclerosis, paraplegia or traumatic brain injury.~~

~~When the number of restoratives coded on the MDS exceeds the allowable limits for reimbursement, the following order shall be used.~~

~~A)~~ ~~Eating Restorative~~

~~B)~~ ~~Scheduled Toileting~~

~~C)~~ ~~Walking Restorative~~

~~D)~~ ~~Transfer Restorative~~

~~E) PROM/AROM~~

~~F) Bed Mobility Restorative~~

~~G) Communication Restorative~~

~~H) Dressing/Grooming Restorative~~

~~I) Other Restorative~~

~~Restorative Services are programs under the direction and supervision of a licensed nurse and are provided by nursing staff. The programs are designed to promote the resident's ability to adapt and adjust to living as independently and safely as possible. The focus is on achieving and/or maintaining optimal physical, mental, and psychosocial functioning. A program is defined as a specific approach that is organized, planned, documented, monitored, and evaluated. Although therapists may participate in designing the initial program, members of nursing staff are still responsible for the overall coordination and supervision of restorative nursing programs. Staff completing the programs should be communicating progress, maintenance, regression and other issues/concerns to the licensed nurse overseeing the programs. To qualify for reimbursement, the provision of restorative programs shall meet the following criteria for each program identified for reimbursement:~~

~~1) When programs are designed using verbal cueing as the only intervention, documentation and/or observation must support the following:~~

~~A) Without such cueing, the resident would be unable to complete the required ADL task.~~

~~B) The verbal interventions are aimed at providing the resident with instructions for completing the task in such a way that promotes the resident's safety and awareness.~~

~~C) Verbal interventions that are simply reminders to complete the task may not be the sole content of the program.~~

~~2) Documentation shall clearly define the resident's need for the program and the program defined shall correspond to the identified need of the resident. Observation and/or interview shall also support the need for the program.~~

~~3) The clinical record shall identify a restorative nursing plan of care to assist the resident in reaching and/or maintaining his or her highest level of functioning. Staff completing the programs shall be aware of the program and the resident's need for the program.~~

~~4) Documentation must support that the program was reevaluated and goals and interventions were revised as necessary to assist the resident in reaching and/or maintaining his or her highest level of functioning.~~

~~5) Documentation shall contain objective and measurable information so that progress, maintenance or regression can be recognized from one report to the next.~~

~~6) Goals shall be resident specific, realistic, and measurable. Goals shall be revised as necessary. Revisions shall be made based on the resident's response to the program.~~

~~7) The resident's ability to participate in the program shall be addressed.~~

~~8) Written evidence of measurable objectives and interventions shall be in the restorative plan of care and be individualized to the resident's problems and needs. There shall be evidence the objectives and interventions were reviewed quarterly and revised as necessary.~~

~~9) There shall be evidence of quarterly evaluation written by a licensed nurse in the clinical record. The evaluation must assess the resident's progress and participation in the program since the last evaluation. It shall contain specific information that includes the resident's response to the program (i.e., amount of assistance required, devices used, the distance, the progress made, how well the resident tolerated the program). An evaluation shall be documented on each restorative program the resident is receiving.~~

~~10) There shall be written evidence that staff carrying out the programs have been trained in techniques that promote resident involvement in the activity.~~

~~11) If volunteers or other staff were assigned to work with specific residents, there shall be written evidence of specific training in restorative techniques that promote the resident's involvement in the restorative program.~~

~~12) There shall be documentation to support that the programs are ongoing and administered as planned outside the look-back period, unless there is written justification in the clinical record that supports the need to discontinue the program. Observation and/or interviews must also support that the programs are ongoing and administered as planned.~~

~~13) If a restorative program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, duration and frequency as part of the care planning process. The results of this reassessment shall be documented in the record.~~

~~14) The actual number of minutes per day spent in a restorative program shall be documented for each resident and for each restorative program during the look-back period.~~

~~15) The Department designated endurance assessment must be completed quarterly on each resident receiving two or more restorative programs. A licensed nurse must complete this assessment.~~

~~16) A resident coded as totally dependent in an ADL function will only be reimbursed for one quarter for the following corresponding restorative programs: bed mobility, transfer, walking, dressing/grooming, and/or eating/swallowing.~~

~~17) A resident scoring and/or receiving hospice services shall not be eligible for the following restorative programs: bed mobility, transfer, walking, dressing/grooming, eating and/or other restoratives.~~

~~18) When multiple restoratives are coded in a facility, the staff levels must support the ability to deliver these programs based on the number and frequency of programs coded.~~

~~19) All restorative programs shall meet the specifications in the RAI Manual for the individual restoratives.~~

~~**Passive Range of Motion (PROM)**~~

~~The following documentation shall support the following for scoring PROM.~~

~~1) The restorative program shall meet the definition of PROM as identified in the RAI Manual.~~

~~2) The PROM program shall address the functional limitations identified in section G4 of the MDS.~~

~~3) There shall be evidence that the program is planned and scheduled. PROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lie~~	~~SW~~	~~Act~~
	~~G4aA > 0 or~~	~~Any function limits in ROM of neck~~				
	~~G4bA > 0 or~~	~~Any function limits in ROM of arm~~				
	~~G4cA > 0 or~~	~~Any function limits in ROM of hand~~				
	~~G4dA > 0 or~~	~~Any function limits in ROM of leg~~				
	~~G4eA > 0 or~~	~~Any function limits in ROM of foot~~				
	~~G4fA > 0 or~~	~~Any function limits in ROM of other limitation or loss~~				
	~~G4aB > 0 or~~	~~Any function limits in voluntary movement of neck~~				

	~~G4bB > 0 or~~ ~~G4cB > 0 or~~ ~~G4dB > 0 or~~ ~~G4eB > 0 or~~ ~~G4fB > 0~~	~~Any function limits in voluntary movement of arm~~ ~~Any function limits in voluntary movement of hand~~ ~~Any function limits in voluntary movement of leg~~ ~~Any function limits in voluntary movement of foot~~ ~~Any function limits in voluntary movement of other limitation or loss~~				
	~~AND~~					
~~I~~	~~3 ≤ P3a ≤ 5~~	~~3 to 5 days of PROM rehab~~	~~10~~	~~3 RN 3 LPN~~		
~~II~~	~~6 ≤ P3a ≤ 7~~	~~6 to 7 days of PROM rehab~~	~~15~~	~~3 RN 3 LPN~~		

~~**Active Range of Motion (AROM)**~~

~~The following documentation shall support the following for scoring AROM.~~

~~1) The restorative program meets the definition of AROM as identified in the RAI Manual.~~

~~2) The AROM programs shall address the functional limitations identified in section G4 of the MDS.~~

~~3) There shall be evidence that the program is planned and scheduled. AROM that is incidental to dressing, bathing, etc., does not count as part of a formal restorative program.~~

~~4) AROM does not include exercise groups with more than four residents assigned per supervising helper or caregiver.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
	~~G4aA > 0 or~~	~~Any function limits in ROM of neck~~				
	~~G4bA > 0 or~~	~~Any function limits in ROM of arm~~				
	~~G4cA > 0 or~~	~~Any function limits in ROM of hand~~				
	~~G4dA > 0 or~~	~~Any function limits in ROM of leg~~				
	~~G4eA > 0 or~~	~~Any function limits in ROM of foot~~				
	~~G4fA > 0 or~~	~~Any function limits in ROM of other limitation or loss~~				
	~~G4aB > 0 or~~	~~Any function limits in voluntary movement of neck~~				
	~~G4bB > 0 or~~	~~Any function limits in voluntary movement of arm~~				
	~~G4cB > 0 or~~	~~Any function limits in voluntary movement of hand~~				
	~~G4dB > 0 or~~	~~Any function limits in voluntary movement of leg~~				
	~~G4eB > 0 or~~	~~Any function limits in voluntary movement of foot~~				
	~~G4fB > 0~~	~~Any function limits in voluntary movement of other limitation or loss~~				
	~~AND~~					
~~I~~	~~3 ≤ P3b ≤ 5~~	~~3 to 5 days of AROM rehab~~	~~8~~	~~2 RN 2 LPN~~		

~~II~~	~~6 ≤ P3b ≤ 7~~	~~6 to 7 days of AROM rehab~~	~~12~~	~~2 RN 2 LPN~~		

~~**Splint/Brace Assistance**~~

~~The program shall meet the specifications of this restorative as defined in the RAI Manual.~~

~~A splint or brace is defined as an appliance for the fixation, union, or protection of an injured part of the body.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~3 ≤ P3c ≤ 5~~	~~3 to 5 days of assistance~~	~~8~~	~~2 RN 2 LPN~~		
~~II~~	~~6 ≤ P3c ≤ 7~~	~~6 to 7 days of assistance~~	~~12~~	~~2 RN 2 LPN~~		

~~**Bed Mobility Restorative**~~

~~The program shall meet the specifications of this restorative as defined in the RAI Manual.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
	~~0 < G1aA < 8 AND~~ ~~G7 = 1~~	~~Need assistance in bed mobility~~ ~~Some or all ADL tasks broken into subtasks~~				
	~~AND~~					
~~I~~	~~3 ≤ P3d ≤ 5~~	~~3 to 5 days of rehab or restorative techniques~~	~~10~~	~~3 RN 3~~		

				~~LPN~~		
~~II~~	~~6 ≤ P3d ≤ 7~~	~~6 to 7 days of rehab or restorative techniques~~	~~15~~	~~3 RN 3 LPN~~		

~~**Mobility (Transfer) Restorative**~~

~~The program shall meet the specifications of this restorative as defined in the RAI Manual.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
	~~0 < G1bA < 8 AND~~ ~~G7 = 1~~	~~Need assistance in transfer~~ ~~Some or all ADL tasks broken into subtasks~~				
	~~AND~~					
~~I~~	~~3 ≤ P3e ≤ 5~~	~~3 to 5 days of rehab or restorative techniques~~	~~10~~	~~3 RN 3 LPN~~		
~~II~~	~~6 ≤ P3e ≤ 7~~	~~6 to 7 days of rehab or restorative techniques~~	~~15~~	~~3 RN 3 LPN~~		

~~**Walking Restorative**~~

~~The program shall meet the specifications of this restorative as defined in the RAI Manual.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~S W~~	~~Act~~
	~~0 < G1cA < 8 or~~	~~Need assistance in walking in room~~				

	~~0 < G1dA < 8 or~~ ~~0 < G1eA < 8 or~~ ~~0 < G1fA < 8 AND~~ ~~G7 = 1~~	~~Need assistance in walking in corridor~~ ~~Need assistance in locomotion on unit~~ ~~Need assistance in locomotion off unit~~ ~~Some or all ADL tasks broken into subtasks~~				
	~~AND~~					
~~I~~	~~3 ≤ P3f ≤ 5~~	~~3 to 5 days of rehab or restorative techniques~~	~~10~~	~~3 RN 3 LPN~~		
~~II~~	~~6 ≤ P3f ≤ 7~~	~~6 to 7 days of rehab or restorative techniques~~	~~15~~	~~3 RN 3 LPN~~		

~~**Dressing or Grooming Restorative**~~

~~The program shall meet the specifications of this restorative as defined in the RAI Manual.~~

~~Grooming programs, including programs to help the resident learn to apply make-up, may be considered restorative nursing programs when conducted by a member of the activity staff.~~

~~These programs shall have goals, objectives, and documentation of progress and be related to the identified deficit.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
	~~0 < G1gA < 8 or~~ ~~0<G1jA<8 AND~~	~~Need assistance in dressing~~ ~~Need assistance in personal hygiene~~				

	~~G7 = 1 AND~~	~~Some or all ADL tasks broken into subtasks~~				
	~~B4 ≤ 2~~	~~Cognitive skills for decision making~~				
	~~AND~~					
	~~S1 = 0 AND~~	~~Does not meet Illinois Department of Public Health (IDPH) Subpart S Criteria~~				
~~I~~	~~3 ≤ P3g ≤ 5~~	~~3 to 5 days of rehab or restorative techniques~~	~~10~~	~~3 RN 3 LPN~~		
~~II~~	~~6 ≤ P3g ≤ 7~~	~~6 to 7 days of rehab or restorative techniques~~	~~15~~	~~3 RN 3 LPN~~		

~~**Eating Restorative**~~

~~The program shall meet the specifications of this restorative as defined in the RAI Manual.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
	~~0 < G1hA < 8 or~~ ~~K1b = 1 AND~~ ~~G7 = 1~~	~~Need assistance in eating~~ ~~Has swallowing problem~~ ~~Some or all ADL tasks broken into subtasks~~				
	~~AND~~					
~~I~~	~~3 ≤ P3h ≤ 5~~	~~3 to 5 days of rehab or restorative techniques~~	~~15~~	~~3 RN 3 LPN~~		

~~II~~	~~6 ≤ P3h ≤ 7~~	~~6 to 7 days of rehab or restorative techniques~~	~~20~~	~~3 RN 3 LPN~~		

~~**Amputation/Prosthetic Care**~~

~~The program shall meet the specifications of this restorative as defined in the RAI Manual.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~3 ≤ P3i ≤ 5~~	~~3 to 5 days of assistance~~	~~10~~	~~3 RN 3 LPN~~		
~~II~~	~~6 ≤ P3i ≤ 7~~	~~6 to 7 days of assistance~~	~~15~~	~~3 RN 3 LPN~~		

~~**Communication Restorative**~~

~~The program shall meet the specifications of this restorative as defined in the RAI Manual.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
	~~C4 > 0~~	~~Deficit in making self understood~~				
	~~AND~~					
~~I~~	~~3 ≤ P3j ≤ 5~~	~~3 to 5 days of rehab or restorative techniques~~	~~10~~	~~3 RN 3 LPN~~		

~~II~~	~~6 ≤ P3j ≤ 7~~	~~6 to 7 days of rehab or restorative techniques~~	~~15~~	~~3 RN 3 LPN~~		

~~**Other Restorative**~~

~~The program shall meet the specifications of this restorative as defined in the RAI Manual.~~

~~Other Restorative shall only be reimbursed for a total of two quarters regardless of the level.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~P3k=3 or greater AND~~	~~Other Restorative~~	~~6~~	~~5 RN 5 LPN~~		
	~~Q2 < 2 AND~~	~~Improved or no change in care needs~~				
	~~B2a = 0 AND~~	~~Short term memory okay~~				
	~~B4 = 0 or 1 AND~~	~~Cognitive skills for decision making~~				
	~~C6 = 0 or 1 AND~~	~~Ability to understand others~~				
	~~S1 = 0~~	~~Does not meet IDPH Subpart S criteria~~				
~~II~~	~~P3k = 3 or greater AND~~	~~Other restorative~~	~~6~~	~~7.5 RN 7.5 LPN~~		
	~~Q1c = 1 or 2 AND~~	~~Stay projected to be of a short duration – discharge expected to be within 90 days~~				

	~~Q2 < 2 AND~~	~~Improved or no change in care needs~~				
	~~P1ar = 1 AND~~	~~Provide training to return to the community~~				
	~~B2a = 0 AND~~	~~Short-term memory~~				
	~~B4 = 0 or 1 AND~~	~~Cognitive skills for decision making~~				
	~~C6 = 0 or 1 AND~~	~~Ability to understand others~~				
	~~S1 = 0~~	~~Does not meet IDPH Subpart S criteria~~				

~~**Scheduled Toileting**~~

~~Documentation shall support the following for scoring scheduled toileting.~~

~~1)~~ ~~The program shall have documentation to support that all the requirements identified in the RAI Manual are met.~~

~~2)~~ ~~The description of the plan, including: frequency, reason, and response to the program.~~

~~3)~~ ~~The plan shall be periodically evaluated and revised, as necessary, including documentation of the resident's response to the plan.~~

~~4)~~ ~~This does not include a "check and change" program or routine changing of the resident's incontinent briefs, pads or linens when wet, where there is no participation in the plan by the resident.~~

~~5)~~ ~~There shall be documentation to support the deficit in toileting and/or the episodes of incontinence.~~

~~6)~~ ~~A resident scoring S1 = 1 (meets Subpart S criteria) shall have corresponding diagnosis of CVA or multiple sclerosis to qualify for reimbursement in scheduled toileting.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~H3a = 1~~ ~~AND~~ ~~S1= 0~~ ~~H3b = 0~~ ~~AND~~ ~~H3d = 0~~ ~~AND~~ ~~H1b > 1 or~~ ~~GliA> 1 and <8~~	~~Any scheduled toileting plan~~ ~~Does not meet criteria for Subpart S~~ ~~No bladder retraining program~~ ~~No indwelling catheter~~ ~~Incontinent at least 2 or more times a week~~ ~~Self performance = limited to total assistance~~	~~22~~	~~1.5 RN~~ ~~1.5 LPN~~		

~~4)~~ ~~**Medical Services**~~

~~**Continence Care**~~

~~Documentation shall support the following for scoring continence care.~~

~~1)~~ ~~That catheter care was administered during the look-back period.~~

~~2)~~ ~~The type and frequency of the care.~~

~~3)~~ ~~RAI requirements for bladder retraining program were administered during the look-back period.~~

~~4)~~ ~~The resident's level of incontinence shall be documented during the look-back period to support the bladder retraining program.~~

~~5)~~ ~~Bladder scanners cannot be the sole content of the bladder retraining program.~~

~~Continence Care – Level II (Bladder Retraining) shall only be reimbursed for two quarters.~~

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~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~Catheter Care~~		~~12~~	~~.5 RN .5 LPN~~		
	~~H3d = 1 AND~~	~~Indwelling catheter present~~				
	~~H3a = 0~~	~~No scheduled toileting plan~~				
~~II~~	~~Bladder Retraining~~					
	~~H3b = 1 AND~~	~~Bladder retraining program~~	~~32~~	~~5 RN 5 LPN~~		
	~~H3a = 0 AND~~	~~No scheduled toileting plan~~				
	~~H1b > 1 AND~~	~~Incontinent at least 2 or more times a week~~				
	~~B4 = 0 or 1 OR~~	~~Cognitive skills for decision making~~				
	~~H3b = 1 AND~~	~~Bladder retraining program~~				
	~~H3a = 0 AND~~	~~No scheduled toileting plan~~				
	~~H1b ≤ 1 AND~~	~~Bladder continence~~				
	~~H4 = 1 AND~~	~~Change in continence~~				
	~~B4 = 0 or 1~~	~~Cognitive skills in decision making~~				

~~**Pressure Ulcer Prevention**~~

~~Documentation shall support the following for scoring pressure ulcer prevention.~~

~~1) History of resolved ulcer in the identified timeframe and/or the use of the identified interventions during the identified timeframe.~~

~~2) Interventions and treatments shall meet the RAI definitions for coding.~~

~~3) A specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.~~

~~4) Resident was assessed related to his or her risk for developing ulcers. A resident assessed to be at high risk shall have interventions identified in the plan of care.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~M3 = 1 or~~	~~History of resolved ulcers in last 90 days~~	~~15~~	~~4 RN 4 LPN~~		
	~~Any two of:~~					
	~~M5a~~	~~Pressure relieving devices for chair~~				
	~~M5b~~	~~Pressure relieving devices for bed~~				
	~~M5c~~	~~Turning or repositioning program~~				
	~~M5d~~	~~Nutrition or hydration intervention for skin~~				
	~~M5i~~	~~Other prevention for skin (other than feet)~~				

~~**Moderate Skin Care/Intensive Skin Care**~~

~~Documentation shall support the following for scoring moderate skin care/intensive skin care.~~

~~1) Interventions and treatments shall meet the RAI definitions for coding.~~

~~2) Documentation of ulcers shall include staging as the ulcers appear during the look-back period.~~

~~3) Documentation of ulcers shall include a detailed description that includes, but is not limited to, the stage of the ulcer, the size, the location, any interventions and treatments used during the look-back period.~~

~~4) Documentation of burns shall include, but is not limited to, the location, degree, extent, interventions and treatments during the look-back period.~~

~~5) Documentation of open lesions shall include, but is not limited to, location, size, depth, any drainage, interventions and treatments during the look-back period.~~

~~6) Documentation of surgical wounds shall include, but is not limited to, type, location, size, depth, interventions and treatment during the look-back period.~~

~~7) All treatments involving M5e, M5f, M5g and M5h shall have a physician's order, with the intervention and frequency.~~

~~8) Documentation to support that the intervention was delivered during the look-back period shall be included.~~

~~9) Documentation of infection of the foot shall contain a description of the area and the location.~~

~~10) Documentation shall support a specific approach that is organized, planned, monitored and evaluated for coding a turning and positioning program.~~

~~11) Documentation for items coded in M4 shall include documentation of an intervention, treatment and/or monitoring of the problem or condition identified.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~		~~Moderate Skin Care Services~~	~~5~~	~~5 RN~~		
	~~M1a > 0 or~~	~~Stage 1 ulcers~~		~~5 LPN~~		

	~~M1b > 0 or~~	~~Stage 2 ulcers~~				
	~~Any of:~~	~~Other Skin Problems (below):~~				
	~~M4b = 1~~	~~Burns~~				
	~~M4c = 1~~	~~Open lesions other than ulcers~~				
	~~M4d = 1~~	~~Rashes~~				
	~~M4e = 1~~	~~Skin desensitized to pain or pressure~~				
	~~M4f = 1~~	~~Skin tears or cuts (other than surgery)~~				
	~~M4g = 1 AND~~	~~Surgical wounds~~				
	~~4 of the following:~~	~~Skin Treatments (below):~~				
	~~M5a = 1~~	~~Pressure relieving devices for chair~~				
	~~M5b = 1~~	~~Pressure relieving devices for bed~~				
	~~M5c = 1~~	~~Turning or repositioning program~~				
	~~M5d = 1~~	~~Nutrition or hydration intervention for skin~~				
	~~M5e = 1~~	~~Ulcer care~~				
	~~M5f = 1~~	~~Surgical wound care~~				
	~~M5g = 1~~	~~Application of dressings (other than feet)~~				
	~~M5h = 1~~	~~Application of ointments (other than feet)~~				
	~~M5i = 1 OR~~	~~Other prevention for skin (other than feet)~~				
	~~(M6b = 1 or~~	~~Infection of the foot~~				

	~~M6c = 1)~~ ~~AND~~ ~~M6f = 1~~	~~Open lesion of the foot~~ ~~And application of a dressing~~				
~~II~~	~~M1c > 0 or~~ ~~M1d > 0~~ ~~AND~~ ~~4 of the following:~~ ~~M5a = 1~~ ~~M5b = 1~~ ~~M5c = 1~~ ~~M5d = 1~~ ~~M5e = 1~~ ~~M5f = 1~~ ~~M5g = 1~~ ~~M5h = 1~~ ~~M5i = 1~~	~~Intensive Skin Care Services~~ ~~Stage 3 ulcers~~ ~~Stage 4 ulcers~~ ~~Skin Treatments (below):~~ ~~Pressure relieving devices for chair~~ ~~Pressure relieving devices for bed~~ ~~Turning or repositioning program~~ ~~Nutrition or hydration intervention for skin~~ ~~Ulcer care~~ ~~Surgical wound care~~ ~~Application of dressings (other than feet)~~ ~~Application of ointments (other than feet)~~ ~~Other prevention for skin (other than feet)~~	~~5~~	~~15~~ ~~RN~~ ~~15~~ ~~LPN~~		

~~**Ostomy Services**~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~

~~I~~	~~P1af = 1~~	~~Ostomy care performed~~	~~5~~	~~2.5 RN 2.5 LPN~~		

~~IV Therapy~~

~~Documentation shall support the following for scoring IV Therapy.~~

~~1) Date delivered, type of medication and method of administration.~~

~~2) Monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse as required under acute medical conditions.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~Plac = 1~~ ~~or~~ ~~K5a = 1~~ ~~AND~~ ~~P1ae = 1~~	~~IV medication~~ ~~Parenteral/IV nutrition~~ ~~Monitoring acute medical condition~~	~~1~~	~~15 RN 15 LPN~~		

~~Injections~~

~~Documentation shall include the drug, route given and dates given.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~O3 = 7~~	~~Number of injections in last 7 days~~		~~3 RN 3 LPN~~		

~~Oxygen Therapy~~

~~Documentation shall include a physician's order and the method of administration and date given.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~P1ag = 1~~	~~Oxygen therapy administered in last 14 days~~	~~9~~	~~7.5 RN 7.5 LPN~~		

~~**Chemotherapy**~~

~~Documentation shall support that the resident was monitored for response to the chemotherapy.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~P1aa = 1~~	~~Chemotherapy given~~	~~1~~	~~5 RN 5 LPN~~		

~~**Dialysis**~~

~~Documentation shall support that the resident was monitored for response to the dialysis.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~P1ab = 1~~	~~Dialysis given~~	~~1~~	~~5 RN 5 LPN~~	~~2~~	

~~**Blood Glucose Monitoring**~~

~~Documentation shall support the following for scoring blood glucose monitoring.~~

~~1) RAI criteria for coding that a diagnosis was met, including a physician documented diagnosis.~~

~~2) Coding of a therapeutic diet being ordered and given to the resident.~~

~~3) Coding of a dietary supplement being ordered and given to the resident during the look-back period. There shall be evidence to support it was not part of a unit's daily routine for all residents.~~

~~4) Coding that injections were given the entire seven days of the look-back period.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~I1a = 1~~ ~~AND~~ ~~K5e = 1 or~~ ~~K5f = 1 or~~ ~~O3 = 7~~	~~Diabetes mellitus~~ ~~Therapeutic diet~~ ~~Dietary supplement~~ ~~Injections daily~~		~~1 RN~~ ~~1 LPN~~		

~~**End Stage Care**~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~J5c = 1~~	~~End stage disease, 6 or fewer months to live~~ ~~Restoratives including scheduled toileting and bladder retraining sets to level '0' except AROM, PROM, splint/brace. Limit of 4 quarters~~	~~10~~	~~6 RN~~ ~~6 LPN~~	~~8~~	

~~If End Stage Care has been scored, Discharge Planning shall be set to zero.~~

~~**Infectious Disease**~~

~~Documentation shall support the following for scoring infectious disease.~~

~~1) Criteria defined in the RAI Manual for coding this section was met.~~

~~2) Active diagnosis by the physician, including signs and symptoms of the illness.~~

~~3) Interventions and treatments shall be documented.~~

~~4) All RAI requirements for coding a urinary tract infection (UTI) are met.~~

~~5) Administration of maintenance medication to prevent further acute episodes of UTI is not sufficient to code I2j.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~I2a = 1 or~~	~~Antibiotic resistant infection~~	~~18~~	~~8.5 RN 8.5 LPN~~	~~1~~	
	~~I2b = 1 or~~	~~Clostridium Difficile~~				
	~~12e = 1 or~~	~~Pneumonia~~				
	~~12g = 1 or~~	~~Septicemia~~				
	~~I2i = 1 or~~	~~TB~~				
	~~12 j = 1 or~~	~~Urinary Tract infection present~~				
	~~I2k = 1 or~~	~~Viral hepatitis~~				
	~~12l = 1 or~~	~~Wound infection~~				
	~~I3 = ICD9 code 041.01,133.0~~	~~Streptococcus Group A, scabies~~				

~~**Acute Medical Conditions**~~

~~Documentation shall support the following for scoring acute medical conditions.~~

~~1) RAI requirements for coding these areas are met.~~

~~2) Monitoring of an acute medical condition (physical or psychiatric illness) by a licensed nurse.~~

~~3) Evidence that the physician has evaluated and identified the medically unstable or acute condition for which clinical monitoring is needed.~~

~~4) Evidence of significant increase in licensed nursing monitoring.~~

~~5) Evidence that the episode meets the definition of acute, which is usually of sudden onset and time-limited course.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~J5b = 1 AND~~	~~Acute episode or flare-up of chronic condition~~	~~1~~	~~11.5 RN 11.5 LPN~~	~~1~~	
	~~P1ae = 1 AND~~	~~Monitoring acute medical condition~~				
	~~P1ao = 0 OR~~	~~Not hospice care~~				
	~~(J5a = 1 AND~~	~~Condition makes resident's cognitive, ADL, mood or behavior patterns unstable~~				
	~~P1ao = 0 AND~~	~~Not hospice care~~				
	~~P1ae = 1) OR~~	~~Monitoring acute medical condition~~				
	~~(B5a = 2 or~~	~~Easily distracted over last 7 days~~				
	~~B5b = 2 or~~	~~Periods of altered perceptions or awareness of surroundings over last 7 days~~				
	~~B5c = 2 or~~	~~Episodes of disorganized speech over last 7 days~~				
	~~B5d = 2 or~~	~~Periods of restlessness over last 7 days~~				

	~~B5e = 2 or~~	~~Periods of lethargy over last 7 days~~				
	~~B5f = 2) AND~~	~~Mental function varies over course of day in last 7 days~~				
	~~P1ae = 1 AND~~	~~Monitoring acute medical condition~~				
	~~P1ao = 0~~	~~Not hospice care~~				

~~**Pain Management**~~

~~There shall be documentation to support the resident's pain experience during the look-back period and that interventions for pain were offered and/or given.~~

~~Residents shall be assessed in a consistent, uniform and standardized process to measure and assess pain.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~J2a > 0 AND~~	~~Demonstrate or complain of pain~~	~~4~~	~~4 RN~~ 4 ~~LPN~~	~~1~~	~~1~~
	~~J2b > 0~~	~~Mild to excruciating intensity~~				

~~**Discharge Planning**~~

~~Discharge planning shall only be reimbursed for two quarters.~~

~~If end stage care has been scored, discharge planning shall be set to zero.~~

~~Documentation shall support the following for scoring discharge planning.~~

~~1) Social services shall document monthly the resident's potential for discharge, specific steps being taken toward discharge, and the progress being made.~~

~~2) Social service documentation shall demonstrate realistic evaluation, planning, and follow-through.~~

~~3) Discharge plans shall address the current functional status of the resident, medical nursing needs, and the availability of family and/or community resources to meet the needs of the resident.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~Q1c = 1 or 2~~ ~~AND~~ ~~Q2 < 2~~ ~~AND~~ ~~P1ar = 1~~ ~~AND~~ ~~Sl=0~~	~~Stay projected to be of short duration – discharge expected to be within 90 days~~ ~~Improved or no change in care needs~~ ~~Provide training to return to community~~ ~~Does not meet IDPH Subpart S criteria~~		~~8~~ ~~RN~~ ~~8~~ ~~LPN~~	~~16~~	

~~**Nutrition**~~

~~Documentation shall support the following for scoring nutrition.~~

~~1) Coding of tube feeding during the look-back period.~~

~~2) Intake and output records and caloric count shall be documented to support the coding of K6.~~

~~3) Planned weight change, including a diet order and a documented purpose or goal, that is to facilitate weight gain or loss.~~

~~4) Dietary supplement, including evidence the resident received the supplement and that it was ordered and given between meals.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~

~~I~~	~~K5h = 1~~ ~~OR~~ ~~K5f = 1~~	~~On a planned weight change program~~ ~~Dietary supplement given between meals~~	~~2~~	~~.5 RN~~ ~~.5~~ ~~LPN~~		
~~II~~	~~K5b =1 and~~ ~~Intake = 1~~ ~~Intake = 1 if~~ ~~K6a = 3 or~~ ~~K6a = 4~~ ~~Or Intake = 1 if~~ ~~K6a = 2 and~~ ~~K6b = 2 or~~ ~~K6b = 3 or~~ ~~K6b = 4 or~~ ~~K6b = 5~~	~~Tube feeding in last 7 days~~ ~~See below~~ ~~Parenteral/ enteral intake 51-75% of total calories~~ ~~Parenteral/enteral intake 76-100% of total calories~~ ~~Parenteral/enteral intake 26-50% of total calories~~ ~~Average fluid intake by IV or tube is 501-1000 cc/day~~ ~~Average fluid intake by IV or tube is 1001-1500 cc/day~~ ~~Average fluid intake by IV or tube is 1501-2000 cc/day~~ ~~Average fluid intake by IV or tube is 2001 or more cc/day~~	~~2~~	~~12~~ ~~RN~~ ~~12~~ ~~LPN~~	~~2~~	

~~**Hydration**~~

~~Documentation shall support the following for scoring hydration.~~

~~1) The resident passes two or fewer bowel movements per week, or strains more than one of four times when having a bowel movement during the look-back period to support the coding of H2b.~~

~~2) Resident received a diuretic medication during the look-back period to support the coding of O4e.~~

~~3) Frequency of episodes and accompanying symptoms to support the coding of vomiting.~~

~~4) Signs and symptoms, interventions and treatments used to support the coding of volume depletion, dehydration or hypovolemia.~~

~~5) Documentation of temperature shall be present to support the coding of fever.~~

~~6) Coding of internal bleeding shall include the source, characteristics and description of the bleeding.~~

~~7) Interventions were implemented related to the problem identified.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~H2b = 1~~	~~Constipation~~	~~10~~	~~2 RN~~ ~~2~~ ~~LPN~~		~~1~~
	~~AND~~					
	~~K5a = 0~~ ~~AND~~	~~No parenteral/IV~~				
	~~K5b = 0~~ ~~OR~~	~~No feeding tube~~				
	~~Any two of the following separate conditions:~~					

	~~1 ≤ O4e ≤ 7 or~~	~~Received a diuretic medication in last 7 days~~				
	~~J1o = 1 or~~	~~Vomiting~~				
	~~I3 a,b,c,d,e = 276.5 or~~	~~Volume depletion~~				
	~~276.52 or~~	~~Hypovolemia~~				
	~~J1c = 1 or~~	~~Dehydrated~~				
	~~J1d = 1 or~~	~~Did not consume most fluids provided (3 days)~~				
	~~J1h = 1 or~~	~~Fever~~				
	~~J1j = 1 AND~~	~~Internal bleeding~~				
	~~K5a = 0 AND~~	~~Not have parenteral/IV~~				
	~~K5b = 0~~	~~No feeding tube~~				

~~5)~~ ~~**Mental Health Services**~~

~~**Psychosocial Adaptation**~~

~~Psychosocial adaptation is intended for residents who require a behavioral symptom evaluation program or group therapy to assist them in dealing with a variety of mood or behavioral issues. The criteria for reimbursement in this area require both an intervention program and the identification of mood or behavioral issues. Residents shall be assessed for mood and behavioral issues and interventions shall be implemented to assist the resident in dealing with the identified issues. To qualify for reimbursement in this area, the facility must meet the following criteria:~~

~~1) Criteria for special behavioral symptom evaluation program.~~

~~A) There must be documentation to support that the program is an ongoing and comprehensive evaluation of behavioral symptoms.~~

~~B) Documentation must support the resident's need for the program.~~

~~C) The documentation must show that the purpose of the program is to attempt to understand the "meaning" behind the resident's identified mood or behavioral issues.~~

~~D) Interventions related to the identified issues must be documented in the care plan.~~

~~E) The care plan shall have interventions aimed at reducing the distressing symptoms.~~

~~2) Criteria for group therapy.~~

~~A) There is documentation that the resident regularly attends sessions at least weekly.~~

~~B) Documentation supports that the therapy is aimed at helping reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve.~~

~~C) This area does not include group recreational or leisure activities.~~

~~D) The therapy and interventions are addressed in the care plan.~~

~~E) This must be a separate session and can not be conducted as part of skills training.~~

~~3) Criteria for indicators of depression.~~

~~A) There must be documentation to support identified indicators occurred during the look-back period.~~

~~B) The documentation shall support the frequency of the indicators as coded during the look-back period.~~

~~C) There shall be documentation to support that interventions were implemented to assist the resident in dealing with these issues.~~

~~4) Criteria for sense of initiative/involvement.~~

~~A) There is documentation to support that the resident was not involved or did not appear at ease with others or activities during the look-back period.~~

~~B) There shall be evidence that interventions were implemented to assist the resident in dealing with these issues.~~

~~5) Criteria for unsettled relationships/past roles.~~

~~A) There is documentation to support the issues coded in this area during the look-back period.~~

~~B) There shall be evidence that interventions were implemented to assist the resident in dealing with the issues identified.~~

~~6) Criteria for behavioral symptoms.~~

~~A) There is documentation to support that the behaviors occurred during the look-back period and the interventions used.~~

~~B) Documentation should reflect the resident's status and response to interventions.~~

~~C) Documentation should include a description of the behavior exhibited and the dates it occurred, as well as staff response to the behaviors.~~

~~D) Documentation supports that the behaviors coded meet the RAI definitions for the identified behavior.~~

~~E) The care plan identifies the behaviors and the interventions to the behaviors.~~

~~7) Criteria for delusions/hallucinations.~~

~~A)~~ ~~There is documentation to support that the delusions or hallucinations occurred during the look back period.~~

~~B)~~ ~~Documentation contains a description of the delusions or hallucinations the resident was experiencing.~~

~~C)~~ ~~There is documentation to support the interventions used.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~(P2a = 1 or~~	~~Behavior symptom evaluation~~	~~12~~	~~3 RN~~ ~~3~~ ~~LPN~~	~~8~~	~~2~~
	~~P2c = 1) AND~~	~~Group therapy~~				
	~~Any E1a-p > 0~~ ~~or~~	~~Indicators of depression~~				
	~~F1g = 1 or~~	~~No indicators of psychosocial well-being~~				
	~~Any F2a-g = 1 or~~	~~Any unsettled relationships~~				
	~~Any F3a-c = 1 or~~	~~Issues with past roles~~				
	~~E4aA > 0 or~~	~~Wandering in last 7 days~~				
	~~E4bA > 0 or~~	~~Verbally abusive in last 7 days~~				
	~~E4cA > 0 or~~	~~Physically abusive in last 7 days~~				
	~~E4dA > 0 or~~	~~Inappropriate or disruptive behavior in last 7 days~~				
	~~E4eA > 0 or~~	~~Resisted care in last 7 days~~				
	~~J1e= 1 or~~	~~Delusions~~				
	~~J1i = 1~~	~~Hallucinations~~				

~~**Psychotropic Medication Monitoring**~~

~~Documentation shall support that the facility followed the documentation guidelines as directed by 42 CFR 483.25(l), Unnecessary drugs (State Operations Manual F-tag F329).~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~O4a = 7 or~~	~~Antipsychotic meds~~	~~5~~	~~2.5 RN 2.5 LPN~~		
	~~O4b = 7 or~~	~~Antianxiety meds~~				
	~~O4c = 7 or~~	~~Antidepressant meds~~				

~~**Psychiatric Services (Section S)**~~

~~Documentation shall support the following for scoring psychiatric services (Section S).~~

~~1) There shall be evidence the resident met IDPH Subpart S criteria during the look-back period.~~

~~2) There shall be evidence a pre-admission screening completed by a Department of Human Services-Division of Mental Health screening entity was completed on the resident that identifies the resident as having a serious mental illness (SMI).~~

~~The following shall be used in coding ancillary provider services.~~

~~1) Ancillary provider services are services that are provided by direct non-facility psychiatric service providers in order to meet 77 Ill. Adm. Code 300, Subpart S requirements.~~

~~2) Psychiatric rehabilitation services that are provided by non-facility providers or an outside entity shall meet the needs of the SMI resident as determined by the resident's individual treatment plan.~~

~~3) Facilities shall ensure compliance with 77 Ill. Adm. Code 300.4050 when utilizing non-facility or outside ancillary providers.~~

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~~4) Adjustments in the rate for utilization of ancillary providers shall be calculated based upon Department claims data for ancillary provider billing.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~S1 = 1~~ ~~AND~~	~~Meets IDPH Subpart S criteria~~	~~6~~	~~1.5 RN~~ ~~1.5 LPN~~	~~10~~	
	~~ADL Index = 4~~ ~~AND~~	~~Activities of Daily Living Composite Score = 15-29~~				
	~~One or more of the following are coded M1c or Mld >0 or~~	~~Stage 3 or stage 4 ulcers~~				
	~~K5b = 1~~ ~~or~~ ~~K5a = 1~~ ~~or~~ ~~Plab = 1~~ ~~or~~	~~Feeding tube~~ ~~Parenteral/IV~~ ~~Dialysis~~				
	~~J5c = 1~~ ~~or~~ ~~Plaa = 1~~ ~~or~~ ~~Plaj = 1~~ ~~or~~ ~~Plal = 1~~ ~~AND~~ ~~Psychiatric Services Level II, Level III, Level IV skills training, close and constant observation, dressing/grooming~~	~~End Stage Disease~~ ~~Chemotherapy~~ ~~Tracheostomy Care provided~~ ~~Ventilator~~				

	~~and other restorative, cognitive performance, dementia care unit and discharge planning reset to zero~~					
~~II~~	~~S1 = 1~~ ~~AND~~	~~Meets IDPH Subpart S criteria~~	~~13~~	~~2.5 RN~~ ~~2.5 LPN~~	~~20~~	
	~~S8 = 1~~ ~~AND~~ ~~Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero~~	~~Ancillary provider services delivered by non-facility providers~~				
~~III~~	~~S1 = 1~~ ~~AND~~ ~~ADL Index=3 or 4~~ ~~AND~~ ~~(AA3-A3a)/365.25 ≥ 65~~ ~~AND~~	~~Meets IDPH Subpart S criteria~~ ~~ADL composite score between 12-29~~ ~~Resident is 65 years of age or older at time of the assessment reference date~~	~~13~~	~~4.5 RN~~ ~~4.5 LPN~~	~~20~~	
	~~Dressing/grooming and other restorative, cognitive performance, and dementia care unit~~					

	~~and discharge planning reset to zero~~					
~~IV~~	~~Sl = 1~~ ~~AND~~ ~~S8 = 0~~ ~~AND~~ ~~Dressing/grooming and other restorative, cognitive performance, and dementia care unit and discharge planning reset to zero~~	~~Meets IDPH Subpart S criteria~~ ~~Ancillary provider services delivered by facility providers~~	~~16~~	~~5 RN~~ ~~5~~ ~~LPN~~	~~25~~	

~~Skills Training – Section S~~

~~Skills training is specific methods for assisting residents who need, and can benefit from, this training to address identified deficits and reach personal and clinical goals. To qualify for reimbursement, the provision of skills training shall meet all of the following criteria.~~

~~1)~~ ~~Skills and capabilities shall be assessed with the use of a standardized skills assessment, a cognitive assessment and an assessment of motivational potential. The assessment of motivational potential will assist in determining the type and size of the group in which a resident is capable of learning.~~

~~2)~~ ~~Addresses identified skill deficits related to goals noted in the treatment plan.~~

~~3)~~ ~~Skills training shall be provided by staff who are paid by the facility and have been trained in leading skills group by a Department approved trainer.~~

~~4)~~ ~~Training shall be provided in a private room with no other programs or activities going on at the same time. The environment shall be conducive to learning in terms of comfort, noise and other distractions.~~

~~5) Training shall be provided in groups no larger than ten, with reduced group size for a resident requiring special attention due to cognitive, motivational or clinical issues, as determined by the skills assessment, cognition and motivational potential. Individual sessions can be provided as appropriate and shall be identified in the care plan.~~

~~6) Training shall utilize a well-developed, structured curriculum and specific written content developed in advance to guide each of the sessions. (Published skills modules developed for the SMI and Mental Illness/Substance Abuse (MISA) populations are available for use and as models.)~~

~~7) The curriculum shall address discrete sets of skills competencies, breaking skills down into smaller components or steps in relation to residents' learning needs.~~

~~8) The specific written content shall provide the rationale for learning, connecting skill acquisition to resident goals.~~

~~9) Training shall employ skill demonstration/modeling, auditory and visual presentation methods, role-playing and skill practice, immediate positive and corrective feedback, frequent repetition of new material, practice assignments between training sessions (homework), and brief review of material from each previous session.~~

~~10) There shall be opportunities for cued skill practice and generalization outside session as identified in the care plan and at least weekly documentation relative to skill acquisition.~~

~~11) Each training session shall be provided and attended in increments of a minimum of 30 minutes each (not counting time to assemble and settle) at least three times per week. Occasional absences are allowable, with individual coverage of missed material as necessary. However, on-going 1:1 training shall not qualify under this area.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~S7 = 1~~ ~~AND~~ ~~S1 = 1~~	~~Skills training provided~~ ~~Meets IDPH Subpart S criteria~~	~~6~~	~~6 RN~~ ~~6~~ ~~LPN~~	~~8~~	~~6~~

~~**Close or Constant Observation = Section S**~~

~~The following criteria shall be met for coding close or constant observation.~~

~~1)~~ ~~Coding of this item is intended only for interventions applied in response to the specific current significant need of an individual resident. This item shall not be coded for observation conducted as standard facility policy for all residents, such as for all new admissions, or as part of routine facility procedures, such as for all returns from the hospital, or as a part of periodic resident headcounts.~~

~~2)~~ ~~There shall be documentation for the reason for use, confirmation that the procedure was performed as coded, with staff initials at appropriate intervals, brief explanation of the resident's condition and reason for terminating the observation.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~S5a-e ≥ 1~~ ~~AND~~ ~~S1 = 1~~	~~Close or constant observation~~ ~~Meets IDPH Subpart S criteria~~	~~6~~	~~2 RN~~ ~~2~~ ~~LPN~~	~~5~~	

~~If close or constant observation is scored, acute medical conditions is reset to zero.~~

~~**6)**~~ ~~**Dementia Services**~~

~~**Cognitive Impairment/Memory Assistance Services**~~

~~Documentation shall support the following for scoring cognitive impairment/memory assistance services.~~

~~1)~~ ~~Description of the resident's short-term memory problems.~~

~~2)~~ ~~Method of assessing and determining the short-term memory problem shall be documented.~~

~~3)~~ ~~Description of the resident's ability to make everyday decisions about tasks or activities of daily living.~~

~~4) Description of the resident's ability to make himself or herself understood.~~

~~Lev~~	~~CPS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~CPS = 2~~ ~~AND~~ ~~S1 = 0~~	~~Cognitive performance scale of 2~~ ~~Does not meet IDPH Subpart S criteria~~	~~6~~			~~4~~
~~II~~	~~CPS = 3 or 4~~ ~~AND~~ ~~S1 = 0~~	~~Cognitive performance scale is 3 or 4~~ ~~Does not meet IDPH Subpart S criteria~~	~~16~~	~~3 RN~~ ~~3~~ ~~LPN~~	~~11~~	~~10~~
~~III~~	~~CPS = 5 or 6~~ ~~AND~~ ~~S1 = 0~~	~~Cognitive performance scale is 5 or 6~~ ~~Does not meet IDPH Subpart S criteria~~	~~21~~	~~5.5~~ ~~RN~~ ~~5.5~~ ~~LPN~~	~~16~~	~~15~~

~~Cognitive Performance Scale Codes~~

~~Scale~~	~~Description~~
~~0~~	~~Intact~~
~~1~~	~~Borderline Intact~~
~~2~~	~~Mild Impairment~~
~~3~~	~~Moderate Impairment~~
~~4~~	~~Moderate Severe Impairment~~
~~5~~	~~Severe Impairment~~
~~6~~	~~Very Severe Impairment~~

~~Impairment Count for the Cognitive Performance Scale~~

~~I code~~	~~MDS items~~	~~Description~~
		~~Note: None of B2a, B4, or C4 can be missing~~
~~IC 1~~	~~B2a = 1~~	~~Memory problem~~
~~IC 2~~	~~B4 = 1 or 2~~	~~Some dependence in cognitive skills~~
~~IC 3~~	~~1 ≤ C4 ≤ 3~~	~~Usually understood to rarely or never understood~~

~~Severe Impairment Count for the Cognitive Performance Scale~~

~~I code~~	~~MDS items~~	~~Description~~
		~~Note: None of B2a, B4, or C4 can be missing~~
~~SIC 0~~	~~Below not met~~	
~~SIC 1~~	~~B4 = 2~~	~~Moderately impaired in cognitive skills~~
~~SIC 2~~	~~C4 = 2 or 3~~	~~Sometimes understood to rarely or never understood~~

~~Cognitive Performance Scale~~

~~Scale~~	~~MDS items~~	~~Description~~
~~Coma~~	~~N1a = 0 and~~	~~Awake all or most of the time in the morning~~
	~~N1b = 0 and~~	~~Awake all or most of the time in the afternoon~~
	~~N1c = 0 and~~	~~Awake all or most of the time in the evening~~
	~~B1 = 1 and~~	~~Is comatose~~
	~~G1aA = 4 or 8 And~~	~~Bed-Mobility Self-Performance = total dependence or did not occur~~
	~~G1bA = 4 or 8 And~~	~~Transfer Self-Performance = total dependence or did not occur~~
	~~G1hA = 4 or 8 And~~	~~Eating Self-Performance = total dependence or did not occur~~
	~~G1iA = 4 or 8 And~~	~~Toilet Use Self-Performance = total dependence or did not occur~~
~~6~~	~~Not (B4 = 0,1, 2)~~	~~Not have cognitive skills independent to moderately impaired~~
~~6~~	~~B4 = 3 And~~	~~Cognitive skills severely impaired~~
	~~G1hA = 4 or 8~~	~~Eating Self-Performance = total dependence or did not occur~~
~~5~~	~~B4 = 3 And~~	~~Cognitive skills severely impaired~~

	~~G1hA = - or ≤ 3~~	~~Eating Self-Performance = missing to extensive assistance~~
~~4~~	~~If IC code = 2 or 3~~ ~~And SIC code = 2~~	~~Some dependence in cognitive skills~~ ~~Usually understood to rarely or never understood~~ ~~Sometimes understood to rarely or never understood~~
~~3~~	~~If IC code = 2 or 3~~ ~~And SIC code = 1~~ ~~If IC code = 2 or 3~~	~~Some dependence in cognitive skills~~ ~~Usually understood to rarely or never understood~~ ~~Moderately impaired in cognitive skills~~ ~~Some dependence in cognitive skills~~ ~~Usually understood to rarely or never understood~~
~~2~~	~~And SIC code = 0~~	~~Better than moderate cognition skills and usually can be understood~~
~~1~~	~~If IC code = 1~~	~~Memory problem~~

~~**Dementia Care Unit**~~

~~Documentation shall support the following for scoring dementia care unit.~~

~~1) Unit was IDPH certified during the look-back period.~~

~~2) Resident resided in the unit during the look-back period.~~

~~3) Activity programming is planned and provided seven days a week for an average of eight hours per day.~~

~~4) If the resident has a CPS score of five, care planning shall address the resident's participation in the unit's activities.~~

~~5) If a particular resident does not participate in a least an average of four activities per day over a one-week period, the unit director shall evaluate the resident's participation and have the available activities modified and/or consult with the interdisciplinary team.~~

~~6) Staff's efforts to involve the resident.~~

~~7) Required assessments were completed on the resident.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~P1an = 1 AND~~ ~~I1q = 1 or~~ ~~I1u = 1 AND~~ ~~S1 = 0 AND~~ ~~CPS 2,3,4,5 AND~~ ~~Dementia care unit is IDPH certified~~	~~Alzheimer's/Dementia special care unit~~ ~~Alzheimer's Disease~~ ~~Dementia other than Alzheimer's~~ ~~Does not meet IDPH Subpart S criteria~~ ~~CPS score~~	~~15~~	~~4 RN~~ ~~4 LPN~~	~~10~~	~~10~~

~~7)~~ ~~**Exceptional Care Services**~~

~~**Respiratory Services**~~

~~Documentation shall support the following for scoring respiratory services.~~

~~1)~~ ~~A respiratory therapist shall evaluate the status of the resident at least monthly if the resident has a tracheostomy.~~

~~2)~~ ~~Respiratory therapy being provided 15 minutes a day shall be present in the clinical record for the look-back period.~~

~~3)~~ ~~Physician's order for the treatments.~~

~~4)~~ ~~Respiratory therapy in the record of the treatment and the times given by a qualified professional (respiratory therapist or trained nurse) as defined in the RAI Manual.~~

~~5)~~ ~~Suctioning, including type, frequency and results of suctioning.~~

~~6)~~ ~~Trach care, including type, frequency and description of the care provided.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~P1ai = 1 or~~ ~~P1aj = 1 or~~ ~~P1bdA = 7~~	~~Perform suctioning~~ ~~Administered trach care~~ ~~Respiratory therapy~~	~~5~~	~~15 RN 15 LPN~~		
~~II~~	~~P1ai = 1 AND~~ ~~P1aj = 1 AND~~ ~~P1bdA > 0~~	~~Performed suctioning~~ ~~Administered trach care~~ ~~Respiratory therapy~~	~~10~~	~~24 RN 24 LPN~~		

~~A $50.00 add-on cost will be applied to all residents receiving trach care.~~

~~**Weaning From Ventilator**~~

~~Documentation shall be in place to support weaning from ventilator.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~P1a1 = 0 on current MDS AND~~	~~Resident no longer on ventilator~~	~~5~~	~~15 RN 15 LPN~~		

	~~P1a1 = 1 on previous MDS~~	~~Resident previously on ventilator~~				

~~**Morbid Obesity**~~

~~Documentation shall support the following for scoring morbid obesity.~~

~~1) A dietician's evaluation was completed with evidence of on-going consultation.~~

~~2) On-going monitoring of weight shall be evident.~~

~~3) The psychosocial needs related to weight issues shall be identified and addressed.~~

~~Lev~~	~~MDS items~~	~~Description~~	~~Unl~~	~~Lic~~	~~SW~~	~~Act~~
~~I~~	~~I3 = 278.01 AND~~	~~ICD9 for morbid obesity is marked~~	~~10~~	~~5 RN 5 LPN~~	~~5~~	
	~~K5e = 1 AND~~	~~On a therapeutic diet~~				
	~~K5h = 1 AND~~	~~On planned weight change program~~				
	~~G1aA = 3 and~~	~~Extensive assist~~				
	~~G1aB=3 or~~	~~Requires 2+ assist with bed mobility~~				
	~~G1bA=3 and~~	~~Extensive assist~~				
	~~G1bB=3 or~~	~~Requires 2+ assist with transfers~~				
	~~G1cA=3 and~~	~~Extensive assist~~				
	~~G1cB=3 AND~~	~~Requires 2+ assist with walk in room~~				

	~~P3d=7~~ ~~or~~ ~~P3e=7~~ ~~or~~ ~~P3f = 7~~	~~On bed mobility restorative~~ ~~On transfer restorative~~ ~~On walking restorative~~				

~~A $40.00 add-on shall be applied to all residents meeting the Morbid Obesity category.~~

~~Complex Wounds~~

~~Facilities shall follow documentation guidelines as directed by 42 CFR 483.25(c) (State Operations Manual F-tag F314). All documentation requirements listed in F314 shall be met.~~
~~There are no minutes assigned to this area. It is strictly a $15.00 add-on applied to residents meeting the following criteria.~~

~~MDS item~~	~~Description~~
~~M1c or M1d > 0~~ ~~AND~~	~~Presence of stage 3 or 4 PU~~
~~M2a > 0 or~~	~~Type of ulcer, pressure~~
~~M2b > 0~~ ~~AND~~	~~Type of ulcer, stasis~~
~~B1 = 1 or~~	~~Comatose~~
~~G1Aa = 3 or 4 or~~	~~Bed mobility (extensive)~~
~~G1Ab = 3 or 4~~	~~Transfer (extensive)~~
~~AND any 3 of the follow:~~	
~~ICD 9 codes of (260, 261, 262, 263.0, 263.1, 263.2, 263.8, 263.9)~~	~~ICD 9-Malnutrition~~
~~ICD 9 585~~	~~ESRD~~
~~I1a = 1~~	~~Diabetes Mellitus~~
~~I1qq = 1~~	~~Renal Failure~~
~~I1j = 1~~	~~Peripheral vascular disease~~
~~I1x = 1~~	~~Paraplegia~~
~~I1z = 1~~	~~Quadriplegia~~

~~I1w = 1~~	~~Multiple Sclerosis~~
~~J5c = 1~~	~~End stage disease~~
~~H1a = 4~~	~~Incontinence of bowel~~
~~H1b = 4~~	~~Incontinence of bladder~~
~~J1c = 1~~	~~Dehydration~~
~~G6a = 1~~	~~Bedfast~~
~~J2a = 2~~	~~Pain daily~~
~~M3 = 1~~	~~History of resolved ulcers~~
~~AND all of the following:~~	
~~M5a = 1 and/or~~	~~Pressure relieving device/chair~~
~~M5b = 1~~ ~~AND~~	~~Pressure relieving device/bed~~
~~M5c = 1~~ ~~AND~~	~~Turn and position~~
~~M5d = 1~~ ~~AND~~	~~Nutrition or hydration~~
~~M5e = 1~~	~~Ulcer care~~

~~**Traumatic Brain Injury**~~

~~Documentation shall support the following for scoring traumatic brain injury.~~

~~1) Psychological therapy shall be delivered by licensed mental health professionals as described in the RAI Manual.~~

~~2) A special symptom evaluation program shall be an on-going, comprehensive, interdisciplinary evaluation of behavioral symptoms as described in the RAI Manual.~~

~~3) Evaluation by a licensed mental health specialist in the last 90 days. This shall include an assessment of a mood, behavioral disorder or other mental health problems by a qualified clinical professional as described in the RAI Manual.~~

~~4) Care plan shall address the behaviors of the resident and the interventions used.~~

~~There are no minutes assigned to this area. It is strictly a $50.00 add-on applied to residents meeting the following criteria.~~

~~MDS item~~	~~Description~~
~~I1cc = 1~~ ~~AND~~	~~Traumatic brain injury~~
~~B1 = 0~~ ~~AND~~	~~Not comatose~~
~~S1 = 0~~ ~~AND~~	~~Does not meet Subpart S criteria~~
~~E4aA = 3 and E4 a B = 1~~ ~~or~~	~~Wandering daily and alterability~~
~~E4bA = 3 and E4bB = 1~~ ~~or~~	~~Verbally abusive behavioral symptoms daily and alterability~~
~~E4cA = 3 and E4cB = 1~~ ~~or~~	~~Physically abusive behavioral symptoms daily and alterability~~
~~E4dA = 3 and E4dB = 1~~ ~~or~~	~~Socially inappropriate/disruptive behavioral symptoms daily and alterability~~
~~E4eA = 3 and E4eB = 1~~ ~~AND~~	~~Resists care daily and alterability~~
~~P1beA ≥ 1~~ ~~AND~~	~~Psychological therapy~~
~~P2a = 1~~ ~~AND~~	~~Special behavior symptom evaluation~~
~~P2b = 1~~	~~Evaluation by a mental health specialist in last 90 days~~

~~**8) Special Patient Need Factors**~~

~~There shall be documentation to support the deficits identified on the MDS in communication and vision problems.~~

~~**Communication**~~

~~Count~~	~~MDS items~~	~~Description~~	~~Staff Minutes~~

~~I~~	~~C4 > 0 or~~ ~~C6 > 0~~	~~Deficit in making self understood~~ ~~Deficit in understanding others~~	~~1% of all staff time accrued in all categories from ADLs through Exceptional Care~~

~~**Vision Problems**~~

~~Count~~	~~MDS items~~	~~Description~~	~~Staff Minutes~~
~~I~~	~~D1 > 0 or~~ ~~D2a = 1 or~~ ~~D2b = 1~~	~~Vision impaired to Severely impaired~~ ~~Decreased peripheral vision~~ ~~Experience halos around lights, light flashes~~	~~2% of all staff time accrued in all categories from ADLs through Exceptional Care~~

~~**Accident/Fall Prevention**~~

~~Documentation shall support the following for scoring accident/fall prevention.~~

~~1) The resident has the risk factor identified on the MDS.~~

~~2) The resident has been assessed for fall risks.~~

~~3) If the resident is identified as high risk for falls, interventions have been identified and implemented.~~

~~Count~~	~~MDS items~~	~~Description~~	~~Staff Minutes~~
~~I~~	~~H1aa = 1 or~~ ~~O4a-d = 7 or~~ ~~H1b > 0 or~~ ~~J1f = 1 or~~	~~Seizure disorder~~ ~~Medications~~ ~~Incontinent urine~~ ~~Dizziness~~	~~3% of all staff time accrued in all categories from ADLs through Exceptional Care~~

	~~J4a = 1 or~~ ~~J4b = 1 or~~ ~~J1n = 1 or~~ ~~E4aA > 0~~	~~Fell in past 30 days~~ ~~Fell in past 31-180 days~~ ~~Has unsteady gait~~ ~~Wandered in last 7 days~~	

~~**Restraint Free**~~

~~There shall be documentation to support the previous use of a restraint and the resident response to the restraint. There shall be evidence that the restraint was discontinued.~~

~~Count~~	~~MDS items~~	~~Description~~	~~Staff Minutes~~
~~I~~		~~In last assessment:~~	
	~~P4c > 1 or~~	~~Used trunk restraint daily in last 7 days~~	~~2% of all staff time accrued in all categories from ADLs through Exceptional Care~~
	~~P4d > 1 or~~	~~Used limb restraint daily in last 7 days~~	
	~~P4e > 1~~	~~Used chair that prevents rising daily in last 7 days~~	
	~~And~~	~~And in current assessment:~~	
	~~P4c = 0 and~~	~~Not used trunk restraint in last 7 days~~	
	~~P4d = 0 and~~	~~Not used limb restraint in last 7 days~~	
	~~P4e = 0~~	~~Not used chair that prevents rising in last 7 days~~	

~~**Activities**~~

~~There shall be documentation to support the average time involved in activities.~~

~~Count~~	~~MDS items~~	~~Description~~	~~Staff Minutes~~
~~I~~	~~N2 = 0 or 1 AND Any of the following checked:~~	~~Average time involved in activities~~	~~2% of all staff time accrued in all categories from ADLs through Exceptional Care~~
	~~G6a = 1 or~~	~~Bedfast all or most of the time~~	
	~~C4 > 1 or~~	~~Sometimes too rarely understood~~	
	~~C6 > 1 or~~	~~Sometimes too rarely understands others~~	
	~~E1o > 0 or~~	~~Withdrawal from activity~~	
	~~AA3 ≤ 50 or~~	~~Age is 50 or younger at assessment reference date~~	
	~~E1p > 0 or~~	~~Reduced social interactions~~	
	~~E4a-eA > 0 or~~	~~Any behavioral symptoms~~	
	~~G4b-dB > 0 OR~~	~~Any limited ROM~~	
	~~N2 = 0 or 1 AND~~	~~Average time involved in activities~~	

	~~E2 > 0 AND~~	~~Mood persistence~~	
	~~E1a > 0 or~~	~~Negative statements~~	
	~~E1n > 0 or~~	~~Repetitive physical movements~~	
	~~E4eA > 0 or~~	~~Resists care~~	
	~~E1o > 0 or~~	~~Withdraws from activity~~	
	~~E1p > 0 or~~	~~Reduced social interaction~~	
	~~E1j > 0 or~~	~~Unpleasant mood in morning~~	
	~~N1d =1 or~~	~~Not awake all or most of the time~~	
	~~E1g > 0 or~~	~~Statements that something terrible will happen~~	
	~~K3a = 1 or~~	~~Weight loss~~	
	~~(N1a,b,c ≤ 1 AND~~	~~Not awake all or most of the time~~	
	~~B1 =0)~~	~~Not comatose~~	

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

Section 147.TABLE B MDS-MH Staff Time (in Minutes) and Allocation by Need Level (Repealed)

~~As part of the transition to a new reimbursement system for Class I IMDs, Table B sets forth the initial criteria that may likely be used to incentivize provision of clinically appropriate services to individual residents of these facilities. The Department intends to secure data and begin analyzing this data, including a sample time study, prior to implementation of this payment model.~~

~~Each MDS-MH item in Table B includes a description of the item from the MDS-MH, and the variable time assigned to each level represents the type of staff that should be delivering the service (aide, licensed, RN, LPN and social services) and the number of minutes allotted to that service item.~~

~~MDS Item~~	~~Description of Medical Services~~	~~Aide~~	~~Licensed~~	~~RN~~	~~LPN~~	~~Social Service~~
	~~Program Base~~	~~25~~	~~11~~	~~1~~	~~1~~	~~25~~
~~G1a=2~~ ~~G1=3~~	~~Hygiene 1~~ ~~Hygiene 2~~	~~8~~ ~~12~~	~~1~~ ~~1~~		~~1~~ ~~1~~	~~3~~ ~~3~~
~~G1b=3 or G1c=3~~ ~~G1b=4 or G1b=5 or G1c=4 or G1c=5~~	~~Mobility 1~~ ~~Mobility 2~~	~~12~~ ~~17~~		~~1~~ ~~1~~	~~1~~ ~~1~~	~~1~~ ~~1~~
~~G1d=2~~ ~~G1d=3~~	~~Toilet 1~~ ~~Toilet 2~~	~~10~~ ~~14~~	~~1~~ ~~1~~	 ~~1~~	~~1.5~~ ~~1~~	~~1~~ ~~1~~
~~G1e=2~~ ~~Gle=3~~	~~Eating 1~~ ~~Eating 2~~	~~10~~ ~~16~~	~~1~~ ~~1~~	 ~~1~~	 ~~1~~	~~2~~ ~~1~~
~~G1f=2~~ ~~G1f=3~~	~~Bathing 1~~ ~~Bathing 2~~	~~10~~ ~~14~~	~~2~~ ~~1~~	 ~~1~~	 ~~1~~	~~3~~ ~~2~~
~~H1=2 or H1=3~~	~~Hearing 1~~	~~3~~			~~1~~	~~3~~
~~H2=2~~ ~~H2=3 or H2=4~~	~~Vision 1~~ ~~Vision 2~~	~~3~~ ~~3~~	 ~~1~~		~~1~~ ~~1~~	~~3~~ ~~3~~

~~H3=2 or H3=3~~ ~~H3=4~~	~~Expression 1~~ ~~Expression 2~~	~~6~~ ~~8~~	~~2~~ ~~2~~			~~4~~ ~~7~~
~~H4=2 or H4=3~~ ~~H4=4~~	~~Understanding 1~~ ~~Understanding 2~~	~~6~~ ~~8~~	~~2~~ ~~2~~			~~4~~ ~~7~~
~~ICD-9=250 to 250.9~~	~~Diabetes 1~~	~~8~~		~~2~~	~~4~~	~~2~~
~~N2a=1 or N2b=1 or N2c=1 or N2d=1 or Hyperlipidemia (ICD-9=272.0 to 272.9)~~	~~Nutrition 1~~	~~5~~	~~1~~	~~1~~	~~2~~	~~2~~
~~N3a=1 or N3b=1 or N3c=1 or N4=1~~	~~Eating Disorders 1~~	~~5~~	~~3~~	~~1~~	~~2~~	~~3~~
~~L2a=1 or L2b=1 or L2c=1~~	~~Nursing Interventions 1~~	~~2~~		~~0.5~~	~~0.5~~	
~~L2a=2 or L2b=2 or L2c=2~~	~~Nursing Interventions 2~~	~~2.5~~	~~1~~	~~0.5~~	~~0.5~~	~~1~~
~~L2a=3 or L2b=3 or L2c=3~~	~~Nursing Interventions 3~~	~~3.5~~	~~1~~	~~1.5~~	~~1.5~~	~~1~~
~~L2a=4 or L2b=4 or L2c=4~~	~~Nursing Interventions 4~~	~~4.5~~	~~1~~	~~1.5~~	~~1.5~~	~~2~~
~~L2a=5 or L2b=5 or L2c=5~~	~~Nursing Interventions 5~~	~~5.5~~	~~1~~	~~2~~	~~2~~	~~2~~
~~L2a=6 or L2b=6 or L2c=6~~	~~Nursing Interventions 6~~	~~6~~	~~2~~	~~2~~	~~2~~	~~2~~
~~L2a=7 or L2b=7 or L2c=7~~	~~Nursing Interventions 7~~	~~7~~	~~2~~	~~3~~	~~2~~	~~2~~
~~CPS=3 or 4~~ ~~CPS=5 or 6~~	~~Cognitive Problems 1~~ ~~Cognitive Problems 2~~	~~4~~ ~~6~~	~~2~~ ~~3~~			~~5~~ ~~7~~

~~Number of E1a to E1g scoring >1=1 or 2~~	~~Behavior Disturbance 1~~	~~5~~	~~2~~			~~5~~
~~Number of E1a to E1g scoring >1=3 or 4~~	~~Behavior Disturbance 2~~	~~10~~	~~2~~			~~8~~
~~Number of E1a to E1g scoring >1=5 or more~~	~~Behavior Disturbance 3~~	~~15~~	~~3~~			~~10~~
~~D1a=1~~ ~~D1a=2~~ ~~D1a=3 or D1a=4~~	~~Self Injury 1~~ ~~Self Injury 2~~ ~~Self Injury 3~~	~~2~~ ~~3~~ ~~10~~	 ~~2~~ ~~5~~	 ~~1~~	 ~~2~~	~~2~~ ~~5~~ ~~10~~
~~D1b=1~~	~~Intent to Kill Self 1~~		~~2~~			~~5~~
~~D1a=0 and D1c=1~~	~~Considered Self Injurious Act 1~~	~~5~~	~~2~~			~~1~~
~~D1a=0 and D1d=1~~	~~At Risk for Self Injury 1~~	~~2~~	~~2~~			~~5~~
~~D2a=1~~ ~~D2a=2~~ ~~D2a=3 or D2a=4~~	~~Violence 1~~ ~~Violence 2~~ ~~Violence 3~~	~~2~~ ~~3~~ ~~10~~	 ~~2~~ ~~5~~	 ~~1~~	 ~~2~~	~~2~~ ~~5~~ ~~10~~
~~D2b=1~~ ~~D2b=2~~ ~~D2b=3 or D2b=4~~	~~Intimidation Threats to Others 1~~ ~~Intimidation Threats to Others 2~~ ~~Intimidation Threats to Others 3~~	~~2~~ ~~3~~ ~~10~~	 ~~2~~ ~~5~~			~~2~~ ~~5~~ ~~10~~
~~D2c=2~~ ~~D2c=3 or D2c=4~~	~~Violent Ideation 1~~ ~~Violent Ideation 2~~	~~2~~ ~~4~~	 ~~2~~			~~1~~ ~~7~~
~~K2b=1~~	~~Medication Support 1~~	~~6~~	~~1~~	~~1~~	~~1~~	~~5~~
~~K5>0~~	~~Acute Control~~	~~2~~	~~1~~	~~2~~	~~2~~	~~5~~

	~~Medications 1~~					
~~M3a>0~~	~~Required Staff Accompaniment~~	~~5~~				~~2~~
~~A5a=1 or 2~~ ~~A5a=3 or 4~~ ~~A5b=1 or 2~~ ~~A5b=3 or 4~~	~~Hx Crim Justice Viol 1~~ ~~Hx Crim Justice Viol 2~~ ~~Hx Crim Justice Nonviol 1~~ ~~Hx Crim Justice Nonviol 2~~		~~2~~ ~~4~~ ~~1~~ ~~2~~			~~3~~ ~~5~~ ~~2~~ ~~4~~
~~M2a>0 or M2b>0~~ ~~M2c>0 or M2d>0 or M2e>0~~	~~Close or Constant Observation 1~~ ~~Close or Constant Observation 2~~	~~15~~ ~~30~~	~~5~~ ~~10~~			~~5~~ ~~10~~
~~P3≤ 5 and L4a>1~~	~~Discharge Planning 1~~		~~10~~			~~25~~
~~L1i≥ 3~~	~~PRS Director or Coordinator Counseling~~					~~5~~
~~L3a or L3b=2 or 3 and L4aA=2 or 3 and P3<5~~	~~Community Reintegration~~	~~3~~	~~3~~			~~5~~
~~L3b=2 or 3 and L4bA=2 or 3~~	~~Social/Family Functioning~~	~~3~~	~~3~~			~~12~~
~~L3b or L3d = 2 or 3 and L4cA=2 or 3~~	~~Psych Rehab/ Recover Readiness and Support~~	~~3~~	~~4~~			~~15~~
~~L3b=2 or 3 and L4dA=2 or 3~~	~~Skills Training and Generalization~~	~~5~~	~~5~~			~~20~~

~~L3a, L3b or L3d=2 or 3 and L4eA=2 or 3 and C1>1 or C2=2~~	~~Substance Use/Abuse Management~~	~~6~~	~~5~~			~~15~~
~~L3a or L3b=2 or 3 and L4fA=2 or 3~~	~~Vocational/ Academic Development~~	~~2~~	~~3~~			~~12~~
~~L3a or L3b + 2 or 3 and L4gA=2 or 3 and D2a=2 or D2b=3 or D2c=3 or E1c>1~~	~~Aggression/Anger Management~~		~~5~~			~~15~~
~~L3a or L3b=2 or 3 and L4hA=2 and E1b or E1d or E1e>0~~	~~Behavior Management~~	~~2~~	~~3~~			~~13~~
~~L3b=2 and L4iA=2~~	~~Enhanced Activity Program~~	~~5~~	~~3~~			~~12~~
~~L3a or L3b=2 and L4jA=2~~	~~Work Program (Department of Labor Compliant)~~		~~5~~			~~25~~
~~L3b=2 or 3 and L4kA=2 or 3~~	~~Illness Self-Management (SAMHSA Toolkit)~~	~~5~~	~~5~~			~~20~~
~~L3a and L3b=2 or 3 and L41A=2 or 3~~	~~Specialized Therapies (DBT)~~		~~5~~			~~25~~
~~L5=1~~	~~Adherence with Programs 1~~	~~10~~	~~4~~			~~10~~
~~L6≥1~~	~~Required staff accompaniment to medical appointment~~	~~10~~				

	~~mandated by the outside medical provider~~					
~~Psychotropic Medications as Listed in Section R~~	~~Psychotropic Medication Monitoring~~	~~7~~		~~8~~	~~8~~	

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~**Compute Cognition Category Using Cognitive Performance Scale (CPS)**~~	
~~**Compute Intermediate Cognition Variables**~~	
~~Count of Non-Independence Items for CPS (Cog1)~~	~~If (F1a=1) add 1 to Cog 1~~ ~~If (F2=1 or 2 or 3) add 1 to Cog 1~~ ~~If (H3=1 or 2 or 3 or 4) add 1 to Cog 1~~
~~Count of Moderate to Severe Impairments for CPS (Cog 2)~~	~~If (F2=2 or 3) add 1 to Cog 2~~ ~~If (H3=3 or 4) add 1 to Cog 2~~
~~**Compute CPS**~~	
~~Compute CPS Level 1~~	~~If (Cog 1=1) CPS=1~~
~~Compute CPS Level 2~~	~~If (Cog 1=2 or 3 and Cog 2=0) CPS=2~~
~~Compute CPS Level 3~~	~~If (Cog 1=2 or 3 and Cog 2=1) CPS=3~~
~~Compute CPS Level 4~~	~~If (Cog 1=2 or 3 and Cog 2=2) CPS=4~~
~~Compute CPS Level 5~~	~~If (F2=4 or 5 and G1e <6) CPS=5~~
~~Compute CPS Level 6~~	~~If (F2=4 or 5 and G1e=6 or 8) CPS=6~~
~~**Convert CPS to Cognition Reimbursement Categories**~~	

(Source: Repealed at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Procedures of the Department of Human Rights

2) Code Citation: 56 Ill. Adm. Code 2520

3)

Section Numbers:	Proposed Action:
2520.415	New
2520.490	New
2520.700	Amend
2520.710	Amend
2520.720	Amend
2520.730	Amend
2520.795	Amend
2520.APPENDIX A	Amend

4) Statutory Authority: Implementing Articles 1 through 7B of the Illinois Human Rights Act [775 ILCS 5/Arts. 1 through 7B] and the Intergovernmental Cooperation Act [5 ILCS 220], and authorized by Sections 7-101(A) and 7-105(A) of the Illinois Human Rights Act [775 ILCS 5/7-101(A) and 7-105(A)]

5) A Complete Description of the Subjects and Issues Involved: The proposed amendments update the Department's affirmative action rules to be consistent with the statutory amendments to the Illinois Human Rights Act which modified the name of the affirmative action groups by PA 97-396, reduce the number of state regions from 11 to 10, and realign the regions to be consistent with the regions used by the Department of Employment Security and Department of Labor. Additionally, the amendments clarify that State Colleges and Universities are not covered by the Illinois Human Rights Act's affirmative action requirements. Further, the amendments add a new rule to explain the procedures for processing charges of discrimination initially filed with the Equal Employment Opportunity Commission and dual filed with the Department pursuant to the Department's work-sharing agreement with the EEOC and PA 97-596. Additionally, the amendments set forth the procedures for the Department's mediation program, including who is permitted to be present for the mediation conference, what happens if the case settles or does not settle, when the mediation conference will be terminated, and confidentiality of the mediation conference.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rule currently in effect? No

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

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 amendments clarify affirmative action requirements of State agencies and will affect a unit of local government only if the Department issues a finding of default against that unit 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:

David T. Rothal, Staff Attorney
Illinois Department of Human Rights – Legal Division
100 W. Randolph St., Ste. 10-100
Chicago, IL 60601

312/814-6257
TTY: 217/785-5125

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: The amendments do not change the duties of small businesses, small municipalities.

B) Reporting, bookkeeping or other procedures required for compliance: No changes

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: The proposed amendments were contained in the regulatory agenda for January 2014.

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

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

TITLE 56: LABOR AND EMPLOYMENT
CHAPTER II: DEPARTMENT OF HUMAN RIGHTS

PART 2520
PROCEDURES OF THE DEPARTMENT OF HUMAN RIGHTS

SUBPART A: INTERPRETATIONS

Section
2520.10 Definition of Terms
2520.20 Computation of Time
2520.30 Service of Documents
2520.40 Filing with the Department
2520.50 Separability
2520.110 Preservation of Records by Employers, Labor Organizations, Employment Agencies and Respondents

SUBPART B: CHARGE

Section
2520.310 Time of Filing (Repealed)
2520.320 Form (Repealed)
2520.330 Contents
2520.340 Requirements for Charge (Repealed)
2520.350 Unperfected Charge
2520.360 Amendment
2520.370 Substitution and Addition of Parties (Repealed)
2520.380 Withdrawal of Charge

SUBPART C: PROCEDURE UPON CHARGE

Section
2520.405 Verified Response to Charge
2520.410 Docketing and Service of Charge (Repealed)
2520.415 Mediation
2520.420 Maintenance of Records (Repealed)
2520.430 Investigation
2520.440 Fact-Finding Conference
2520.450 Administrative Closure (Repealed)

DEPARTMENT OF HUMAN RIGHTS

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2520.460 Determination After Investigation (Repealed)
2520.470 Conciliation (Repealed)
2520.480 Complaint (Repealed)
2520.490 EEOC Dual Filed Charges

SUBPART D: SETTLEMENTS

Section
2520.510 Settlement
2520.520 Non-Disclosure (Repealed)
2520.530 Dismissal for Refusal to Accept Settlement Offer (Repealed)
2520.540 Non-Compliance with Settlement Terms (Repealed)

SUBPART E: ADMINISTRATIVE CLOSURE, DISMISSAL AND DEFAULT

Section
2520.550 Administrative Closure
2520.560 Dismissal
2520.570 Default

SUBPART F: REQUESTS FOR REVIEW

Section
2520.573 Filing with Chief Legal Counsel
2520.575 Contents of Request for Review
2520.577 Notice by the Chief Legal Counsel
2520.580 Extensions of Time
2520.583 Reply to Request for Review and Surreply
2520.585 Additional Investigation
2520.587 Decision

SUBPART G: RELATIONS WITH LOCAL HUMAN RIGHTS AGENCIES

Section
2520.610 Scope and Purpose (Repealed)
2520.620 Definitions (Repealed)
2520.630 Cooperative Agreements
2520.640 Nature of Cooperative Agreements
2520.650 Training and Technical Assistance

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

2520.660 Promotion of Communication and Goodwill

SUBPART H: EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION BY STATE EXECUTIVE AGENCIES

Section
2520.700 Definitions
2520.710 Scope and Purpose
2520.720 Affirmative Action Groups
2520.730 Consideration of Additional Groups
2520.740 Definitions (Renumbered)
2520.750 Nondiscrimination (Repealed)
2520.760 Plans
2520.770 Reporting and Record-Keeping
2520.780 Equal Employment Opportunity Officers
2520.790 Complaint Process
2520.795 EEO/AA Performance Reviews
2520.797 Sanctions for Noncompliance

SUBPART I: SEXUAL HARASSMENT IN HIGHER EDUCATION POLICIES

Section
2520.810 Posting of Sexual Harassment Policies
2520.820 Notice to Show Cause

2520.APPENDIX A Contents of Affirmative Action Plans
2520.APPENDIX B Value Weight Assignment Chart (Repealed)
2520.APPENDIX C Contents of Layoff Reports
2520.APPENDIX D Illinois Counties by Region

AUTHORITY: Implementing Articles 1 through 7B of the Illinois Human Rights Act [775 ILCS 5/Arts. 1 through 7B] and the Intergovernmental Cooperation Act [5 ILCS 220], and authorized by Sections 7-101(A) and 7-105(A) of the Illinois Human Rights Act [775 ILCS 5/7-101(A) and 7-105(A)].

SOURCE: Adopted November 20, 1972 by the Fair Employment Practices Commission; transferred to the Department of Human Rights by P.A. 81-1216, effective July 1, 1980; emergency amendments at 4 Ill. Reg. 39, p. 335, effective September 17, 1980, for a maximum of 150 days; amended at 5 Ill. Reg. 1627, effective February 9, 1981; amended at 6 Ill. Reg.

2125, effective February 8, 1982; amended at 6 Ill. Reg. 3076, effective March 15, 1982; amended at 6 Ill. Reg. 8090, effective July 1, 1982; codified at 8 Ill. Reg. 17884; amended at 17 Ill. Reg. 15556, effective September 13, 1993; amended at 18 Ill. Reg. 16829, effective November 4, 1994; emergency amendment at 20 Ill. Reg. 445, effective January 1, 1996, for a maximum of 150 days; emergency amendment at 20 Ill. Reg. 5084, effective March 15, 1996, for a maximum of 150 days; amended at 20 Ill. Reg. 6291, effective April 18, 1996; amended at 20 Ill. Reg. 10631, effective July 24, 1996; amended at 21 Ill. Reg. 14081, effective October 10, 1997; amended at 26 Ill. Reg. 17217, effective November 18, 2002; amended at 29 Ill. Reg. 804, effective December 28, 2004; amended at 30 Ill. Reg. 1343, effective January 13, 2006; amended at 30 Ill. Reg. 13403, effective July 31, 2006; amended at 30 Ill. Reg. 18715, effective November 20, 2006; amended at 31 Ill. Reg. 12319, effective August 8, 2007; amended at 31 Ill. Reg. 14815, effective October 19, 2007; amended at 32 Ill. Reg. 13482, effective August 1, 2008; amended at 33 Ill. Reg. 11311, effective July 20, 2009; amended at 33 Ill. Reg. 17086, effective December 4, 2009; amended at 34 Ill. Reg. 11413, effective July 20, 2010; amended at 36 Ill. Reg. 8699, effective June 1, 2012; amended at 38 Ill. Reg. _____, effective _____.

SUBPART C: PROCEDURE UPON CHARGE

Section 2520.415 Mediation

a) Purpose. Pursuant to Section 7A-102(B-1) of the Act, the Department may conduct a conference for the purpose of negotiating a settlement to resolve the issues in dispute if the parties to a charge voluntarily agree to submit the charge to mediation.

b) Termination of Mediation. The Department will terminate the mediation proceedings if either party fails to comply with this Section or if the Department determines that continuation of the mediation proceedings is unlikely to result in a settlement of the charge of discrimination.

c) Extension. Prior to scheduling a mediation conference, the Department will require parties to the charge to agree in writing to extend the 365 days for processing the case pursuant to Section 7A-102(G)(1) of the Act.

d) Attorneys, Witnesses. A party may be accompanied at a mediation conference by his/her attorney or other representative, and by a translator if necessary. An attorney for a party not previously having entered an appearance must do so at the beginning of the conference. The parties shall not bring witnesses to the mediation conference.

e) Conduct. The mediator or other designee of the Department shall conduct the mediation conference and control the proceedings. The Department may limit the number of attendees who attend the mediation conference for each party.

f) Settlement Agreement. Pursuant to Section 7A-102(B-1) of the Act, no party attending a mediation conference shall be required to accept the result of a mediation. Each party to a settlement agreement will have 10 consecutive calendar days from the date of the conference to revoke his/her acceptance of a settlement. The 10 day revocation period may be waived by written agreement of the parties.

g) Failure to Settle. If the parties are unable to reach an agreement, or if a party revokes his/her acceptance of the settlement within 10 days, the Department will investigate the charge of discrimination.

h) Confidentiality. The mediation conference will be confidential. No tape recording, stenographic report or other verbatim record of the conference will be permitted.

(Source: Added at 38 Ill. Reg. _____, effective _____)

Section 2520.490 EEOC Dual Filed Charges

a) The following will apply to all charges filed after August 26, 2011 with the Equal Employment Opportunity Commission (EEOC) and dual filed with the Department pursuant to Section 7A-102(A-1) of the Act:

1) The charge will be initially investigated by the EEOC pursuant to the EEOC's rules and procedures.

2) The Department will not take any action on the charge until the EEOC issues its final determination.

3) Within 30 days after receiving the final determination from the EEOC, the complainant must submit a copy of the EEOC's determination to the Department in order to preserve the complainant's rights under the Act.

b) The Department will investigate a charge filed with the EEOC and dual filed with the Department pursuant to Section 7A-102(A) and (B) through (G) of the Act if:

1) The EEOC dismisses the charge or a portion of the charge of discrimination because, under federal law, the EEOC lacks jurisdiction over the charge and the Department has jurisdiction over the charge; or

2) The EEOC defers the case to the Department for investigation pursuant to the Department's work sharing agreement with the EEOC.

c) After receiving notice from the EEOC that a charge has been filed pursuant to Section 7A-102(A-1) of the Act, the Department will notify the parties that:

1) A charge has been received by the EEOC and has been sent to the Department for dual filing purposes;

2) The EEOC is the governmental agency responsible for investigating the charge and the investigation shall be conducted pursuant to the rules and procedures adopted by the EEOC;

3) The Department will take no action on the charge until the EEOC issues its final determination;

4) The complainant must submit a copy of the EEOC's final determination within 30 days after service of the final determination by the EEOC on the complainant in order to preserve the complainant's rights under the Act; and

5) The time period to investigate the charge contained in Section 7A-102(G) is tolled from the date on which the charge is filed with the EEOC until the EEOC issues its final determination.

d) If the complainant fails to submit a copy of the EEOC's final determination to the Department within 30 days after receipt of the EEOC's final determination, the Department may dismiss the charge for lack of jurisdiction. The complainant may request to have the Illinois Human Rights Commission review the Department's determination that it lacks jurisdiction over the charge by filing a Request for Review with the Illinois Human Rights Commission within 90 days

after receipt of the Department's Notice of Dismissal in accordance with Section 8-103 of the Act.

e) If the Department does not receive notification from the EEOC that a charge has been filed until after the EEOC has already issued its final determination, the complainant shall have 30 days from receipt of the Department's notice to submit a copy of the EEOC's final determination to the Department.

f) If the EEOC finds reasonable cause for a violation, the EEOC's final determination is the issuance of a Notice of Right to Sue after conciliation has failed. The EEOC's finding of cause is not a final determination and the Department will not take any action until the EEOC's conciliation process is complete, which occurs when the EEOC either files its complaint or when it issues to the complainant a Notice of Right to Sue after conciliation has failed. The complainant has 30 days from receipt to submit a copy of the EEOC's Notice of Right to Sue to the Department.

g) If the complainant first files a charge with the EEOC and then files a charge containing the same or similar allegations with the Department, the Department may administratively close the charge filed with the Department as a duplicate charge. The Department shall process the EEOC-filed charge pursuant to Section 7A-102(A-1) of the Act.

h) If the complainant first files a charge with the Department and then files a charge containing the same or similar allegations with the EEOC, and the EEOC charge is dual filed with the Department pursuant to Section 7A-102(A-1) of the Act, the Department may administratively close the dual filed charge with the EEOC as a duplicate charge. The Department shall process the Department charge pursuant to Section 7A-102(B) through (G).

i) If the complainant timely notifies the Department of the EEOC's determination and concurrently requests that the Department review the EEOC's determination, the Department will serve a copy of the charge on the respondent and review the EEOC's determination pursuant to Section 7A-102(A-1)(3)(b) without further notice to the parties.

j) If the complainant timely notifies the Department of the EEOC determination and concurrently submits a written request for the Department to adopt the EEOC's determination, the Department may adopt the EEOC's determination as a

dismissal for lack of substantial evidence pursuant to Section 7A-102(A-1)(3)(a) of the Act without further notice to the parties.

k) The Department will adopt the EEOC's determination after the complainant has requested the Department review the EEOC's determination if the complainant notifies the Department in writing, and within a reasonable period of time after requesting the Department to review the EEOC determination, that the complainant desires to withdraw the previous request and have the Department adopt the EEOC's finding.

l) As part of any further investigation pursuant to Section 7A-102(A-1)(3)(b) of the Act, the Department will not require:

1) The respondent to file a verified response to Complainant's charge pursuant to Section 7A-102(B) of the Act or Section 2520.405 of this Part; or

2) The parties to attend a fact finding conference pursuant to Section 7A-102(C)(4) of the Act or Section 2520.440 of this Part.

m) The 365-day time period to investigate the charge pursuant to Section 7A-102(G) of the Act shall be tolled from the date the charge is filed with the EEOC until the date the EEOC issues its final determination. The Department will consider the EEOC final determination issued on the date set forth in the EEOC's final determination.

n) Complainants may withdraw the charge with the Department prior to the EEOC issuing a final determination by submitting a withdrawal form identifying the parties' names and the Department's control number. Upon receiving a properly submitted withdrawal form, the Department shall administratively close the charge pursuant to Section 2520.550.

(Source: Added at 38 Ill. Reg. _____, effective _____)

SUBPART H: EQUAL EMPLOYMENT OPPORTUNITY AND AFFIRMATIVE ACTION BY STATE EXECUTIVE AGENCIES

Section 2520.700 Definitions

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

For purposes of this Subpart, the following terms shall have the meanings indicated:

Affirmative Action Group – any of the groups listed in Section 2520.720 or 2520.730.

Agency – any instrumentality or facility of the executive branch of State government, as specified in Section 2520.710.

Central Management Services or CMS – the Department of Central Management Services or any successor agency responsible for its functions.

Chief Executive Officer – the director or other chief executive or administrator of any agency other than the Department.

Disability – as used in Section 2-105(B) of the Act and this Subpart, long-lasting impairment of physical, mental, hearing, cognition, ambulation, self care, independent living or other functions.

EEO – Equal Employment Opportunity.

EEO/AA – Equal Employment Opportunity/Affirmative Action.

EEO Job Categories – the following 8 categories: officials/managers; professionals; paraprofessionals; technicians; office/clerical workers; protective services workers; skilled craft workers; and service/maintenance workers.

EEO Officer – the Equal Employment Opportunity Officer, whether full or part-time, appointed by a State agency pursuant to Section 2-105(B)(4) of the Act and Section 2520.780 of this Part.

Layoff – the placement of an employee in non-paid and non-working status without prejudice, either temporarily or for an indeterminate length of time. Layoff does not include, either temporarily or indeterminately, a means or form of discipline.

Minority – those groups, or members of a group, listed in Section 2520.720 or 2520.730, other than women and disabled persons.

Numerical Goals – the number of members of an affirmative action group that

have been determined to be available to an agency for employment in each of the EEO job categories.

Petitioning Group – a chartered not-for-profit organization that is recognized by the community it purports to represent that has as its purpose fostering the interests and well being of that community.

Plan – an affirmative action plan for employment as described in Section 2520.760.

Program Goals – a set of actions established to address affirmative action or EEO problems cited in the agency's plan.

Promotable – agency employees who, within the fiscal year, under standard employment practices, are able to move from one of the EEO job categories to another.

Reasonable Accommodation – as it relates to disabled employees and applicants, modification of the work site, work process and/or work schedule to enable a disabled person to perform the major functions of a specific job; however, such an accommodation cannot impose an undue hardship on the conduct of the business of the employer or labor organization.

Region – a group of adjacent counties. There are 10~~11~~ regions within Illinois as identified in Appendix D.

Trainable – agency employees who, within the fiscal year, are eligible for participation in established training programs that, when completed, would allow them to move from one of the EEO job categories to another.

Transferable – agency employees eligible for transfer within the fiscal year from one region to another.

Underutilized Category – a category in which the number of employed members of an affirmative action group for which numerical goals have been set does not reflect the availability of that group in the agency workforce in that EEO job category.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

Section 2520.710 Scope and Purpose

This Subpart implements the affirmative action provisions of the Act, which apply to *every State executive department, State agency, board, commission and instrumentality* [775 ILCS 5/2-105(B) and 7-105]. Agencies of the legislative and judicial branches and local government entities and State colleges and universities are excluded. This Subpart interprets the responsibilities imposed on covered agencies to practice EEO and affirmative action in employment. This Subpart also describes the methods by which the Department will monitor and assist agencies in complying with those obligations.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 2520.720 Affirmative Action Groups

Section 2-105(B) of the Act requires agencies to keep records, analyze their workforces, and establish numerical and program goals for employment *by race, national origin, sex and disability, and any other category which the Department may require by rule* [775 ILCS 5/2-105(B)]. State agency affirmative action efforts should focus upon the following groups: Blacks and African Americans, women, Hispanics and Latinos, American Indians and Alaskan Natives~~Native Americans~~, Asians, Native Hawaiians and Other Pacific Islanders, and disabled persons. The Department will apply the criteria of Section 2520.730 to identify other groups to be added to this list.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 2520.730 Consideration of Additional Groups

a) Criteria – In order for an affirmative action group to be recognized, a petitioning group must present to the Director the following criteria:

1) the relationship between the proportion of an affirmative action group in the State population and the proportion of the affirmative action group in State employees, and whether that proportion is less than 4/5 of the availability of that group in each of the 8 EEO categories;

2) other authoritative statistical evidence, surveys and studies reflective of the discrimination experienced by the group, particularly, but not exclusively, as they relate to experience in Illinois;

3) the frequency with which charges alleging the discrimination, as compared to discrimination against other minorities, have been filed with the Department, its predecessors and other federal and local entities that investigate employment discrimination charges;

4) whether employment discrimination is longstanding against the group in question and is without an adequate legal remedy that is under ~~color of~~ State law; and

5) evidence of a continuing cycle of discrimination that, without affirmative action, will continue.

b) Consideration Process – If the Director determines that the criteria in subsection (a) have been met and that a petitioning group has submitted a petition as specified in 2 Ill. Adm. Code 925.110 of the Department's Rules:

1) A Notice of Proposed Rulemaking will be published by the Department in the Illinois Register, and the Department will commence rulemaking within 90 days after submission of a petition.

2) The Department shall convene a hearing, if required, in accordance with Section 5-40(b)(5) of the Illinois Administrative Procedure Act [5 ILCS 100/5-40(b)(5)].

3) If the rulemaking results in the addition of an affirmative action group, each agency shall develop numerical and program goals for that group.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 2520.795 EEO/AA Performance Reviews

The Department shall conduct periodic performance reviews of all agencies. On a quarterly basis, the EEO/AA reports submitted by agencies will be reviewed and the results of the review shall be shared with the agency in question, indicating whether corrective action is needed. On an annual basis, the Department shall determine whether each agency is in compliance with the EEO and affirmative action obligations of the Act and this Subpart. In the course of such a review, the Department may request documentation and reports reflecting the agency's employment practices and profile and may visit the agency's worksites and interview employees.

a) EEO/AA Criteria – The Department shall judge the agency's concerted effort and progress to provide equal employment opportunity and affirmative action for minorities, women and disabled persons, using the following criteria:

1) existence of an approved plan;

2) demonstration of the implementation of the agency's goals within the timeframe cited in the agency's plan. In order to be found in compliance with numerical goals, the agency must show that its percentage of hires and promotions for minorities and females in underutilized categories equals or exceeds 80% of the labor market availability rate of minorities and females in question based on Illinois Department of Employment Security Workforce Availability Information at http://www.ides.illinois.gov/page.aspx?item=2854~~http://www.ides.illinois.gov/page.aspx?item=925~~ or that the agency has made a concerted effort to reach those goals. In determining whether an agency made a concerted effort, the Department will evaluate the agency's overall actions taken over the course of the fiscal year to reduce its underutilization when there have been opportunities to hire and/or promote in underutilized categories. When agency underutilization occurs in a geographic region with labor market availability rates less than 2 percent for a specific affirmative action group, the Department will consider the availability of this group in evaluating an agency's performance. Compliance with program goals will be determined by an agency's documentation that those goals have either been achieved or a demonstration of a concerted effort to achieve those goals;

3) demonstration that the agency's EEO/AA policy has been disseminated throughout the agency;

4) documentation of the inclusion of EEO/AA principles and procedures in appropriate in-service training programs;

5) documentation of the inclusion of the agency's EEO Officer in the investigation and disposition of all internal and external discrimination grievances and complaints;

6) maintenance and timely submission of appropriate employment data and

reports as required in this Subpart and by federal authorities;

7) in an agency with 1,000 or more employees, documentation of the appointment, with the Director's approval, of an EEO Officer;

8) in an agency with fewer than 1,000 employees, documentation of the designation of an EEO Officer who may serve as a full-time EEO Officer or be responsible for other duties within the agency beyond those of an EEO Officer; and

9) documentation that the agency's EEO Officer has performed the duties and responsibilities outlined in the Act and this Subpart.

b) EEO/AA Profile – The Department shall complete an annual EEO/AA profile summarizing the agency's satisfaction of the various EEO/AA criteria outlined in subsection (a). The profile shall be sent to the agency's Chief Executive Officer and the EEO/AA officer with a letter of findings signed by the Director, and shall find the agency in:

1) Compliance: all EEO/AA criteria set forth in subsection (a) have been met by the agency; or

2) Non-compliance: EEO/AA criteria as set forth in subsection (a) have not been met.

c) Compliance Process

1) If the Department finds the agency is in compliance, the Director shall send a letter of findings of compliance to the agency and attach the EEO/AA profile. The agency will not be required to take any further action.

2) If the Department finds that an agency is in non-compliance in regards to subsection (a)(2) for the first year, in accordance with Section 7-105(H) of the Act, the Department will send a letter of findings of non-compliance to the agency and attach the EEO/AA profile. The Director will notify the agency and the Department of Central Management Services (CMS) that the agency must establish necessary training programs for preparation and

promotion of the category of individuals affected by the failure, in cooperation with CMS.

3) If the Department finds that an agency is in non-compliance in regards to subsection (a)(2) for the second consecutive year, in accordance with Section 7-105(H) of the Act, the Department will send a letter of findings of non-compliance to the agency and attach the EEO/AA profile. The Director will notify the agency and CMS that the agency must continue necessary training programs for preparation and promotion of the category of individuals affected by the failure, in cooperation with CMS.

4) If the Department finds that an agency is in non-compliance in regards to subsection (a)(2) for the third consecutive year, in accordance with Section 7-105(H) of the Act, the Department will inform the agency that it must continue training. Further, the Director may request that the Chief Executive Officer of the agency in question meet with him/her to discuss the agency's EEO/AA performance. In addition, the Department shall direct that the agency furnish to the Department a monthly report due on the fifth working day of each month that must be signed by the Chief Executive Officer and EEO Officer.

A) The monthly report shall list each employment transaction for the month by job title, EEO job category, pay grade or merit compensation level, geographic region and affirmative action group of the employee affected. The report shall also indicate the number of people in each affirmative action group who applied and who were selected for each transaction.

B) After an agency has completed training for failure to meet numerical and program goals, the agency shall describe in its monthly reports the training instituted and indicate the numbers of each affirmative action group participating in the training.

5) If the Department finds an agency in non-compliance with subsection (a)(2) for the third consecutive year, sanctions for non-compliance provided in Section 2520.797 will be invoked.

6) If the Department finds an agency in non-compliance with any other EEO/AA criteria other than subsection (a)(2):

A) The Director shall send a letter of findings of non-compliance to the agency, attach the EEO/AA profile report, and set forth recommendations for the agency to achieve compliance. The agency shall submit, within 30 days after receipt of the letter of findings of non-compliance, a corrective action plan incorporating the Director's recommendations, as well as other plans the agency develops to achieve compliance.

B) If the Department determines the corrective action plan is sufficient to bring the agency into compliance, the Department will notify the agency that it has 30 days to implement the plan.

C) The Department will monitor and periodically evaluate the implementation of the agency's corrective action plan.

D) If the Department determines that an agency's corrective action plan is not sufficient to bring the agency into compliance, the Department will notify the agency and request a plan with alternative measures to be submitted within 30 days after the agency's receipt of the Department's notice. If the alternative action plan is sufficient, the Department will proceed pursuant to subsections (b) and (c).

E) If the agency fails to provide an alternative action plan that is sufficient to bring the agency into compliance, the Department will invoke the sanctions for non-compliance provided in Section 2520.797.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

Section 2520.APPENDIX A Contents of Affirmative Action Plans

Part I

a) A completed Equal Employment Opportunity/Affirmative Action Certification Form;

b) An agency EEO/AA policy statement signed by the Chief Executive Officer;

c) An agency profile statement, describing the mission of the agency and its specific EEO/AA problems and needs;

d) Identification of the agency's primary EEO Officer and his/her work location and telephone number;

e) An organizational chart depicting the agency personnel at all levels responsible for implementing and monitoring the agency's affirmative action plan; and

f) A description of the methods to be used in accomplishing both internal and external dissemination of the agency's affirmative action policy and plan.

Part II

a) Workforce Transactions Report: an assessment of the agency's personnel transactions for the previous fiscal year, including, but not limited to, a breakdown of new hires, promotions, demotions, transfers and separations by affirmative action groups.

b) Workforce Analysis: an analysis, as of June 30 of the previous fiscal year, of the distribution of present employees by affirmative action group among the 8 EEO job categories in the 10~~11~~ regions.

Part III

a) Availability Analysis for Woman and Minorities~~each Affirmative Action Group~~:

1) Numerical goals must be determined when there are 10 or more employees in an EEO job category within a region where the labor market

availability rate for a specific affirmative action group is greater than 2 percent. The following factors must be considered in determining availability for each affirmative action group in each of the EEO job categories in each region of the State:

A) Those having requisite skills in the region; and

B) Those promotable, trainable and transferable, as these terms are defined in Section 2520.700.

2) The availability of members of each affirmative action group is determined by using the following methodology:

A) Each factor is assigned a value weight by the agency on a scale of 0 percent to 100 percent. The value weight indicates the applicability of each factor to the agency/facility in recruiting employees for that EEO job category. The sum of all value weights must be 100 percent, representing all persons available to work in a job category.

B) Each value weight is multiplied by the percentage of the affirmative action group in each of the factors. The result is a weighted factor for each of the categories.

C) The sum of the weighted factors is the availability percentage or ratio for that affirmative action group for that category for that region. This availability percentage or ratio is applied to the total number of positions in the agency's EEO job category to determine the numerical availability of the affirmative action group in each EEO job category.

b) Goals and Timetables: Agencies shall set numerical goals equal to the underutilization of affirmative action group members resulting from the process set forth in Part III(a)(2). No such goals shall be set when the labor force availability of an affirmative action group is less than 2 percent in the DHR region in which it occurs. Program goals must be developed in conjunction with the problems identified as the result of the agency's internal and external workforce analyses. Each numerical or program goal should include a brief description of the area of concern, objectives that delineate specific intentions, action items

outlining steps to be taken to achieve the objectives, the individual responsible for carrying out the action item, the target date for completion, and the procedure for monitoring the progress toward meeting the goal.

Part IV

Discrimination Complaint Process: A description of the procedures established by the agency to address charges of employment discrimination. This Part should include a statement that employees will be advised of their rights to file charges of discrimination with the Department, the U.S. Equal Employment Opportunity Commission, or any other appropriate government agency.

Part V

Affirmative Action for Disabled Persons

a) Methodology for Disabled Persons:

1) Factors: A numerical goal must be determined on an agency-wide basis, considering the proportion of people with disabilities in the Illinois labor force, as reflected in the most recent data provided by the U.S. Census Bureau American Community Survey.

2) Survey: Employees working after June 1, 2012 shall be surveyed to determine the State's utilization of people with disabilities, as defined in Section 2520.700. Subsequently hired employees shall be surveyed at the time of hire.

3) Availability: Availability must be determined by using the following methodology:

A) The total number of agency employees is multiplied by the percentage of employees with disabilities in the Illinois labor force (as supplied by the Department);

B) The agency will enter the number of employees identifying themselves as having disabilities through the disability survey process;

C) The number of employees in subsection (a)(3)(B) is subtracted from the result of subsection (a)(3)(A);

D) If the result of subsection (a)(3)(C) is a positive number, the agency must adopt that number as its goal for employing persons with disabilities. If the result of subsection (a)(3)(C) is "0" or a negative number, the agency is considered to be at parity with the external labor force; and

E) If there is underutilization, a numerical goal must be developed and should include a brief description of the area of concern, objectives that delineate specific intentions, action items outlining steps to be taken to achieve the objectives, the individual responsible for carrying out the action item, the target date for completion, and the procedure for monitoring progress toward meeting the goal.

b) Recruitment Procedures: Identification of sources used to recruit applicants with disabilities when persons with disabilities are underutilized.

c) Application Process Procedures

1) A review of employment criteria to assure they have no adverse impact on disabled persons;

2) Pre-employment inquiries – a statement regarding the inadmissibility of inquiries regarding an applicant's disability during the interview process;

3) Employment testing (for agencies conducting their own tests) – a statement that the tests do not have an adverse impact on disabled applicants and that reasonable accommodation will be provided in the administration of the tests, as required;

4) The prohibition of pre-employment medical examinations before an offer of employment;

5) The prohibition of pre-employment medical examinations after an offer of employment, unless the examinations are job related and required of all applicants for that position.

d) Reasonable Accommodation

1) Agency policy committing the agency to providing reasonable accommodations to disabled employees, signed by the Chief Executive Officer of the agency.

2) A description of the procedure to determine reasonable accommodation.

e) Physical Accessibility for Employment:

1) Of personnel offices;

2) Of the worksite;

3) For evacuation of disabled persons in emergency situations.

Part VI

Applicable EEO Laws: This Part should set forth the relevant text of any federal law that mandates the agency to adhere to additional EEO/AA requirements.

Part VII

This Part should have an appendix to the affirmative action plan that contains all supporting data, including the Hiring and Promotion Monitors and the exit questionnaire.

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

REGION 1
Cook
Dekalb
DuPage
Grundy
Kane
Kankakee
Kendall
Lake
McHenry
Will

REGION 2
Boone
Ogle
Stephenson
Winnebago

REGION 3
Bureau
Carroll
Henry
Jo Daviess
LaSalle
Lee
Mercer
Putnam
Rock Island
Whiteside

REGION 4
Adams
Brown
Hancock
Henderson
Knox
McDonough
Pike
Schuyler
Warren

REGION 5
DeWitt
Fulton
Livingston
Marshall
Mason
McLean
Peoria
Stark
Tazewell
Woodford

REGION 6
Champaign
Douglas
Ford
Iroquois
Piatt
Vermilion

REGION 7
Christian
Cass
Greene
Logan
Macon
Macoupin
Menard
Montgomery
Morgan
Sangamon
Scott
Shelby

REGION 8
Bond
Calhoun
Clinton
Jersey
Madison
Monroe
Randolph
St. Clair
Washington

REGION 9
Clark
Clay
Coles
Crawford
Cumberland
Edgar
Effingham
Fayette
Jasper

REGION 10
Alexander
Edwards
Franklin
Gallatin
Hamilton
Hardin
Jackson
Jefferson
Johnson
Perry
Pope
Pulaski
Saline
Union
Wabash
Wayne
White
Williamson

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

Lawrence
Marion
Moultrie
Richland
Massac

~~REGION 1~~	~~REGION 2~~	~~REGION 3~~	~~REGION 4~~
~~Cook~~	~~Boone~~	~~Bureau~~	~~Fulton~~
~~DuPage~~	~~Carroll~~	~~Henderson~~	~~Mason~~
~~Grundy~~	~~DeKalb~~	~~Henry~~	~~Peoria~~
~~Kane~~	~~Jo Daviess~~	~~Knox~~	~~Tazewell~~
~~Kendall~~	~~Lee~~	~~Mercer~~	~~Woodford~~
~~Lake~~	~~Ogle~~	~~Rock Island~~	-
~~McHenry~~	~~Stephenson~~	~~Stark~~	-
~~Will~~	~~Whiteside~~	~~Warren~~	-
-	~~Winnebago~~	-	-

~~REGION 5~~	~~REGION 6~~	~~REGION 7~~	~~REGION 8~~
~~Kankakee~~	~~Champaign~~	~~Christian~~	~~Adams~~
~~LaSalle~~	~~Douglas~~	~~DeWitt~~	~~Brown~~
~~Livingston~~	~~Ford~~	~~Logan~~	~~Calhoun~~
~~Marshall~~	~~Iroquois~~	~~Macon~~	~~Cass~~
~~McLean~~	~~Vermilion~~	~~Macoupin~~	~~Greene~~
~~Putnam~~		~~Menard~~	~~Hancock~~
		~~Montgomery~~	~~Jersey~~
		~~Piatt~~	~~McDonough~~
		~~Sangamon~~	~~Morgan~~
			~~Pike~~
			~~Schuyler~~
			~~Scott~~

~~REGION 9~~	~~REGION 10~~		~~REGION 11~~	
~~Bond~~	~~Clark~~	~~Marion~~	~~Alexander~~	~~Perry~~

DEPARTMENT OF HUMAN RIGHTS

NOTICE OF PROPOSED AMENDMENTS

~~Clinton~~	~~Clay~~	~~Moultrie~~	~~Edwards~~	~~Pope~~
~~Madison~~	~~Coles~~	~~Richland~~	~~Franklin~~	~~Pulaski~~
~~Monroe~~	~~Crawford~~	~~Shelby~~	~~Gallatin~~	~~Randolph~~
~~St. Clair~~	~~Cumberland~~		~~Hamilton~~	~~Saline~~
~~Washington~~	~~Edgar~~		~~Hardin~~	~~Union~~
	~~Effingham~~		~~Jackson~~	~~Wabash~~
	~~Fayette~~		~~Jefferson~~	~~Wayne~~
	~~Jasper~~		~~Johnson~~	~~White~~
	~~Lawrence~~		~~Massac~~	~~Williamson~~

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF PROPOSED RULES

1) Heading of the Part: Mental Health Reporting for Firearm Owner's Identification Card

2) Code Citation: 59 Ill. Adm. Code 150

3)

Section Numbers:	Proposed Action:
150.10	New Section
150.20	New Section
150.30	New Section
150.40	New Section
150.100	New Section
150.110	New Section
150.120	New Section
150.200	New Section
150.210	New Section
150.220	New Section
150.230	New Section
150.400	New Section
150.500	New Section
150.600	New Section

4) Statutory Authority: Implementing and authorized by the Firearm Concealed Carry Act [430 ILCS 66/95] and Section 6-103.2 and 6-103.3 of the Mental Health and Developmental Disabilities Code [405 ILCS 5/6-103.2 and 6-103.3]

5) A Complete Description of the Subjects and Issues involved: Pursuant to provisions of PA 98-63, this rulemaking is being proposed to establish the procedures by which the Department of Human Services (DHS) will collect information which the Illinois State Police (ISP) will be able to use to determine eligibility or continued eligibility for a Firearm Owner's Identification Card.

Besides creating the Concealed Carry Act, PA 98-63 made significant changes to the Firearm Owner's Identification Card Act (FOID ACT) and other acts related to reporting of persons with mental illness relative to possessing a firearm. On December 6, 2013, PA 98-600 was signed into law and it made some modifications to the earlier Act (PA 98-63). The changes in statute require that additional data elements to be collected and reported by hospitals, nursing homes and other in-patient mental health facilities. As a result of this rulemaking, clinicians and out-patient mental health facilities will also have to report specific events to DHS. This rulemaking clarifies the mental health reporting parameters for providers in order to make it easier for them to comply with the law.

DEPARTMENT OF HUMAN SERVICES

NOTICE OF PROPOSED RULES

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rule currently in effect? Yes

8) Does this proposed rulemaking contain an automatic repeal date? No

9) Does this proposed 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 does not create or expand a State mandate.

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may present their comments concerning this rulemaking within 45 days after the date of this issue of the *Illinois Register*. All requests and comments should be submitted in writing to:

Tracie Drew, Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Building, 3rd Floor
Springfield IL 62762

217/785-9772

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 2014

DEPARTMENT OF HUMAN SERVICES

NOTICE OF PROPOSED RULES

The full text of the Proposed Rules is identical to that of the Emergency Rules and begins in this issue of the *Illinois Register* on page 2413:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Grade A Pasteurized Milk and Milk Products

2) Code Citation: 77 Ill. Adm. Code 775

3) Section Number: 775.20 Proposed Action: Amend

4) Statutory Authority: Authorized by the Grade A Pasteurized Milk and Milk Products Act [410 ILCS 635] and the Illinois Food, Drug and Cosmetic Act [410 ILCS 620].

5) A Complete Description of the Subjects and Issues Involved: This rulemaking will update references to several documents that are incorporated by reference in the Grade A Pasteurized Milk and Milk Products rules. Documents that are being updated include the Grade A Pasteurized Milk Ordinance (PMO), the Methods of Making Sanitation Ratings of Milk Shippers (MMSR), the Procedures Governing the Cooperative State-Public Health Service/Food and Drug Administration (FDA) Program of the National Conference on Interstate Milk Shipments and the incorporated sections of the Code of Federal Regulations and the Evaluation of Milk Laboratories, all published by the FDA. These proposed amendments also add the Illinois Food, Drug and Cosmetic Act as an authority for this Code, which will link the Grade A Code to the permits and associated fees and connect procedures for the issuance of both. It also sets the stage for development of a future amendment for the procedure of issuance of a pasteurizer sealer certification.

The economic effect of this proposed rulemaking is unknown. Therefore, the Department requests any information that would assist in calculating this effect.

The Department anticipates adoption of this rulemaking approximately six to nine months after publication of the Notice in the *Illinois Register*.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: This rulemaking references several documents that are incorporated by reference in the Grade A Pasteurized Milk and Milk Products rules. Documents that are being used include the Grade A Pasteurized Milk Ordinance (PMO), the Methods of Making Sanitation Ratings of Milk Shippers (MMSR), the Procedures Governing the Cooperative State-Public Health Service/Food and Drug Administration (FDA) Program of the National Conference on Interstate Milk Shipments and the incorporated sections of the Code of Federal Regulations and the Evaluation of Milk Laboratories, all published by the FDA.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENT

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? Yes

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objective: This rulemaking does not create or expand any state mandates on units of local government.

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: Written or e-mail comments may be submitted within 45 days after this issue of the *Illinois Register* to:

Susan Meister
Division of Legal Services
Illinois Department of Public Health
535 W. Jefferson St., 5th floor
Springfield, Illinois 62761

217/782-2043
e-mail: dph.rules@illinois.gov

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not for profit corporations affected: Bulk milk hauler/samplers, milk tank truck owners, dairy producers (farms) and processors (plants)

B) Reporting, bookkeeping or other procedures required for compliance: There will be no change in the reporting, bookkeeping or other procedures required for compliance.

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: This rulemaking was not included on either of the two most recent Regulatory Agendas because the need for the rulemaking was not apparent at the time that the Regulatory Agendas were prepared.

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENT

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

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENT

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER m: FOOD, DRUGS AND COSMETICS

PART 775
GRADE A PASTEURIZED MILK AND MILK PRODUCTS

Section

775.1 Minimum Regulations (Renumbered)
775.10 Definitions
775.20 Incorporated and Referenced Materials
775.30 Minimum Requirements
775.40 Local Government Implementation
775.50 Permits
775.60 Suspension of Permits
775.70 Inspections and Investigations
775.80 Approval of Construction Plans
775.90 Administrative Hearings
775.100 Milk Hauler-Samplers Examination
775.110 Milk Tank Trucks
775.120 Cleaning and Sanitizing Procedures
775.130 Action Levels for Added Water in Milk
775.140 Pesticide, Herbicide and Mycotoxin Residue Control Program (Repealed)
775.150 Drug Residue Control Program

AUTHORITY: Authorized by and implementing the Grade A Pasteurized Milk and Milk Products Act [410 ILCS 635] and the Illinois Food, Drug and Cosmetic Act [410 ILCS 620].

SOURCE: Adopted and codified at 8 Ill. Reg. 4190, effective March 16, 1984; amended at 11 Ill. Reg. 1464, effective February 1, 1987; amended at 12 Ill. Reg. 17925, effective December 1, 1988; amended at 17 Ill. Reg. 14015, effective August 15, 1993; amended at 19 Ill. Reg. 12271, effective August 10, 1995; amended at 22 Ill. Reg. 20633, effective November 10, 1998; amended at 25 Ill. Reg. 11904, effective September 1, 2001; amended at 25 Ill. Reg. 12629, effective September 25, 2001; amended at 27 Ill. Reg. 15979, effective October 1, 2003; amended at 32 Ill. Reg. 8432, effective May 21, 2008; amended at 35 Ill. Reg. 14193, effective August 2, 2011; amended at 37 Ill. Reg. 7166, effective May 13, 2013; amended at 38 Ill. Reg. _____, effective _____.

Section 775.20 Incorporated and Referenced Materials

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENT

a) The following regulations, guidelines and standards are incorporated in this Part:

1) Federal government guidelines:

A) The Grade A Pasteurized Milk Ordinance (PMO), and Appendices A through R (except Sections 16 and 17) Recommendations of the United States Public Health Service/Food and Drug Administration, 2011 Revision (Publication 229). U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-316), 5100 Paint Branch Parkway, College Park MD 20740-3835. In addition, the jurisdiction name, left blank in Sections 1, 2, 3, 5, and 11 of the PMO, for the purposes of this Part, shall mean the State of Illinois; and the regulatory agency referred to in Section 1 shall mean the Illinois Department of Public Health. (See Section 775.30(a).)

B) Evaluation of Milk Laboratories (2013~~2011~~ Revision), U.S. Department of Health and Human Services, Public Health Service/Food and Drug Administration, Milk Safety Branch (HFS-316), 5100 Paint Branch Parkway, College Park MD 20740-3835.

C) Methods of Making Sanitation Ratings of Milk Supplies (2013~~2011~~ Revision), U.S. Department of Health and Human Services, Public Health Service/Food and Drug Administration, Milk Safety Branch (HFS-316), 5100 Paint Branch Parkway, College Park MD 20740-3835.

D) Procedures Governing the Cooperative State-Public Health Service/Food and Drug Administration Program of the National Conference on Interstate Milk Shipments (2013~~2011~~ Revision), U.S. Department of Health and Human Services, Public Health Service/Food and Drug Administration, Milk Safety Branch (HFS-316), 5100 Paint Branch Parkway, College Park MD 20740-3835.

2) Private and professional standards:

A) Standard Methods for the Examination of Dairy Products (17th

Edition, 2004, American Public Health Association, 1015 – 18th Street, N.W., Washington, D.C. 20036). (See Section 775.70(b).)

B) Official Methods of Analysis of the Association of Official Analytical Chemists (18th Edition, 2010, Association of Official Analytical Chemists, P.O. Box 540, Ben Franklin Station, Washington, D.C. 20044). (See Section 775.70(b).)

3) Federal regulations:

A) 21 CFR 131.110, Milk (2013~~2011~~). (See Section 775.10, the definition of "milkfat and nonfat solid content standards".)

B) 21 CFR 556, Tolerances for Residues or New Animal Drugs in Food (2013~~2011~~). (See Section 775.10, the definition of "violative drug residue".)

C) 40 CFR 180, Tolerances and Exemptions from Tolerances for Pesticide Chemicals in Food (2013~~2011~~). (See Section 775.140(a)(1).)

b) The following rules and statutes are referenced in this Part:

1) Illinois Plumbing Code (77 Ill. Adm. Code 890), Illinois Department of Public Health. (See Section 775.30(c)(4).)

2) Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100), Illinois Department of Public Health. (See Section 775.90.)

3) The Veterinary Medicine and Surgery Practice Act of 2004 [225 ILCS 115].

4) Illinois Administrative Procedure Act [5 ILCS 100].

c) All incorporations by reference of federal guidelines and regulations and the standards of professional organizations refer to the materials on the date specified and do not include any amendments or editions subsequent to the date specified.

d) All citations to federal regulations in this Part concern the specified regulation in

the 2013~~2011~~ Code of Federal Regulations, unless another date is specified.

e) Copies of all incorporated materials are available for inspection and copying by the public at the Department's Central Office, Division of Food, Drugs, and Dairies, 525 West Jefferson Street, Springfield, Illinois 62761.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Tanning Facilities Code

2) Code Citation: 77 Ill. Adm. Code 795

3)

Section Numbers:	Proposed Action:
795.30	Amend
795.40	Amend
795.60	Amend
795.130	Amend
795.190	Amend
795.220	Amend

4) Statutory Authority: Authorized by the Tanning Facility Permit Act [210 ILCS 145]

5) A Complete Description of the Subjects and Issues Involved: This Part is being amended to implement PA 98-349 (effective 1/1/14), which amended the Tanning Facility Permit Act to prohibit any person under the age of 18 from the use of tanning equipment in a tanning facility in the State of Illinois. Definitions are being updated and new definitions for "personal use" and "private residence" are being added, as well as new statutory language defining equipment. An exemption is being added for personal use of a tanning bed in a private residence. Application requirements are being updated. Permit denial and renewal requirements are being amended to refer to use of the facility by a person under age 18. Record-keeping requirements will require verification of age by facility patrons.

The economic effect of this proposed rulemaking is unknown. Therefore, the Department requests any information that would assist in calculating this effect.

The Department anticipates adoption of this rulemaking approximately six to nine months after publication of the Notice in the *Illinois Register*.

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

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

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 create or expand any State mandates on units of local government.

12) Time, place and manner in which interested persons may comment on this proposed rulemaking:

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

Susan Meister
Division of Legal Services
Illinois Department of Public Health
535 W. Jefferson St., 5th floor
Springfield, Illinois 62761

217/782-2043
e-mail: dph.rules@illinois.gov

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Tanning facilities and other small businesses that include tanning equipment, such as health clubs, hair salons and video stores

B) Reporting, bookkeeping or other procedures required for compliance: Checking ID to verify age of customers to utilize tanning equipment.

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: July 2013

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

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH

PART 795
TANNING FACILITIES CODE

Section

795.10 Purpose and Scope
795.20 Incorporated Materials
795.30 Definitions
795.40 Exemptions
795.50 Liability
795.60 Application for Permit to Operate a Tanning Facility
795.70 Issuance of Permit to Operate a Tanning Facility
795.80 Expiration of Permit to Operate a Tanning Facility
795.90 Renewal of Permit to Operate a Tanning Facility
795.100 Report of Changes
795.110 Non-Transfer of Permit
795.120 Approval Not Implied
795.130 Denial, Suspension, Revocation or Non-Renewal of a Permit to Operate a Tanning Facility
795.140 Hearings
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795.170 Protective Eyewear
795.180 Operators
795.190 Records
795.200 Injury Reports
795.210 Sanitation
795.220 Enforcement and Penalties
795.APPENDIX A Examples of Human Skin Types
795.APPENDIX B Determination of Skin Types

AUTHORITY: Implementing and authorized by the Tanning Facility Permit Act [210 ILCS 145].

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF PROPOSED AMENDMENTS

SOURCE: Adopted at 16 Ill. Reg. 19895, effective December 7, 1992; emergency amendment at 19 Ill. Reg. 11648, effective August 1, 1995, for a maximum of 150 days; amended at 20 Ill. Reg. 2422, effective February 1, 1996; amended at 38 Ill. Reg. _____, effective _____.

Section 795.30 Definitions

The definitions and interpretations contained in section~~Section~~ 201 of the Federal Food, Drug and Cosmetic Act (21 USC~~U.S.C.~~ 301 et seq.), 21 CFR 1040.20, and the Illinois Food, Drug and Cosmetic Act [410 ILCS 620] are applicable to those terms~~such items~~ when used in this Part. The following definitions shall also apply:

"Act" means the Tanning Facility Permit Act [210 ILCS 145].

"Agent" means a local health department recognized by the Department.

"Applicant" means any person who applies to the Department for a permit to maintain and operate a tanning facility.

"Change of ownership" means any of the following:

In the case of a tanning facility owned by a corporation, the transfer of the facility by the corporation to another corporation, to a partnership or association, or to a natural person. Transfer of stock in a corporation does not constitute change of ownership.

In the case of a tanning facility owned by a partnership or association, the transfer of the facility by the partnership or association to another partnership or association, to a corporation, or to a natural person. Transfer of interest in the partnership or association or substitution of any or all partners or members of the association does not constitute change of ownership.

In the case of a tanning facility owned by a natural person, the transfer of the facility to any corporation, partnership, association or other natural person whether or not the owner retains any interest in the facility.

"Consumer" means any member of the public who is provided access to a tanning facility in exchange for a fee or other compensation, or any individual who, in

exchange for a fee or other compensation, is afforded use of a tanning facility as a condition or benefit of membership or access. (Section 5 of the Act)

"Department" means the Illinois Department of Public Health or other health authority designated as its agent. (Section 5 of the Act)

"Director" means the Director of Public Health or his or her *designee*. (Section 5 of the Act)

"Disinfect or disinfection" means a process that~~which~~ provides an effective concentration of a United States Environmental Protection Agency approved chemical for enough time as specified by the manufacturer to reduce bacterial count, including pathogens, to a safe level (when those disease organisms which may be present are destroyed so as to prevent transfer) on tanning equipment surfaces and in toilet and hand-washing~~handwashing~~ facilities.

"Existing facility" means a tanning facility that submitted an application for a permit to operate a tanning facility on or before March 8, 1993 and remains in operation with an unexpired tanning facility permit at the same location under the same ownership as listed in the original tanning facility permit application.

"Expired facility" means a previously permitted tanning facility that has not renewed its tanning facility permit on or before the expiration date of the~~said~~ permit, except as provided in the definition of new facility.

"Extensively remodeled" means conversion of an existing structure for use as a tanning facility; structural additions or alterations to existing facilities; or changes, modifications or extensions of plumbing or electrical systems, excluding routine maintenance of the~~such~~ systems.

"Facility" means tanning facility.

"Fee" means the payment or exchange of goods, or anything of value, for the use of the tanning facility or facilities. (Section 5 of the Act)

"Individual" means any human being.

"Injury" means any circumstance or incident, resulting from the use of a tanning

device that~~,which~~ prompts a consumer to seek medical attention.

"Inspection" means an official examination or observation that~~which~~ includes, but is not limited to, tests, surveys, and monitoring to determine compliance with this Part~~rules, regulations, orders, requirements and conditions of the Department~~.

"Licensee" means the same as "permittee~~permitee~~".

"New facility" includes any tanning facility that submitted an initial application for a tanning facility permit on or after March 9, 1993. Previously permitted facilities that have changed location or ownership are considered to be new facilities upon their relocation or change of ownership. Expired facilities that fail to renew their tanning facility permit within 90 days after the permit expiration shall be considered new facilities.

"Operator" means the trained *person designated by the licensee for the facility* to control the operation of a tanning facility in compliance with the Act and this Part and *to assist and instruct the public in the correct operation of the tanning facility* and its equipment. (Section 5 of the Act)

"Other compensation" means the payment or exchange of goods, or anything of value, for use of the tanning facility or facilities. (Section 5 of the Act)

"Permanent" means a minimum of five years for record keeping~~records related to an adult and a minimum of five years past emancipation for records related to a minor~~.

"Permit" means a permit issued by the Department in accordance with this Part.

"Permittee~~Permitee~~" means any person who is licensed by the Department in accordance with this Part.

"Person" means any individual, corporation, partnership, firm, association, society, trust, estate, public or private institution, group, agency, political subdivision of this State, any other State or political subdivision or agency of any other state or political subdivision~~thereof~~, and any legal successor, representative, agent, or agency of any of the entities listed~~the foregoing~~.

"Personal use" means the use of tanning equipment in a private residence for the owner or owners of the residence and other individuals living at the residence.

"Private residence" means a place in which an individual, group or family can live and store personal property, such as a single-family detached home, apartment, duplex or condominium. Private residence does not mean an apartment complex or a condominium complex or community and does not apply to the common or public areas found in the complex or community.

"Photosensitizing agent" means any food, drug, cosmetic, toiletry or other substance, whether ingested or topically applied, that~~which~~ may induce hypersensitivity of an individual to exposure to the sun or other sources of ultraviolet radiation, resulting in inflammation of the skin and its underlying structures, often accompanied by edema.

"Protective eyewear" means eyewear that has been designed and tested in accordance with ~~the provisions set forth in~~ 21 CFR 1040.20. Protective~~Such protective~~ eyewear shall~~must have been determined to~~ allow for the required protection to ultraviolet radiation while also allowing for adequate vision to maintain balance and to locate~~location of~~ the tanning equipment's ~~'~~emergency cut-off~~'~~ switch.

"Radiation" means ultraviolet radiation.

"Radiation machine" means any device capable of producing radiation.

"Registrant" means any person who obtains a permit or other entitlement from the Department~~Agency~~, and who is obligated to obtain the~~such~~ permit or other entitlement from the Department pursuant to the Act and this Part.

"Registration" means registration with the Department in accordance with this Part.

"Tanning equipment" means sunlamp products and ultraviolet lamps intended to induce skin tanning through the irradiation of any part of the living body~~.~~ (Section 5 of the Act) and *equipment that emits ultraviolet (UV) radiation used for tanning of the skin, such as a sunlamp, tanning booth, or tanning bed that emits electromagnetic radiation with wavelengths in the air between 200 and 400*

nanometers. "Tanning equipment" includes, but is not limited to, *any accompanying equipment, such as protective eyewear, timers, and handrails* (Section 25(g)(2) of the Act) as well as~~Tanning equipment includes, but is not limited to, protective eyewear, accurate timers, original equipment lamp type~~, protective barriers, ~~handrails,~~ warning labels, recommended exposure schedules, and recommended exposure distances. Tanning equipment shall be manufactured in accordance with 21 CFR 1040.20.

"Tanning facility" or "Tanning facilities" means a room or a booth or a group of rooms or booths, or a structure or business *that houses ultraviolet lamps or products containing lamps intended for the irradiation of any part of the living body for cosmetic or nonmedical related purposes but does not include any hotel or motel guest rooms where sunlamps are installed in the restroom area*. (Section 5 of the Act)

"Ultraviolet radiation" means electromagnetic radiation with wavelengths in air between ~~two hundred (~~200~~)~~ nanometers and ~~four hundred (~~400~~)~~ nanometers.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 795.40 Exemptions

a) Equipment intended for purposes other than the deliberate exposure of parts of the living human body to ultraviolet radiation and that produce or emit ultraviolet radiation incidental to its proper operation are exempt from the provisions of this Part.

b) Radiation machines while in transit or storage ~~incidental thereto~~ are exempt from ~~provisions of~~ this Part.

c) Any physician licensed to practice medicine in all of its branches, any licensed dentist, or any licensed podiatrist is exempt from ~~the provisions of~~ this Part to the extent that the~~such~~ practitioner uses, in the practice of medicine, dentistry or podiatry, medical diagnostic and therapeutic equipment that~~which~~ emits ultraviolet radiation.

d) Personal use by an individual in a private residence and by other individuals living at the residence is exempt from ~~the provisions of~~ this Part to the extent that

the~~such~~ individual owns the tanning equipment exclusively for personal use and no fee or other compensation is involved in the use of the tanning equipment.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 795.60 Application for Permit to Operate a Tanning Facility

a) Each person~~ having a tanning facility in operation on the effective date of this Part~~ shall apply to the Department for a permit to operate a tanning facility~~such facility within 90 days following the effective date of this Part or, thereafter,~~ prior to acquiring or establishing the operation of a tanning facility. Application for the permit shall be completed on forms prescribed by and available from the Department and shall contain all of the information required by the form and any accompanying instructions. Unless otherwise stated, the term "application" as used in this Section~~herein~~ shall include original and renewal applications.

b) In the event of a change of ownership, the new owner shall apply for a permit to operate a tanning facility prior to taking possession of the property. The Department may issue a~~A~~ provisional permit ~~may be issued by the Department~~ until an initial inspection for a permit can be performed by the Department or its designated agent.

c) The Department shall require at least the following information on the Application for Permit to Operate a Tanning Facility form:

1) Name~~name~~, physical address, mailing address and telephone number or numbers~~number(s)~~ of the following:

A) The~~the~~ tanning facility;

B) The~~the~~ applicant (owner or owners~~owner[s]~~) of the tanning facility;

2) The~~the~~ manufacturer, model number, serial number, year and month of manufacture, and type of each ultraviolet lamp or piece of tanning equipment located within the facility;

3) The~~the~~ primary function of the business in which the tanning facility is

located;

4) The~~the~~ geographic areas within the State to be covered, if the facility is mobile;

5) Copies~~copies~~ of any posted warnings or other notices that~~which~~ are not required by this Part and that~~which~~ address the safe or proper use of tanning equipment and protective devices;

~~6) copies of consent forms and statements which consumers, parents or guardians will be required to sign pursuant to this Part;~~

6~~7~~) Names~~names~~ and addresses of the tanning equipment supplier or suppliers, installer or installers, and service agent or agents~~supplier(s), installer(s), and service agent(s)~~;

7~~8~~) A~~a~~ copy of the operating procedures to be used in the tanning facility;

8~~9~~) The~~the~~ hours of operation of the tanning facility;

9~~10~~) The~~the~~ name of the on-site manager of the tanning facility;

10~~11~~) A~~a~~ signed and dated certification that the applicant has received, read and understood the requirements of this Part.

~~d) Each applicant shall provide such additional information as the Department may reasonably require.~~

d~~e~~) Each initial application shall be submitted with a nonrefundable $250 fee.

e~~f~~) Each annual renewal application shall be submitted with a nonrefundable $150 fee, except that each expired facility shall pay a nonrefundable $250 fee for renewal of the permit.

f~~g~~) If the owner owns or operates more than one tanning facility, the owner shall file a separate application and submit a separate fee for each facility owned and operated.

g~~h~~) Expired facilities that fail to pay a nonrefundable $250 permit renewal fee within 90 days after the permit expiration shall submit a new permit application and comply with requirements for new facilities in order to receive a tanning facility permit.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 795.130 Denial, Suspension, Revocation or Non-Renewal of a Permit to Operate a Tanning Facility

The Department may deny, suspend, revoke or refuse to renew a permit to operate a tanning facility sought or issued pursuant to this Part for any of the following reasons:

a) Failure~~the failure~~ to submit information required pursuant to Section 795.60 that~~which~~ demonstrates that the tanning facility will be constructed, operated and maintained in accordance with the requirements of this Part;

b) Submission~~submission~~ of incorrect, false or misleading information in the documents required under this Part;

c) Failure~~failure~~ to construct, operate or maintain the tanning facility in accordance with this Part, except as the~~such~~ maintenance may involve the replacement of lamps by "equivalent" lamps as~~which have been~~ defined in Section 795.100 ~~above~~;

d) Operation~~operation~~ of the tanning facility in a way that causes or creates a nuisance or hazard to the public health or safety;

e) Violation~~violation~~ of the ~~provisions of the~~ Act or this Part~~the rules and regulations adopted by the Department~~;

f) Violation~~violation~~ of any condition upon which the permit was issued;

g) Failure~~failure~~ to allow duly authorized agents of the Department or its designated health authorities to conduct inspections of the facility;

h) Conviction~~conviction~~ of an applicant or permit holder of an offense arising from false, fraudulent, deceptive, or misleading advertising (The record of conviction

or a certified copy of the~~such~~ record shall be conclusive evidence of the conviction.);

i) Revocation~~revocation~~ of a permit during the past five~~5~~ years, or surrender or expiration of the permit during the pendency of action by the Department to revoke or suspend the permit during the previous five~~5~~ years, if before the permit was issued to the individual applicant, a controlling owner or controlling combination of owners of the applicant, or any affiliate of the individual applicant or controlling owner of the applicant or affiliate of the applicant was a controlling owner of the prior permit;

j) Payment~~payment~~ of permit fees or fines with checks returned for non-sufficient funds; ~~or~~

k) Failure~~failure~~ to pay any permit fees or applicable fines; or~~.~~

l) Allowing anyone under the age of 18 years to use a permitted facility's tanning equipment.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 795.190 Records

a) At the consumer's initial visit to a tanning facility, and at least annually after the initial visit, the~~thereafter, such~~ consumer shall be given a written statement of warning as described in Section 795.150(a) and shall sign a written statement acknowledging that he/she has read and has understood the warning statement. For illiterate or visually handicapped persons, the operator shall read the warning statement ~~shall be read by the operator~~ to the consumer in the presence of a witness. Both the witness and the operator shall sign the statement, indicating that it has been read to the consumer.

b) Each consumer desiring to use the facility shall fill out a form specifying ~~any and~~ all prescription medicines and over-the-counter (non-prescription) medications the consumer is taking, and any cosmetics and toiletries, including any tanning accelerators, he or she may have applied prior to using the tanning facility. The consumer shall certify that he or she has not used the services of a tanning facility within the immediately previous ~~twenty-four (~~24~~)~~ hours. The form or record shall

be kept as a confidential, permanent part of the record of the individual's attendance and progress. Information~~No information~~ concerning a consumer's prescription and non-prescription medications as listed on the required form or record shall not~~may~~ be released to any person without the written consent of the consumer. The~~Such~~ information ~~, however,~~ shall be made available to the Department or an agent of the Department during the regular course of an inspection.

c) No person~~minor~~ under 18~~fourteen~~ years of age shall be allowed to use ~~a~~ tanning equipment~~device~~, either alone or in the presence of another individual. Proof of age shall be verified by a government-issued identification (ID) that contains both a birth date and picture. A copy of the ID shall not be required to be maintained on site.~~Minors age fourteen through seventeen shall obtain the written consent of a parent or legal guardian prior to being provided access to a tanning device. The parent or legal guardian shall sign a consent form in the presence of the operator who is not a minor, indicating that such parent or guardian has read and understood the warnings required under Section 795.150(a). The parent or guardian shall not be required to be in the tanning room or booth with the minor.~~

d) The facility operator shall keep a~~A~~ record ~~shall be kept by the facility operator~~ of each consumer's total number of tanning visits, dates and duration of tanning exposures and the tanning equipment used. The~~Such~~ records shall be kept as a permanent part of the record of the individual's attendance and progress. Records shall be maintained and available for inspection for a minimum of five years past a facility's termination of business.

e) Information required by this Section that the facility maintains~~which is maintained by the facility~~ on computer systems shall be regularly copied, at least monthly, and updated on storage media other than the hard drive of the computer.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 795.220 Enforcement and Penalties

a) Any tanning facility operating without a valid permit or operating on a revoked permit shall be guilty of committing a public nuisance.

b) A person convicted of knowingly maintaining a public nuisance commits a Class

A misdemeanor. Each subsequent offense under the Act is a Class 4 felony.

c) Penalties or fines shall not exceed $1,000 per day for each day the permit holder remains in violation.

d) In addition to any other action authorized by the Act or this Part, the Department may assess fines against a tanning facility for violation of any provision of the Act or this Part. The Department shall review each inspection report according to criteria in subsections (e) through (h)~~ below~~.

e) The Department shall consider the following criteria independently and aggregately to determine whether a fine shall be assessed.

1) Whether a violation has been noted on an inspection report, and whether the facility corrected the violation~~such violation was corrected by the facility~~.

2) Whether the facility or owner has previously been cited for a violation of the Act or this Part~~rules~~, except that any previously cited violation shall not be considered if the~~such~~ violation was held to be unfounded or unapproved by a final order of the Department or by a court of competent jurisdiction, or if any previous citations for violations occurred more than three ~~(3)~~ years prior to the current violation.

3) Whether the violation creates~~is of such a nature as to result in~~ the possibility of injury or other harm to the environment, to the owner's employees, to the building owner, to users or occupants, or to the general public.

4) Whether the violation appears to be the result of any degree of negligence by the owner, the operator, or the owner's other employees.

5) Whether the owner demonstrated good faith efforts (e.g., taking steps to correct or agreeing to correct the cited violations within a specified period of time) to correct the violations upon receipt of oral or written notice of the violation and whether the~~such~~ actions ~~in fact~~ corrected the violation.

f) The following criteria shall be used~~Criteria~~ to determine the amount of a fine~~ are~~

~~the following~~, and all amounts determined pursuant to the criteria shall be added together to determine the total fine against the tanning facility:

1) For each violation related to the operation of a tanning facility without having submitted an application for a permit to operate a tanning facility, pursuant to Section 795.60: $250.

2) For each violation related to the failure to notify the Department of changes to the information specified in the permit application, pursuant to Section 795.100: $50.

3) For each violation related to the failure to maintain an equipment maintenance log, as required by Section 795.100: $100.

4) For each violation related to the failure to post warnings as required by the Act and Section 795.150(a)~~ of this Part~~: $100.

5) For each violation related to tanning equipment timers that~~which~~ fail to operate in accordance with the manufacturer's recommended exposure limit as required by Section 795.150(b)(2): $250.

6) For each violation related to the presence of tanning equipment that~~which~~ fails to incorporate a manual control that~~which~~ allows the user to terminate radiation, as required by Section 795.150(b)(3): $250.

7) For each violation related to the presence of tanning equipment lacking physical barriers to protect consumers from injury induced by touching or breaking ~~of~~ the lamps, as required by Section 795.150(b)(6): $250.

8) For each violation related to the use of lamps and bulbs that~~which~~ are not certified for use in the equipment in which they are found to be installed, as required by Section 795.150(b)(8): $250.

9) For each violation related to the absence of an adequate supply of eyewear meeting the specifications of 21 CFR 1040.20, as required by Section 795.170(a): $250.

10) For each violation related to the failure to properly sanitize eyewear in

accordance with Section 795.170(c): $100.

11) For each violation related to allowing consumers to use tanning equipment without use of protective eyewear as required by Section 795.170(f): $250.

12) For each violation in which the tanning facility was operated in the absence of a trained operator, as required by Section 795.180(c): $250.

13) For each violation related to the failure to maintain consumer use records, as required by the Act and Section 795.190 ~~of this Part~~: $250.

14) For each violation related to the failure to maintain prescription and non-prescription drug information required by Section 795.190(b) in a confidential manner: $500.

15) For each violation allowing the use of tanning equipment by persons~~minors~~ under the age of 18,~~14 or use by an individual age 14 to 17 without a signed consent form by a parent or guardian~~ as prohibited~~required~~ by Section 795.190(d): $250.

16) For each violation in which an injury resulting from the use of the tanning equipment was not reported to the Department, as required by Section 795.200: $500.

17) For each violation related to the failure to provide proper sanitation of tanning equipment or the tanning facility, as required by Section 795.210: $100.

g) Violations~~Violation~~ of any provision of the Tanning Facility Permit Act or any provision of ~~the rules of~~ this Part shall be issued as the following:

1) First violation – the permittee shall be issued a warning letter.

2) Second violation – the permittee shall be issued a fine according to this Section ~~795.220~~. The repeat violation fine will be a minimum of $250 plus a fine according to this Section.

3) Third violation – the permitteepermitee shall be issued a fine according to this Section 795.220. The repeat violation fine will be a minimum of $500 plus a fine according to this Section. The permitteepermitee shall be notified of the Department's intent to revoke the permit and shall be offered a hearing in accordance with Section 795.140.

h) Each day that a violation exists shall constitute a separate violation.

i) The Department shall serve any notice of assessment of fine on the permitteepermitee in the same manner as any notice of permit revocation provided pursuant to the Act and this Part, and the permitteepermitee shall have the same rights and opportunity for hearing as elsewhere provided pursuant to the Act and this Part. IfIn the event that the permitteepermitee does not request a hearing within the time allowed by the Act and this Part, the fine assessed shall be due in full at the expiration of time allowed to request a hearing.

j) All fine assessments thatassessment which are upheld in whole or in part by final order of the Department shall be due in full at the conclusion of the time period for filing for administrative review pursuant to the Administrative Review Law [735 ILCS 5/Art. III] (Ill. Rev. Stat. 1991, ch. 110, pars. 3-101 et seq.), unless the permitteepermitee has within that time filed proceedings in administrative review specifically appealing the fine assessment and unless the court has stayed the enforcement of the fine assessment.

k) Following the issuance of the notice of violation, the Department or its agent willshall reinspect a facility to determine compliance with the Act and this Part.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Retailers' Occupation Tax

2) Code Citation: 86 Ill. Adm. Code 130

3) Section Number: 130.120 Proposed Action: Amend

4) Statutory Authority: 20 ILCS 2505/2505-25

5) A Complete Description of the Subjects and Issues Involved: This rulemaking implements the provisions of PA 98-583 (sales of electricity delivered to customers by wire and natural or artificial gas and water that is delivered to customers through pipes, pipelines, or mains are not subject to tax); PA 98-456 (retroactively reinstates the exemption for coal and aggregate exploration, mining, offhighway hauling, processing, maintenance, and reclamation equipment); PA 98-422 (imposes new criteria for air carriers in order to claim the exemption for fuel and petroleum products consumed in foreign trade or trade between the United States and any of its possessions); PA 97-636 (extends the sunset date for the exemption for food for human consumption, prescription and nonprescription medicines, drugs, medical appliances, and insulin, urine testing materials, syringes, and needles used by diabetics, for human use, when purchased for use by a person who resides in a licensed long-term care facility); PA 98-574 (expands the types of motor vehicles of the second division exempt from the Retailers' Occupation Tax Act and subjects them to the Automobile Renting Occupation and Use Tax); PA 97-431 (amends the definition of the type of game birds that are exempt); and PA 98-534 (limits the exemption for materials, parts, equipment, components, and furnishings incorporated into or upon an aircraft as part of the modification, refurbishment, completion, replacement, repair, or maintenance of the aircraft to persons who actually modify, refurbish, complete, replace, or maintain an aircraft).

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

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

11) Statement of Statewide Policy Objective: This rulemaking does not create a State mandate, nor does it modify any existing State mandates.

12) Time, place and manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rulemaking may submit them in writing by no later than 45 days after publication of this Notice to:

Debra M. Boggess, Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, IL 62794

217/782-2844

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Small businesses and not for profit corporations that want to claim any of these exemptions.

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 2013

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

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 130
RETAILERS' OCCUPATION TAX

SUBPART A: NATURE OF TAX

Section
130.101 Character and Rate of Tax
130.105 Responsibility of Trustees, Receivers, Executors or Administrators
130.110 Occasional Sales
130.111 Sale of Used Motor Vehicles, Aircraft, or Watercraft by Leasing or Rental Business
130.115 Habitual Sales
130.120 Nontaxable Transactions

SUBPART B: SALE AT RETAIL

Section
130.201 The Test of a Sale at Retail
130.205 Sales for Transfer Incident to Service
130.210 Sales of Tangible Personal Property to Purchasers for Resale
130.215 Further Illustrations of Sales for Use or Consumption Versus Sales for Resale
130.220 Sales to Lessors of Tangible Personal Property
130.225 Drop Shipments

SUBPART C: CERTAIN STATUTORY EXEMPTIONS

Section
130.305 Farm Machinery and Equipment
130.310 Food, Soft Drinks and Candy
130.311 Drugs, Medicines, Medical Appliances and Grooming and Hygiene Products
130.315 Fuel Sold for Use in Vessels on Rivers Bordering Illinois
130.320 Gasohol, Majority Blended Ethanol, Biodiesel Blends, and 100% Biodiesel
130.321 Fuel Used by Air Common Carriers in International Flights
130.325 Graphic Arts Machinery and Equipment Exemption
130.330 Manufacturing Machinery and Equipment
130.331 Manufacturer's Purchase Credit
130.332 Automatic Vending Machines

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

130.335 Pollution Control Facilities and Low Sulfur Dioxide Emission Coal-Fueled Devices
130.340 Rolling Stock
130.341 Commercial Distribution Fee Sales Tax Exemption
130.345 Oil Field Exploration, Drilling and Production Equipment
130.350 Coal Exploration, Mining, Off Highway Hauling, Processing, Maintenance and Reclamation Equipment
130.351 Aggregate Manufacturing

SUBPART D: GROSS RECEIPTS

Section
130.401 Meaning of Gross Receipts
130.405 How to Avoid Paying Tax on State or Local Tax Passed on to the Purchaser
130.410 Cost of Doing Business Not Deductible
130.415 Transportation and Delivery Charges
130.420 Finance or Interest Charges – Penalties – Discounts
130.425 Traded-In Property
130.430 Deposit or Prepayment on Purchase Price
130.435 State and Local Taxes Other Than Retailers' Occupation Tax
130.440 Penalties
130.445 Federal Taxes
130.450 Installation, Alteration and Special Service Charges
130.455 Motor Vehicle Leasing and Trade-In Allowances

SUBPART E: RETURNS

Section
130.501 Monthly Tax Returns – When Due – Contents
130.502 Quarterly Tax Returns
130.505 Returns and How to Prepare
130.510 Annual Tax Returns
130.515 First Return
130.520 Final Returns When Business is Discontinued
130.525 Who May Sign Returns
130.530 Returns Covering More Than One Location Under Same Registration – Separate Returns for Separately Registered Locations
130.535 Payment of the Tax, Including Quarter Monthly Payments in Certain Instances
130.540 Returns on a Transaction by Transaction Basis

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

130.545 Registrants Must File a Return for Every Return Period
130.550 Filing of Returns for Retailers by Suppliers Under Certain Circumstances
130.551 Prepayment of Retailers' Occupation Tax on Motor Fuel
130.552 Alcoholic Liquor Reporting
130.555 Vending Machine Information Returns
130.560 Verification of Returns

SUBPART F: INTERSTATE COMMERCE

Section
130.601 Preliminary Comments
130.605 Sales of Property Originating in Illinois
130.610 Sales of Property Originating in Other States

SUBPART G: CERTIFICATE OF REGISTRATION

Section
130.701 General Information on Obtaining a Certificate of Registration
130.705 Procedure in Disputed Cases Involving Financial Responsibility Requirements
130.710 Procedure When Security Must be Forfeited
130.715 Sub-Certificates of Registration
130.720 Separate Registrations for Different Places of Business of Same Taxpayer Under Some Circumstances
130.725 Display
130.730 Replacement of Certificate
130.735 Certificate Not Transferable
130.740 Certificate Required For Mobile Vending Units
130.745 Revocation of Certificate

SUBPART H: BOOKS AND RECORDS

Section
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AUTHORITY: Implementing the Illinois Retailers' Occupation Tax Act [35 ILCS 120] and authorized by Section 2505-25 of the Civil Administrative Code of Illinois [20 ILCS 2505/2505-25].

SOURCE: Adopted July l, 1933; amended at 2 Ill. Reg. 50, p. 71, effective December 10, 1978; amended at 3 Ill. Reg. 12, p. 4, effective March 19, 1979; amended at 3 Ill. Reg. 13, pp. 93 and 95, effective March 25, 1979; amended at 3 Ill. Reg. 23, p. 164, effective June 3, 1979; amended at 3 Ill. Reg. 25, p. 229, effective June 17, 1979; amended at 3 Ill. Reg. 44, p. 193, effective October 19, 1979; amended at 3 Ill. Reg. 46, p. 52, effective November 2, 1979; amended at 4 Ill. Reg. 24, pp. 520, 539, 564 and 571, effective June l, 1980; amended at 5 Ill. Reg. 818, effective January 2, 1981; amended at 5 Ill. Reg. 3014, effective March 11, 1981; amended at 5 Ill. Reg. 12782, effective November 2, 1981; amended at 6 Ill. Reg. 2860, effective March 3, 1982; amended at 6 Ill. Reg. 6780, effective May 24, 1982; codified at 6 Ill. Reg. 8229; recodified at 6 Ill. Reg. 8999; amended at 6 Ill. Reg. 15225, effective December 3, 1982; amended at 7 Ill. Reg. 7990, effective June 15, 1983; amended at 8 Ill. Reg. 5319, effective April 11, 1984; amended at 8 Ill. Reg. 19062, effective September 26, 1984; amended at 10 Ill. Reg. 1937, effective January 10, 1986; amended at 10 Ill. Reg. 12067, effective July l, 1986; amended at 10 Ill. Reg. 19538, effective November 5, 1986; amended at 10 Ill. Reg. 19772, effective

November 5, 1986; amended at 11 Ill. Reg. 4325, effective March 2, 1987; amended at 11 Ill. Reg. 6252, effective March 20, 1987; amended at 11 Ill. Reg. 18284, effective October 27, 1987; amended at 11 Ill. Reg. 18767, effective October 28, 1987; amended at 11 Ill. Reg. 19138, effective October 29, 1987; amended at 11 Ill. Reg. 19696, effective November 23, 1987; amended at 12 Ill. Reg. 5652, effective March 15, 1988; emergency amendment at 12 Ill. Reg. 14401, effective September 1, 1988, for a maximum of 150 days, modified in response to an objection of the Joint Committee on Administrative Rules at 12 Ill. Reg. 19531, effective November 4, 1988, not to exceed the 150 day time limit of the original rulemaking; emergency expired January 29, 1989; amended at 13 Ill. Reg. 11824, effective June 29, 1989; amended at 14 Ill. Reg. 241, effective December 21, 1989; amended at 14 Ill. Reg. 872, effective January 1, 1990; amended at 14 Ill. Reg. 15463, effective September 10, 1990; amended at 14 Ill. Reg. 16028, effective September 18, 1990; amended at 15 Ill. Reg. 6621, effective April 17, 1991; amended at 15 Ill. Reg. 13542, effective August 30, 1991; amended at 15 Ill. Reg. 15757, effective October 15, 1991; amended at 16 Ill. Reg. 1642, effective January 13, 1992; amended at 17 Ill. Reg. 860, effective January 11, 1993; amended at 17 Ill. Reg. 18142, effective October 4, 1993; amended at 17 Ill. Reg. 19651, effective November 2, 1993; amended at 18 Ill. Reg. 1537, effective January 13, 1994; amended at 18 Ill. Reg. 16866, effective November 7, 1994; amended at 19 Ill. Reg. 13446, effective September 12, 1995; amended at 19 Ill. Reg. 13568, effective September 11, 1995; amended at 19 Ill. Reg. 13968, effective September 18, 1995; amended at 20 Ill. Reg. 4428, effective March 4, 1996; amended at 20 Ill. Reg. 5366, effective March 26, 1996; amended at 20 Ill. Reg. 6991, effective May 7, 1996; amended at 20 Ill. Reg. 9116, effective July 2, 1996; amended at 20 Ill. Reg. 15753, effective December 2, 1996; expedited correction at 21 Ill. Reg. 4052, effective December 2, 1996; amended at 20 Ill. Reg. 16200, effective December 16, 1996; amended at 21 Ill. Reg. 12211, effective August 26, 1997; amended at 22 Ill. Reg. 3097, effective January 27, 1998; amended at 22 Ill. Reg. 11874, effective June 29, 1998; amended at 22 Ill. Reg. 19919, effective October 28, 1998; amended at 22 Ill. Reg. 21642, effective November 25, 1998; amended at 23 Ill. Reg. 9526, effective July 29, 1999; amended at 23 Ill. Reg. 9898, effective August 9, 1999; amended at 24 Ill. Reg. 10713, effective July 7, 2000; emergency amendment at 24 Ill. Reg. 11313, effective July 12, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15104, effective October 2, 2000; amended at 24 Ill. Reg. 18376, effective December 1, 2000; amended at 25 Ill. Reg. 941, effective January 8, 2001; emergency amendment at 25 Ill. Reg. 1792, effective January 16, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 4674, effective March 15, 2001; amended at 25 Ill. Reg. 4950, effective March 19, 2001; amended at 25 Ill. Reg. 5398, effective April 2, 2001; amended at 25 Ill. Reg. 6515, effective May 3, 2001; expedited correction at 25 Ill. Reg. 15681, effective May 3, 2001; amended at 25 Ill. Reg. 6713, effective May 9, 2001; amended at 25 Ill. Reg. 7264, effective May 25, 2001; amended at 25 Ill. Reg. 10917, effective August 13, 2001; amended at 25 Ill. Reg. 12841, effective October 1, 2001; amended at 26 Ill. Reg. 958, effective January 15, 2002; amended at 26 Ill. Reg. 1303, effective January 17, 2002; amended at 26 Ill. Reg. 3196,

effective February 13, 2002; amended at 26 Ill. Reg. 5369, effective April 1, 2002; amended at 26 Ill. Reg. 5946, effective April 15, 2002; amended at 26 Ill. Reg. 8423, effective May 24, 2002; amended at 26 Ill. Reg. 9885, effective June 24, 2002; amended at 27 Ill. Reg. 795, effective January 3, 2003; emergency amendment at 27 Ill. Reg. 11099, effective July 7, 2003, for a maximum of 150 days; emergency expired December 3, 2003; amended at 27 Ill. Reg. 17216, effective November 3, 2003; emergency amendment at 27 Ill. Reg. 18911, effective November 26, 2003, for a maximum of 150 days; emergency expired April 23, 2004; amended at 28 Ill. Reg. 9121, effective June 18, 2004; amended at 28 Ill. Reg. 11268, effective July 21, 2004; emergency amendment at 28 Ill. Reg. 15193, effective November 3, 2004, for a maximum of 150 days; emergency expired April 1, 2005; amended at 29 Ill. Reg. 7004, effective April 26, 2005; amended at 31 Ill. Reg. 3574, effective February 16, 2007; amended at 31 Ill. Reg. 5621, effective March 23, 2007; amended at 31 Ill. Reg. 13004, effective August 21, 2007; amended at 31 Ill. Reg. 14091, effective September 21, 2007; amended at 32 Ill. Reg. 4226, effective March 6, 2008; emergency amendment at 32 Ill. Reg. 8785, effective May 29, 2008, for a maximum of 150 days; emergency expired October 25, 2008; amended at 32 Ill. Reg. 10207, effective June 24, 2008; amended at 32 Ill. Reg. 17228, effective October 15, 2008; amended at 32 Ill. Reg. 17519, effective October 24, 2008; amended at 32 Ill. Reg. 19128, effective December 1, 2008; amended at 33 Ill. Reg. 1762, effective January 13, 2009; amended at 33 Ill. Reg. 2345, effective January 23, 2009; amended at 33 Ill. Reg. 3999, effective February 23, 2009; amended at 33 Ill. Reg. 15781, effective October 27, 2009; amended at 33 Ill. Reg. 16711, effective November 20, 2009; amended at 34 Ill. Reg. 9405, effective June 23, 2010; amended at 34 Ill. Reg. 12935, effective August 19, 2010; amended at 35 Ill. Reg. 2169, effective January 24, 2011; amended at 36 Ill. Reg. 6662, effective April 12, 2012; amended at 38 Ill. Reg. _____, effective _____.

SUBPART A: NATURE OF TAX

Section 130.120 Nontaxable Transactions

The tax does not apply to receipts from sales:

a) of intangible personal property, such as shares of stocks, bonds, evidences of interest in property, corporate or other franchises and evidences of debt;

b) of real property, such as lands and buildings that are permanently attached to the land;

c) of tangible personal property for purposes of resale in any form as tangible personal property, provided that the purchaser (except in the case of an out-of-

State purchaser who will always resell and deliver the property to his customers outside Illinois) has an active registration number or active resale number from the Department and gives the number to the vendor in connection with certifying to the vendor that the sale to the purchaser is nontaxable on the ground of being a sale for resale (see Subparts B and N of this Part);

d) of personal services, where rendered as such (see various rules relating to particular service occupations); however, for information concerning the tax on persons engaged in the business of making sales of service, see the Regulations pertaining to the Service Occupation Tax Act (86 Ill. Adm. Code 140);

e) that are within the protection of the Commerce Clause of the Constitution of the United States (see Subpart F of this Part);

f) that are isolated or occasional (see Section 130.110 of this Subpart);

g) of newspapers and magazines (see Section 130.2105 of this Part);

h) that are made to any corporation, society, association, foundation or institution organized and operated exclusively for charitable, religious or educational purposes, or any not-for-profit corporation, society, association, foundation, institution or organization that has no compensated officers or employees and that is organized and operated primarily for the recreation of persons 55 years of age or older. A limited liability company may qualify for the exemption under this subsection only if the limited liability company is organized and operated exclusively for educational purposes (see Section 130.2005 of this Part);

i) that are made to any governmental body (see Section 130.2080 of this Part);

j) through June 30, 2003, of pollution control facilities (see Section 130.335 of this Part);

k) *of fuel consumed or used in the operation of ships, barges or vessels that are used primarily in or for the transportation of property or the conveyance of persons for hire on rivers bordering on this State if the fuel is delivered by the seller to the purchaser's barge, ship or vessel while it is afloat upon that bordering river* [35 ILCS 120/2-5(24)] (see Section 130.315 of this Part);

l) of tangible personal property to interstate carriers for hire for use as rolling stock moving in interstate commerce (see Section 130.340 of this Part);

m) except as otherwise provided in Section 130.605(b)(1)(C), of a motor vehicle in this State to a nonresident even though the motor vehicle is delivered to the nonresident in this State, if the motor vehicle is not to be titled in this State, and if a drive-away permit is issued to the motor vehicle as provided in Section 3-603 of the Illinois Vehicle Code [625 ILCS 5/3-603], or if the nonresident purchaser has vehicle registration plates to transfer to the motor vehicle upon returning to his home state (see Section 130.605);

n) until December 31, 2001, of merchandise in bulk when sold from a vending machine for 1¢; on and after January 1, 2002, the exemption applies to merchandise in bulk when sold from a vending machine for 50¢ or less (see 35 ILCS 120/1 and Section 130.2135 of this Part);

o) of food and beverages by a person who is the recipient of a grant or contract under Title VII of the Older Americans Act of 1965 (42 USC 3021) and serves meals to participants in the Federal Nutrition Program for the Elderly in return for contributions established in amount by the individual participant pursuant to a schedule of suggested fees as provided for in the Federal Act;

p) of farm chemicals (see Section 130.1955 of this Part);

q) of manufacturing machinery and equipment that qualifies for exemption under provisions of Section 130.330 of this Part;

r) of services included in gross receipts for purposes of the Retailers' Occupation Tax and that are designated mandatory service charges by vendors of meals to the extent that the proceeds of the service charge are in fact turned over to the employees who would normally have received tips had the service charge policy not been introduced. Service charges that are used to fund or pay wages, labor costs, employee benefits or employer costs of doing business are taxable gross receipts;

s) *of any petroleum product, if the seller is prohibited by federal law from charging tax to the purchaser* [35 ILCS 120/2-5(16)].

1) For example, federal law prohibits sellers from charging tax to Amtrak when it purchases petroleum products. However, federal law does not relieve the seller of Retailers' Occupation Tax liability in these transactions. For that reason, the exemption set out in this subsection is necessary to relieve the seller of Retailers' Occupation Tax liability when making sales of petroleum products to Amtrak.

2) The nontaxable transaction set out above is also applicable to local Retailers' Occupation Taxes imposed by municipalities, counties, the Regional Transportation Authority and Metro East Mass Transit District;

t) *of farm machinery and equipment, both new and used including that manufactured on special order, certified by the purchaser to be used primarily for production agriculture, or state or federal agricultural programs, including individual replacement parts for the machinery and equipment and including machinery and equipment purchased for lease* [35 ILCS 120/2-5(2)] (see Section 130.305);

u) through June 30, 2003, *of distillation machinery and equipment, sold as a unit or kit, certified by the user to be used only for the production of ethyl alcohol that will be used for consumption as a motor fuel or as a component of motor fuel for personal use of the user and not subject to sale or resale* [35 ILCS 120/2-5(3)]*;*

v) through June 30, 2003, and beginning again on September 1, 2004 *through August 30, 2014*, *of graphic arts machinery and equipment, including repair and replacement parts* [35 ILCS 120/2-5(4)] (see Section 130.325);

w) through August 31, 2007, and beginning again on January 11, 2008:~~,~~

1) any~~a~~ *motor vehicle of the first division that is used for automobile renting, as defined in the Automobile Renting Occupation and Use Tax Act; or*~~,~~

2) *a motor vehicle of the second division that is used for automobile renting, as defined in the Automobile Renting Occupation and Use Tax Act, and which:*~~*that*~~

A) *is a self-contained motor vehicle designed or permanently converted to provide living quarters for recreational, camping, or*

travel use, with direct walk through access to the living quarters from the driver's seat;

B) *is~~, or a motor vehicle of the second division that is~~ of the van configuration designed for the transportation of not less than 7 nor more than 16 passengers, as defined in Section 1-146 of the Illinois Vehicle Code; or*

C) beginning on January 1, 2014, *has a Gross Vehicle Weight Rating, ~~that is used for automobile renting~~ as defined in Section 1-124.5 of the Illinois Vehicle Code, of 8,000 pounds or less~~the Automobile Renting Occupation and Use Tax Act~~* [35 ILCS 120/2-5(5)]*;*

x) *of personal property sold by a teacher-sponsored student organization affiliated with an elementary or secondary school located in Illinois* [35 ILCS 120/2-5(6)] (see Section 130.2006);

y) through June 30, 2003, *of that portion of the selling price of a passenger car, the sale of which is subject to the replacement vehicle tax of the Illinois Vehicle Code* [625 ILCS 5/3-2001] [35 ILCS 120/2-5(7)];

z) *of personal property sold to an Illinois county fair association* for use in conducting, operating or promoting the *county fair* [35 ILCS 120/2-5(8)];

aa) *of personal property sold to any not-for-profit arts or cultural organization that establishes that it has received an exemption under Section 501(c)(3) of the Internal Revenue Code (26 USCA 501) and that is organized and operated for the presentation or support of arts or cultural programming, activities, or services. On and after July 1, 2001, the qualifying organizations listed* in this subsection (aa) *must also be organized and operated primarily for the presentation or support of arts or cultural programming, activities, or services. These organizations include, but are not limited to, music and dramatic arts organizations such as symphony orchestras and theatrical groups, arts and cultural service organizations, local arts councils, visual arts organizations, and media arts organizations* [35 ILCS 120/2-5(9)] (see Section 130.2004 of this Part)*;*

bb) *of personal property sold by a corporation, society, association, foundation, institution or organization that is organized and operated as a not-for-profit*

service enterprise for the benefit of persons 65 years of age or older if the personal property was not purchased by the enterprise for the purpose of resale by the enterprise [35 ILCS 120/2-5(10)] (see Section 130.2008);

cc) *of legal tender, currency, medallions, or gold or silver coinage issued by the State of Illinois, the government of the United States of America or the government of any foreign country and bullion* [35 ILCS 120/2-5(18~~11~~)], unless the items are transferred as jewelry and therefore subject to tax;

dd) through June 30, 2003, *of oil field exploration, drilling and production equipment* [35 ILCS 120/2-5(19)] (see Section 130.345);

ee) *of photoprocessing machinery and equipment, including repair and replacement parts* [35 ILCS 120/2-5(20)] (see Section 130.2000);

ff) beginning July 1, 2003,~~through June 30, 2003,~~ *of coal exploration, mining, off highway hauling, processing, maintenance and reclamation equipment, including replacement parts and equipment, and including equipment purchased for lease, but excluding motor vehicles required to be registered under the Illinois Motor Vehicle Code. The Department, however, will not approve any claims or refunds on or after August 16, 2013, for taxes due or paid during the period beginning July 1, 2003 through August 16, 2013.* This exemption will terminate by operation of the sunset provisions of Section 2-70 of the Retailers' Occupation Tax Act on August 16, 2018 [35 ILCS 120/2-5(21)] (see Section 130.350);

gg) until June 30, 2013, *of fuel and petroleum products sold to or used by an air common carrier, certified by the carrier to be used for consumption, shipment or storage in the conduct of its business as an air common carrier, for a flight destined for or returning from a location or locations outside the United States without regard to previous or subsequent domestic stopovers. Beginning July 1, 2013, fuel and petroleum products sold to or used by an air carrier, certified by the carrier to be used for consumption, shipment, or storage in the conduct of its business as an air common carrier, for a flight that is engaged in foreign trade or is engaged in trade between the United States and any of its possessions and that transports at least one individual or package for hire from the city of origination to the city of final destination on the same aircraft, without regard to a change in the flight number of that aircraft.* This exemption will terminate by operation of the sunset provisions of Section 2-70 of the Retailers' Occupation Tax Act on August 16, 2018 [35 ILCS 120/2-5(22)] (see Section 130.321);

hh) *of semen used for artificial insemination of livestock for direct agricultural production*. [35 ILCS 120/2-5(26)] Exemption certifications must be executed by the purchaser. The certificate must include the seller's name and address, the purchaser's name and address, the purchaser's registration number with the Department, the purchaser's signature and date of signing and a statement that the semen purchased will be used for artificial insemination of livestock for direct agricultural production. The certificates shall be retained by the retailer and shall be made available to the Department for inspection or audit;

ii) *beginning with taxable years ending on or after December 31, 1995 and ending with taxable years ending on or before December 31, 2004, of personal property that is donated for disaster relief to be used in a State or federally declared disaster area in Illinois or bordering Illinois by a manufacturer or retailer that is registered in this State to a corporation, society, association, foundation, or institution that has been issued a sales tax exemption identification number by the Department that assists victims of the disaster who reside within the declared disaster area*. [35 ILCS 120/2-5(30)] Exemption certifications must be executed by the purchaser. The certificate must include the seller's name and address, the purchaser's name and address, the purchaser's registration number with the Department, if applicable, the purchaser's signature and the date of signing, a description of the items being purchased for donation, a statement that the property purchased will be donated for disaster relief to be used in a State or federally declared disaster area in Illinois or bordering Illinois to a corporation, society, association, foundation, or institution that has been issued a sales tax exemption identification number by the Department that assists victims of the disaster who reside within the declared disaster area, and that entity's sales tax exemption identification number. The certificates shall be retained by the retailer and shall be made available to the Department for inspection or audit;

jj) *beginning with taxable years ending on or after December 31, 1995 and ending with taxable years ending on or before December 31, 2004, of personal property that is used in the performance of infrastructure repairs in this State, including but not limited to municipal roads and streets, access roads, bridges, sidewalks, waste disposal systems, water and sewer line extensions, water distribution and purification facilities, storm water drainage and retention facilities, and sewage treatment facilities, resulting from a State or federally declared disaster in Illinois or bordering Illinois when such repairs are initiated on facilities located in the declared disaster area within 6 months after the disaster.* [35 ILCS 120/2-5(31)]

Exemption certifications must be executed by the purchaser. The certificate must include the seller's name and address, the purchaser's name and address, the purchaser's registration number with the Department, if applicable, the purchaser's signature and date of signing, a description of the items being purchased, and a statement that the property purchased is for use in the performance of infrastructure repairs initiated on facilities located in the declared disaster area within six months after the disaster in this State resulting from a State or federally declared disaster area in Illinois or bordering Illinois. The certificates shall be retained by the retailer and shall be made available to the Department for inspection or audit;

kk) *of a transaction in which the purchase order is received by a florist who is located outside Illinois, but who has a florist located in Illinois deliver the property to the purchaser or the purchaser's donee in Illinois* [35 ILCS 120/2-5(23)];

ll) of *horses, or interests in horses, registered with and meeting the requirements of any of the Arabian Horse Club Registry of America, Appaloosa Horse Club, American Quarter Horse Association, United States Trotting Association, or Jockey Club, as appropriate, used for purposes of breeding or racing for prizes. This exemption applies for all periods beginning May 30, 1995, but no claim for credit or refund is allowed on or after January 1, 2008 for taxes paid during the period beginning May 30, 2000 and ending January 1, 2008* [35 ILCS 120/2-5(27)];

mm) *effective January 1, 1996 through December 31, 2000, and on and after August 2, 2001*, *of computers and communications equipment utilized for any hospital purpose and equipment used in the diagnosis, analysis or treatment of hospital patients sold to a lessor who leases the equipment, under a lease of one year or longer executed or in effect at the time of the purchase, to a hospital that has been issued an active tax exemption identification number by the Department under Section 1g of the Retailers' Occupation Tax Act* [35 ILCS 120/2-5(36~~28~~)] (see Section 130.2011 of this Part);

nn) *effective January 1, 1996 through December 31, 2000, and on and after August 2, 2001*, *of personal property sold to a lessor who leases the property, under a lease of one year or longer executed or in effect at the time of the purchase, to a governmental body that has been issued an active tax exemption identification*

number by the Department under Section 1g of the Retailers' Occupation Tax Act [35 ILCS 120/2-5(37~~29~~)] (see Section 130.2012 of this Part);

oo) *of tangible personal property sold to a common carrier by rail or motor that receives the physical possession of the property in Illinois and that transports the property, or shares with another common carrier in the transportation of the property, out of Illinois on a standard uniform bill of lading showing the seller of the property as the shipper or consignor of the property to a destination outside Illinois, for use outside Illinois* [35 ILCS 120/2-5(17)];

pp) *beginning July 1,* ~~through June 30,~~ 2003, *of aggregate exploration, mining, off highway hauling, processing, maintenance, and reclamation equipment, including replacement parts and equipment, and including equipment purchased for lease, but excluding motor vehicles required to be registered under the Illinois Vehicle Code. The Department, however, will not approve any claims or refunds on or after August 16, 2013, for taxes due or paid during the period beginning July 1, 2003 through August 16, 2013.* This exemption will terminate by operation of the sunset provisions of Section 2-70 of the Retailers' Occupation Tax Act on August 16, 2018 [35 ILCS 120/7] (see Section 130.351);

qq) Game Birds

1) beginning July 1~~20~~, 1999 through August 15, 2011, of game or game birds purchased at:

A~~1~~) a game breeding and hunting preserve area licensed by the Department of Natural Resources (see Section 3.27 of the Wildlife Code [520 ILCS 5/3.27]);

B~~2~~) an exotic game hunting area licensed by the Department of Natural Resources (see Section 3.34 of the Wildlife Code [520 ILCS 5/3.34]); or

C~~3~~) a hunting enclosure approved through rules adopted by the Department of Natural Resources;

2) beginning August 16, 2011, of *game or game birds purchased at a "game breeding and hunting preserve area" as that term is used in the Wildlife Code;*

rr) *beginning January 1, 2000,* of *personal property, including food, purchased through fundraising events for the benefit of a public or private elementary or secondary school, a group of those schools, or one or more school districts if the events are sponsored by an entity recognized by the school district that consists primarily of volunteers and includes parents and teachers of the school children. This* subsection (rr) *does not apply to fundraising events:*

1) *for the benefit of private home instruction; or*

2) *for which the fundraising entity purchases the personal property sold at the events from another individual or entity that sold the property for the purpose of resale by the fundraising entity and that profits from the sale to the fundraising entity* [35 ILCS 120/2-5(34)];

ss) *of machinery or equipment used in the operation of a high impact service facility located within an enterprise zone established pursuant to the Illinois Enterprise Zone Act. "High impact service facility" means a facility used primarily for the sorting, handling and redistribution of mail, freight, cargo, or other parcels received from agents or employees of the handler or shipper for processing at a common location and redistribution to other employees or agents for delivery to an ultimate destination on an item-by-item basis, and which:*

1) *will make an investment in a business enterprise project of $100,000,000 or more;*

2) *will cause the creation of at least 750 to 1,000 jobs or more in an enterprise zone established pursuant to the Illinois Enterprise Zone Act; and*

3) *is certified by the* Department of Commerce and Economic Opportunity *as contractually obligated to meet the requirements specified in* subsection (11)(1) and (2) *within the time period as specified by the certification. The certificate of eligibility for exemption shall be presented by the business enterprise to its supplier when making the initial purchase of machinery and equipment for which an exemption is granted by Section 1j of the Act, together with a certification by the business enterprise that such machinery and equipment is exempt from taxation under Section 1j of the*

Act and by indicating the exempt status of each subsequent purchase on the face of the purchase order [35 ILCS 120/1i];

tt) through December 31, 2002, *of jet fuel and petroleum products sold to and used in the conduct of its business of sorting, handling and redistribution of mail, freight, cargo or other parcels in the operation of a high impact service facility located within an enterprise zone established pursuant to the Illinois Enterprise Zone Act, provided that the business enterprise has waived its right to a tax exemption of the charges imposed under Section 9-222.1 of the Public Utilities Act* [35 ILCS 120/1j.1]. *High impact service facilities qualifying under the Act and seeking the exemption under Section 1j.1 shall be ineligible for the exemptions of taxes imposed under Section 9-222.1 of the Public Utilities Act. High impact service facilities qualifying under the Act and seeking the exemption under Section 9-222.1 of the Public Utilities Act shall be ineligible for the exemptions of taxes as described in Section 1j.1* of the Act. [35 ILCS 120/1j.2] *The certification of eligibility for exemption shall be presented by the business enterprise to its supplier when making the purchase of jet fuel and petroleum products for which an exemption is granted by Section 1j.1 of the Act, together with a certification by the business enterprise that such jet fuel and petroleum product is exempt from taxation under Section 1j.1 of the Act, and by indicating the exempt status of each subsequent purchase on the face of the purchase order* [35 ILCS 120/1i];

uu) through August 20, 2004, *of a motor vehicle, as that term is defined in Section 1-146 of the Illinois Vehicle Code, that is donated to a corporation, limited liability company, society, association, foundation, or institution that is determined by the Department to be organized and operated exclusively for educational purposes. For purposes of this exemption, "a corporation, limited liability company, society, association, foundation, or institution organized and operated exclusively for educational purposes" means all tax-supported public schools, private schools that offer systematic instruction in useful branches of learning by methods common to public schools and that compare favorably in their scope and intensity with the course of study presented in tax-supported schools, and vocational or technical schools or institutes organized and operated exclusively to provide a course of study of not less than 6 weeks duration and designed to prepare individuals to follow a trade or to pursue a manual, technical, mechanical, industrial, business, or commercial occupation.* [35 ILCS 120/2-5(33)] Exemption certifications must be executed by the purchaser. The certificate must include: the seller's name and address; the purchaser's name and address; the

purchaser's registration number with the Department, if applicable; the purchaser's signature and date of signing; a description of the motor vehicle that is being purchased for immediate donation to a corporation, limited liability company, society, association, foundation, or institution that is determined by the Department to be organized and operated exclusively for educational purposes (see Section 130.2005); the donee's sales tax exemption identification number; and a statement that the motor vehicle is being purchased for immediate donation to a corporation, limited liability company, society, association, foundation, or institution that is determined by the Department to be organized and operated exclusively for educational purposes. The certificates shall be retained by the retailer and shall be made available to the Department for inspection or audit;

vv) *beginning August 23, 2001 and through June 30, 2016~~June 30, 2011~~, of food for human consumption that is to be consumed off the premises where it is sold (other than alcoholic beverages, soft drinks, and food that has been prepared for immediate consumption) and prescription and nonprescription medicines, drugs, medical appliances, and insulin, urine testing materials, syringes, and needles used by diabetics, for human use, when purchased for use by a person receiving medical assistance under Article 5 of the Illinois Public Aid Code who resides in a licensed long-term care facility, as defined in the Nursing Home Care Act or, beginning July 1, 2010 through January 1, 2012, a licensed facility as defined in the MR/DD Community Care Act, or beginning January 1, 2012, a licensed facility as defined in the ID/DD Community Care Act, or beginning June 28, 2011, a licensed facility as defined in the Specialized Mental Health Rehabilitation Act* [35 ILCS 120/2-5(35-5)];

ww) *beginning January 1, 2000 through December 31, 2001, of new or used automatic vending machines that prepare and serve hot food and beverages, including coffee, soup, and other items, and replacement parts for these machines. Beginning January 1, 2002* and through June 30, 2003, *of machines and parts for machines used in commercial, coin-operated amusement and vending business if a use or occupation tax is paid on the gross receipts from the use of the commercial, coin-operated amusement and vending machines~~.~~* [35 ILCS 120/2-5(35)] (See Section 130.332 of this Part.);

xx) *beginning July 1, 2007, of an aircraft, as that term is defined in Section 3 of the Illinois Aeronautics Act, if all of the following conditions are met:*

1) *the aircraft leaves this State within 15 days after the later of either the final billing for the sale of the aircraft or the approval for return to service, completion of the maintenance record entry, and completion of the test flight and ground test for inspection, as required by 14 CFR 91.407;*

2) *the aircraft is not based or registered in this State after the sale of the aircraft; and*

3) *the seller retains documents as required by the Department.* [35 ILCS 120/2-5(25-7)] (See Section 130.605);

yy) *effective October 11, 2007, of tangible personal property sold to a public-facilities corporation, as described in 65 ILCS 5/11-65-10, for purposes of constructing or furnishing a municipal convention hall. If, before* October 11, 2007*, a municipality has incorporated a public-facilities corporation and the public-facilities corporation complies with the requirements set forth in Section 11-65-10, then this exemption applies to that public-facilities corporation.* [65 ILCS 5/11-65-10, 15 and 25 and 35 ILCS 120/2-5(41~~40~~)];

zz) *beginning January 1, 2008, of tangible personal property used in the construction or maintenance of certain community water supplies* [35 ILCS 120/2-5(39)];

aaa) Aircraft Maintenance

1) *beginning January 1, 2010,* of *materials, parts, equipment, components, and furnishings incorporated into or upon an aircraft as part of the modification, refurbishment, completion, replacement, repair, or maintenance of the aircraft. This exemption includes consumable supplies used in the modification, refurbishment, completion, replacement, repair, and maintenance of aircraft, but excludes any materials, parts, equipment, components, and consumable supplies used in the modification, replacement, repair, and maintenance of aircraft engines or power plants, whether such engines or power plants are installed or uninstalled upon any such aircraft. "Consumable supplies" include, but are not limited to, adhesive, tape, sandpaper, general purpose lubricants, cleaning solution, latex gloves, and protective films. This exemption applies only to those organizations that hold an Air Agency Certificate and are empowered to operate an approved repair station by the Federal Aviation*

Administration, have a Class IV Rating, and conduct operations in accordance with Part 145 of the Federal Aviation Regulations. The exemption does not include aircraft operated by a commercial air carrier providing scheduled passenger airservice pursuant to authority issued under Part 121 or Part 129 of the Federal Aviation Regulations~~.~~ [35 ILCS 120/2-5(40~~41~~)];

2) beginning August 23, 2013, *of qualifying tangible personal property to persons who modify, refurbish, complete, repair, replace, or maintain aircraft and who hold an Air Agency Certificate and are empowered to operate an approved repair station by the Federal Aviation Administration, have a Class IV Rating, and conduct operations in accordance with part 145 of the Federal Aviation Regulations. The exemption does not include aircraft operated by a commercial air carrier providing scheduled passenger airservice pursuant to authority issued under part 121 or part 129 of the Federal Aviation Regulations* [35 ILCS 120/2-5(40)];

bbb) *effective*~~*Effective*~~ *July 12, 2006,* ~~each *retailer that makes a qualified sale*~~ *of building materials to be incorporated into real estate within a River Edge Redevelopment Zone in accordance with the River Edge Redevelopment Zone Act by remodeling, rehabilitating, or new construction may deduct receipts from those sales when calculating the tax imposed by* the *Act*~~.~~ [35 ILCS 120/2-54] (See Section 130.1954~~130.605~~.);

ccc) *of electricity delivered to customers by wire; natural or artificial gas that is delivered to customers through pipes, pipelines, or mains; and water that is delivered to customers through pipes, pipelines, or mains. These provisions are declaratory of existing law as to the meaning and scope of the Retailers' Occupation Tax Act* [35 ILCS 120/2].

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Automobile Renting Occupation Tax

2) Code Citation: 86 Ill. Adm. Code 180

3) Section Number: 180.101 Proposed Action: Amend

4) Statutory Authority: 35 ILCS 155

5) A Complete Description of the Subjects and Issues Involved: This rulemaking implements the provisions of PA 98-574 which, in relevant part, amended the Automobile Renting Occupation and Use Tax Act's definition of "automobile" to include a motor vehicle of the second division that has a Gross Vehicle Weight Rating, as defined in Section 1-124.5 of the Illinois Vehicle Code, of 8,000 pounds or less.

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 create a State mandate, nor does it modify any existing State mandates.

12) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rulemaking may submit them in writing by no later than 45 days after publication of this Notice to:

Debra Boggess, Associate Counsel
Sales & Excise Tax
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, IL 62794

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

217/782-2844

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: Car rental businesses

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 2013

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

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 180
AUTOMOBILE RENTING OCCUPATION TAX

SUBPART A: NATURE OF THE TAX

Section
180.101 Character And Rate Of The Tax
180.105 Responsibility Of Trustees, Receivers, Executors Or Administrators
180.110 Occasional Rental Transactions
180.115 Habitual Rental Transactions

SUBPART B: GROSS RECEIPTS, AUTHORIZED DEDUCTIONS AND NONTAXABLE TRANSACTIONS

Section
180.120 The Meaning of Gross Receipts
180.125 Authorized Deductions from Gross Receipts
180.130 Nontaxable Transactions
180.135 Rentals for Re-rental

SUBPART C: RETURNS

Section
180.140 Monthly Tax Returns – When Due – Contents

SUBPART D: INCORPORATION BY REFERENCE

Section
180.145 Incorporation of Certain Retailers' Occupation Tax Regulations

AUTHORITY: Implementing the Automobile Renting Occupation and Use Tax Act [35 ILCS 155] and authorized by Section 2505-25 of the Civil Administrative Code of Illinois [20 ILCS 2505/2505-25].

SOURCE: Adopted and codified at 7 Ill. Reg. 9397, effective July 25, 1983; amended at 13 Ill. Reg. 9332, effective June 6, 1989; amended at 16 Ill. Reg. 4859, effective March 12, 1992;

amended at 24 Ill. Reg. 12063, effective July 28, 2000; amended at 25 Ill. Reg. 8323, effective June 22, 2001; amended at 26 Ill. Reg. 4935, effective March 15, 2002; amended at 38 Ill. Reg. _____, effective _____.

SUBPART A: NATURE OF THE TAX

Section 180.101 Character And Rate Of The Tax

a) The Automobile Renting Occupation and Use Tax Act [35 ILCS 155] (the Act) *imposes a tax upon persons engaged in this State in the business of renting automobiles in Illinois under lease terms of one year or less at the rate* of *5% of the gross receipts from such business.* (Section 3 of the Act)

b) *"Automobile" means any motor vehicle of the first division that is used for automobile renting, as defined in the Act, or~~,~~ a motor vehicle of the second division that is used for automobile renting, as defined in the Act, and which is a self-contained motor vehicle designed or permanently converted to provide living quarters for recreational, camping or travel use, with direct walk through access to the living quarters from the driver's seat; is~~, or a motor vehicle of the second division which is~~ of the van configuration designed for the transportation of not less than 7 nor more than 16 passengers, as defined in Section 1-146 of the Illinois Vehicle Code* [625 ILCS 5/1-146]*; or, beginning January 1, 2014, has a Gross Vehicle Weight Rating, as defined in Section 1-124.5 of the Illinois Vehicle Code, of 8,000 pounds or less*. (Section 2 of the Act) This includes motorcycles and motor driven cycles.

1) Under Section 1-146 of the Illinois Vehicle Code, a motor vehicle is defined as *every vehicle which is self-propelled and every vehicle which is propelled by electric power obtained from overhead trolley wires, but not operated upon rails, except for vehicles moved solely by human power and motorized wheelchairs.* [625 ILCS 5/1-146]

2) Under Section 1-146 of the Illinois Vehicle Code, motor vehicles are classified as either first or second division motor vehicles. The manner in which a vehicle is classified generally reflects the purpose for which it is primarily used. As a result of this classification, a motor vehicle will be registered as either a first or second division vehicle, and will receive a plate reflecting such registration. The following examples are illustrative:

DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENT

A) Under Section 1-146 of the Illinois Vehicle Code, first division motor vehicles are defined as *motor vehicles which are designed for carrying not more than 10 persons.* [625 ILCS 5/1-146] Under Section 2 of the Act, all motor vehicles registered with the Secretary of State as first division motor vehicles qualify as automobiles subject to tax under the Act. Consequently, passenger cars and motorcycles are "automobiles" subject to tax under the Act.

B) Second division motor vehicles generally include motor vehicles serving purposes other than or in addition to serving as passenger cars. Second division vehicles include *motor vehicles designed for pulling or carrying freight, cargo or implements of husbandry; motor vehicles designed for carrying more than 10 persons; motor vehicles designed or used for living quarters; and motor vehicles of the first division remodeled for use and used as motor vehicles of the second division.* [625 ILCS 5/1-146] A pick-up truck is a second division vehicle because it is designed for pulling or carrying freight. Section 2 of the Act provides that the only types of second division vehicles subject to tax include:

i) self-contained motor vehicles designed or permanently converted to provide living quarters for recreational, camping or travel use, with direct walk through access to the living quarters from the driver's seat; ~~and~~

ii) motor vehicles which are of the van configuration designed for the transportation of not less than 7 nor more than 16 passengers; and~~.~~

iii) beginning January 1, 2014, a motor vehicle that has a Gross Vehicle Weight Rating, as defined in Section 1-124.5 of the Illinois Vehicle Code, of 8,000 pounds or less.

C) Pick-up Trucks

i) Until January 1, 2014, pick-up~~Pick-up~~ trucks are not subject to tax under the Act because they are not one of the types of second division motor vehicles specified as

automobiles under the terms of the Act.

ii) Beginning January 1, 2014, pick-up~~Pick-up~~ trucks are~~are not~~ subject to tax under the Act only if they are~~because they are not~~ one of the types of second division motor vehicles specified as automobiles under subsection (b)(2)(B)(iii)~~the terms of the Act~~.

D) SUVs

i) Multipurpose passenger vehicles, commonly referred to as "sport utility vehicles (SUVs)", may be registered as either first or second division motor vehicles. If an SUV is registered as a first division motor vehicle, it is an automobile subject to tax under the Act. Until December 31, 2013, if~~If~~ an SUV is registered as a second division motor vehicle, it is not an automobile subject to tax under the Act because it is not one of the types of second division motor vehicles specified as automobiles under the terms of the Act.

ii) Beginning January 1, 2014, if an SUV is registered as a second division motor vehicle, it is an automobile subject to tax only if it is one of the types of second division motor vehicles specified as automobiles under subsection (b)(2)(B)(iii).

~~E) Effective date of subsections (b)(2)(C) and (D). If a rentor or rentee paid tax under the Act before April 5, 2002 for the type of motor vehicles described in subsections (b)(2)(C) or (D) of this Section, the Department shall not consider that tax to be improperly paid or seek additional tax liability under the provisions of the Use Tax Act [35 ILCS 105] for the rental of such motor vehicles. However, on and after April 5, 2002, the provisions of subsections (b)(2)(C) and (D) shall be fully enforced.~~

3) Lessors engaged in the business of leasing motor vehicles that are not subject to tax under the Act generally incur a Use Tax liability on the cost price of motor vehicles purchased for leasing purposes. For more

information on the liability of lessors, see the provisions of 86 Ill. Adm. Code 130.220 and 130.2010.

c) How To Determine Effective Rate
Automobile Renting Occupation Tax liability shall be computed by applying to the gross receipts from taxable rental transactions, the tax rate in effect during the rentee's possession of the rented automobile. Where a rate change takes effect during a rentee's possession, all rental receipts received from that rentee after the effective date of the rate change are subject to the new rate. If a rentee takes possession after a rate change in a rental transaction in which the rentor received rental receipts before the date of the rate change and the tax was paid on such receipts when received by the rentor at the rate in effect when the rentor received those receipts, no additional tax will be due or credit allowed because the rentee took possession after the effective date of the rate change.

d) Effective Date of New Taxes
When something that has been exempted becomes taxable as to rental transactions that are made on and after some particular date, the date of rental for this purpose shall be deemed to be the date of possession or right to possession of the automobile. This is true even if such possession is taken under a contract that was entered into before the effective date of the new tax.

e) Relation of Automobile Renting Occupation Tax To The Automobile Renting Use Tax

1) The Automobile Renting Occupation Tax is an occupation tax, the legal incidence of which is on the rentor rather than on the rentee.

2) However, the rentor becomes a tax collector under the Automobile Renting Use Tax and is required to collect that tax from rentees. In making that collection, rentors may rely on the tax collection schedules prescribed in the Department's Use Tax Regulations for the collection of the Use Tax by retailers from users. Consequently, the tax collection schedules set out in 86 Ill. Adm. Code 150.Table A are incorporated by reference herein.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

a) Heading of the Part: Cancellation, Revocation or Suspension of Licenses or Permits

2) Code Citation: 92 Ill. Adm. Code 1040

3)

Section Numbers:	Proposed Action:
1040.20	Amend
1040.100	Amend
1040.115	Amend

4) Statutory Authority: 625 ILCS 5/2-104, 625 ILCS 5/6-201, 625 ILCS 5/6-205.2, 625 ILCS 5/6-306.7, 625 ILCS 5/11-601.5, 625 ILCS 5/11-605.1; 625 ILCS 5/12-604.1, 625 ILCS 5/12-610.1 and 625 ILCS 5/12-610.2

5) A Complete Description of the Subjects and Issues Involved: 1040.20 is being amended due to the passage of the following public acts:

PA 98-168, which requires the Secretary of State to cancel a graduated driver's license issued to a person who falsely answered "no" to the question of whether the applicant had a pending citation at the time of application.

PA 98-178, which requires the Secretary of State to cancel the driver's license of a person who has submitted an affidavit that that the person no longer resides in Illinois.

PA 98-337, which allows the Secretary of State to suspend the driver's license of a person convicted of a second violation of speeding in a construction or maintenance zone only if workers were present at the time of the violation (previously workers were not required to be present to impose a driver's license suspension).

PA 98-506, which prohibits the use of hands-held cell phones and provides that a second or subsequent conviction is a moving violation.

PA 98-507, which created new aggravated offenses involving the use of video devices and cell phones which result in death or bodily harm to another. 1040.20 sets forth the driver's license sanctions imposed for a violation of those offenses.

PA 98-511, which modified the Class A and B misdemeanor speeding offenses (the number of miles per hour over the speed limit).

Section 1040.20 is also being amended to remove outdated and obsolete references to Chapter 27 of the Municipal Code of Chicago.

Section 1040.100 sets forth the procedure to be used in the rescission of all sanctions imposed by the Secretary of State. The rule inadvertently omitted the rescission of toll violation or toll evasion suspensions. This amendment corrects this oversight.

Section 1040.115 is amended to include a conviction of theft of motor fuel pursuant to Section 16-25 of the Criminal Code of 2012, as amended by PA 97-597.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rule currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this proposed rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: The rulemaking will not create or enlarge a State mandate.

12) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Text of the prepared amendments is posted on the Secretary of State's website, www.sos.il.us/departments/index/home as part of the Illinois Register. Interested persons may present their comments concerning this proposed rulemaking in writing within 45 days after publication of this Notice to:

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

13) Initial Regulatory Flexibility Analysis:

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

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 2013

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

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

TITLE 92: TRANSPORTATION
CHAPTER II: SECRETARY OF STATE

PART 1040
CANCELLATION, REVOCATION OR SUSPENSION
OF LICENSES OR PERMITS

Section
1040.1 Definitions
1040.10 Court to Forward Licenses and Reports of Convictions
1040.20 Illinois Offense Table
1040.25 Suspension or Revocation for Driving Without a Valid Driver's License
1040.28 Suspension or Revocation for Traffic Offense Committed by a Person Under the Age of 21 Years After a Prior Suspension Under Part 1040.29
1040.29 Suspension or Revocation for Two or More Traffic Offenses Committed Within 24 Months by a Person Under the Age of 21
1040.30 Suspension or Revocation for Three or More Traffic Offenses Committed Within 12 Months
1040.31 Operating a Motor Vehicle During a Period of Suspension or Revocation
1040.32 Suspension or Revocation of Driver's Licenses, Permits or Identification Cards Used Fraudulently
1040.33 Suspension or Revocation of Driver's Licenses/Permits for Fictitious or Unlawfully Altered Disability License Plate or Parking Decal or Device or Fraudulent Disability License Plate or Parking Decal or Device
1040.34 Suspension or Revocation for Conviction for Possession/Consumption of Alcohol for Persons Under Age 21
1040.35 Administrative Revocation for Commission of an Offense Requiring Mandatory Revocation Upon Conviction, and Suspension or Revocation Based Upon a Local Ordinance Conviction
1040.36 Suspension for Violation of Restrictions on Driver's License
1040.37 Suspension for Violation of Restrictions on Instruction Permit
1040.38 Commission of a Traffic Offense in Another State
1040.40 Suspension or Revocation for Repeated Convictions or Collisions
1040.41 Suspension of Licenses for Curfew or Night Time Driving Restriction Violations
1040.42 Suspension or Revocation for Fleeing and Eluding
1040.43 Suspension or Revocation for Illegal Transportation
1040.46 Suspension or Revocation for Fatal Accident and Personal Injury Suspensions or Revocations
1040.48 Vehicle Emission Suspensions (Repealed)

1040.50	Occupational Driving Permit
1040.52	Driver Remedial Education Course
1040.55	Suspension or Revocation for Driver's License Classification Violations
1040.60	Release of Information Regarding a Disposition of Court Supervision
1040.65	Offenses Occurring on Military Bases
1040.66	Invalidation of a Restricted Driving Permit
1040.70	Problem Driver Pointer System
1040.80	Cancellation of Driver's License Upon Issuance of a Disabled Person Identification Card
1040.100	Rescissions
1040.101	Reinstatement Fees
1040.102	Bankruptcy Rule for Suspensions, Cancellations, Failure to Pay and Returned Checks Actions
1040.105	Suspension for Five or More Tollway Violations and/or Evasions
1040.107	Suspension for Violation of Improperly Approaching a Stationary Emergency Vehicle
1040.108	Suspension for Failure to Make Report of Vehicle Accident Violations
1040.109	Suspension for Two or More Convictions for Railroad Crossing Violations
1040.110	Bribery
1040.111	Suspension for Failure to Yield upon Entering a Construction or Maintenance Zone when Workers Are Present
1040.115	Suspension for Theft of Motor Fuel
1040.116	Discretionary Suspension/Revocation; Committing Perjury; Submitting False/Fraudulent Documents; Notification by Department of Administrative Hearings
1040.117	Suspension for Concealment or Obstruction of Registration to Hinder Law Enforcement

AUTHORITY: Implementing Articles II and VII of the Illinois Vehicle Code [625 ILCS 5/Ch. 6, Arts. II and VII] and authorized by Section 2-104(b) of the Illinois Vehicle Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/2-104(b)].

SOURCE: Filed September 22, 1972; amended at 3 Ill. Reg. 26, p. 282, effective June 30, 1979; amended at 5 Ill. Reg. 3533, effective April 1, 1981; amended at 6 Ill. Reg. 4239, effective April 2, 1982; codified at 6 Ill. Reg. 12674; amended at 8 Ill. Reg. 2200, effective February 1, 1984; amended at 8 Ill. Reg. 3783, effective March 13, 1984; amended at 8 Ill. Reg. 18925, effective September 25, 1984; amended at 8 Ill. Reg. 23385, effective November 21, 1984; amended at 10 Ill. Reg. 15265, effective September 4, 1986; amended at 11 Ill. Reg. 16977, effective October 1, 1987; amended at 11 Ill. Reg. 20659, effective December 8, 1987; amended at 12 Ill. Reg. 2148,

effective January 11, 1988; amended at 12 Ill. Reg. 14351, effective September 1, 1988; amended at 12 Ill. Reg. 15625, effective September 15, 1988; amended at 12 Ill. Reg. 16153, effective September 15, 1988; amended at 12 Ill. Reg. 16906, effective October 1, 1988; amended at 12 Ill. Reg. 17120, effective October 1, 1988; amended at 13 Ill. Reg. 1593, effective January 23, 1989; amended at 13 Ill. Reg. 5162, effective April 1, 1989; amended at 13 Ill. Reg. 7802, effective May 15, 1989; amended at 13 Ill. Reg. 8659, effective June 2, 1989; amended at 13 Ill. Reg. 17087, effective October 16, 1989; amended at 13 Ill. Reg. 20127, effective December 8, 1989; amended at 14 Ill. Reg. 2944, effective February 7, 1990; amended at 14 Ill. Reg. 3664, effective February 7, 1990; amended at 14 Ill. Reg. 5178, effective April 1, 1990; amended at 14 Ill. Reg. 5560, effective March 22, 1990; amended at 14 Ill. Reg. 14177, effective August 21, 1990; amended at 14 Ill. Reg. 18088, effective October 22, 1990; amended at 15 Ill. Reg. 14258, effective September 24, 1991; amended at 17 Ill. Reg. 8512, effective May 27, 1993; amended at 17 Ill. Reg. 9028, effective June 2, 1993; amended at 17 Ill. Reg. 12782, effective July 21, 1993; amended at 18 Ill. Reg. 7447, effective May 3, 1994; amended at 18 Ill. Reg. 10853, effective June 27, 1994; amended at 18 Ill. Reg. 11644, effective July 7, 1994; amended at 18 Ill. Reg. 16443, effective October 24, 1994; amended at 20 Ill. Reg. 2558, effective January 26, 1996; amended at 21 Ill. Reg. 8398, effective June 30, 1997; amended at 21 Ill. Reg. 10985, effective July 29, 1997; amended at 21 Ill. Reg. 12249, effective August 26, 1997; amended at 21 Ill. Reg. 12609, effective August 29, 1997; amended at 22 Ill. Reg. 1438, effective January 1, 1998; amended at 22 Ill. Reg. 5083, effective February 26, 1998; amended at 22 Ill. Reg. 13834, effective July 10, 1998; amended at 24 Ill. Reg. 1655, effective January 11, 2000; emergency amendment at 24 Ill. Reg. 8398, effective June 2, 2000, for a maximum of 150 days; emergency expired October 29, 2000; emergency amendment at 24 Ill. Reg. 16096, effective October 12, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 16689, effective October 30, 2000; amended at 25 Ill. Reg. 2723, effective January 31, 2001; amended at 25 Ill. Reg. 6402, effective April 26, 2001; emergency amendment at 26 Ill. Reg. 2044, effective February 1, 2002, for a maximum of 150 days; emergency expired June 30, 2002; emergency amendment at 26 Ill. Reg. 3753, effective February 21, 2002, for a maximum of 150 days; emergency expired July 20, 2002; amended at 26 Ill. Reg. 12373, effective July 25, 2002; amended at 26 Ill. Reg. 13684, effective August 28, 2002; amended at 29 Ill. Reg. 2441, effective January 25, 2005; amended at 29 Ill. Reg. 13892, effective September 1, 2005; amended at 29 Ill. Reg. 15968, effective October 7, 2005; amended at 30 Ill. Reg. 1896, effective January 26, 2006; amended at 30 Ill. Reg. 2557, effective February 10, 2006; amended at 30 Ill. Reg. 11299, effective June 12, 2006; amended at 31 Ill. Reg. 4792, effective March 12, 2007; amended at 31 Ill. Reg. 5647, effective March 20, 2007; amended at 31 Ill. Reg. 7296, effective May 3, 2007; amended at 31 Ill. Reg. 7656, effective May 21, 2007; amended at 31 Ill. Reg. 11356, effective July 19, 2007; amended at 31 Ill. Reg. 14559, effective October 9, 2007; amended at 31 Ill. Reg. 16880, effective January 1, 2008; amended at 33 Ill. Reg. 2603, effective January 22, 2009; amended at 33 Ill. Reg. 9801, effective June 25, 2009; amended at 33 Ill. Reg.

15073, effective October 21, 2009; amended at 34 Ill. Reg. 570, effective December 22, 2009; amended at 35 Ill. Reg. 1667, effective January 13, 2011; amended at 35 Ill. Reg. 8512, effective May 31, 2011; amended at 36 Ill. Reg. 10055, effective June 29, 2012; amended at 36 Ill. Reg. 11211, effective July 5, 2012; amended at 37 Ill. Reg. 1762, effective January 25, 2013; amended at 37 Ill. Reg. 8832, effective June 17, 2013; amended at 38 Ill. Reg. _____, effective _____.

Section 1040.20 Illinois Offense Table

a) The conviction report furnished to the Driver Services Department by the court where a person was convicted of a traffic violation shall be entered upon the driving record by classification (Type Action) and used as a source of information. In the absence of statutory amendment, this Section shall be followed and the number of points assigned to a person's driving record shall be determined by using the point table set out in subsections (c) and (d).

1) Classification for convictions of traffic offenses:

Type Action 68: Record history item only
Type Action 82: Conviction
Type Action 83: Immediate action (no points assigned)
Type Action 85: Conviction (no points assigned)
Type Action 87: Conviction (points assigned)
Type Action 89: Withdrawal (no points assigned)
Type Action 93: Immediate action bond forfeiture (no points assigned)
Type Action 94: Immediate action conviction (no points assigned)
Type Action 95: Bond forfeiture (no points assigned)
Type Action 96: Conviction (no points assigned)
Type Action 97: Bond forfeiture (points assigned − moving violation)
Type Action 99: Conviction (points assigned − moving violation)

2) Description of Offense: The code used to describe the offense is composed of the IVC Chapter and/or Section number, the Municipal Code of the City of Chicago (Municipal Code of Chicago, Title 9~~ch. 27~~), the Criminal Code of 2012 [720 ILCS 5], the Cannabis Control Act [720 ILCS 550], the Illinois Controlled Substances Act [720 ILCS 570], the Liquor Control Act of 1934 [235 ILCS 5/Art. VI], or the Illinois Identification Card Act [15 ILCS 335]. Preceding the Section number for these codes, with the exception of those listed in subsection (a)(1), will be

a single digit code to identify the specific law that will be as follows:

0 – The Criminal Code of 2012, Cannabis Control Act, Illinois Controlled Substances Act, the Liquor Control Act of 1934, or the Illinois Identification Card Act
1 – Illinois Vehicle Code
2 – Local ordinance (all municipal ordinance convictions), or violations occurring on military installations, to be considered, are to be coded exactly as Illinois Vehicle Code Violations with the exception of the first digit that shall be a "2"
4 – Motor Vehicle Theft Law of the Illinois Vehicle Title and Registration Law of the IVC [625 ILCS 5/Ch. 4, Art. I]
6 – The Illinois Driver Licensing Law
7 – Chicago Municipal Code~~Ordinance~~
8 – Foreign state and other (all out-of-state convictions to be considered are to be coded exactly as Illinois Vehicle Code violations with the exception of the first digit, which shall be an "8")

NOTE: The position for the single digit codes 1, 2, 6 or 8, will be symbolized by a # throughout the point table set out in this Part.

3) Any one of the last positions of the offense code may be used to indicate the paragraph of the Section violated, or refer to the number of miles per hour (in code form) the driver was operating above the posted speed limit (refer to Electronic Data Processing Machine (EDPM) Offense Codes set out in this Part).

4) The Secretary of State's Traffic Violation Advisory Committee relied upon the following criteria in determining whether specific convictions for traffic violations should be utilized in determining driver license suspension or revocation under the authority of IVC Section 6-206(a)(2), as well as the number of points that should be assigned to those convictions, which in turn determines the length and/or type of such action.

A) A thorough review of literature relating to the general concept of point systems utilized by other states.

B) A specific review of point systems and ranges of point assignments utilized by other states.

C) An exhaustive and detailed review of the current Illinois point system.

D) Based on the above, the relative criticality of the violations was determined and the specific number of points to be assigned was proposed, discussed, and agreed upon by the consensus of the group.

b) Illinois Vehicle Code, the Criminal Code of 2012, the Liquor Control Act of 1934, the Cannabis Control Act, the Illinois Controlled Substances Act and the Illinois Identification Card Act. The following violations of the Illinois Vehicle Code, the Criminal Code of 2012, the Liquor Control Act of 1934, the Cannabis Control Act, the Illinois Controlled Substances Act and the Illinois Identification Card Act will not be assigned points but will be entered on the record as Type Action -93- bond forfeiture immediate action; or Type Action -94- conviction immediate action.

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
3-413(j)	413010	3 413 J	Violation of modification of rear registration plate
3-707(c-1)	707301	3 707 C1	Convicted of driving without liability insurance
4-102	102000	4 102 00	Motor Vehicle Anti-Theft Law, misdemeanor [625 ILCS 5/4-100]
4-103	103000	4 103 00	Motor Vehicle Anti-Theft Law, felony [625 ILCS 5/Ch. 4, Art. I]
4-103.1	103100	4 103 01	Motor Vehicle Anti-Theft Law, conspiracy [625 ILCS 5/Ch. 4, Art.

			I]
6-101	101000	# 101 00	Operating a motor vehicle without a valid license or permit (a serious traffic violation if committed in a commercial motor vehicle)
6-104(a)	104001	# 104 01	Violation of license classification for first and second division vehicles (a serious traffic violation if committed in a commercial motor vehicle)
6-104(b)	104002	# 104 02	Violation of classification for transporting persons for hire (a serious traffic violation if committed in a commercial motor vehicle)
6-104(c)	104003	# 104 03	Violation of classification for transporting property for hire (a serious traffic violation if committed in a commercial motor vehicle)
6-104(d)	104004	# 104 04	Violation of school bus driver permits (a serious traffic violation if committed in a commercial motor vehicle)
6-104(e)	104005	# 104 05	Violation of religious bus driver endorsement (a serious traffic violation if committed in a commercial motor vehicle)
6-104(f)	104006	# 104 06	Violation of classification for transportation of the elderly (a serious traffic violation if committed in a commercial motor vehicle)
6-105	105000	6 105 00	Violation of instruction permit (a serious traffic violation if committed

			in a commercial motor vehicle)
6-107.1(a)	107110	6 107.1A	Violation of instruction permit
6-107.1(b)	107120	6 107.1B	Violation of curfew law (prior to 1-1-08)
6-107.1(b)	107102	6 107.1B	Violation of nighttime driving restrictions – under the age of 18 (effective 1-1-08)
6-110(a)	110000	6 110 00	Violation of curfew law – under age of 17 (Child Curfew Act [720 ILCS 555/1 and 2])
6-110(a-1)	110101	6 110 A-1	Violation of nighttime driving restrictions
6-113(e)	113501	# 113 E1	Violation of driver's license restriction
6-113(e)	113502	# 113 E2	Violation of restriction on special restricted license or permit
6-205(a)3	205103	# 205 A3	Any felony under the laws of any state or federal government in the commission of which a vehicle was used
6-205(a)5	205105	6 205 A5	Conviction of perjury or making of false affidavit or statement under oath to the Secretary of State under the Driver License Act or any other law relating to the ownership or the operation of a motor vehicle
6-205(b)1	205201	6 205 B1	Notice provided for in Section 1-8 of the Juvenile Court Act of 1987 [705 ILCS 405/1-8] that minor has been

			adjudicated under that Act as having committed an offense relating to motor vehicles described in Section 4-103
6-205(b)2	205202	6 205 B2	When any other law of this State requires either the revocation or suspension of such license or permit
6-206.2(a)	206201	6 206.2 A	Operating a vehicle without interlock device when one is required
6-206.2(a-5)	206215	6 206.2 A-5	Allowing an unauthorized person to blow into an interlock device
6-206.2(c)	206203	# 206 02c	Tamper with or circumvent a BAIID
6-210(1)	210001	# 210 01	Driving during the period of suspension/revocation
6-210(2)	210002	# 210 02	Driving during the period of suspension/revocation
6-301(1)	301001	# 301 01	To display or cause to be displayed or have in his possession any cancelled, revoked, or suspended license or permit
6-301(2)	301002	# 301 02	To lend his license or permit to any other person or knowingly allow the use thereof by another
6-301(3)	301003	# 301 03	To display or represent as his own any license or permit issued to another
6-301(4)	301004	# 301 04	To fail or refuse to surrender to the Secretary of State or his agent or any

			peace officer, upon his lawful demand, any license or permit that has been suspended, revoked or cancelled
6-301(5)	301005	# 301 05	To allow any unlawful use of a license or permit issued to him
6-301(6)	301006	# 301 06	To submit to an examination or to obtain the services of another person to submit to an examination for the purpose of obtaining a driver's license or permit for some other person
6-301.1(b)1	301121	# 301121	Possess fictitious altered driver's license or permit
6-301.1(b)2	301122	# 301122	Possess/display altered fictitious driver's license or permit
6-301.1(b)3	301123	# 301123	Possess fictitious altered driver's license or permit
6-301.1(b)4	301124	# 301124	Possess fictitious altered driver's license or permit
6-301.1(b)5	301125	# 301125	Possess fictitious altered driver's license or permit
6-301.1(b)6	301126	# 301126	Possess fictitious altered driver's license or permit
6-301.1(b)7	301127	# 301127	Issue fictitious driver's license or permit
6-301.1(b)8	301128	# 301128	Alter/attempt to alter driver's license or permit

6-301.1(b)9	301129	# 301129	Provide ID for obtaining fictitious driver's license or permit
6-301.1(b)10	301120	# 301120	To knowingly use any fictitious or unlawfully altered driver's license or permit to purchase or attempt to purchase any ticket for, or to board or attempt to board any common carrier
6-301.1(b)11	011211	# 3011211	To knowingly possess any fictitious or unlawfully altered driver's license or permit if the person has, at the time, a different driver's license issued by the Illinois Secretary of State or other driver's license agency in another jurisdiction that is suspended or revoked
6-301.2(b)1	301221	# 301221	Possess fraudulent driver's license or permit
6-301.2(b)2	301222	# 301222	Possess/display fraudulent driver's license or permit
6-301.2(b)3	301223	# 301223	Possess fraudulent driver's license or permit
6-301.2(b)4	301224	# 301224	Possess fraudulent driver's license or permit
6-301.2(b)5	301225	# 301225	Possess fraudulent driver's license or permit
6-301.2(b)6	301226	# 301226	Possess fraudulent driver's license or permit
6-301.2(b)7	301227	# 301227	Possess driver's license making implement

6-301.2(b)8	301228	# 301228	Possess stolen driver's license making implement
6-301.2(b)9	301229	# 301229	Duplicate/sell fraudulent driver's license or permit
6-301.2(b)10	301220	# 301220	Advertise or distribute fraudulent driver's license or permit
6-301.2(b)11	012211	# 3012211	To knowingly use a fraudulent driver's license or permit to purchase or attempt to purchase any ticket for a common carrier or to board or attempt to board any common carrier as used in this Section
6-301.2(b)12	012212	# 3012212	To knowingly possess any fraudulent driver's license or permit if the person has, at the time, a different driver's license issued by the Secretary of State or another official driver's license agency in another jurisdiction that is suspended or revoked
6-301.2(b-1)	301201	# 3012b-1	Possess, use, or allow to be used any material to obtain information from the bar code or magnetic strip of an official Illinois Driver's License issued by the Secretary of State
6-302(a)1	302101	# 302101	Present false information in an application. For driver's license/permit
6-302(a)2	302102	# 302102	Accept false information/ID in an application for driver's license/permit

6-302(a)3	302103	# 302103	Make false affidavit swear or affirm falsely
6-303(a)1	303101	# 303 Al	Driving during a suspension or revocation
6-303(a)2	303102	# 303 A2	Driving during a revocation or suspension
6-303(d)	303400	# 303 D0	Second conviction of driving during revocation for a violation of Sections 11-401 and 11-501 and Section 9-3 of the Criminal Code of 2012 or similar provisions of a local ordinance
6-303(d)2	303402	# 303 D2	Third conviction of driving during a revocation or violations of Sections 11-401 and 11-501 and Section 9-3 of the Criminal Code of 2012 or similar provisions of a local ordinance
6-303(d)3	303403	# 303 D3	Fourth or subsequent conviction of driving during revocation for a violation of Sections 11-401 and 11-501 and Section 9-3 of the Criminal Code of 2012 or similar provisions of a local ordinance
6-303(d)4	303404	6-303(D-4)	Tenth through fourteenth conviction of driving during revocation or suspension for a violation of Section 11-401 or 11-501 or Section 9-3 of the Criminal Code of 2012 or similar provisions of a local ordinance
6-303(d)5	303405	6-303(D-5)	Fifteenth or subsequent conviction

			of driving during revocation or suspension for a violation of Section 11-401 or 11-501 or Section 9-3 of the Criminal Code of 2012 or a similar provision of a local ordinance
6-507(a)2	507102	# 507 A2	Driving a commercial motor vehicle (CMV) without obtaining a commercial driver's license (CDL)
6-507(a)3	507103	# 507 A3	Driving without the proper commercial driver's license classification or endorsements
6-507(b)	507200	6 507 B0	No person may drive a commercial motor vehicle while driving privilege, license or permit is suspended, revoked, cancelled, nor while subject to disqualification or while subject to or in violation of an "out-of-service" order
6-507(b)1	507201	# 507 B1	No person may drive a commercial motor vehicle while driving privileges, license, or permit is suspended, revoked, cancelled or disqualified
6-507(b)2	507202	# 507 B2	No person may drive a commercial motor vehicle while driving privileges, license, or permit is subject to or in violation of an out-of-service order
6-507(b)3	507203	# 507 B3	No person may drive commercial motor vehicle while driving privileges, license, or permit is subject to or in violation of an out-

			of-service order and while transporting passengers or hazardous materials
6-507(b)5	507250	# 507 B5	Driving commercial motor vehicle in violation of out-of-service order
8-101	008000	8000	Failure to show proof of financial responsibility – persons who operate motor vehicles in transportation of passengers for hire
11-204	020400	# 0204 00	Fleeing or attempting to elude a peace officer
11-204.1	020401	# 0204 01	Aggravated fleeing or eluding a peace officer
11-401	040100	# 0401 00	Leaving scene or failure to report an accident involving death or personal injury
11-402(b)	040202	# 0402 02	Leaving the scene of an accident involving damage to a vehicle in excess of $1000
11-406(a)	040610	# 0406 A0	Failure to make report of vehicle accident
11-406(b)	040620	# 0406 B0	Failure to make report of school bus accident
11-501(a)1	050111	# 0501 A1	Driving with a blood alcohol concentration above the legal limit
11-501(a)2	050112	# 0501 A2	Driving while under the influence of alcohol
11-501(a)3	050113	# 0501 A3	Driving while under the influence of

			any other drug or combination of drugs (prior to 1-1-99)
11-501(a)3	050103	# 0501 A3	Driving while under the influence of any intoxicating compound or combination of intoxicating compounds (effective 1-1-99)
11-501(a)4	050114	# 0501 A4	Driving under the combined influence of alcohol and other drug or drugs (prior to 1-1-99)
11-501(a)4	050104	# 0501 A4	Driving while under the influence of any other drug or combination of drugs (effective 1-1-99)
11-501(a)5	050115	# 0501 A5	Driving while there is any amount of a drug, substance or compound in such person's blood or urine resulting from the unlawful use or consumption of cannabis listed in the Cannabis Control Act, or a controlled substance listed in the Illinois Controlled Substances Act (prior to 1-1-99)
11-501(a)5	050105	# 0501 A5	Driving while under the combined influence of alcohol and other drug or drugs or intoxicating compound or compounds (effective 1-1-99)
11-501(a)6	050106	# 0501 A6	Driving while there is any amount of a drug, substance or compound in the person's breath, blood or urine resulting from the unlawful use or consumption of cannabis, a controlled substance or an intoxicating compound (effective 1-1-99)

11-501(b)	501200	# 11-0501 B	Initial conviction of violating Section 11-501(b)
11-501(b-3)	050123	# 0501 B-3	Second conviction of violating Section 11-501(a) or a similar provision committed within 5 years of a previous violation of Section 11-501(a) or similar provision
11-501(b-4)	050124	# 0501 B-4	Third or subsequent violation committed within 5 years of a previous violation of Section 11-501(a) or a similar provision
11-501(c)	501300	# 11-0501 C	A violation of Section 11-501(c)
11-501(c-1)1	501311	# 0501 C11	Driving under the influence while revoked for driving while under the influence, Section 11-501, leaving the scene, Section 11-401, reckless homicide, Section 9-3 of the Criminal Code of 2012, or suspended for statutory summary suspension under Section 11-501.1
11-501(c-1)2	501312	# 0501 C12	Third violation of driving under the influence while revoked for driving under the influence, Section 11-501, leaving the scene, Section 11-401, reckless homicide, Section 9-3 of the Criminal Code of 2012, or suspended for statutory summary suspension under Section 11-501.1
11-501(c-1)3	501313	# 0501 C13	Fourth or subsequent violation of driving under the influence while revoked for driving under the influence, Section 11-501, leaving

			the scene, Section 11-401, reckless homicide, Section 9-3 of the Criminal Code of 2012, or suspended for statutory summary suspension under Section 11-501.1
11-501(c-4)1	501341	# 0501 C41	Convicted of violating Section 11-501(a) for first time when blood, breath, or urine was .16 or more, or is convicted of violating Section 11-501 while transporting a child under the age of 16
11-501(c-4)2	501342	# 0501 C42	Second conviction within 10 years for violating Section 11-501(a) when blood, breath or urine was .16 or more, or is convicted of violating Section 11-501 while transporting a child under the age of 16
11-501(c-4)3	501343	# 0501 C43	Third conviction within 20 years for violating Section 11-501(a) when blood, breath or urine was .16 or more, or is convicted of violating Section 11-501 while transporting a child under the age of 16. This is considered a Class 4 felony
11-501(c-4)4	501344	# 0501 C44	Fourth or subsequent conviction for violating Section 11-501(a) when blood, breath, or urine was .16 or more, or is convicted of violating Section 11-501 while transporting a child under the age of 16. This is considered a Class 2 felony
11-501(c-5)1	501351	# 0501 C5(1)	Violation of Section 11-501(a) while transporting a person under the age of 16

11-501(c-5)2	501352	# 0501 C5(2)	Second violation of Section 11-501(a) and at the time of the violation the person was transporting a person under the age of 16
11-501(c-5)3	501353	# 0501 C5(3)	Second violation of Section 11-501(a) or a similar provision within 10 years and at the time of the violation the person was transporting a person under the age of 16
11-501(c-5)4	501354	# 0501 C5(4)	Second conviction of Section 11-501(a) or a similar provision within 5 years and at the time of the violation the person was transporting a person under the age of 16
11-501(c-5)5	501355	# 0501 C5(5)	Third conviction for violating Section 11-501(a) or a similar provision and at the time of the violation the person was transporting a person under the age of 16 (felony)
11-501(c-5)6	501356	# 0501 C5(6)	Third conviction of Section 11-501(a) or a similar provision within 20 years and at the time the person was transporting a person under the age of 16 (felony)
11-501(c-5)7	501357	# 0501 C5(7)	Fourth or subsequent conviction for violating Section 11-501(a) or similar provision and at the time of the fourth or subsequent violation the person was transporting a person

			under age 16, 3 prior violations of transporting a person under age 16 or while BAC .16 or more (felony)
11-501(c-6)1	501361	# 0501 C6(1)	Conviction of Section 11-501(a) or a similar provision and the alcohol concentration was .16 or more
11-501(c-6)2	501362	# 0501 C6(2)	Second conviction of Section 11-501(a) or a similar provision within 10 years and at the time the BAC was .16 or more
11-501(c-6)3	501363	# 0501 C6(3)	Third conviction of Section 11-501(a) or a similar provision within 20 years and at the time of the violation the person's BAC was .16 or more (felony)
11-501(c-6)4	501364	# 0501 C6(4)	Fourth or subsequent conviction for violating Section 11-501(a) or a similar provision and at the time of the fourth or subsequent violation the person's BAC was .16 or more, three prior convictions of transporting a person under the age of 16 or while BAC was .16 or more (felony)
11-501(d)	501400	# 0501 D	A violation of Section 11-501(d)
11-501(d)1	050141	# 0501 D1	Such person committed a violation of Section 11-501(a) for the third or subsequent time
11-501(d)2	050142	# 0501 D2	Such person committed a violation of Section 11-501(a) while driving a school bus with children on board

11-501(d)3	050143	# 0501 D3	Such person in committing a violation of Section 11-501(a) was involved in a motor vehicle accident that resulted in great bodily harm or permanent disability or disfigurement to another, when such violation was the proximate cause of such injuries
11-501(d)4	050144	# 0501 D4	Committed a violation of Section 11-501(a) for a second time and was previously convicted of violating Section 9-3 of the Criminal Code of 2012 for reckless homicide in which the person was determined to have been under the influence of alcohol or other drug as an element of the offense
11-501(d)1A	501411	# 0501D1A	Convicted of committing a violation of Section 11-501(a) for the third or subsequent time
11-501(d)1B	501412	# 0501D1B	Such person committed a violation of Section 11-501(a) while driving a school bus with children on board
11-501(d)1C	501413	# 0501D1C	Such person, in committing a violation of Section 11-501(a), was involved in a motor vehicle accident that resulted in great bodily harm or permanent disability or disfigurement to another when such violation was the proximate cause of such injuries
11-501(d)1D	501414	# 0501D1D	Committed a violation of Section 11-501(a) for a second time and was previously convicted of violating

			Section 9-3 of the Criminal Code of 2012 for reckless homicide in which the person was determined to have been under the influence of alcohol or other drug as an element of the offense or Section 11-501(d)(1)(C) or (F)
11-501(d)1E	501415	# 0501D1E	Committed a violation of Section 11-501(a) in a school zone when a 20 MPH speed limit was in effect and was involved in an accident that resulted in bodily harm
11-501(d)1F	501416	# 0501D1F	Committed a violation of Section 11-501(a) and was involved in a motor vehicle, snowmobile, all-terrain vehicle or water craft accident that resulted in the death of another person when the violation of Section 11-501(a) was a proximate cause of death
11-501(d)1G	501417	# 0501D1G	Committed a violation of Section 11-501(a) and the driver did not possess a valid driver's license or permit
11-501(d)1H	501418	# 0501D1H	Committed a violation of Section 11-501(a) and the driver knew that the vehicle being driven was not covered by a liability insurance policy
11-503(b)1	503201	# 0503B1	Reckless driving, bodily harm to a child or school crossing guard
11-503(c)	050303	# 050303	Aggravated reckless driving

11-503(d)	050304	# 0503 04	Aggravated reckless driving, great bodily harm to a child or school crossing guard
11-504	050400	# 0504 00	Drag racing
11-506(a)	050601	#050601	Street racing
11-907(c)	090763	# 0907 P3	Failure to yield to a stopped emergency vehicle resulting in property damage
11-907(c)	090773	# 0907 I3	Failure to yield to a stopped emergency vehicle resulting in personal injury
11-907(c)	090783	# 0907 D3	Failure to yield to a stopped emergency vehicle resulting in death
11-908(a)1	090811	1 908 A1	Failure to yield and proceed with due caution upon entering a construction zone when workers are present
11-1301 3a-1	301311	# 13013A1	Unauthorized use of handicap placard or device
11-13-01 3a-2	301312	# 13013A2	Unauthorized use of deceased person's disability placard or device
11-1301.5(b)1	301521	1 13015B1	To knowingly possess any fictitious or unlawfully altered person-with-disabilities license plate or parking decal or device
11-1301.5(b)2	301522	1 13015B2	To knowingly issue or assist in the issuance of, by the Secretary of State or unit of local government, any fictitious person-with-disabilities

			license plate or parking decal or device
11-1301.5(b)3	301523	1 13015B3	To knowingly alter any person-with-disabilities license plate or parking decal or device
11-1301.5(b)4	301524	1 13015B4	To knowingly manufacture, possess, transfer, or provide any documentation used in the application process, whether real or fictitious, for the purpose of obtaining, a fictitious person-with-disabilities license plate or parking decal or device
11-1301.5(b)5	301525	1 13015B5	To knowingly provide any false information to the Secretary of State or a unit of local government in order to obtain a person-with-disabilities license plate or parking decal or device
11-1301.5(b)6	301526	1 13015B6	To knowingly transfer a person-with-disabilities license plate or parking decal or device for the purpose of exercising the privileges granted to any authorized holder of a person-with-disabilities license plate or parking decal or device under this Code in the absence of the authorized holder
11-1301.5(b)7	301527	1 13015B7	Falsify a certification that a person is disabled
11-1301.6(b)1	301621	1 13016B1	To knowingly possess any fraudulent person-with-disabilities license plate or parking decal or

			devise
11-1301.6(b)2	301622	1 13016B2	To knowingly possess without authority any implement to duplicate and/or manufacture any person-with-disabilities license plate or parking decal or device
11-1301.6(b)3	301623	1 13016B3	To knowingly duplicate, manufacture, sell, or transfer any fraudulent or stolen person-with-disabilities license plate or parking decal or devise
11-1301.6(b)4	301624	1 13016B4	To knowingly assist in the duplication, manufacturing, selling, or transferring of any fraudulent or stolen person-with-disabilities license plate or parking decal or device
11-1301.6(b)5	301625	1 13016B5	To advertise or distribute a fraudulent person-with-disabilities license plate or parking decal or device
11-1414(a)	141401	# 1414 01	Passing school bus receiving or discharging children (1-1-13)
11-1425(b)	142520	# 1425b	Failure to have space to drive through railroad crossing
12-215(g)	221507	# 2215 07	Conviction of Section 12-215 without lawful authority to stop
12-604.1(a-5)	604185	2 604D5	Aggravated use of video device accident involving death

12-610.1(b-5)	610185	2 610D5	Under age 19 aggravated wireless phone accident involving death
12-610.1(e-5)	610585	2 601D5	Aggravated use wireless phone school/construction zone accident involving death
12-610.2(b-5)	610285	2 602D5	Aggravated electronic communication device accident involving death

CRIMINAL CODE OF 2012	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
9-3	009003	9 03	Reckless homicide resulting from operation of a motor vehicle
11-15.1	011151	11 151	Conviction of soliciting for a juvenile prostitute
11-19.1	011191	11 191	Conviction of juvenile pimping
12-5	012005	12 05	Conviction of reckless conduct
12-13	012013	12 13	Conviction of criminal sexual assault
12-14	012014	12 14	Conviction of aggravated criminal sexual assault
12-15	012015	12 15	Conviction of criminal sexual abuse
12-16	012016	12 16	Conviction of aggravated criminal sexual abuse
16J-15	161015	16J-15	Conviction for violation of theft of motor fuel

16K-15	161115	16K-15	Conviction for violation of theft of motor fuel
18-3	0018003	18 3	Conviction of vehicular hijacking
18-4	0018004	18 4	Conviction of aggravated vehicular hijacking
21-2	021002	21 02	Criminal trespass to motor vehicles
22-51	022051	22 51	Violation of the Hypodermic Syringes and Needles Act [720 ILCS 635/2] concerning the sale of instruments used for illegal drug use or abuse
24-1(a)3	241103	241 A3	Conviction of unlawful use of weapons while using a motor vehicle
24-1(a)4	241104	241 A4	Conviction of unlawful use of weapons while using a motor vehicle
24-1(a)7	241107	241 A7	Conviction of unlawful use of weapons while using a motor vehicle
24-1(a)9	241109	241 A9	Conviction of unlawful use of weapons while using a motor vehicle
24-1.2	241200	241 200	Conviction of aggravated discharge of a firearm
24-1.5(b)	241520	24 15B	Conviction of reckless discharge of a firearm

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

THE LIQUOR CONTROL ACT OF 1934	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
43-131(a)	431311	43 131A	Minor presents false ID to buy alcoholic beverage
6-20	006020	6-20	Violation of Section 6-20
6-20(a)	060201	6-20A	Violation of Section 6-20(a) of the Liquor Control Act
6-20(c)	060203	6-20C	Violation of Section 6-20(c) of the Liquor Control Act
6-20(d)	060204	6-20D	Violation of Section 6-20(d) of the Liquor Control Act
6-20(e)	060205	6-20E	Violation of Section 6-20(e) of the Liquor Control Act

CANNABIS CONTROL ACT	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
704(a)	070401	704 01	Conviction for violation of Section 4(a) concerning the possession of not more than 2.5 grams of any substance containing cannabis
704(b)	070402	704 02	Conviction for violation of Section 4(b) concerning the possession of more than 2.5 grams but more than 10 grams of any substance containing cannabis
704(c)	070403	704 03	Conviction for violation of Section 4(c) concerning the possession of

			more than 10 grams but not more than 30 grams of any substance containing cannabis
704(d)	070404	704 04	Conviction for violation of Section 4(d) concerning the possession of more than 30 grams but not more than 500 grams of any substance containing cannabis
704(e)	070405	704 05	Conviction for violation of Section 4(e) concerning the possession of more than 500 grams of any substance containing cannabis
705	00705	705 00	Violation of the Cannabis Control Act concerning the unauthorized manufacture or delivery of cannabis
707	00707	707 00	Violation of the Cannabis Control Act concerning the unauthorized delivery of cannabis to a person under 18 by an adult

ILLINOIS CONTROLLED SUBSTANCES ACT	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	********	**********	**********
1401(a)	140101	1401 01	Class X violation of the Illinois Controlled Substances Act concerning the unauthorized manufacture or delivery of a controlled substance
1401(b)	140102	1401 02	Class 1 violation of the Illinois Controlled Substances Act concerning the unauthorized manufacture or delivery of a

			controlled substance
1401(c)	140103	1401 03	Class 2 violation of the Illinois Controlled Substances Act concerning the unauthorized manufacture or delivery of a controlled substance
1401(d)	140104	1401 04	Class 3 violation of the Illinois Controlled Substances Act concerning the unauthorized manufacture or delivery of a controlled substance
1401(e)	140105	1401 05	Class 3 violation of the Illinois Controlled Substances Act concerning the unauthorized manufacture or delivery of a controlled substance
1401(f)	140106	1401 06	Class 3 violation of the Illinois Controlled Substances Act concerning the unauthorized manufacture or delivery of a controlled substance
1401(g)	140107	1401 07	Class 3 violation of the Illinois Controlled Substances Act concerning the unauthorized manufacture or delivery of a controlled substance
1402(a)1	014201	1402 01	Conviction for violation of Section 402(a) concerning the possession of 15 grams or more of any substance containing heroin

1402(a)2	014202	1402 02	Conviction for violation of Section 402(a) concerning the possession of 15 grams or more of any substance containing cocaine
1402(a)3	014203	1402 03	Conviction for violation of Section 402(a) concerning the possession of 15 grams or more of any substance containing morphine
1402(a)4	014204	1402 04	Conviction for violation of Section 402(a) concerning the possession of 200 grams or more of any substance containing peyote
1402(a)5	014205	1402 05	Conviction for violation of Section 402(a) concerning the possession of 200 grams or more of any substance containing a derivative of barbituric acid or any of the salts of a derivative of barbituric acid
1402(a)6	014206	1402 06	Conviction for violation of Section 402(a) concerning the possession of 200 grams or more of any substance containing amphetamine or any salt of an optical isomer of amphetamine or methamphetamine
1402(a)7	014207	1402 07	Conviction for violation of Section 402(a) concerning the possession of 15 grams or more, but less than 100 grams of any substance containing lysergic acid diethylamide (LSD)
1402(a)8	014208	1402 08	Conviction for violation of Section 402(a) concerning the possession of 30 grams or more of any substance containing pentazocine or any of

			the salts, isomers and salts of isomers of pentazocine
1402(a)9	014209	1402 09	Conviction for violation of Section 402(a) concerning the possession of 30 grams or more of any substance containing methaqualone or any of the salts, isomers and salts of isomers of methaqualone
1402(a)10	014210	1402 10	Conviction for violation of Section 402(a) concerning the possession of 30 grams or more of any substance containing phencyclidine or any of the salts, isomers and salts of isomers of phencyclidine (PCP)
1402(a)11	014211	1402 11	Conviction for violation of Section 402(a) concerning the possession of 200 grams or more of any other controlled or counterfeit substance classified as a narcotic drug in Schedule I or II that is not otherwise included in this subsection
1402(b)	014220	1402 20	Conviction for violation of Section 402(b) concerning the possession of any other amount of a controlled or counterfeit substance
1407	014070	1407 00	Adult delivers controlled or counterfeit substances to minor
1407.1	014701	1407 01	Adult uses minor to deliver controlled/counterfeit substances
2103	021003	21 03	Violation of the Drug Paraphernalia Control Act [720 ILCS 600]

ILLINOIS IDENTIFICATION CARD ACT	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
			concerning the sale of instruments used for illegal drug use or abuse
**********	**********	**********	**********
335-14a1	014101	14A1	To possess, display, or cause to be displayed any cancelled or revoked identification card
335-14a2	014102	14A2	To display or represent as the person's own any identification card issued to another
335-14a3	014103	14A3	To allow any unlawful use of an identification card issued to another person
335-14a4	014104	14A4	To lend an identification card to another or knowingly allow the use thereof
335-14a5	014105	14A5	To fail or refuse to surrender to the Secretary of State, the Secretary's agent, or any peace officer upon lawful demand, any identification card that has been revoked or cancelled
335-14a6	014106	14A6	To knowingly possess, use or allow to be used any materials, hardware or software specifically designed for or primarily used in the manufacture, assembly, issuance or authentication of an official Illinois identification card or Illinois disabled person identification card by the Secretary of State

335-14a7	014107	14A7	To knowingly possess, use or allow to be used a stolen identification card making implement
335-14(A-1)	014011	14-A-1	Possess or use materials to obtain information from an identification card
335-14ab1	014121	14AB1	To knowingly possess, display, or cause to be displayed any fictitious or unlawfully altered identification card
335-14ab2	014122	14AB2	To knowingly possess, display, or cause to be displayed any fictitious or unlawfully altered identification card for the purpose of obtaining any account, credit, credit card, or debit card from a bank, financial institution, or retail mercantile establishment
335-14ab3	014123	14AB3	To knowingly possess any fictitious or unlawfully altered identification card with the intent to commit a theft, deception or credit or debit card fraud in violation of any law of this state or any law of any other jurisdiction
335-14ab4	014124	14AB4	To knowingly possess any fictitious or unlawfully altered identification card with the intent to commit any other violation of any law of this State or any law of any other jurisdiction for which a sentence to a term of imprisonment in a penitentiary for one year or more is

			provided
335-14ab5	014125	14AB5	To knowingly possess any fictitious or unlawfully altered identification card while in unauthorized possession of any document, instrument or device capable of defrauding another
335-14ab6	014126	14AB6	To knowingly possess any fictitious or unlawfully altered identification card with the intent to use the identification card to acquire any other identification document
335-14ab7	014127	14AB7	To knowingly issue or assist in the issuance of any fictitious identification card
335-14ab8	014128	14AB8	To knowingly alter or attempt to alter any identification card
335-14ab9	014129	14AB9	To knowingly manufacture, possess transfer, or provide any identification document for the purpose of obtaining a fictitious identification card
335-14ab10	0141210	14AB10	To make application for the purpose of obtaining a fictitious identification card for another person
335-14ab11	0141211	14AB11	To obtain the services of another person to make application for the purpose of obtaining a fictitious identification card

335-14bb2	014221	14BB2	To knowingly possess, display or cause to be displayed any fraudulent identification card
335-14bb1	014222	14BB1	To knowingly possess, display or cause to be displayed any fraudulent identification card for the purpose of obtaining any account, credit, credit card or debit card from a bank, financial institution or retail mercantile establishment
335-14bb3	014223	14BB3	To knowingly possess any fraudulent identification card with the intent to commit a theft, deception or credit or debit card fraud in violation of any law of this State or any law of any other jurisdiction
335-14bb4	014224	14BB4	To knowingly possess any fraudulent identification card with the intent to commit any other violation of any law of this State or any law of any other jurisdiction for which a sentence to a term of imprisonment in a penitentiary for one year or more is provided
335-14bb5	014225	14BB5	To knowingly possess any fraudulent identification card while in unauthorized possession of any document, instrument or device capable of defrauding another
335-14bb6	014226	14BB6	To knowingly possess any fraudulent identification card with the intent to use the identification

			card to acquire any other identification document
335-14bb7	014227	14BB7	To knowingly possess without authority any identification card making implement
335-14bb8	014228	14BB8	To knowingly possess any stolen implement for duplicating or manufacturing an identification card
335-14bb9	014229	14BB9	To knowingly duplicate, manufacture, sell or transfer any fraudulent identification card
335-14bb10	0142210	14BB10	To advertise or distribute any information or materials that promote the selling, giving, or furnishing of a fraudulent identification card
335-14cal	014311	14CA1	Present false information in application for identification card
335-14ca2	014312	14CA2	Accept false information in application for identification card
335-14ca3	014313	14CA3	Make false affidavit, swear or affirm falsely

c) Illinois Vehicle Code
The following point assigned violations will be entered on the driving record as Type Action -97- Bond forfeiture or Type Action -99- conviction

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE	POINTS

**********	********	**********	**********	********
3-413(g)	413007	3 413 G	Operating a motor vehicle equipped with registration plate covers	10
6-107(e)	107005	6 107 05	Violation of Graduated Driver's License (GDL) restrictions on passengers	10
6-107(f)	107006	6 107 06	Violation of GDL restrictions on passenger seat belt/child restraints	10
6-107(g)	107007	6 107 07	Violation of GDL restrictions on number of passengers	10
6-501	501000	6 501 00	Violation of more than one driver's license	50
6-507(a)(1)	507101	6 507 A1	Driving without a commercial driver's license (CDL) in possession (a serious traffic violation if committed in a commercial motor vehicle)	50
6-526(a)	526100	6 526 A	Texting while driving a commercial motor vehicle (a serious violation)	20
6-527(a)	527100	6 527 A	Using a hand held mobile telephone while driving a commercial motor vehicle (a serious violation)	20
11-203	020300	# 0203 00	Failure to obey lawful order of authorized officer	10

11-305	030500	# 0305 00	Disregarding official traffic control device	20
11-306	030600	# 0306 00	Disregarding traffic control light	20
11-308	030800	# 0308 00	Disregarding lane control signal	20
11-309	030900	# 0309 00	Disregarding flashing traffic signal	20
11-402(a)	040201	# 0402 01	Collision involving damage to vehicles only – failure to stop, exchange information and make report	25
11-403	040300	# 0403 00	Failure to stop and exchange information after motor vehicle collision property damage only	25
11-403	040370	# 0403 G0	Failure to stop and exchange information or give aid after motor vehicle collision – personal injury involved	50
11-403	040380	# 0403 H0	Failure to stop and exchange information or give aid after motor vehicle collision − fatality	50
11-404	040400	# 0404 00	Failure to notify owner after collision with unattended vehicle or other property	15
11-502(a)	050201	# 0502 01	Illegal transportation, of any alcoholic liquor within the passenger area of any motor vehicle	25

11-503	050300	# 0503 00	Reckless driving (a serious traffic violation if committed in a commercial motor vehicle)	55
11-505	050500	# 0505 00	Squealing or screeching tires	10
11-507	050700	# 0507 00	Supervising minor driver while under the influence	20
11-601(a)	060100	# 0601 00	Speeding too fast for conditions or failure to reduce speed to avoid an accident (a serious traffic violation if committed in a commercial motor vehicle)	10
11-601(b)	060101	# 0601 01	1-10 MPH above limit	5
11-601(b)	060103	# 0601 03	11-14 MPH above limit	15
11-601(b)	060105	# 0601 05	15-25 MPH above limit (a serious traffic violation if committed in a commercial motor vehicle)	20
11-601(b)	060107	# 0601 07	Over 25 MPH above limit (a serious traffic violation if committed in a commercial motor vehicle)	50
11-601(b)	060108	# 0601 08	26-29 MPH above limit (a serious violation if committed in a commercial motor vehicle) (arrests occurring prior to 1/27/11)	50
11-601(b)	601008	# 6010 08	26-30 MPH above limit (a serious violation if committed in a commercial motor vehicle) (arrests occurring on or after	50

			1/27/11 and prior to 1/1/14)	
11-601(b)	060109	# 0601 09	Over 29 MPH above limit (a serious violation if committed in a commercial motor vehicle) (arrests occurring prior to 1/27/11)	50
11-601(b)	601009	#6010 09	Over 30 MPH above limit (a serious violation if committed in a commercial motor vehicle) (arrests occurring on or after 1/27/11 and prior to 1/1/14)	50
11-601.5	060109	# 0601 09	Driving 40 MPH or more in excess of the applicable speed limit (a serious violation if committed in a commercial motor vehicle) (arrests occurring prior to 1/27/11)	50
11-601.5(a)	060151	# 06015A	30-39 MPH above limit (a serious violation if committed in a commercial motor vehicle) (arrests occurring prior to 1/1/14)	50
11-601.5(a)	601051	#60105A	31-39 MPH above limit (a serious violation if committed in a commercial motor vehicle) (arrests occurring prior to 1/1/14)	50
11-601.5(a)	601510	#0601 510	26-34 MPH above limit (a serious violation in a commercial motor vehicle) (arrests occurring on or after 1/1/14)	50

11-601.5(b)	601520	#0601 520	35 MPH or more above limit (a serious violation in a commercial motor vehicle) (arrests occurring on or after 1/1/14)	50
11-601.5(b)	060152	# 06015B	40 or more MPH above limit (a serious violation if committed in a commercial motor vehicle) (arrests occurring on or after 12/31/10 and prior to 1/1/14)	50
11-605	060500	# 0605 00	Exceeding the maximum speed limit in a school zone (a serious traffic violation if committed in a commercial motor vehicle)	20
11-605(a)	060501	# 0605 01	Exceeding the maximum speed limit in a school zone (a serious violation in a commercial motor vehicle)	20
11-605(b)	060502	# 060502	Exceeding the maximum speed limit through a highway construction or maintenance zone (a serious traffic violation if committed in a commercial motor vehicle)	20
11-605.1	060510	# 0605 1	Exceeding the maximum speed limit in a construction zone when workers are present (a serious traffic violation if committed in a commercial motor vehicle)	20
11-605.1(a-5)	605115	# 605 1 15	Exceeding the maximum speed limit in a construction zone when workers are not present (a	10

			serious traffic violation if committed in a commercial motor vehicle)	
11-605.3b	060532	# 0605 3b	Exceeding the maximum speed limit on a park zone street	20
11-605.3c	060533	# 0605 3c	Failure to obey stop sign or red light on a park zone street	20
11-606(a)	060601	# 0606 01	Driving below minimum speed limit	5
11-606(b)	060602	# 0606 02	Driving below minimum speed limit on Illinois Tollway	20
11-608	060800	# 0608 00	Exceeding maximum speed limit on bridge or elevated structure	10
11-701	070100	# 0701 00	Failure to drive on right side of roadway	20
11-702	070200	# 0702 00	Improper passing upon meeting an approaching vehicle	20
11-703(a)	070301	# 0703 01	Improper passing on left	20
11-703(b)	070302	# 0703 02	Failure to yield right-of-way to vehicle passing on the left	20
11-703(c)	070303	# 0703 03	Improper passing with a two wheeled vehicle	20
11-703(d)	070304	# 0703 04	Improper passing of bicycle or pedestrian	20
11-703(e)	070305	# 0703 05	Driving too close to, toward, or near a bicyclist, pedestrian or	20

			person riding a horse or driving an animal drawn vehicle	
11-704	070400	# 0704 00	Improper passing on the right	20
11-705	070500	# 0705 00	Improper passing on the left	20
11-706	070600	# 0706 00	Driving on left side of roadway where prohibited	20
11-707(b)	070702	# 0707 02	Driving on left side of roadway in a no passing zone	20
11-707(d)	070704	# 0707 04	No passing in unincorporated area where there exists a school speed zone as defined in Section 11-605	10
11-708	070800	# 0708 00	Driving wrong way on one-way street or highway or around traffic island	5
11-709(a)	070901	# 0709 01	Improper traffic lane usage (a serious traffic violation if committed in a commercial motor vehicle)	20
11-709(b)	070902	# 0709 02	Improper center lane usage (a serious traffic violation if committed in a commercial motor vehicle)	20
11-709(c)	070903	# 0709 03	Improper traffic lane usage (a serious traffic violation if committed in a commercial motor vehicle)	20
11-709(d)	070904	# 0709 04	Improper traffic lane usage (a serious traffic violation if	20

			committed in a commercial motor vehicle)	
11-709.1	070911	# 0709 11	Passing on shoulder while merging into traffic	20
11-710	071000	# 0710 00	Following too closely (a serious traffic violation if committed in a commercial motor vehicle)	25
11-711(a)	071101	# 0711 01	Improper entry or exit from controlled access roadway	10
11-711(b)	071102	# 0711 02	Operating an improper vehicle on a controlled access roadway	10
11-801	080100	# 0801 00	Improper turn at intersection	10
11-802	080200	# 0802 00	Improper U-turn	20
11-803	080300	# 0803 00	Unsafe movement of vehicle from parked position	15
11-804	080400	# 0804 00	Failure to give stop or turn signal	15
11-805	080500	# 0805 00	Improper stop or turn signal	15
11-806	080600	# 0806 00	Improper arm signal	15
11-901	090100	# 0901 00	Failure to yield right-of-way at intersection	15
11-901.1	090101	# 901 01	Failure to yield right-of-way at T intersection	15
11-902	090200	# 0902 00	Improper left turn with oncoming traffic	25

11-903	090300	# 0903 00	Failure to stop or yield right-of-way to pedestrians at intersections or crosswalks with traffic control devices	20
11-904	090400	# 0904 00	Failure to obey stop or yield right-of-way sign	20
11-905	090500	# 0905 00	Improper merging into traffic	20
11-906	090600	# 0906 00	Failure to yield right-of-way upon emerging from private road or roadway	20
11-907	090700	# 0907 00	Failure to yield right-of-way to emergency vehicle	15
11-907(c)	090703	# 0907 03	Failure to yield the right-of-way or drive with due caution upon approaching a stationary emergency vehicle	15
11-908(a)	090801	# 0908 01	Failure to yield right-of-way to authorized vehicle or pedestrian engaged in work within any highway construction or maintenance area	15
11-908(b)	090802	# 0908 02	Failure to yield right-of-way to authorized vehicle displaying flashing lights engaged in work upon a highway	15
11-908(c)	090803	# 0908 03	Failure to stop at highway construction sign	15
11-1002(a)	100201	# 1002 01	Failure to stop and/or yield right-of-way to pedestrians at crosswalks without traffic	20

			control devices	
11-1002(d)	100204	# 1002 04	Passing vehicle stopped for pedestrian	20
11-1002(e)	100205	# 1002 05	Failure to yield right-of-way to pedestrian at an intersection	20
11-1002.5	100250	# 1002 50	Failure to stop and/or yield to a pedestrian at crosswalk in school zone	20
11-1003.1	100301	# 1003 01	Failure to exercise due care for pedestrian or bicyclist	10
11-1004	100400	# 1004 00	Failure to yield right-of-way to a blind or hearing impaired pedestrian	20
11-1008	100800	# 1008 00	Failure to yield to a pedestrian on a sidewalk	20
11-1101	110100	# 1101 00	Improper passing of street car on the left	10
11-1102	110200	# 1102 00	Improper passing on the right or failure to stop for a street car	20
11-1103	110300	# 1103 00	Obstructing street car traffic	5
11-1104	110400	# 1104 00	Driving through safety zone	20
11-1201	120100	# 1201 00	Failure to stop for approaching railroad train, railroad track equipment or signal	20
11-1201(a)	120110	# 1201 A	For drivers who are not always required to stop, failing to stop before reaching the railroad	20

			crossing, if tracks are not clear (serious traffic violation if committed in a commercial motor vehicle)	
11-1201(a)2	120112	# 1201 A2	Failing to obey a traffic control device or the directions of an enforcement official at the railroad crossing	20
11-1201(a-5)	120115	# 1201 A5	For drivers who are not always required to stop, failing to slow down and check that the tracks are clear of approaching train or railroad track equipment (serious traffic violation if committed in a commercial motor vehicle)	20
11-1201(d-1)	120141	# 1201 D1	For all drivers, failing to negotiate a railroad-highway grade crossing because of insufficient undercarriage clearance (serious traffic violation if committed in a commercial motor vehicle)	20
11-1202	120200	# 1202 00	Failure to stop at railroad grade crossing	20
11-1202	120020	# 1202	Failure to stop before driving onto crossing	20
11-1203	120300	# 1203 00	Improper movement of heavy equipment across railroad grade crossing	5
11-1204	120400	# 1204 00	Disregarding stop or yield sign at an intersection	20

11-1205	120500	# 1205 00	Failure to yield right-of-way upon emerging from alley or driveway	20
11-1402(a)	140201	# 1402 01	Limitations on backing	10
11-1402(b)	140202	# 1402 02	Limitations on backing upon controlled access highway	20
11-1403	140300	# 1403 00	Motorcycle operating violation or passenger equipment violation	5
11-1403.1	140301	# 1403 01	Motorized pedalcycle operating violation	5
11-1403.2	140302	# 1403 02	Operation of motorcycle on one wheel – reckless driving	55
11-1404	140400	# 1404 00	Motorcycle glasses, goggles or shield violation	5
11-1405	140500	# 1405 00	Motorcycle equipment violation	5
11-1412.1	141201	# 1412 01	Driving upon sidewalk	20
11-1414(a)	141401	# 1414 01	Passing school bus receiving or discharging children (Discontinued 12/31/12)	25
11-1418	141800	# 1418 00	Illegal operation of farm tractor upon highway	10
11-1426.2g	142627	# 14262g	Operating a low speed vehicle without a valid license	15
11-1505	150500	# 1505 00	Improper position of motorized pedalcycles on roadway	10

11-1505.1	150501	# 1505 01	Riding motorized pedalcycle more than two abreast on roadways	10
11-1507.1	150701	# 1507 01	Violation of lamps on motorized pedalcycles	10
11-1510(b)	151020	# 1510 B0	Improper left turn on pedalcycle	10
12-201(b)	220102	# 2201 02	Head, tail or side light violation	10
12-208(a)	220801	# 2208 01	No stop lights	5
12-208(b)	220802	# 2208 02	No turn signal lights	5
12-208(c)	220803	# 2208 03	No turn signal lights on trailers or semi-trailers	5
12-301	230100	# 2301 00	Defective brakes	20
12-604.1(a)	2604110	# 2604 1A	Abuse of use of a video device	15
12-604.1(a-5)	261025	# 2604 1A5	Aggravated use of video device accident involving personal injury	30
12-610.1b	261012	# 2610 1B	Driver under age 18 using a wireless phone	10
12-610.1b	261010	# 2610 1b	Driving under age 19 using a wireless phone	
12-610.1(b-5)	261025	# 2610 1B5	Under age 19 aggravated wireless phone accident involving personal injury	30
12-610.1e	261015	# 2610 1e	Using a wireless phone in a school or construction zone or	15

			within 500 feet of an emergency scene (a serious violation if committed in a commercial motor vehicle)	
12-610.1(e-5)	261055	# 2610 1E5	Aggravated use wireless phone school/construction zone accident involving personal injury	30
12-610.2b	261022	# 2610 2b	Using an electronic communications device ~~to compose, send or read a message~~ (a serious violation if committed in a commercial motor vehicle) (Second or subsequent violation)	20
12-610.2(b-5)	261025	#2620 2b5	Aggravated electronic communication device accident involving personal injury	30
12-610.5b	261052	# 2610 5b	Unlawful use of registration plate covers	5
12-804	280400	# 2804 00	School bus identification and warning light violation	5
15-106	510600	# 5106 00	Failure to fasten or secure any protruding component of a vehicle	15
15-109	510900	# 5109 00	Spilling or unsafe load	15
15-110	511000	# 5110 00	Improper towing of a vehicle	10
15-114	511400	# 5114 00	Improper pushing of another vehicle	10

d) City of Chicago Traffic Regulations – Title 9~~Chapter 27~~ of the Municipal Code of Chicago
The following point assigned violations will be entered on the driving record as Type Action -97- bond forfeiture or Type Action -99- conviction

CHICAGO TRAFFIC CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE	POINTS
**********	*********	**********	**********	*******
~~7-201~~	~~201000~~	~~7 201 00~~	~~Disregarding official traffic control device~~	~~20~~
~~7-202~~	~~202000~~	~~7 202 00~~	~~Disregarding traffic control light~~	~~20~~
~~7-203~~	~~203000~~	~~7 203 00~~	~~Disregarding flashing traffic signal~~	~~20~~
~~7-204~~	~~204000~~	~~7 204 00~~	~~Disregarding lane control light~~	~~20~~
~~7-205~~	~~205000~~	~~7 205 00~~	~~Avoiding official traffic control device~~	~~20~~
~~7-210~~	~~210000~~	~~7 210 00~~	~~Driving motor-driven cycle on access roadway~~	~~10~~
~~7-211~~	~~211000~~	~~7 211 00~~	~~Improper traffic lane usage~~	~~20~~
~~7-212~~	~~212000~~	~~7 212 00~~	~~Speeding too fast for conditions~~	~~10~~
~~7-212.01~~	~~212001~~	~~7 212 01~~	~~1-10 MPH above limit~~	~~5~~
~~7-212.03~~	~~212003~~	~~7 212 03~~	~~11-14 MPH above limit~~	~~15~~
~~7-212.05~~	~~212005~~	~~7 212 05~~	~~15-25 MPH above limit (a serious traffic violation if committed in a commercial motor vehicle)~~	~~20~~

~~7-212.07~~	~~212007~~	~~7-212-07~~	~~Over 25 MPH above limit (a serious traffic violation if committed in a commercial motor vehicle)~~	~~50~~
~~7-213~~	~~213000~~	~~7-213-00~~	~~Driving below minimum speed limit~~	~~5~~
~~7-214~~	~~214000~~	~~7-214-00~~	~~Improper turn at intersection~~	~~10~~
~~7-215~~	~~215000~~	~~7-215-00~~	~~Improper or illegal turn on red signal light~~	~~20~~
~~7-216~~	~~216000~~	~~7-216-00~~	~~Improper U-turn~~	~~10~~
~~7-217~~	~~217000~~	~~7-217-00~~	~~Improper U-turn in Loop district~~	~~10~~
~~7-218~~	~~218000~~	~~7-218-00~~	~~Disobeying no-turn sign~~	~~10~~
~~7-219~~	~~219000~~	~~7-219-00~~	~~Driving wrong way on one-way street~~	~~5~~
~~7-220~~	~~220000~~	~~7-220-00~~	~~Driving wrong way on one-way street—restrictive period~~	~~5~~
~~7-221~~	~~221000~~	~~7-221-00~~	~~Disregarding stop sign at intersection~~	~~20~~
~~7-222~~	~~222000~~	~~7-222-00~~	~~Failure to yield right-of-way at stop intersection~~	~~20~~
~~7-223~~	~~223000~~	~~7-223-00~~	~~Failure to yield right-of-way upon emerging from alley or driveway~~	~~20~~
~~7-224~~	~~224000~~	~~7-224-00~~	~~Entering intersection when traffic is obstructed~~	~~20~~

~~7-225~~	~~225000~~	~~7-225-00~~	~~Failure to observe yield right-of-way~~	~~20~~
~~7-226~~	~~226000~~	~~7-226-00~~	~~Failure to stop for approaching railroad train or signal~~	~~20~~
~~7-227~~	~~227000~~	~~7-227-00~~	~~Failure to observe bridge signal~~	~~20~~
~~7-228~~	~~228000~~	~~7-228-00~~	~~Failure to yield right-of-way to emergency vehicles~~	~~15~~
~~7-229~~	~~229000~~	~~7-229-00~~	~~Failure to yield right-of-way to pedestrian at intersection~~	~~20~~
~~7-230~~	~~230000~~	~~7-230-00~~	~~Failure to yield right-of-way at intersection~~	~~15~~
~~7-231~~	~~231000~~	~~7-231-00~~	~~Failure to yield right-of-way to pedestrian~~	~~20~~
~~7-232~~	~~232000~~	~~7-232-00~~	~~Failure to yield right-of-way to equestrian~~	~~20~~
~~7-233~~	~~233000~~	~~7-233-00~~	~~Failure to yield right-of-way to blind person~~	~~20~~
~~7-236(a)~~	~~236001~~	~~7-236-01~~	~~Improper passing on the left~~	~~20~~
~~7-236(b)~~	~~236002~~	~~7-236-02~~	~~Failure to yield right-of-way to vehicle passing on the left~~	~~20~~
~~7-237~~	~~237000~~	~~7-237-00~~	~~Improper passing on the right~~	~~20~~
~~7-238~~	~~238000~~	~~7-238-00~~	~~Improper passing on the left~~	~~20~~
~~7-239~~	~~239000~~	~~7-239-00~~	~~Failure to drive on right side of roadway~~	~~5~~

~~7-240~~	~~240000~~	~~7 240 00~~	~~Passing stopped school bus receiving or discharging children~~	~~25~~
~~7-241~~	~~241000~~	~~7 241 00~~	~~Passing vehicle stopped for pedestrian~~	~~20~~
~~7-244~~	~~244000~~	~~7 244 00~~	~~Failure to obey lawful order or authorized officer~~	~~10~~
~~7-247~~	~~247000~~	~~7 247 00~~	~~Driving in area designated as play street~~	~~20~~
~~7-248~~	~~248000~~	~~7 248 00~~	~~Driving on sidewalk or parkway~~	~~20~~
~~7-249~~	~~249000~~	~~7 249 00~~	~~Driving through safety zone~~	~~20~~
~~7-250~~	~~250000~~	~~7 250 00~~	~~Driving in bus lane~~	~~20~~
~~7-251~~	~~251000~~	~~7 251 00~~	~~Driving on left side of roadway where prohibited~~	~~20~~
~~7-252~~	~~252000~~	~~7 252 00~~	~~Improper backing~~	~~10~~
~~7-253~~	~~253000~~	~~7 253 00~~	~~Improper entry or exit from controlled access roadway~~	~~10~~
~~7-255~~	~~255000~~	~~7 255 00~~	~~Negligent driving~~	~~10~~
9-40-140	940140	9 40 140	Negligent driving	10
~~7-256~~	~~256000~~	~~7 256 00~~	~~Following too closely~~	~~25~~
~~7-257~~	~~257000~~	~~7 257 00~~	~~Failure to exercise due care for pedestrian~~	~~10~~
~~7-260~~	~~260000~~	~~7 260 00~~	~~Unsafe movement of vehicle from parked position~~	~~15~~

~~7-261~~	~~261000~~	~~7-261-00~~	~~Failure to give stop or turn signal~~	~~15~~
~~7-262~~	~~262000~~	~~7-262-00~~	~~Improper stop or turn signal~~	~~15~~
~~7-266~~	~~266000~~	~~7-266-00~~	~~Improper towing or pushing of vehicle~~	~~10~~
~~7-270~~	~~270000~~	~~7-270-00~~	~~Failure to drive within bus lane – bus drivers~~	~~20~~
~~7-271~~	~~271000~~	~~7-271-00~~	~~Failure to observe mass transportation vehicle regulations~~	~~20~~
~~7-278~~	~~278000~~	~~7-278-00~~	~~Illegal operation of motorcycle or motor driven cycle~~	~~10~~
~~7-342~~	~~342000~~	~~7-342-00~~	~~Defective brakes~~	~~20~~
~~7-346~~	~~346000~~	~~7-346-00~~	~~Head, tail, or side light violation~~	~~10~~
~~7-359~~	~~359000~~	~~7-359-00~~	~~Towing vehicles without bar or other safety device~~	~~10~~
~~7-369~~	~~369000~~	~~7-369-00~~	~~Failure to notify owner after collision with unattended vehicle~~	~~25~~
~~7-402(c)~~	~~402003~~	~~7-402-03~~	~~Restricted turn signs – prohibited right or left turn~~	~~10~~

e) Illinois Vehicle Code

The following violations will be entered on the driving record as Type Action -95- bond forfeiture or Type Action -96- conviction with no point value:

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

IVC VIOLATION CODE **********	EDPM OFFENSE CODE *********	ABSTRACT DESCRIPTION CODE **********	DESCRIPTION OF OFFENSE **********
11-407(a)	040710	# 0407 A0	Failure of driver to give notice of accident
11-407(b)	040720	# 0407 B0	Failure of passenger to give notice of accident
11-506(b)	050602	# 0506 B	Vehicle owner permitting street racing
11-1412	141200	# 1412 00	Crossing fire hose
11-1420	142000	# 1420 00	Funeral procession violation
12-201(c)	220103	# 2201 03	Registration light violation
12-203	220300	# 2203 00	Lamps on parked vehicle
12-207	220700	# 2207 00	Spot light or auxiliary light violation
12-209	220900	# 2209 00	Other light violation
12-211(a)	221101	# 2211 01	Headlight violation
12-211(b)	221102	# 2211 02	Front light violation
12-212	221200	# 2212 00	Front red or flashing light violation
12-214	221400	# 2214 00	Special lighting equipment on rural mail delivery vehicle
12-603.1	260301	# 2603 01	Violation of the seat belt act
12-604.1	260401	# 260401	Driving while using prohibited video devices
12-610.2(b)	261002	# 2610 02	Using an electronic communication device (a serious violation if committed in a commercial motor vehicle) (First violation)

12-613(a)	261301	# 2613 A	Violation of possession and use of radar or laser jamming devices
12-714(a)	271401	# 2714 01	Violation of possession and use of a radar detecting device in a commercial motor vehicle
12-715(a)	271501	# 2715 01	Violation of possession and use of a radar jamming device in a commercial motor vehicle
1104	001104	# 01104 00	Violation of the Child Passenger Protection Act [625 ILCS 25] − child under age 4
1104(a)	101104	# 01104 10	Violation of the Child Passenger Protection Act [625 ILCS 25] − child age 4 but under age 6
25/4	250400	25 04	Violation of the Child Passenger Protection Act [625 ILCS 25] − child under age 4
25/4a	250401	25 04A	Violation of the Child Passenger Protection Act [625 ILCS 25] − child age 4 but under age 16
25/4b	250402	25 04B	Unrestrained – age 8 but under age 19 [625 ILCS 25]

~~f) City of Chicago Traffic Regulations – Chapter 27 of the Municipal Code of Chicago~~
~~The following violations will be entered on the driving record as Type Action -95- bond forfeiture or Type Action -96- conviction with no point value:~~

~~CHICAGO TRAFFIC CODE~~	~~EDPM OFFENSE CODE~~	~~ABSTRACT DESCRIPTION CODE~~	~~DESCRIPTION OF OFFENSE~~
~~**********~~	~~*********~~	~~**********~~	~~**********~~
~~7-235~~	~~235000~~	~~7 235 00~~	~~Driving through a funeral procession~~

~~7-246~~	~~246000~~	~~7-246-00~~	~~Crossing fire hose~~
~~7-274~~	~~274000~~	~~7-274-00~~	~~Driving in a funeral procession~~
~~7-342.1~~	~~342001~~	~~7-342-01~~	~~Violation of seat belt ordinance~~
~~7-347~~	~~347000~~	~~7-347-00~~	~~Spotlight violation~~
~~7-348~~	~~348000~~	~~7-348-00~~	~~Other light violation~~
~~7-349~~	~~349000~~	~~7-349-00~~	~~Front red or flashing light~~

f~~g~~) Case Review

1) After each case is entered to the appropriate driving record, suspension, revocation, disqualification or cancellation action is determined by review of the driving record by a trained Driver Services Technician or action is taken for suspension, revocation, or disqualification by automated computer programs using criteria set forth in this Part.

2) Driver control action shall be entered upon the driver's record by classification (Type Action).

A) Classification for driver control actions:

Type Action 01	Mandatory Revocation
Type Action 02	Discretionary Revocation
Type Action 03	Discretionary Suspension
Type Action 04	Safety Responsibility Suspension
Type Action 05	Financial Responsibility Suspension
Type Action 06	Unsatisfied Judgment Suspension
Type Action 07	Mandatory Suspension
Type Action 08	Cancellation of License
Type Action 09	Mandatory Suspension
Type Action 17	Statutory Summary Suspension
Type Action 45	Cancellation/Suspension/Denial of School Bus Permit
Type Action DN	Denial of License and/or Privileges

Type Action DQ	Discretionary/Mandatory Disqualification
Type Action FR	Family Financial Responsibility Suspension
Type Action IV	Invalidation of License
Type Action MC	Mandatory Conviction Suspension
Type Action OS	Out of Service Law Enforcement History Item
Type Action ZT	Zero Tolerance Suspension

B) Description of driver control action:
The code used to describe the action is composed of the Chapter and/or Section number of the Illinois Vehicle Code that provides the Secretary of State with the authority to take such action.

g~~h~~) Mandatory Revocation – Type Action 01

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
6-205(a)1	205101	6 205 A1	Reckless homicide
6-205(a)2	205102	6 205 A2	Driving while under the influence of alcohol, other drug, or combination thereof
6-205(a)3	205103	6 205 A3	Felony involving the use of a motor vehicle
6-205(a)4	205104	6 205 A4	Leaving the scene of a traffic accident involving death of personal injury – violation of Section 11-401
6-205(a)5	205105	6 205 A5	Perjury under oath relating to ownership or operation of a motor vehicle
6-205(a)6	205106	6 205 A6	Three convictions of reckless driving committed within a 12-month period
6-205(a)7	205107	6 205 A7	Conviction of motor vehicle theft as defined

			in Section 4-102
6-205(a)8	205108	6 205 A8	Conviction of drag racing under Section 11-504
6-205(a)9	205109	6 205 A9	Violation of financial responsibility in operation of a motor vehicle for the purpose of hire (Chapter 8) or for rent (Chapter 9)
6-205(a)10	205110	6 205 A10	Reckless conduct, Section 12-5 of the Criminal Code of 2012
6-205(a)11	205111	6 205 A11	Conviction of aggravated fleeing or eluding a peace officer
6-205(a)12	205112	6 205 A12	Violation of Section 6-507(b) or a similar law of another state relating to the unlawful operation of a commercial motor vehicle
6-205(a)13	205113	6 205 A13	A second or subsequent violation of Section 11-502(a) or a similar provision of a local ordinance and the driver was less than 21 years of age at the time of the offense.
6-205(a)14	205114	6 205 A14	Conviction of Section 11-506(a) or a similar provision of a local ordinance relating to street racing
6-205(a)15	205115	6 205 A15	A second or subsequent conviction of driving while the person's driver's license, permit or privilege was revoked for reckless homicide or a similar out-of-state offense
6-205(a)16	205116	6 205 A16	Conviction of any offense regulating the movement of traffic that was the proximate cause of death of any person
6-205(a)17	205117	6 205 A17	Unauthorized use of deceased person's disability placard or device

6-205(a)18	205118	6 205 A18	Second or subsequent conviction of illegal possession of a controlled substance or cannabis
6-205(b)1	205201	6 205 B1	Notice provided for in Section 1-8 of the Juvenile Court Act of 1987, that minor has been adjudicated under that Act as having committed an offense relating to motor vehicles prescribed in IVC Section 4-103
6-205(b)2	205202	6 205 B2	When any other law of this State requires either the revocation or suspension of such license or permit
6-205(b)3	205203	6 205 B3	Committing a gang-related offense involving a motor vehicle or driver's license
6-205(c)	205300	6 205 C0	Revocation of a restricted driving permit
11-501.1	050101	1 0501 01	Statutory Summary Revocation

h~~i~~) Discretionary Revocations and Suspensions – Type Action 02 or 03

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
6-113(d)	113400	6 113 D0	Violation of a restriction on a license or permit
6-206(a)1	206101	6 206 A1	Has committed an offense requiring revocation upon conviction
6-206(a)2	206102	6 206 A2	Three or more convictions of moving traffic violations committed within a 12-month period
6-206(a)3	206103	6 206 A3	Habitually been in violation of vehicle laws

6-206(a)4	206104	6 206 A4	Accident resulting in death or injury
6-206(a)5	206105	6-206 A5	Permitted unlawful or fraudulent use of license, ID card or permit
6-206(a)6	206106	6 206 A6	Conviction of an offense in another state requiring a suspension or revocation in this State including authorization contained in Section 6-203.1
6-206(a)7	206107	6 206 A7	Refused or failed to submit to an examination
6-206(a)8	206108	6 206 A8	Ineligible for license or permit under Section 6-103.
6-206(a)9	206109	6 206 A9	False statement or knowingly concealed a material fact in application for license, ID card or permit
6-206(a)10	206110	6 206 A10	Has displayed or attempted to fraudulently use any driver's license, ID card or permit not issued to such person
6-206(a)11	206111	6 206 A11	Driving while license or permit has been revoked
6-206(a)12	206112	6-206 A12	Obtained the services of another person to take an examination for the purpose of obtaining a license, ID card or permit for some other person
6-206(a)13	206113	6 206 A13	Violation of Curfew Act (prior to 1-1-08)
6-206(a)13	206113	6 206 A13	Violation of nighttime driving restrictions (effective 1-1-08)

6-206(a)14	206114	6 206 A14	Unlawful use of license or permit under IVC Section 6-301 or Section 14, 14A or 14B of the Illinois Identification Card Act [15 ILCS 335]
6-206(a)15	206115	6 206 A15	Conviction of criminal trespass to vehicles as defined in Section 21-2 of the Criminal Code of 2012
6-206(a)16	206116	6 206 A16	Violation of Section 11-204, fleeing from a peace officer
6-206(a)17	206117	6 206 A17	Has refused to submit to a test as required under Section 11-501.1, and such person has not sought a hearing as provided for in Section 11-501.1
6-206(a)18	206118	6 206 A18	Has been adjudged to be afflicted with or suffering from any mental disability or disease
6-206(a)19	206119	6 206 A19	Has violated Section 6-101 – driving without a valid license
6-206(a)20	206120	6 206 A20	Has violated Section 6-104 – driving without a proper classification on a driver's license
6-206(a)21	206121	6 206 A21	Has violated Section 11-402 relating to leaving the scene of an accident resulting in damage to a vehicle in excess of $1000
6-206(a)22	206122	6 206 A22	Has used a motor vehicle in violation of Section 24-1(a)(3), (4), (7), or (9) of the Criminal Code of 2012
6-206(a)23	206123	6 206 A23	Has been convicted of violating Section 11-502(a) for a second or subsequent time within one year

6-206(a)24	206124	6 206 A24	Has been convicted by court martial or punished by non-judicial punishment by military authorities of the United States at a military installation in Illinois of a traffic related offense that is the same or similar to an offense specified under Section 6-205 or 6-206
6-206(a)25	206125	6 206 A25	Has permitted any form of identification to be used by another in the application process in order to obtain a license, identification card or permit
6-206(a)26	206126	6 206 A26	Has altered or attempted to alter a license or has possessed an altered license, identification card or permit
6-206(a)27	206127	6 206 A27	Has violated Section 6-16 of the Liquor Control Act of 1934
6-206(a)28	206128	6 206 A28	Conviction for the illegal possession of any controlled substance prohibited under the Illinois Controlled Substances Act or any cannabis prohibited under the Cannabis Control Act while operating a motor vehicle
6-206(a)29	206129	6 206 A29	Conviction of criminal sexual assault, aggravated criminal sexual assault, criminal sexual abuse, aggravated criminal sexual abuse, juvenile pimping, soliciting for a juvenile prostitute or the manufacture, sale or delivery of controlled substances or instruments used for illegal drug use or abuse while operating a motor vehicle
6-206(a)30	206130	6 206 A30	Conviction of a second or subsequent time of a sex offense and/or an offense against drug laws while operating a motor vehicle as enumerated in Section 6-206(a)(29)

6-206(a)31	206131	6 206 A31	Refused to submit/failed test as required by Section 11-501.6
6-206(a)32	206132	6 206 A32	Has used a motor vehicle in violation of Section 24-1.2 of the Criminal Code of 2012
6-206(a)33	206133	6 206 A33	A violation of Section 11-502(a) or a similar provision of a local ordinance and the driver was less than 21 years of age at the time of the offense
6-206(a)34	206134	6 206 A34	Two or more convictions of moving traffic violations committed within a 24-month period (Type Action 02 prior to 8-8-98) (Type Action 03 prior to 8-11-98)
6-206(a)34	206134	6 206 A34	Use of fictitious or unlawfully altered person-with-disabilities license plate or parking decal or device as defined in Section 11-1301.5 (effective 8-8-98)
6-206(a)35	206135	6 206 A35	Use of fictitious or unlawfully altered person-with-disabilities license plate or parking decal or device as defined in Section 11-1301.5 (prior to 8-8-98)
6-206(a)35	206135	6 206 A35	Use of fraudulent person-with-disabilities license plate or parking decal or device as defined in Section 11-1301.6 (effective 8-8-98)
6-206(a)36	206136	6 206 A36	Use of fraudulent person-with-disabilities license plate or parking decal or device as defined in Section 11-1301.6 (prior to 8-8-98)
6-206(a)36	206136	6 206 A36	Two or more convictions of moving traffic violations committed within a 24 month

			period (Type Action 02 effective 8-8-98) (Type Action 03 effective 8-11-98)
6-206(a)37	206137	6 206 A37	Has been convicted of a violation of Section 11-907(c) that resulted in property damage, personal injury, or death
6-206(a)38	206138	6 206 A38	Has been convicted of a violation of Section 6-20 of the Liquor Control Act of 1934
6-206(a)39	206139	6 206 A39	Has committed a second or subsequent violation of Section 11-1201
6-206(a)40	206140	6 206 A40	Failure to yield and proceed with due caution upon entering a construction zone when workers are present
6-206(a)41	206141	6 206 A41	Committed a second or subsequent violation of Section 11-605.1 of the Illinois Vehicle Code, a similar provision of a local ordinance or a similar violation in any other state, within 2 years of the date of the previous violation
6-206(a)42	206142	6 206 A42	Has committed a violation of Section 11-1301.3(a-1)
6-206(a)43	206143	6 206 A43	Supervision for violation of Section 6-20 of the Liquor Control Act
6-206(a)44	206144	6 206 A44	Has been convicted of a moving violation after having previously been suspended or revoked pursuant to Section 6-206(a)36
6-206(a)45	206145	6 206 A45	Committed perjury or submitted false documents at a formal hearing
6-206(a)46	206146	6 206 A46	Has committed a violation of subsection (j) of Section 3-413

6-206(c)3	206303	6 206 C3	Conviction of an offense while holding a Restricted Driving Permit
6-206.1(J)	206010	6 206.1 J	Violation of the requirements of the monitoring device driving permit (MDDP)
6-206.1(L)	206012	6 206.1 L	Convicted or received court supervision of violation listed in Section 6-206.1(c-1) or de-installed MDDP without authorization

ii) Discretionary or Mandatory – Suspension – Type Action 03, 07, 09, 17 or 18, or ZT

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
6-205(c)	205300	6 205 C0	Suspension of a Restricted Driving Permit
6-205.2	205002	6 205 02	Theft of motor fuel
6-303(b)	303200	6 303 B0	Driving while license or permit has been revoked or suspended
6-306.3	306003	6 306 03	Failure to appear in court to answer a traffic violation charge after depositing a valid Illinois license in lieu of bail
6-306.5	306005	6 306 05	Failure to pay fines – parking violations or automated traffic law violations
6-306.7	306007	6 306 07	Failure to pay fines – Illinois State Toll Highway Authority
11-406(e)	040650	1 0406 E0	Suspended for failure or neglect to make a report of a traffic accident as required by Section 11-406

11-501.1	050101	1 0501 01	Statutory Summary Suspension
11-501.8	050108	1 0501 08	Zero Tolerance Suspension
11-1414(f)	141460	1 1414 F0	Failure to stop for school bus when loading or discharging passengers
11-1425(d)	142540	1 1425 D	Failure to have space to drive through railroad crossing
13A 112(b)	311122	13A 112 B	Vehicle Emissions Suspension
13B 55(b)	132552	13B 55B	Vehicle Emissions Suspension

j~~k~~) Safety Responsibility Suspension – Type Action 04

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
7-201			Motor vehicle operator and/or owner of a vehicle involved in an accident in excess of $500 without liability insurance coverage, with a reasonable possibility of a civil judgment being entered in court

k~~l~~) Financial Responsibility Suspension – Type Action 05

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
7-305			Failure to maintain proof of financial responsibility (SR-22 insurance) for a designated period of time

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UNIFIED CODE OF CORRECTIONS	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
730/5	5-6-3.1(m)		Fail to file proof of financial responsibility after receiving supervision or three convictions for a mandatory insurance violation

l~~m~~) Unsatisfied Judgment Suspension – Type Action 06

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
7-303			Failure to satisfy court judgment relating to property damage or personal injury resulting from the operation of any motor vehicle

m~~n~~) Cancellation – Type Action 08

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
6-108(1)	108001	6 108 01	Request for withdrawal of consent
6-108(2)	108002	6 108 02	Death of person giving consent
6-108(3)	108003	6 108 03	Person giving consent no longer has legal custody
6-108(A)(5)	108105	6 108 A5	Failed to disclose a pending citation at the time of the graduated driver's license application
6-108(4)	108004	6 108 04	Reported to be a chronic or habitual truant as defined in Section 26-2a of the School Code

			[105 ILCS 5/26-2a]
6-113(d)	113400	6 113 D0	Cancellation of a Restricted Driving Permit based on evidence of violation of restriction
6-201(a)1	201101	6 201 A1	Not entitled to the issuance of the license or permit
6-201(a)2	201102	6 201 A2	Failed to give the required or correct information
6-201(a)3	201103	6 201 A3	Failed to pay fees or taxes due
6-201(a)4	201104	6 201 A4	Committed any fraud in the making of such application
6-201(a)5	201105	6 201 A5	Ineligible therefore under the provisions of Section 6-103
6-201(a)6	201106	6 201 A6	Has refused or neglected to submit to examination or re-examination as required under this Code
6-201(a)7	201107	6 201 A7	Has violated the Cannabis Control Act or the Illinois Controlled Substances Act while in physical control of a motor vehicle
6-201(a)8	201108	6 201 A8	Failed to notify Secretary of State of a medical condition that is likely to cause loss of consciousness or loss of ability to safely operate a motor vehicle within 10 days after becoming aware of the condition
6-201(a)9	201109	6 201 A9	Convicted of a sex offense as defined in the Sex Offender Registration Act [730 ILCS 150]
6-201(a)11	201111	6 201 A11	Refused or neglected to appear at a driver services facility to have a license corrected

			or failed to appear to present documentation for verification of identity
6-201(a)12	201112	6 201 A12	Fraudulent document or failed to submit medical card/variance
6-201(a)13	201113	6 201 A13	Medical Certification/variance removed by FMCSA
6-201(a)14	201114	6 201 A14	Failure to self certify
6-201(a)15	201115	6 201 A15	Out of state resident/SR22 not required
6-205(c)	205300	6 205 C0	Cancellation of a permit issued subsequent to a mandatory revocation pursuant to Section 6-205
6-206(c)3	206303	6 206 C3	Cancellation of a permit subsequent to a discretionary revocation or suspension pursuant to Section 6-206
6-206.1(a)4	206014	6 206.1 A4	Failure to install BAIID
6-206.1(c-1)	206013	6 206.1 C-1	De-installed BAIID without prior authorization from Secretary of State

ILLINOIS IDENTIFICATION CARD ACT	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
335 13(b)1	013201	335-13 B1	Not entitled to the issuance of an identification card
335 13(b)2	013202	335-13 B2	False statement or knowingly concealed a material fact in your application for an identification card
335 13(b)3	013203	335-13 B3	Displayed or represented as your own an identification card not issued to you

335 13(b)4	013204	335-13 B4	Permitted an unlawful use of your identification card by allowing another person to use your identification card
335 13(b)5	013205	335-13 B5	Signature of the applicant or the signature on the identification card is a forgery
335 13(b)6	013206	335-13 B6	Identification card has been used for an unlawful or fraudulent purpose
335 13(b)7	013207	335-13 B7	Identification card has been altered or defaced
335 13(b)8	013208	335-13 B8	Identification card has been duplicated for any purpose
335 13(b)9	013209	335-13 B9	Identification card was utilized for counterfeit purposes
335 13(b)10	013210	335-13 B10	Not a disabled person as defined in Section 4A of the Illinois Identification Card Act
335 13(b)11	013211	335-13 B11	The holder failed to appear at a Driver Services Facility for the re-issuance of an identification card or was issued based on invalid, altered, fictitious or fraudulent documents

n~~o~~) Discretionary/Mandatory Cancellation/Suspension/Denial of School Bus Driver Permit – Type Action 45

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
6-106.1	106001	6 106 01	Discretionary/mandatory suspension/ cancellation/denial of a school bus driver permit pursuant to Section 6-106.1

6-106.1(a)	106011	Zero tolerance cancellation of school bus driver permit

o~~p~~) Denial – Type Action DN

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
6-103(18)			Denial of driver's license and/or driving privileges pursuant to Section 6-103(18)
6-107(c)			Denial of driver's license and/or driving privileges pursuant to Section 6-107(c)
6-107(d)			Denial of driver's license pursuant to Section 6-107(d)
6-108.1			Denial of driver's license pursuant to Section 6-108.1

p~~q~~) Discretionary/Mandatory Disqualification –Type Action DQ

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
6-514(a)1	514101	6 514 A1	Refusal to submit/failure to complete chemical test

6-514(a)2	514102	6 514 A2	Operating commercial motor vehicle/non-commercial motor vehicle with alcohol concentration .04 or more or any amount of a drug, substance, or compound in such person's blood or urine resulting from the unlawful use or consumption of cannabis listed in the Cannabis Control Act or a controlled substance listed in the Illinois Controlled Substances Act
6-514(a)3I	514131	6 514 A31	Driving under influence of alcohol/other drugs
6-514(a)3II	514132	6 514 A32	Leaving scene of accident while operating commercial motor vehicle
6-514(a)3III	514133	6 514 A33	Driving commercial motor vehicle while committing any felony
6-514(b)	514200	6 514 B	Second conviction of violation Section 6-514(a)
6-514(c)	514300	6 514 C	Conviction of felony drug offenses using commercial motor vehicle
6-514(e)	514500	6-514 E	Conviction of 2 or more serious traffic violations within 3 years
6-514(i)1	514901	6-514 I1	Conviction for a first violation of operating a commercial motor vehicle while driving privileges, license or permit is subject to or in violation of an out-of-service order
6-514(i)2	514902	6 514 I2	Conviction for a second violation of operating a commercial motor vehicle while driving privileges, license or permit is subject to or in violation of an out-of-service order

6-514(i)3	514903	6 514 I3	Conviction for a third or more violation of operating a commercial motor vehicle while driving privileges, license or permit is subject to or in violation of an out-of-service order
6-514(i)4	514904	6 514 I4	Conviction for a first violation of operating a commercial motor vehicle while driving privileges, license, or permit is subject to or in violation of an out-of-service order and while transporting passengers or hazardous materials
6-514(i)5	514905	6 514 I5	Conviction for a second violation of operating a commercial motor vehicle while driving privileges, license or permit is subject to or in violation of an out-of-service order and while transporting passengers or hazardous materials
6-514(i)6	514906	6 515 I6	Conviction for a third or more violation of operating a commercial motor vehicle while driving privileges, license or permit is subject to or in violation of an out-of-service order and while transporting passengers or hazardous materials
6-514(j)2i	514021	6 514 J2i	Convicted for a first violation of railroad-highway grade crossing
6-514(j)2ii	514022	6 514 J2ii	Convicted for a second violation of railroad-highway grade crossing within a three-year period
6-514(j)2iii	514023	6 514 J2iii	Convicted of a third or subsequent violation of railroad-highway grade crossing within a three-year period
6-514(k)	514110	6 514 K	Notification of a disqualification of a driver's

			CMV privileges imposed by USDOT, Federal Motor Carrier Safety Administration, in accordance with 49 CFR 383.52, the Secretary of State shall immediately record the notice of disqualification and confirm the action to the driver
6-514(a)3iv	514134	6 514 A3iv	Driving a CMV when, as a result of prior violations committed while operating a CMV, the driver's CDL is revoked, suspended, disqualified or cancelled
6-514(a)3v	514135	6 514 3v	Causing a fatality through the negligent operation of a CMV, including but not limited to the crimes of motor vehicle manslaughter, homicide by motor vehicle and negligent homicide

q~~r~~) Family Financial Responsibility Suspension – Type Action FR

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
**********	*********	**********	**********
7-702	702000	7 702 00	Individuals who are 90 days or more delinquent in court ordered child support payments and have been found in contempt by the court
7-703			Individuals who are 90 days or more delinquent in court ordered child support payment
7-704.1			Individual certified by Illinois Department of Healthcare & Family Services of delinquency of child support payments
7-705.2			Receipt of court order indicating the driver has engaged in abuse of a child visitation

order

rs) Invalidation – Type Action IV

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
6-301.3			Invalidation of driver's license or permit pursuant to Section 6-301.3

st) Out-Of-Service – Law Enforcement Sanction History Item – Type Action OS

IVC VIOLATION CODE	EDPM OFFENSE CODE	ABSTRACT DESCRIPTION CODE	DESCRIPTION OF OFFENSE
6-515	515000	6 515	24 hour out-of-service order

tu) The following violations will not be assigned points but will be entered on the driving record as Type Action -68- record history item conviction. In the following Table, ACD means AAMVANet Code Dictionary.

ACD CODE	DESCRIPTION OF OFFENSE
A24	Driving under the influence of medication not intended to intoxicate
A33	Illegal possession of drugs (controlled substances)
A60	Underage conviction of drinking and driving at .02 or higher BAC
A61	Underage Administrative Per Se – drinking and driving at .02 or higher BAC
B63	Failed to file future proof of financial responsibility
B64	Failed to file insurance certification

B65	Failed to file medical/certification disability information
B74	Failed to show insurance certification
B78	Failed to show non-commercial driver's license (includes Instruction Permit)
D02	Misrepresentation of identity or other facts on application for driver's license (includes DL, CDL, and Instruction Permit)
D16	Present or use improperly driver's license (includes DL, CDL, and Instruction Permit)
D35	Failure to comply with financial responsibility law
D36	Failure to maintain required liability insurance
D37	Failure to pay for damages or make installment payment
D38	Failure to post security or obtain release from liability
D39	Unsatisfied judgment
D45	Failure to appear for trial or court appearance
D51	Failure to make required payment of child support
D53	Failure to make required payment of fines and costs
D56	Failure to answer a citation, pay fines, penalties and/or costs related to the original violation
D72	Inability to control vehicle
D74	Operating a motor vehicle improperly due to drowsiness
D75	Operating a motor vehicle improperly due to physical or mental disability
E03	Operating without HAZMAT safety equipment as required by law

E04	Operating without HAZMAT placards/markings as required by law
E33	Defective HAZMAT safety devices
E37	Defective tires
E50	Failure to use equipment as required
E53	Failure to use HAZMAT safety devices as required
E54	Failure to use headlight dimmer as required (arrests occurring after 12-31-07)
E57	Failure to use snow tires or chains as required
E70	Equipment used improperly or obstructed
F05	Carrying unsecured passengers in open area of vehicle
F06	Improper operation of or riding on a motorcycle
F34	Stopping, standing or parking: obstructing or impeding traffic
F66	Unsafe condition of vehicle (no specified component)
M02	Failure to obey barrier
M03	Failure to obey construction or maintenance zone markers
M04	Failure to obey flagger
M09	Failure to obey railroad crossing restrictions
M13	Failure to obey school crossing guard
M32	Following emergency vehicle unlawfully
M33	Following fire equipment unlawfully
M43	Ran off road

M47	Improper lane or location – in bicycle lane
M55	Improper lane or location – on rail or streetcar tracks
M80	Inattentive, careless or negligent driving
M81	Careless driving
M82	Inattentive driving
M83	Negligent driving
N02	Failure to yield right of way to animal rider or animal-drawn vehicle
N41	Failure to cancel directional signals
N44	Giving wrong signal
N80	Coasting (operating with gears disengaged)
N84	Unsafe operation
S97	Operating at erratic or suddenly changing speeds
U02	Resisting arrest
U04	Using a motor vehicle in connection with a misdemeanor (not a traffic offense)
U05	Using a motor vehicle to aid and abet a felon
U06	Vehicular assault
U21	Illegal operation of emergency vehicle
W80	Failed employer-directed drug test
W81	Refusal to submit to an employer-directed drug test

u~~v~~) The following violations will not be assigned points but will be entered on the driving record as Type Action -82- conviction immediate action:

ACD CODE	DESCRIPTION OF OFFENSE
A04	Driving under the influence of alcohol with BAC of at least .04 but not greater than .079
A08	Driving under the influence of alcohol with BAC at or over .08
A10	Driving under the influence of alcohol with BAC at or over .10
A11	Driving under the influence of alcohol with BAC at _____
A12	Refuse to submit to test for alcohol – Implied Consent Law
A20	Driving under the influence of alcohol or drugs
A21	Driving under the influence of alcohol
A22	Driving under the influence of drugs
A23	Driving under the influence of alcohol and drugs
A25	Driving while impaired
A90	Admin Per Se for BAC at or over .10
A91	Admin Per Se for BAC at _____ (detail field required)
A94	Admin Per Se for BAC of at least .04 but not greater than .079
A98	DUI at .08 Admin
B21	Driving while license barred
B22	Driving while license cancelled

B23	Driving while license denied
B27	Driving while license out-of-service order is in effect (for violations not covered by B19)
D06	Misrepresentation of identify or other facts to obtain alcohol
D07	Possess multiple driver's licenses (including DL, CDL and Instruction Permit) (Serious violation)
D10	Manufacture or duplicate false driver's license (includes DL, CDL and Instruction Permit)
D27	Violate limited license conditions (Serious violation)
D29	Violate restrictions of driver's license (includes DL, CDL and Instruction Permit) (Serious violation)
S95	Speed contest (racing) on road open to traffic

v~~w~~) The following violations will not be assigned points but will be entered on the driving record as Type Action -83- conviction immediate action:

ACD CODE	DESCRIPTION OF OFFENSE
A41	Driver violation of ignition interlock or immobilization device
A50	Motor vehicle used in the commission of a felony involving manufacturing, distribution, or dispensing a controlled substance
B06	Leaving scene of an accident before police arrive – fatal accident
B07	Leaving scene of an accident before police arrive – personal injury accident
B19	Driving while out-of-service order is in effect and transporting 16 or more passengers, including the driver, and/or transporting hazardous materials that require a placard

B20	Driving while license withdrawn
B24	Driving while license disqualified
B25	Driving while license revoked
B26	Driving while license suspended
B41	Possess or provide counterfeit or altered driver's license (includes DL, CDL and Instruction Permit) or ID
B51	Expired or no driver's license (includes DL, CDL and Instruction Permit)
B56	Driving a CMV without obtaining a CDL (Serious violation)
B91	Improper classification or endorsement on driver's license (includes DL, CDL and Instruction Permit) (Serious violation)
D78	Perjury about the operation of a motor vehicle
M23	Failure to have space to drive through railroad crossing
U01	Fleeing or evading police or roadblock
U03	Using a motor vehicle in connection with a felony (not traffic offense)
U07	Vehicular homicide
U08	Vehicular manslaughter (Serious violation)
U09	Negligent homicide while operating a CMV
U10	Causing a fatality through the negligent operation of a CMV
U27	Vehicular feticide (first degree)
U28	Vehicular feticide (second degree)

w~~x~~) The following violations will not be assigned points but will be entered on the driving record as Type Action -85- conviction:

ACD CODE	DESCRIPTION OF OFFENSE
B61	Failed to file accident report
D70	Driver's view obstructed
E01	Operating without equipment as required by law
E23	Use of radar or laser detector prohibited by law
E34	Defective lights
E54	Failure to use headlight dimmer as required (arrests occurring prior to 1-1-08)
F02	Child or youth restraint not used properly as required
F04	Seat belt not used properly as required
M30	Following improperly
M56	Improper lane or location – on fire hose
N05	Failure to yield right of way to funeral procession, procession or parade

x~~y~~) The following point assigned violations will be entered on the driving record as Type Action -87- conviction:

ACD CODE	DESCRIPTION OF OFFENSE	POINTS
A26	Drinking alcohol while operating a vehicle	25
A31	Illegal possession of alcohol	25
A35	Possession of open alcohol container	25

B01	Hit and run – failure to stop and render aid after accident	25
B02	Hit and run – failure to stop and render aid after accident – fatal accident	50
B02	Hit and run – failure to stop and render aid after accident – fatal accident	50
B03	Hit and run – failure to stop and render aid after accident – personal injury accident	50
B04	Hit and run – failure to stop and render aid after accident – property damage accident	25
B05	Leaving scene of accident before police arrive	25
B08	Leaving scene of accident before police arrive – property damage accident	25
B14	Failure to reveal identity after fatal or personal injury accident	50
B57	Driving a CMV without a CDL in the driver's possession	50
E02	Operating without brakes as required by law	20
E05	Operating without lights as required by law	10
E06	Operating without school bus equipment as required by law	5
E31	Defective brakes	20
E36	Defective school bus equipment	5
E51	Failure to use brakes	20
E55	Failure to use lights as required	10
E56	Failure to use school bus safety equipment as required	5

E71	Brakes used improperly	20
F03	Motorcycle safety equipment not used properly as required	5
M05	Failure to obey land markings or signal	20
M08	Failure to obey police of peace officer	10
M10	Failure to obey railroad gates, signs, or signals	20
M11	Failure to obey restricted lane (Serious violation)	20
M12	Failure to obey safety zone	20
M14	Failure to obey sign or traffic control device	20
M15	Failure to obey stop sign	20
M16	Failure to obey traffic signal or light	20
M17	Failure to obey traffic sign	20
M18	Failure to obey warning light or flasher	20
M19	Failure to obey yield sign, or when entering roadway	20
M20	Failure to slow down at a railroad crossing and check tracks are clear	20
M21	Failure to stop before reaching tracks at a railroad-highway grade crossing when the tracks are not clear	20
M22	Failure to stop as required before driving onto railroad-highway grade crossing	20
M24	Fail to negotiate a railroad-highway grade crossing because of insufficient undercarriage clearance	20

M25	Failure to stop; basic rule at unsigned intersection or when entering roadway from private driveway, alley, etc.	20
M31	Failure to leave sufficient distance for overtaking by other vehicles	20
M34	Following too closely (Serious violation)	20
M40	Improper lane or location	20
M41	Failure to keep in proper lane	20
M42	Improper or erratic (unsafe) lane changes (Serious violation)	20
M44	Improper lane or location – crossover	20
M45	Improper lane or location – crosswalk	20
M46	Improper lane or location – entrance/exit ramp or way	10
M48	Improper lane or location – in occupied lane	20
M49	Improper lane or location – in human occupant violator or restricted lane	20
M50	Improper lane or location – limited access highway	10
M51	Improper lane or location – median	20
M57	Improper lane or location – oncoming traffic lane	20
M58	Improper lane or location – road shoulder, ditch, or sidewalk	20
M60	Improper lane or location – slower vehicle lane	20
M61	Improper lane or location – straddling center lines	20
M62	Improper lane or location – traveling in turn (or center) lane	20

M70	Improper passing	10
M71	Passing in violation of posted sign or pavement marking	20
M72	Passing in violation of opposite directions restrictions	10
M73	Passing on wrong side	20
M74	Passing on hill or curve	20
M75	Passing school bus displaying warning not to pass	25
M76	Passing where prohibited	20
M77	Passing with insufficient distance or visibility	20
M84	Reckless driving (Serious violation)	55
M85	Texting while driving (Serious violation)	10
M86	Using a handheld mobile telephone while driving (Serious violation)	10
N01	Failure to yield right of way	20
N03	Failure to yield right of way to cyclist	10
N04	Failure to yield right of way (i.e., ambulance, fire equipment, police, etc.)	15
N06	Failure to yield right of way to other vehicle	20
N07	Failure to yield right of way to overtaking vehicle	20
N08	Failure to yield right of way to pedestrian (includes handicapped or blind)	20
N09	Failure to yield right of way to school bus	20

N20	Failure to yield right of way at crosswalk	20
N21	Failure to yield right of way at rotary/roundabout/circular intersection	20
N22	Failure to yield right of way at stop sign	20
N23	Failure to yield right of way at traffic sign	20
N24	Failure to yield right of way at traffic signal	20
N25	Failure to yield right of way at unsigned intersection	15
N26	Failure to yield right of way at yield sign	20
N30	Failure to yield right of way when warning displayed on other vehicle	15
N31	Failure to yield right of way when turning	20
N40	Failure to use or improper signal	15
N42	Failure to signal intent to pass	15
N43	Failure to signal lane change or turn	15
N50	Improper turn	10
N51	Improper method of turning	10
N52	Improper position for turning	10
N53	Making improper left turn	10
N54	Making improper right turn	10
N55	Making improper turn around (not U turn)	10
N56	Making improper U turn	20

N60	Driving wrong way	5
N61	Driving wrong way at rotary/roundabout/circular intersection	5
N62	Driving wrong way on divided highway	5
N63	Driving wrong way on one way street or road	5
N70	Driving on wrong side	20
N71	Driving on wrong side of divided highway	20
N72	Driving on wrong side of undivided street or road	20
N82	Improper backing	10
N83	Improper start from a parked position	15
S01	01-05 mph over speed limit (detail optional)	5
S06	06-10 mph over speed limit (detail optional)	5
S14	11-14 mph over speed limit	15
S15	Speeding 15 mph or more over the speed limit (detail optional) (Serious violation)	20
S16	16-20 mph over speed limit (detail optional) (Serious violation)	20
S21	21-25 mph over speed limit (detail optional) (Serious violation)	20
S26	26-30 mph over speed limit (detail optional) (Serious violation)	50
S31	31-35 mph over the speed limit (detail optional) (Serious violation)	50

S36	36-40 mph over the speed limit (detail optional) (Serious violation)	50
S41	41 mph or more over the speed limit (detail optional) (Serious violation)	50
S51	01-10 mph over speed limit (detail optional)	5
S71	21-30 mph over speed limit (detail optional) (Serious violation)	20
S81	31-40 mph over speed limit (detail optional) (Serious violation)	50
S91	41 mph or more over speed limit (detail optional) (Serious violation)	50
S92	Speeding – speed limit and actual speed (detail required)	10
S93	Speeding	10
S94	Prima facie speed violation or driving too fast for conditions	10
S96	Speed less than minimum	5
S98	Speeding on freeway (wasting fuel)	10
U31	Violation resulting in fatal accident (Serious violation)	20

y~~z~~) The following withdrawals will not be assigned points but will be entered on the driving record as Type Action -89- withdrawal:

ACD CODE	DESCRIPTION OF OFFENSE
A04	Driving under the influence of alcohol with BAC at or over .04
A08	Driving under the influence of alcohol with BAC at or over .08

A10	Driving under the influence of alcohol with BAC at or over .10
A11	Driving under the influence of alcohol with BAC at or over _____ (detail field required)
A12	Refused to submit to test for alcohol-Implied Consent Law
A20	Driving under the influence of alcohol or drugs
A21	Driving under the influence of alcohol
A22	Driving under the influence of drugs
A23	Driving under the influence of alcohol and drugs
A24	Driving under the influence of medication not intended to intoxicate
A25	Driving while impaired
A26	Drinking alcohol while operating a vehicle
A31	Illegal possession of alcohol
A33	Illegal possession of drugs (controlled substances)
A35	Possession of open alcohol container
A41	Driver violation of ignition interlock or immobilization device
A50	Motor vehicle used in the commission of a felony involving manufacturing, distributing, or dispensing a controlled substance
A60	Underage convicted of drinking and driving at .02 or higher BAC
A61	Underage Administrative Per Se – drinking and driving at .02 or higher BAC
A90	DUI at .10 Admin

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A91	Administrative Per Se for blood alcohol concentration at ___
A94	DUI at .04 Admin
A98	DUI at .08 Admin
B01	Hit and run – failure to stop and render aid after accident
B02	Hit and run – failure to stop and render aid after accident – fatal accident
B03	Hit and run – failure to stop and render aid after accident – personal injury accident
B04	Hit and run – failure to stop and render aid after accident – property damage accident
B05	Leaving accident scene before police arrive
B06	Leaving accident scene before police arrive – fatal accident
B07	Leaving accident scene before police arrive – personal injury accident
B08	Leaving accident scene before police arrive – property damage accident
B14	Failure to reveal identity after fatal or personal injury accident
B19	Driving while out-of-service order is in effect and transporting 16 or more passengers, including the driver and/or transporting hazardous materials that require a placard
B20	Driving while license withdrawn
B21	Driving while license barred
B22	Driving while license cancelled
B23	Driving while license denied
B24	Driving while license disqualified

B25	Driving while license revoked
B26	Driving while license suspended
B27	Driving while license out of service order is in effect
B41	Possess or provide counterfeit or altered driver's license (includes DL, CDL and Instruction Permit) or ID
B51	Expired or no driver's license (includes DL, CDL and Instruction Permit)
B56	Driving a CMV without obtaining a CDL
B57	Driving a CMV without a CDL in the driver's possession
B61	Failed to file accident report
B63	Failed to file future proof of financial responsibility
B64	Failed to file insurance certification
B65	Failed to file medical certification/disability information
B74	Failed to show insurance certification
B78	Failed to show non-commercial driver's license (includes Instruction Permit)
B91	Improper classification or endorsement on driver's license (includes DL, CDL and Instruction Permit)
D02	Misrepresentation of identity or other facts on application for driver's license (includes DL, CDL and Instruction Permit)
D06	Misrepresentation of identity or other facts to obtain alcohol
D07	Possess multiple driver's licenses (includes DL, CDL and Instruction Permit)
D10	Manufacture or duplicate false driver's license (includes DL, CDL and

	Instruction Permit)
D16	Present or use improperly – driver's license (includes DL, CDL and Instruction Permit)
D27	Violate limited license conditions
D29	Violate restrictions of driver's license (includes DL, CDL and Instruction Permit)
D35	Failure to comply with financial responsibility law
D36	Failure to maintain required liability insurance
D37	Failure to pay for damages or make installment payment
D38	Failure to post security or obtain release from liability
D39	Unsatisfied judgment
D45	Failure to appear for trial or court appearance
D51	Failure to make required payment of child support
D53	Failure to make required payment of fines and costs
D56	Failure to answer a citation, pay fines, penalties and/or costs related to the original violation
D70	Driver's view obstructed
D72	Inability to control vehicle
D74	Operating a motor vehicle improperly because of drowsiness
D75	Operating a motor vehicle improperly due to physical or mental disability
D78	Perjury about the operation of a motor vehicle

SECRETARY OF STATE

NOTICE OF PROPOSED AMENDMENTS

E01	Operating without equipment as required by law
E02	Operating without brakes as required by law
E03	Operating without HAZMAT safety equipment as required by law
E04	Operating without HAZMAT placards/markings as required by law
E05	Operating without lights as required by law
E06	Operating without school bus equipment as required by law
E23	Use of radar or laser detector prohibited by law
E31	Defective brakes
E33	Defective HAZMAT safety devices
E34	Defective lights
E36	Defective school bus equipment
E37	Defective tires
E50	Failure to use equipment as required
E51	Failure to use brakes
E53	Failure to use HAZMAT safety devices as required
E55	Failure to use lights as required
E56	Failure to use school bus safety equipment as required
E57	Failure to use snow tires or chains as required
E70	Equipment used improperly or obstructed
E71	Brakes used improperly

F02	Child or youth restraint not used properly as required
F03	Motorcycle safety equipment not used properly as required
F04	Seat belt not used properly as required
F05	Carrying unsecured passengers in open area of vehicle
F06	Improper operation of or riding on a motorcycle
F34	Stopping, standing, or parking: obstructing or impeding traffic
F66	Unsafe condition of vehicle (no specified component)
M02	Failure to obey barrier
M03	Failure to obey construction or maintenance zone markers
M04	Failure to obey flagger
M05	Failure to obey lane markings or signal
M08	Failure to obey police or peace officer
M09	Failure to obey railroad highway traffic control device
M10	Failure to obey railroad traffic control device
M11	Failure to obey restricted lane
M12	Failure to obey safety zone
M13	Failure to obey school crossing guard
M14	Failure to obey sign or traffic control device
M15	Failure to obey stop sign

M16	Failure to obey traffic signal or light
M17	Failure to obey traffic signal
M18	Failure to obey warning light or flasher
M19	Failure to obey yield sign
M20	Failure to slow down at a railroad crossing and check tracks are clear
M21	Failure to stop before reaching tracks at a railroad-highway grade crossing when the tracks are not clear
M22	Failure to stop as required before driving onto railroad-highway grade crossing
M23	Failure to have sufficient space to drive completely through the highway crossing
M24	Failure to negotiate a railroad-highway grade crossing because of insufficient undercarriage clearance
M25	Failure to stop; basic rule at unsigned intersection or when entering roadway from private driveway, alley, etc.
M30	Following improperly
M31	Failure to leave sufficient distance for overtaking by other vehicles
M32	Following emergency vehicle unlawfully
M33	Following fire equipment unlawfully
M34	Following too closely
M40	Improper lane or location
M41	Failure to keep in proper lane

M42	Improper or erratic (unsafe) lane changes
M43	Ran off road
M44	Improper lane or location – crossover
M45	Improper lane or location – crosswalk
M46	Improper lane or location – entrance/exit ramp or way
M47	Improper lane or location – in bicycle lane
M48	Improper lane or location – in occupied lane
M49	Improper lane or location – in human occupant violator or restricted lane
M50	Improper lane or location – limited access highway
M51	Improper lane or location – median
M55	Improper lane or location – on rail or streetcar tracks
M56	Improper lane or location – on fire hose
M57	Improper lane or location – oncoming traffic lane
M58	Improper lane or location – road shoulder, ditch or sidewalk
M60	Improper lane or location – slower vehicle lane
M61	Improper lane or location – straddling center lines
M62	Improper lane or location – traveling in turn (or center) lane
M70	Improper passing
M71	Passing in violation of posted sign or pavement marking
M72	Passing in violation of opposite directions restriction

M73	Passing on wrong side
M74	Passing on hill or curve
M75	Passing school bus displaying warning not to pass
M76	Passing where prohibited
M77	Passing with insufficient distance or visibility
M80	Inattentive, careless or negligent driving
M81	Careless driving
M82	Inattentive driving
M83	Negligent driving
M84	Reckless driving
M85	Texting while driving
M86	Using a handheld mobile telephone while driving
N01	Failure to yield right of way
N02	Failure to yield right of way to animal rider or animal drawn vehicle
N03	Failure to yield right of way to cyclist
N04	Failure to yield right of way to emergency vehicle (i.e., ambulance, fire equipment, police, etc.)
N05	Failure to yield right of way to funeral procession, procession or parade
N06	Failure to yield right of way to other vehicle
N07	Failure to yield right of way to overtaking vehicle

N08	Failure to yield right of way to pedestrian (includes handicapped or blind)
N09	Failure to yield right of way to school bus
N20	Failure to yield right of way at crosswalk
N21	Failure to yield right of way at rotary/roundabout/circular intersection
N22	Failure to yield right of way at stop sign
N23	Failure to yield right of way at traffic sign
N24	Failure to yield right of way at traffic signal
N25	Failure to yield right of way at unsigned intersection
N26	Failure to yield right of way at yield sign
N30	Failure to yield right of way when warning displayed on other vehicle
N31	Failure to yield right of way when turning
N40	Failure to use signal or improper signal
N41	Failure to cancel directional signals
N42	Failure to signal intention to pass
N43	Failure to signal lane change
N44	Giving wrong signal
N50	Improper turn
N51	Improper method of turning
N52	Improper position for turning

N53	Making improper left turn
N54	Making improper right turn
N55	Making improper turn around (not U turn)
N56	Making improper U turn
N60	Driving wrong way
N61	Driving wrong way at rotary/roundabout/circular intersection
N62	Driving wrong way on divided highway
N63	Driving wrong way on one way street or road
N70	Driving on wrong side
N71	Driving on wrong side of divided highway
N72	Driving on wrong side of undivided street or road
N80	Coasting (operating with gears disengaged)
N82	Improper backing
N83	Improper start from parked position
N84	Unsafe operations
S01	01-05 mph above speed limit (detail optional)
S06	06-10 mph above speed limit (detail optional)
S14	11-14 mph over speed limit
S15	Speeding 15 mph or more above speed limit (detail optional)
S16	16-20 mph above speed limit (detail optional)

S21	21-25 mph above speed-limit (detail optional)
S26	26-30 mph above speed limit (detail optional)
S31	31-35 mph above speed limit (detail optional)
S36	36-40 mph above speed limit (detail optional)
S41	41 mph or more above speed limit (detail optional)
S51	01-10 mph above speed limit (detail optional)
S71	21-30 mph above speed limit (detail optional)
S81	31-40 mph above speed limit (detail optional)
S91	41 mph or more above speed limit (detail optional)
S92	Speeding; speed limit and actual speed (detail required)
S93	Speeding
S94	Prima facie speed violation or driving too fast for conditions
S95	Speed contest (racing) on road open to traffic
S96	Speed less than minimum
S97	Operating at erratic or suddenly changing speeds
S98	Speeding or freeway (wasting fuel)
U01	Fleeing or evading police or roadblock
U02	Resisting arrest
U03	Using motor vehicle in connection with a felony (not traffic offense)

U04	Using a motor vehicle in connection with a misdemeanor (not traffic offense)
U05	Using a motor vehicle to aid and abet a felon
U06	Vehicular assault
U07	Vehicular homicide
U08	Vehicular manslaughter
U09	Negligent homicide while operating a CMV
U10	Causing a fatality through the negligent operation of a CMV
U21	Illegal operation of emergency vehicle
U27	Vehicular feticide (first degree)
U28	Vehicular feticide (second degree)
U31	Violation resulting in fatal accident
W00	Withdrawal, non-ACD violation
W01	Accumulation of convictions (including point systems and/or being judged a habitual offender or violator)
W09	Failure to surrender hazmat endorsement as required by the USA Patriot Act
W13	Parental consent withdrawn
W14	Physical or mental disability
W15	Physician's or specialist's report recommended
W20	Unable to pass DL test(s) or meet qualifications
W30	2 serious violations within 3 years

W31	3 serious violations within 3 years
W40	The accumulation of two or more major offenses
W41	An additional major offense after reinstatement
W45	Withdrawn for driving a CMV while disqualified for previous violations in a CMV
W50	The accumulation, within 10 years, of two out-of-service general violations
W51	The accumulation of two out-of-service order violations within 10 years when the second is while transporting 16 or more passengers, including the driver, and/or transporting hazardous materials that require a placard
W52	The accumulation of three or more out-of-service order violations within 10 years
W60	Accumulation of two railroad-highway grade crossing violations within a three year period
W61	Accumulation of three or more railroad-highway grade crossing violations in a three year period
W70	Imminent hazard
W72	Suspended pending final disposition
W80	Failed employer-directed drug test
W81	Refusal to submit to an employer-directed drug test

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 1040.100 Rescissions

a) The Department shall rescind the following orders when the specified criteria are met:

1) Suspensions, revocations, disqualifications and denials of driver's license and/or driving privileges, except warrant parking/traffic suspensions, failure to appear suspensions (as applied to residents and non-residents) and statutory summary suspensions, upon receipt of certified court evidence reporting non-conviction, supervision, stricken on leave (SOL), or a correction or an amendment stating there was an error that formed the basis of the suspension, the revocation, or the denial of driver's license/driving privilege and/or it has been vacated or that a previously submitted judgment has been reversed.

2) Cancellation of driver's license and/or driving privileges upon receipt by the Department of one of the following:

   A) evidence from an instructor of a driver education program indicating the driver has re-enrolled in the program; or

   B) favorable physical or psychiatric report from a licensed medical specialist prior to the effective date of the cancellation or receipt of a second report completed by the licensed medical specialist showing the original report submitted was incorrect; or

   C) evidence from a licensed medical specialist indicating that he/she failed to submit a favorable medical report for the driver within 90 days; or

   D) evidence reversing a decision made by the Department that two driver's license records are for the same person; or

   E) court evidence changing the disposition of a conviction previously reported upon which the cancellation was based; or

   F) documentation from another state licensing agency that reverses an original report upon which the cancellation was based.

3) Failure to Appear Suspensions upon receipt of certified court evidence vacating the Failure to Appear or when the Department receives a compliance notice or court receipt prior to the effective date of the suspension indicating that the charges have been satisfied.

4) Statutory Summary Suspensions upon receipt of a Certified Hearing Disposition Notice or court order from the court of venue to rescind the suspension.

5) Warrant/Parking Traffic Suspensions upon receipt of certified evidence from the court or municipality indicating the original report was in error or the person identified in the original report was the wrong defendant or the Department receives notice of final disposition prior to the effective date of the suspension.

6) Toll violation or evasion suspensions upon receipt of certified evidence from the Illinois State Toll Highway Authority indicating the original report was in error or the person identified in the original report was the wrong defendant or the Department receives Notice of Final Disposition prior to the effective date of the suspension.

b) The Department shall rescind a suspension, revocation or cancellation pursuant to a decision rendered by the Department of Administrative Hearings within the Office of the Secretary of State as provided in IVC Section 2-118 and 92 Ill. Adm. Code 1001.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

Section 1040.115 Suspension for Theft of Motor Fuel

a) A person who has been convicted of theft of motor fuel as defined in Section 16J-15 of the Criminal Code of 1961 [720 ILCS 5/16J-15] prior to August 21, 2007 or Section 16K-15 of the Criminal Code of 1961 [720 ILCS 5/16K-15] on or after August 21, 2007 or Section 16-25 on or after January 1, 2012, shall have his/her driving privileges suspended by the Department.

b) Upon notice of conviction, the Department shall take the following action:

ACTION TABLE

Convictions	Action
1st Conviction	6-month Suspension

2nd or subsequent Conviction	12-month Suspension

c) A conviction for theft of motor fuel may be considered with prior convictions only if the arrest date falls within seven years after any previous conviction for theft of motor fuel.

(Source: Amended at 38 Ill. Reg. _____, effective _____)

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Reports of Child Abuse and Neglect

2) Code Citation: 89 Ill. Adm. Code 300

3)

Section Numbers:	Adopted Action:
300.20	Amend
300.30	Amend
300.130	Amend

4) Statutory Authority: Implementing and authorized by the Abused and Neglected Child Reporting Act [325 ILCS 5], the Abandoned Newborn Infants Protection Act [325 ILCS 2] and Section 3 of the Consent by Minors to Medical Procedures Act [410 ILCS 210/3]

5) Effective Date of Rule: December 31, 2013

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rule contain incorporations by reference? No

8) A copy of the adopted rule, including any material incorporated by reference, is on file in the Agency's principal office and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 5207; April 26, 2013

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version: Added the following to the list of mandated reporters: *recreational or athletic program* and *early intervention provider as defined in the Early Intervention Services System Act*.

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 rule currently in effect? No

14) Are there any rulemakings pending on this Part? Yes

Section Number:	Proposed Action:	*Illinois Register* Citation:
300.APPENDIX B	Amend	38 Ill. Reg. 608; January 10, 2013

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

15) Summary and Purpose of Rulemaking: Amendments to the Abused and Neglected Child Reporting Act required the following revisions of this Part:

Section 300.20 is amended to add the definition of Human Trafficking, as defined in Section 10-9 of the Criminal Code of 2012, to the definition of an Abused Child and to the definition of a Person Responsible for the Child's Welfare.

Section 300.30 is amended to include the following in the listing of Types of Mandated Reporters: athletic program staff; personnel of institutions of higher learning; and early intervention providers, as defined in the Early Intervention Services System Act.

Section 300.130 is amended to require the Department to include in a written Notice of Whether Child Abuse or Neglect Occurred a copy of any documents, files, records, books or papers created or used by the Department in the investigation of cases of death or life-threatening injury to a child.

16) Information and questions regarding this rule should be directed to:

Jeff Osowski
Office of Child and Family Policy
Department of Children and Family Services
406 E. Monroe, Station #65
Springfield, Illinois 62701-1498

Telephone: 217/524-1983
TDD: 217/524-3715
E-Mail: cfpolicy@idcfs.state.il.us

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

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER III: DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SUBCHAPTER a: SERVICE DELIVERY

PART 300
REPORTS OF CHILD ABUSE AND NEGLECT

Section

300.10 Purpose
300.20 Definitions
300.30 Reporting Child Abuse or Neglect to the Department
300.40 Content of Child Abuse or Neglect Reports
300.45 Five Year Demonstration of the Differential Response Program
300.50 Transmittal of Child Abuse or Neglect Reports
300.60 Special Types of Reports (Recodified)
300.70 Referrals to the Local Law Enforcement Agency and State's Attorney
300.80 Delegation of the Investigation
300.90 Time Frames for the Investigation
300.100 Initial Investigation
300.110 The Formal Investigative Process
300.120 Taking Children into Temporary Protective Custody
300.130 Notices Whether Child Abuse or Neglect Occurred
300.140 Transmittal of Information to the Illinois Department of Professional Regulation and to School Superintendents
300.150 Referral for Other Services
300.160 Special Types of Reports
300.170 Child Death Review Teams
300.180 Abandoned Newborn Infants
300.APPENDIX A Acknowledgement of Mandated Reporter Status
300.APPENDIX B Child Abuse and Neglect Allegations

AUTHORITY: Implementing and authorized by the Abused and Neglected Child Reporting Act [325 ILCS 5], the Abandoned Newborn Infants Protection Act [325 ILCS 2] and Section 3 of the Consent by Minors to Medical Procedures Act [410 ILCS 210/3].

SOURCE: Adopted and codified as 89 Ill. Adm. Code 302 at 5 Ill. Reg. 13188, effective November 30, 1981; amended at 6 Ill. Reg. 15529, effective January 1, 1983; recodified at 8 Ill. Reg. 992; peremptory amendment at 8 Ill. Reg. 5373, effective April 12, 1984; amended at 8 Ill. Reg. 12143, effective July 9, 1984; amended at 9 Ill. Reg. 2467, effective March 1, 1985;

amended at 9 Ill. Reg. 9104, effective June 14, 1985; amended at 9 Ill. Reg. 15820, effective November 1, 1985; amended at 10 Ill. Reg. 5915, effective April 15, 1986; amended at 11 Ill. Reg. 1390, effective January 13, 1987; amended at 11 Ill. Reg. 1151, effective January 14, 1987; amended at 11 Ill. Reg. 1829, effective January 15, 1987; recodified from 89 Ill. Adm. Code 302.20, 302.100, 302.110, 302.120, 302.130, 302.140, 302.150, 302.160, 302.170, 302.180, 302.190, and Appendix A at 11 Ill. Reg. 3492; emergency amendment at 11 Ill. Reg. 4058, effective February 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 12619, effective July 20, 1987; recodified at 11 Ill. Reg. 13405; amended at 13 Ill. Reg. 2419, effective March 1, 1989; emergency amendment at 14 Ill. Reg. 11356, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 17558, effective October 15, 1990; amended at 14 Ill. Reg. 19827, effective November 28, 1990; emergency amendment at 15 Ill. Reg. 14285, effective September 25, 1991; amended at 15 Ill. Reg. 17986, effective December 1, 1991; emergency amendment at 17 Ill. Reg. 15658, effective September 10, 1993, for a maximum of 150 days; emergency expired February 7, 1994; amended at 18 Ill. Reg. 8377, effective May 31, 1994; amended at 18 Ill. Reg. 8601, effective June 1, 1994; amended at 19 Ill. Reg. 3469, effective March 15, 1995; amended at 19 Ill. Reg. 10522, effective July 1, 1995; amended at 20 Ill. Reg. 10328, effective July 19, 1996; amended at 22 Ill. Reg. 18847, effective October 1, 1998; amended at 23 Ill. Reg. 13590, effective November 15, 1999; amended at 24 Ill. Reg. 7707, effective June 1, 2000; amended at 25 Ill. Reg. 12781, effective October 1, 2001; amended at 26 Ill. Reg. 7435, effective May 15, 2002; amended at 26 Ill. Reg. 11730, effective August 1, 2002; amended at 27 Ill. Reg. 1114, effective January 15, 2003; amended at 27 Ill. Reg. 9431, effective June 9, 2003; peremptory amendment at 29 Ill. Reg. 21065, effective December 8, 2005; amended at 33 Ill. Reg. 7862, effective June 15, 2009; amended at 34 Ill. Reg. 6373, effective May 1, 2010; amended at 35 Ill. Reg. 1599, effective January 15, 2011; amended at 35 Ill. Reg. 2861, effective February 8, 2011; amended at 36 Ill. Reg. 4026, effective March 5, 2012; amended at 36 Ill. Reg. 16756, effective November 15, 2012; amended at 38 Ill. Reg. 1962, effective December 31, 2013

Section 300.20 Definitions

"Abandonment" means parental conduct that demonstrates the purpose of relinquishing all parental rights and claims to the child. Abandonment is also defined as any parental conduct that evinces a settled purpose to forego all parental duties and relinquish all parental claims to the child.

"Abused child" means a child whose parent or immediate family member, or any person responsible for the child's welfare, or any individual residing in the same home as the child, or a paramour of the child's parent:

inflicts, causes to be inflicted, or allows to be inflicted upon such child physical or mental *injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function;*

creates a substantial risk of physical or mental *injury to such child by other than accidental means which would be likely to cause death, disfigurement, impairment of physical or emotional health, or loss of or impairment of any bodily function;*

commits or allows to be committed any sex offense against such child, as such sex offenses are defined in the Criminal Code of 2012~~1961~~ [720 ILCS 5]*, and extending those definitions of sex offenses to include children under 18 years of age;*

commits or allows to be committed the offense of involuntary servitude, involuntary sexual servitude of a minor, or trafficking in persons as defined in Section 10-9 of the Criminal Code of 2012 *against the child;*

commits or allows to be committed an act or acts of torture upon such child;

inflicts excessive corporal punishment; or

commits or allows to be committed the offense of female genital mutilation, as defined in Section 12-34 of the Criminal Code of 2012~~1961~~*, against the child.* [325 ILCS 5/3]

"Act" means the Abused and Neglected Child Reporting Act [325 ILCS 5].

"Blatant disregard" means an incident where the real, significant, and imminent risk of harm would be so obvious to a reasonable parent or caretaker that it is unlikely that a reasonable parent or caretaker would have exposed the child to the danger without exercising precautionary measures to protect the child from harm. [325 ILCS 5/3]

"CANTS/SACWIS 8" or "C/S8" means the Department's document titled Notification of a Report of Suspected Child Abuse and/or Neglect. This document explains the Department's child abuse/neglect allegation investigation process.

"CANTS/SACWIS 9" or "C/S9" means the Department's document titled Notification of Intent to Indicate Child Care Worker for Report of Child Abuse and/or Neglect. This document is used to notify a person that the Department plans to indicate that person as a perpetrator of child abuse/neglect.

"CANTS/SACWIS 10" or "C/S10" means the Department's document titled Notice of Intent to Indicate a Child Care Worker for Report of Child Abuse and/or Neglect-Questions and Answers. This is an informational document explaining the impact of a determination of indicated child abuse/neglect and the appeal process.

"CANTS/SACWIS 11" or "C/S11" means the Department's document titled Notification of Indicated Decision in an Employment Related Report of Suspected Child Abuse and/or Neglect. This is the document by which the Department notifies a person that the Department has determined that there is credible evidence that he or she is responsible for the child abuse or neglect described in that document.

"Caregiver" means the child's parents, guardian, custodian or relative with whom the child lives and who has primary responsibility for the care and supervision of the child.

"Child" means any person under the age of 18 years, unless legally emancipated by reason of marriage or entry into a branch of the United States armed services. [325 ILCS 5/3]

"Child care facility" means any person, group of persons, agency, association or organization, whether established for gain or otherwise, who or which receives or arranges for care or placement of one or more children, unrelated to the operator of the facility, apart from the parents, with or without the transfer of the right of custody in any facility as defined in the Child Care Act of 1969 [225 ILCS 10]*, established and maintained for the care of children. Child care facility includes a relative who is licensed as a foster family home under Section 4 of the Child Care Act of 1969.* [225 ILCS 10/2.05]

"Child care worker" means any person who is employed to work directly with children and any person who is an owner/operator of a child care facility, regardless of whether the facility is licensed by the Department. Child care

facilities, for purposes of this definition, include child care institutions; child welfare agencies; day care/night care centers; day care/night care homes; day care/night care group day care homes; group homes; hospitals or health care facilities; schools, including school teachers and administrators, but not tenured school teachers or administrators who have other disciplinary processes available to them; and before and after school programs, recreational programs and summer camps. "Child care worker" also means persons employed as full-time nannies. A child care worker may, at his or her discretion, be subject to this Part if alleged to be responsible for child abuse or neglect outside of his or her employment. "Child care worker" includes a person: currently employed as a child care worker; currently enrolled in an academic program that leads to a position as a child care worker; or who has applied for a license required for a child care worker position. A person will be considered to be "employed as a child care worker" under this Part if, at the time of the notice of the investigation, he or she: has applied for, or will apply within 180 days for, a position as a child care worker; is enrolled in, or will commence within 180 days, an academic program that leads to a position as a child care worker; or has applied for a license as a child care worker.

"Child-placing agency" means a licensed public or private agency that receives a child for the purpose of placing or arranging for the placement of the child in a foster family home or other facility for child care, apart from the custody of the child's parents. [325 ILCS 2/10]

"Child Protective Service Unit" or "CPS" means certain specialized State employees of the Department assigned by the Director or his or her designee to perform the duties and responsibilities described under this Part. CPS staff is also referred to as investigative staff. [325 ILCS 5/3]

"Children for whom the Department is legally responsible" means children for whom the Department has temporary protective custody, custody or guardianship via court order, or children whose parents have signed an adoptive surrender or voluntary placement agreement with the Department.

"CPSW" means a Child Protective Service Worker.

"Collateral contact" means obtaining information concerning a child, parent, or other person responsible for the child from a person who has knowledge of the family situation but was not directly involved in referring the child or family to the Department for services.

"Credible evidence of child abuse or neglect" means that the available facts, when viewed in light of surrounding circumstances, would cause a reasonable person to believe that a child was abused or neglected.

"Delegation of an investigation" means the investigation of a report of child abuse or neglect has been deferred to another authority. The Department maintains responsibility for determining whether the report is indicated or unfounded, entering information about the report in the State Central Register and notifying the subjects of the report and mandated reporters of the results of the investigation.

"Department" or "DCFS" means the Department of Children and Family Services.

"Determination" means a final Department decision about whether there is credible evidence that child abuse or neglect occurred. A determination must be either "indicated" or "unfounded".

"DR Specialist" means a Differential Response Specialist as described in Section 300.45(e)(1).

"Disfigurement" means a serious or protracted blemish, scar, or deformity that spoils a person's appearance or limits bodily functions.

"Ecomap" means a pictorial representation of family connections to different systems and community and other resources to identify significant people and/or systems around the family to illustrate the strengths, impact and quality of each connection. (Hartman, A., Diagrammatic Assessment of Family Relationships. Social Casework, 59, 465-476 (1978).)

"Emergency medical facility" means a freestanding emergency center or trauma center, as defined in the Emergency Medical Services (EMS) Systems Act [210 ILCS 50]. [325 ILCS 2/10]

"Emergency medical professional" includes licensed physicians, and any emergency medical technician-basic, emergency medical technician-intermediate, emergency medical technician-paramedic, trauma nurse specialist, and pre-hospital RN, as defined in the Emergency Medical Services (EMS) Systems Act. [325 ILCS 2/10]

"Fire station" means a fire station within the State with at least one staff person. [325 ILCS 2/10]

"Formal investigation" means those activities conducted by Department investigative staff necessary to make a determination as to whether a report of suspected child abuse or neglect is indicated or unfounded. Those activities shall include: *an evaluation of the environment of the child named in the report and any other children in the same environment; a determination of the risk to such children if they continue to remain in the existing environments, as well as a determination of the nature, extent and cause of any condition enumerated in such report, the name, age and condition of other children in the environment; and an evaluation as to whether there would be an immediate and urgent necessity to remove the child from the environment if appropriate family preservation services were provided. After seeing to the safety of the child or children, the Department shall forthwith notify the subjects of the report, in writing, of the existence of the report and their rights existing under* the *Act in regard to amendment or expungement.* [325 ILCS 5/3]

"Genogram" means a pictorial representation of an individual's family relationships.

"Godparent" is a person who sponsors a child at baptism or one in whom the parents have entrusted a special duty that includes assisting in raising a child if the parent cannot raise the child. The worker shall verify the godparent/godchild relationship by contacting the parents to confirm the fact that they did, in fact, designate the person as the godparent. If the parents are unavailable, the worker should contact other close family members to verify the relationship. If the person is considered to be the child's godparent, in order for placement to occur, the same placement selection criteria as contained in 89 Ill. Adm. Code 301.60 (Placement Selection Criteria) must be met. If the godparent is not a licensed foster parent, all the conditions currently in effect for placement with relatives in 89 Ill. Adm. Code 301.80 must be met.

"Hospital" has the same meaning as in the Hospital Licensing Act [210 ILCS 85].

"Indicated report" means any report of child abuse or neglect made to the Department for which it is determined, after an investigation, that credible evidence of the alleged abuse or neglect exists.

"Initial investigation" means those activities conducted by Department investigative staff to determine whether a report of suspected child abuse or neglect is a good faith indication of abuse or neglect and, therefore, requires a formal investigation. Good faith in this context means that the report was made with the honest intention to identify actual child abuse or neglect.

"Initial oral report" means a report alleging child abuse or neglect for which the State Central Register has no prior records on the family.

"Involved subject" means a child who is the alleged victim of child abuse or neglect or a person who is the alleged perpetrator of the child abuse or neglect.

"Legal custody" means the relationship created by a court order in the best interest of a newborn infant that imposes on the infant's custodian the responsibility of physical possession of the infant, the duty to protect, train, and discipline the infant, and the duty to provide the infant with food, shelter, education, and medical care, except as these are limited by parental rights and responsibilities. [312 ILCS 2/10]

"Local law enforcement agency" means the police of a city, town, village or other incorporated area or the sheriff of an unincorporated area or any sworn officer of the Illinois Department of State Police.

"Mandated reporters" means those individuals required to report suspected child abuse or neglect to the Department. A list of these persons and their associated responsibilities is provided in Section 300.30 of this Part.

"Member of the clergy" means a clergyman or practitioner of any religious denomination accredited by the religious body to which he or she belongs. [325 ILCS 5/3]

"Neglected child" means any child who is not receiving the proper or necessary nourishment or medically indicated treatment including food or care not provided solely on the basis of present or anticipated mental or physical impairment as determined by a physician acting alone or in consultation with other physicians or otherwise is not receiving the proper or necessary support, or medical or other remedial care recognized under State law as necessary for a child's well-being (including where there is harm or substantial risk of harm to the child's health or

welfare), or other care necessary for a child's well-being, including adequate food, clothing and shelter; or who is subjected to an environment which is injurious insofar as the child's environment creates a likelihood of harm to the child's health, physical well-being or welfare and the likely harm to the child is the result of a blatant disregard of parent or caretaker responsibilities; or who is abandoned by his or her parents or other person responsible for the child's welfare without a proper plan of care; or who is a newborn infant whose blood, urine or meconium contains any amount of controlled substance as defined in Section 102(f) of the Illinois Controlled Substances Act [720 ILCS 570] *or a metabolite thereof, with the exception of a controlled substance or metabolite thereof whose presence in the newborn infant is the result of medical treatment administered to the mother or newborn infant. A child shall not be considered neglected for the sole reason that the child's parent or other person responsible for his or her welfare has left the child in the care of an adult relative for any period of time. A child shall not be considered neglected or abused for the sole reason that such child's parent or other person responsible for his or her welfare depends upon spiritual means through prayer alone for the treatment or cure of disease or remedial care under Section 4 of* the Abused and Neglected Child Reporting Act. Where the circumstances indicate harm or substantial risk of harm to the child's health or welfare and necessary medical care is not being provided to treat or prevent that harm or risk of harm because the parent or other person responsible for the child's welfare depends upon spiritual means alone for treatment or cure, the child is subject to the requirements of the~~this~~ Act for the reporting of, investigation of, and provision of protective services with respect to the child and his or her health needs, and in such cases spiritual means through prayer alone for the treatment or cure of disease or for remedial care will not be recognized as a substitute for necessary medical care, if the Department or, as necessary, a juvenile court determines that medical care is necessary. *A child shall not be considered neglected or abused solely because the child is not attending school in accordance with the requirements of Article 26 of the School Code* [105 ILCS 5/Art. 26]. [325 ILCS 5/3]

"Newborn infant" means a child who a licensed physician reasonably believes is 30 days old or less at the time the child is initially relinquished to a hospital, police station, fire station, or emergency medical facility, and who is not an abused or a neglected child. [325 ILCS 2/10]

"Perpetrator" means a person who, as a result of investigation, has been determined by the Department to have caused child abuse or neglect.

"Person responsible for the child's welfare" means the child's parent, guardian, foster parent, relative caregiver, an operator, supervisor, or employee of *a public or private residential agency or institution* or *public or private profit or not-for-profit child care facility; or any other person responsible for the child's welfare at the time of the alleged abuse or neglect, or any person who came to know the child through an official capacity or position of trust, including but not limited to health care professionals, educational personnel, recreational supervisors, members of the clergy and volunteers or support personnel in any setting where children may be subject to abuse or neglect, including any person that is the custodian of a child under 18 years of age who commits or allows to be committed, against a child, the offense of involuntary servitude, involuntary sexual servitude of a minor, or trafficking in persons for forced labor or services, as provided in Section 10-9 of the Criminal Code of* 2012. [325 ILCS 5/3]

"Police station" means:

a municipal police station;

a county sheriff's office;

a campus police department located on any college or university owned or controlled by the State or any private college or private university that is not owned or controlled by the State when employees or the campus police department are present; or

any of the district headquarters of the Illinois State Police. [325 ILCS 2/10]

"Private guardianship" means an individual person appointed by the court to assume the responsibilities of the guardianship of the person as defined in Section 1-3 of the Juvenile Court Act of 1987 [705 ILCS 405/1-3] or Article XI of the Probate Act of 1975 [755 ILCS 5/Art. XI].

"Relative", for purposes of placement of children for whom the Department is legally responsible, *means any person, 21 years of age or over, other than the parent, who:*

is currently related to the child in any of the following ways by blood or

adoption: grandparent, sibling, great-grandparent, uncle, aunt, nephew, niece, first cousin, first cousin once removed (children of one's first cousin to oneself), *second cousin* (children of first cousins are second cousins to each other), *godparent* (as defined in this Section), *great-uncle, or great-aunt;*

is the spouse, or party to a civil union, *of such a relative;*

is the child's step-father, step-mother, or adult step-brother or step-sister; or

is the partner, or adult child of a partner, in a civil union with the child's mother or father.

Relative also includes a person related in any of the foregoing ways to a sibling of a child, even though the person is not related to the child, when the child and its sibling are placed together with that person. [20 ILCS 505/7(b)]

"Relinquish" means to bring a newborn infant, who a licensed physician reasonably believes is 30 days old or less, to a hospital, police station, fire station, or emergency medical facility and to leave the infant with personnel of the facility, if the person leaving the infant does not express an intent to return for the infant or states that he or she will not return for the infant. In the case of a mother who gives birth to an infant in a hospital, the mother's act of leaving the new born infant at the hospital without expressing an intent to return for the infant or stating that she will not return for the infant is not a "relinquishment" under the Act. [325 ILCS 2/10]

"Strengthening and Supporting Families service period" means a level of service intervention that will average 90 days, but no more than 120 days.

"State Central Register" is the record of child abuse and/or neglect reports maintained by the Department pursuant to the Act.

"Subject of a report" means any child reported to the child abuse/neglect State Central Register, and his or her parent, personal guardian or other person responsible for the child's welfare who is named in the report.

"SSF worker" means a Strengthening and Supporting Families worker.

"Temporary protective custody" means custody within a hospital or other medical facility or a place previously designated by the Department, subject to review by the Court. Temporary protective custody cannot exceed 48 hours, excluding Saturdays, Sundays and holidays.

"Undetermined report" means any report of child abuse or neglect made to the Department in which it was not possible to complete an investigation within 60 days on the basis of information provided to the Department.

"Unfounded report" means any report of child abuse or neglect for which it is determined, after an investigation, that no credible evidence of the alleged abuse or neglect exists.

(Source: Amended at 38 Ill. Reg. 1962, effective December 31, 2013

Section 300.30 Reporting Child Abuse or Neglect to the Department

a) Reports of suspected child abuse or neglect may be immediately made to the State Central Register via its toll-free number [1-800-25A-BUSE] at any time, day or night, or on any day of the week. Reports may also be made to the nearest Department office. The Department encourages use of the toll-free hotline number.

b) Persons Mandated to Report Child Abuse or Neglect

1) Types of Mandated Reporters
Any of the following individuals who have reasonable cause to believe that a child known to them in their professional or official capacity may be abused or neglected shall immediately report or cause a report to be made to the Department. These mandated reporters include:

A) *physicians, residents, interns and physician assistants;*

B) *hospitals;*

C) *hospital administrators and personnel engaged in the examination, care and treatment of persons;*

D) *surgeons;*

E) *dentists;*

F) *dentist hygienists;*

G) *osteopaths;*

H) *chiropractors;*

I) *podiatrists;*

J) Christian Science practitioners;

K) *coroners;*

L) *medical examiners;*

M) *emergency medical technicians;*

N) *crisis line or hotline personnel;*

O) *school personnel;*

P) *educational advocate assigned to a child pursuant to the School Code;*

Q) *truant officers;*

R) *social workers;*

S) *social services administrators;*

T) *domestic violence program personnel;*

U) *registered nurses;*

V) *licensed practical nurses, advanced practice nurses, home health*

aides;

W) *directors or staff assistants of nursery schools or child day care centers;*

X) *recreational or athletic program or facility personnel;*

Y) *law enforcement officers;*

Z) *registered psychologists;*

AA) *assistants working under the direct supervision of a psychologist or psychiatrist;*

BB) *field personnel of the Illinois Departments of Healthcare and Family Services, Human Services, Public Health, Corrections, Children and Family Services or Human Rights;*

CC) *probation officers;*

DD) *foster parents, homemakers or any other child care worker;*

EE) *supervisors and administrators of General Assistance under the Illinois Public Aid Code;*

FF) *substance abuse treatment personnel;*

GG) *funeral home directors or their employees;*

HH) *members of the clergy;*

II) *licensed professional counselors or licensed clinical professional counselors;*

JJ) *acupuncturists;*

KK) *animal control officers or Illinois Department of Agriculture Bureau of Animal Health and Welfare field investigators;*

LL) *members of a school board or the Chicago Board of Education or the governing body of a private school;* ~~*or*~~

MM) *medical technicians or certified nursing assistants of any office, clinic or any other physical location that provides abortions, abortion referral or contraceptives;*~~.~~

NN) *personnel of institutions of higher education;* ~~[325 ILCS 5/4]~~

OO) *early intervention* providers *as defined in the Early Intervention Services System Act.* [325 ILCS 5/4]

2) Members of the Clergy
Any member of the clergy having reasonable cause to believe that a child known to that member of the clergy in his or her professional capacity may be an abused child, as defined in this Part, *shall immediately report or cause a report to be made to the Department.* [325 ILCS 5/4]

3) Acknowledgement of Reporting Responsibility

A) Individuals who became mandated reporters on or after July 1, 1986, by virtue of their employment shall sign statements acknowledging that they are mandated to report suspected child abuse and neglect in accordance with Section 4 of the Act. The statement shall be on a form prescribed by the Department, but provided by the employer. (See Appendix A.) The statement shall be signed before beginning employment and shall be retained by the employer as a permanent part of the personnel record.

B) The Department shall provide, upon request at a reasonable cost of $.50 each, copies of the Act to all employers employing persons who are mandated to report under the Act.

4) Interference with Reporting Prohibited

A) *Whenever such person is required to report under* the *Act in his* or her *capacity as a member of the staff of a medical or other public or private institution, school, facility or agency, or as a member of the clergy, he shall make report immediately to the Department in*

accordance with provisions of the *Act and may also notify the person in charge of such institution, school, facility or agency, or church, synagogue, temple, mosque, or other religious institution, or his designated agent that such a report has been made. Under no circumstances shall any person in charge of such institution, school, facility or agency, or church, synagogue, temple, mosque or other religious institution, or designated agent to whom such notification has been made exercise any control, restraint, modification or other change in the report or the forwarding of such report to the Department.* [325 ILCS 5/4]

B) *Any person who knowingly transmits a false report to the Department commits the offence of disorderly conduct under Section 26-1(a)(7) of the Criminal Code of* 2012~~1961~~. *A violation of this provision is a Class 4 felony. Any person who knowingly and willfully violates any provision of subsection (b)(4) other than a second or subsequent violation of transmitting a false report as described in this subsection (b)(4)(B), is guilty of a Class A misdemeanor for the first violation and a Class 4 felony for a second or subsequent violation.* [325 ILCS 5/4]

C) *No employer shall discharge, demote or suspend, or threaten to discharge, demote or suspend, or in any manner discriminate against any employee who makes any good faith oral or written report of suspected child abuse or neglect, or who is or will be a witness or testify in any investigation or proceeding concerning a report of suspected child abuse or neglect.* [325 ILCS 5/9.1]

5) Consequences of Failure to Report

A) *The privileged quality of communication between any professional person required to report and his* or her *patient or client shall not apply to situations involving abused or neglected children and shall not constitute grounds for failure to report as required by the Act or constitute grounds for failure to share information or documents with the Department during the course of a child abuse or neglect investigation. If requested by the professional, the Department shall confirm in writing that the information or documents disclosed by the professional were gathered in the*

course of a child abuse or neglect investigation. [325 ILCS 5/4] Mandated reporters who willfully fail to report suspected child abuse or neglect are subject to license suspension or revocation in accordance with, but not limited to, the following statutes:

i) Nurse Practice Act [225 ILCS 65];

ii) Medical Practice Act of 1987 [225 ILCS 60];

iii) Podiatric Medical Practice Act of 1987 [225 ILCS 100];

iv) Clinical Psychologist Licensing Act [225 ILCS 15];

v) Clinical Social Work and Social Work Practice Act [225 ILCS 20];

vi) The School Code [105 ILCS 5];

vii) The Illinois Dental Practice Act [225 ILCS 25];

viii) Physician Assistant Practice Act of 1987 [225 ILCS 95];

ix) Illinois Optometric Practice Act of 1987 [225 ILCS 80];

x) Illinois Physical Therapy Act [225 ILCS 90]; and

xi) Illinois Athletic Trainers Act [225 ILCS 5].

B) *Any physician who willfully fails to report child abuse or neglect shall be referred to the Illinois State Medical Disciplinary Board for action. Any other person required to report suspected child abuse or neglect who willfully fails to report such abuse or neglect shall be guilty of a Class A misdemeanor.* [325 ILCS 5/4]

C) Members of the clergy of any religious denomination accredited by the religious body to which he or she belongs shall not be compelled to disclose a confession or admission made to him or her in his or her professional character or as a spiritual advisor.

6) Written Confirmation of Reports
Mandated reporters shall confirm their telephone report in writing on a form prescribed by the Department within 48 hours after the oral report. The Department shall provide forms to mandated reporters – one for the exclusive use of medical professionals and another for use by all other mandated reporters. These confirmation reports shall be admissible as evidence in any administrative or judicial proceeding related to child abuse or neglect. Local investigative staff shall transmit confirmation reports to the State Central Register within 24 hours after receipt.

c) Other Persons May Report
Other persons may report suspected child abuse or neglect if they have reasonable cause to believe a child may be abused or neglected.

d) Consequences of False Reporting
Any person who knowingly transmits a false report to the Department commits the offense of disorderly conduct under Section 26-1(a)(7) of the Criminal Code of 2012~~1961~~. *A violation of this provision is a Class 4 felony. Any person who knowingly and willfully violates any provision of this Section other than a second or subsequent violation of submitting a false report is guilty of a Class A misdemeanor for a first violation and a Class 4 felony for a second or subsequent violation.* [325 ILCS 5/4] The Department shall refer cases of false reporting to the local State's Attorney when the reporter is known.

e) Cooperation in Court or Administrative Hearings
Any person who makes a report or who investigates a report under the Act shall testify fully in any judicial proceeding or administrative hearing resulting from such report, as to any evidence of abuse or neglect, or the cause thereof. Any person who is required to report a suspected case of abuse or neglect shall testify fully in any administrative hearing resulting from such report, as to any evidence of abuse or neglect or the cause thereof. No evidence shall be excluded by reason of any common law or statutory privilege relating to communications between the alleged perpetrator of abuse or neglect, or the child subject of the report and any person who is required to report a suspected case of abuse or neglect or the person making or investigating the report. [325 ILCS 5/10]

f) Referrals to Public Health
All mandated reporters listed in subsection (b)(1) may refer to the Department of Public Health any pregnant person in Illinois who is addicted as defined in the

Alcoholism and Other Drug Abuse and Dependency Act [20 ILCS 301].

g) Depending upon Spiritual Means Through Prayer Alone for the Treatment or Cure of Disease or Remedial Care
A child whose parent, guardian or custodian in good faith selects and depends upon spiritual means through prayer alone for the treatment or cure of disease or remedial care may be considered neglected or abused, but not for the sole reason that his parent, guardian, or custodian accepts and practices such beliefs. [325 ILCS 5/4] Where the circumstances indicate harm or substantial risk of harm to the child's health or welfare and medical care necessary to treat or prevent that harm or risk of harm is not being provided because a parent or other person responsible for the child's welfare depends upon such spiritual means, the child shall be subject to the requirements of the Act for the reporting of, investigation of, and provision of protective services with respect to the child and his or her health needs.

(Source: Amended at 38 Ill. Reg. 1962, effective December 31, 2013

Section 300.130 Notices Whether Child Abuse or Neglect Occurred

a) Written Notices of Decision
The Department provides a written notice to mandated reporters who reported suspected child abuse or neglect as well as to the child's parent, personal guardian, or legal custodian; the Juvenile Court Judge (when a State ward is involved); and the alleged perpetrator concerning the final determination of the report.

b) Mandated Reporters

1) Mandated reporters who have reported suspected child abuse or neglect are informed via a written notice that a formal investigation was conducted. The written notice also provides an explanation of how further information on an indicated report may be secured. Department staff will notify them in writing:

A) of the name of the child who was the subject of a report of abuse or neglect;

B) whether the report was indicated or unfounded;

C) whether the Department took temporary protective custody.

2) Requests for additional information must be directed, in writing, to the State Central Register and must include:

A) the identity of the requestor;

B) the subject's name for whom the record is requested;

C) a notary public's attestation as to the identity of the requestor;

D) the purpose of the request.

3) Upon receipt of an appropriate request, only the following information will be disclosed to the mandated reporter:

A) whether a Department case has been opened for the family or children; and

B) what Department services are being provided to the family or children.

4) All requested information is sent in writing through certified mail and is deliverable only to the mandated reporter who made the request.

5) Whenever the Department determines that a reported incident of child abuse or neglect from a mandated reporter is unfounded, the mandated reporter may request a review of the investigation within ten days after the notification of the final findings. Multi-disciplinary Review Committees established in each of the Department's regions shall conduct requested reviews.

6) Multi-disciplinary Review Committees shall draw upon the expertise of the Child Death Review Teams (see Section 300.170 of this Part). Each committee shall be composed of a health care professional, Department employee, law enforcement official, licensed social worker, and representative of a State's Attorney's office. When appointing committee members, primary consideration shall be given to candidates with prior child abuse and neglect case experience.

7) Multi-disciplinary Review Committees will have access to all information in the Department's possession related to the case being reviewed. Committee recommendations concerning the adequacy of the investigation and accuracy of the final finding determination shall be made to the regional Child Protection Manager.

8) Department records of investigations provided to committees and committee recommendation reports shall not be public record.

c) Parents, Personal Guardians, Legal Custodians, and Alleged Perpetrators

1) Custodial and non-custodial parents, personal guardians, or legal custodians of child subjects, and alleged perpetrators shall receive notification within five calendar days after the report has been indicated or unfounded which indicate that the allegations were either:

A) unfounded, and that all identifying information in the computer and local index files will be retained in accordance with 89 Ill. Adm. Code 431 (Confidentiality of Information of Persons Served by the Department); or

B) indicated, and all Department records will be maintained intact.

2) In addition, written notices shall explain that:

A) the subjects of the report have access to the Department's records on the report, with the exception of the identity of the reporter or other persons who cooperated in the investigation;

B) the subjects of the report have the right to request a review of the determination that the report was indicated including the decision to maintain a record of the report in the Department's computer and local index files. 89 Ill. Adm. Code 336 (Appeal of Child Abuse and Neglect Investigation Findings) fully explains the Department's review and appeal process; and

C) the subjects of the report may request, within 10 days of the date on the written notice, that an unfounded report be retained in the

Department's computer and local index files, if the subjects of the report believe the report was not made in good faith. All such requests will be honored.

d) Extended Family
An extended family member interviewed for relevant information during the course of an investigation by the Child Protective Service Unit may request and receive the following information about the findings and actions taken by the Child Protective Service Unit to ensure the safety of the child or children who were the subjects of the investigation:

1) name of the child who was the subject of the abuse or neglect report;

2) whether the report was indicated or unfounded;

3) whether the Department took protective custody;

4) whether a Department case has been opened for the family or children;

5) what Department services are being provided the family or children; and

6) whether a safety plan has been established.

e) Child's School

1) The Department shall send a copy of final finding reports involving indicated allegations of physical or sexual abuse to the indicated victim's school within ten days after the investigation is completed. Reports completed during the summer months shall be sent to the last known school attended by the child.

2) The final finding report shall be sent confidential and the school shall ensure that the report remains confidential in accordance with the Illinois School Student Records Act.

3) The victim's school shall purge the final finding report from the student's record and return the report to the Department upon notification from the Department that the report was overturned in an appeal or hearing or an indicated finding has been expunged from the State Central Register or

that the Department has determined that the child is no longer at risk of physical or sexual harm.

f) Other Parties
The Department shall notify, in writing, those supervisors or administrators referenced in Section 300.100(i) of this Part whether a report involving the persons they supervise was indicated or unfounded and, if unfounded, that Section 13 of the Personnel Record Review Act [820 ILCS 40/13] requires that any record of the investigation must be expunged from the employee's personnel records. The Department shall also notify the employee, in writing, that notification has been sent to the employer informing the employer that the Department's investigation has resulted in an unfounded report. The notice to the employee shall also contain a statement of the employee's right to take the notice to the employer to have any record of the investigation expunged from the employee's record.

g) Child Abuse and Neglect Reports on Children in Department Custody

1) When a child is reported to the Department as being abused or neglected while in a foster home or relative home placement, whether by the foster parent, caregiver, or any other person residing in the home, the Department shall promptly notify the following persons when the report has been made, when an investigation is pending, and when the report has been indicated or unfounded:

A) the parents or private guardians of the alleged abuse or neglect victim;

B) all Department caseworkers or case managers responsible for the alleged victim and for any other children in the same foster home or relative home placement;

C) those persons designated by the Director as responsible for evaluating the investigation and the disposition of the report;

D) Department staff responsible for licensing and making placements with the facility.

2) When a child is reported to the Department as being abused or neglected

while in residential placement, the Department shall promptly notify the following persons when the report has been made, an investigation is pending, and when the report has been indicated or unfounded:

A) the parents or private guardians of the alleged abuse or neglect victim;

B) those Department caseworkers or case managers responsible for the alleged victim, for each child alleged to be a witness to the incident, and for each child alleged to be a perpetrator of the incident;

C) those persons designated by the Director responsible for evaluating the investigation and the disposition of the report;

D) Department staff responsible for licensing and making placements with the facility.

3) The Department shall notify the following when a report involving a child in Department custody is indicated:

A) the Juvenile Court. If services are being provided by the Department or its providers, the notice shall also give the name and location of the Department office serving the children;

B) the Department's administrative case reviewer responsible for reviewing the case plans of the children involved.

4) The Department shall transmit a copy of the report to the guardian ad litem appointed under the Juvenile Court Act of 1987 when a report has been indicated, unfounded, or undetermined and the minor who is the subject of the report is also the minor for whom the guardian ad litem has been appointed.

(Source: Amended at 38 Ill. Reg. 1962, effective December 31, 2013

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Department of Children and Family Services Scholarship Program

2) Code Citation: 89 Ill. Adm. Code 312

3)

Section Numbers:	Adopted Actions
312.20	Amend
312.40	Amend
312.50	Amend
312.60	Amend
312.80	Amend
312.90	Amend
312.100	Amend

4) Statutory Authority: Implementing and authorized by Section 8 of the Children and Family Services Act [20 ILCS 505/8]

5) Effective Date of Rule: December 31, 2013

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 rule is on file in the Agency's principal office and is available for public inspection

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 5233; April 26, 2013

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version: The Department added language that spells out the membership of the Scholarship Awards Selection Committee (SASC). A contact number was added for the Office of Education and Transition Services (OETS) Administrator for students to contact when providing a change of address.

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 rule currently in effect? No

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: The adopted amendments clarify who is eligible to compete for the scholarship, what documents are required for the application packet and the individuals who are represented on the Scholarship Selection committee.

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

Jeff Osowski
Office of Child and Family Policy
Department of Children and Family Services
406 E. Monroe, Station #65
Springfield IL 62701-1498

217/524-1983
TDD: 217/524-3715
e-mail: cfpolicy@idcfs.state.il.us

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

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER III: DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SUBCHAPTER a: SERVICE DELIVERY

PART 312
DEPARTMENT OF CHILDREN AND
FAMILY SERVICES SCHOLARSHIP PROGRAM

Section

312.10 Purpose
312.20 Definitions
312.30 Description
312.40 Eligibility Requirements
312.50 Application
312.60 Selection
312.70 Service Planning and Living Arrangements
312.80 Ongoing Eligibility Requirements
312.90 Benefits
312.100 Discharge from the Scholarship Program

AUTHORITY: Implementing and authorized by Section 8 of the Children and Family Services Act [20 ILCS 505/8].

SOURCE: Adopted by emergency rulemaking at 20 Ill. Reg. 924, effective December 29, 1995, for a maximum of 150 days; emergency expired May 27, 1996; new Part adopted at 23 Ill. Reg. 6784, effective June 1, 1999; amended at 28 Ill. Reg. 8456, effective June 4, 2004; amended at 32 Ill. Reg. 1144, effective January 30, 2008; amended at 33 Ill. Reg. 7880, effective June 15, 2009; amended at 38 Ill. Reg. 1988, effective December 31,2013

Section 312.20 Definitions

"Accredited high school", as used in this Part, means any high school that has met all compliance rules and regulations as required by the State of Illinois.

"ACT" means American College Test.

"Adopted child" means a child for whom the Department was legally responsible immediately before the adoption was finalized.

"Children for whom the Department is legally responsible" means children for whom the Department has temporary protective custody or guardianship via court order or children whose parent has signed an adoptive surrender or voluntary placement agreement with the Department.

"Children of veterans" means youth who are either wards of the Department or in the subsidized guardianship program or who have been adopted and whose birth parent or adoptive parent has served honorably in a branch of the United States Armed Services.

"Department" means the Department of Children and Family Services.

"FAFSA" means Free Application for Federal Student Aid.

"GED" means General Educational Development certificate/diploma.

"KinGap Program" means the subsidized guardianship program that allows the State to enter into guardianship agreements to provide assistance payments to grandparents and other relatives who have assumed the legal guardianship of children for whom they have cared as a licensed foster parent and for whom they have committed to care on a permanent basis.

"SAT" means Scholastic Aptitude Test.

~~"Subsidized Guardianship Program" means a child welfare demonstration project that offers a financial subsidy to relative care or licensed foster home caregivers that are willing to assume private guardianship of children who are eligible for the program. The Subsidized Guardianship Program is further defined in 89 Ill. Adm. Code 302.405, Subsidized Guardianship.~~

(Source: Amended at 38 Ill. Reg. 1988, effective December 31, 2013

Section 312.40 Eligibility Requirements

Applicants must meet the following criteria in order to be considered for a DCFS scholarship:

a) the applicant must be at least 16 years of age and have earned a high school diploma from an accredited institution, or a General Education Development certificate/diploma, or have met the State criteria for high school

graduationpossess a diploma from an accredited high school or a GED by the end of the current school year;

b) the Department must have court-ordered legal responsibility for the applicant, the applicant must have aged out of the Department's care at age 18 or older, or the Department must have had legal responsibility for the applicant immediately prior to the adoption being finalized, or the applicant must be in the KinGapSubsidized Guardianship Program.

(Source: Amended at 38 Ill. Reg. 1988, effective December 31, 2013

Section 312.50 Application

a) The application package will contain the following:

1) completed DCFS Scholarship Program Student Application, CFS 438;

2) transcript of high school grades through the first semester of the senior year and class standing information, or copy of GED and score, or copy of alternative acceptable high school transcript;.

3) college transcript if applicable;College student applicants are only required to submit a transcript of their college grades provided by the college or university directly to the DCFS Office of Education and Transition Services (OETS);

43) ACT or SAT test and score; and

5) documentation of legal relationship with the Department; and

64) three letters of recommendation from persons unrelated to the applicant.

b) Applications must be postmarked no later than March 31. Applications received with a postmark after that date will be ineligible for consideration.

(Source: Amended at 38 Ill. Reg. 1988, effective December 31, 2013

Section 312.60 Selection

a) The Office of Education and Transition Services shall coordinate the Scholarship Awards Selection Committee (SASC). SASC shall include senior leadership of the Department, including, but not limited to, persons who oversee the offices of guardian, legal services, clinical and operations, and key representatives from Department advisory groups, including the Child Welfare Advisory Committee, Child Care Association of Illinois, Illinois Foster Parent Association, Statewide Foster Care Advisory Council and Council on Adoptable Children. ~~Members of the SASC are appointed by the Deputy Director of Service Intervention and shall include the following: Deputy Director, Division of Field Operations; Deputy Director, Division of Placement/Permanency; Deputy Director, Division of Service Intervention; Deputy Director, Division of Child Protection; Deputy Director, Division of Performance Monitoring/Quality Assurance; DCFS Regional Administrators; a representative from the Director's Office; DCFS Legislative Liaison; Chairperson, Child Welfare Advisory Committee; Chairperson, DCFS Advisory Committee; Chairperson, Child Care Association of Illinois; Chairperson, Illinois Foster Parent Association; Chairperson, Statewide Foster Care Advisory Council; President, Council on Adoptable Children; and a representative of the Walter and Connie Payton Foundation.~~

b) The SASC shall meet in April to evaluate each applicant's scholastic record, including grade point average and college entrance test scores; ~~ACT, SAT or GED test scores;~~ community and extracurricular activities; letters of recommendation; and a personal statement expressing the applicant's interest in higher education. Each application will be reviewed by three SASC members who shall assign an assessed value ~~of 0 to 20 points~~ to each area of consideration. To assure fairness, grade point average and test score each have an assigned point value. The other areas of consideration are assigned a range of points. Each reviewer must assign a value within the prescribed range. Score sheets are collected and tabulated. Each application will be assigned a final score, which is the average of the three scores received from the SASC reviewers. The ~~and the~~ applicants with the highest composite scores shall be awarded~~be recommended to the Director to receive~~ a Department Scholarship. Applicants will be notified no later than May 1~~20~~ of their award status.

(Source: Amended at 38 Ill. Reg. 1988, effective December 31, 2013

Section 312.80 Ongoing Eligibility Requirements

Scholarship recipients are required to take a minimum of 12 credit hours per semester or quarter~~,~~

during fall and spring term and 6 credit hours in the summer term (see Section 312.90(b)(2)(A)), maintain a "C" grade point average and provide a copy of their semester or quarter grades to their caseworker and OETS Business Office. Recipients who are under the care of the Department shall also notify their caseworkers and the OETS Business Office if they transfer to another school, change their address, attend summer school or withdraw from school. Youth who are no longer the legal responsibility of the Department shall submit the above-required documentation to the OETS Business Office. Scholarship recipients are responsible for filing a FAFSA form and applying for other forms of financial aid annually, if needed, and for paying their own room and board, as well as other costs not covered by the Department scholarship.

(Source: Amended at 38 Ill. Reg. 1988, effective December 31, 2013

Section 312.90 Benefits

a) Tuition and Fee Waiver
The OETS Business Office will request a waiver of tuition and mandatory fees for scholarship youth that attend an Illinois State university or community college if the youth does not have a tuition and/or fee scholarship from another source.

b) Monthly Grant

1) Youth must provide their caseworkers with written verification of their acceptance/enrollment in a college or university and their school address prior to the beginning of their initial semester or quarter. Caseworkers will verify the information and forward it to the OETS Business Office. Youth that no longer have a legal relationship with the Department must forward the information directly to the OETS Business Office. The OETS Business Office will forward payment information to the Central Payment Unit (CPU). Grant payments will be effective the first day the youth is at school and continue throughout the school year. Youth will receive their first payments the following month. The amount will be prorated based on the day of the month the youth was first located at the school.

2) Caseworkers must provide youth with an explanation of the financial and security benefits of having their grant checks directly deposited and assist the youth with completing the C-95, Authorization for Deposit of Recurring Payments. Youth who do not choose direct deposit will have their grant checks mailed directly to them. Youth are required to report their address change immediately to the OETS Scholarship Administrator

at 217/557-2689~~Business Office (5415 N. University, Peoria IL 61615, 309/693-5150, facsimile 309/693-5433)~~ and their caseworker to ensure timely receipt of correspondence and their grant payments.

A) Summer Grant Payments

i) The OETS will continue grant payments through the summer when the youth is enrolled in summer school and taking a minimum of six college credit hours, or participating in an approved internship program. Youth that choose to continue their education through the summer months must submit an official class schedule or documentation of participation in an approved internship program to the OETS Business Office and their caseworker no later than the first Monday in May.

ii) Youth that choose not to attend summer school or participate in an approved internship program will continue to receive their grant payments through the summer months if the Department has guardianship of the youth or the Department's guardianship of the youth was terminated at age 21 after the youth entered the scholarship program and the youth has a grade point average of "C" or better, submits requested class schedules, has current contact information on file with OETS, and submits documentation of college or university enrollment for the fall semester to the OETS Business Office no later than June 1.

B) Terminating Payment

i) When a youth no longer meets the requirements to remain in the DCFS Scholarship Program, the youth's caseworker will notify the OETS Business Office immediately. Youth who are no longer the legal responsibility of the Department shall notify the OETS Business Office when they no longer meet the requirements of the program. The OETS Business Office will notify the CPU of the effective payment termination date for the youth.

ii) The OETS Business Office will notify the youth in writing 30 days prior to stopping grant payments for any reason other than summer breaks. If the youth has a legal relationship with the Department and resides in Cook County, the Cook County Public Guardian will also receive a copy of the termination notification. Youth may request a review of the decision to suspend or discharge them from the Scholarship Program in accordance with 89 Ill. Adm. Code 337 (Service Appeal Process). If the youth's grant does not continue during the appeals process, it will be issued retroactively if the youth's appeal is successful.

C) Marriage or Termination of Guardianship
Marriage or termination of guardianship does not terminate a Department scholarship. The Department will continue to make monthly grant payments to the youth, and the youth's medical needs will continue to be met under the Medicaid program.

c) Start-Up Grant
This is a $200 one time grant youth will receive upon entrance into the DCFS Scholarship Program. The purpose of the grant is to assist the youth with their initial college living expenses. Youth will receive the Start-Up Grant payment in July.

d) Medical and Dental Payments

1) Medical and dental services are available to DCFS scholarship youth ~~for whom the Department is legally responsible~~. Medical and dental services are provided through the Department of Healthcare and Family Services Medical Assistance Program via the DCFS issued medical card.

2) Medical case management services are provided to pregnant and parenting youth and their children, zero to five years of age, through the Department of Human Services.

e) Mandatory Supplies and Book Payments
The Department may pay for required textbooks and supplies for youth that do not have sufficient resources to purchase the required items.

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF ADOPTED AMENDMENTS

(Source: Amended at 38 Ill. Reg. 1988, effective December 31, 2013

Section 312.100 Discharge from the Scholarship Program

a) Students will be discharged from the Scholarship Program for the following reasons:

1) completion of four years in the Scholarship Program, or the student reaches age 23, whichever occurs first;

2) failure to enroll in school;

3) failure to maintain a "C" grade point average;

4) failure to maintain an academic load of 12 credit hours each semester or quarter during the fall and spring semesters;

5) withdrawal from school; or

6) dismissal from school due to disciplinary reasons.

b) With the exception of a scholarship recipient completing four years in the Scholarship Program, the Deputy Director of the Bureau of Operations~~Division of Service Intervention~~ may waive the requirement to discharge a scholarship recipient when the recipient provides information mitigating the reason or reasons for discharge (family illness or other emergency that necessitated withdrawing from the program and college or university for the semester/quarter/term, assuming the recipient is under the age of 23).

(Source: Amended at 38 Ill. Reg. 1988, effective December 31, 2013

ILLINOIS COMMERCE COMMISSION

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1) Heading of the Part: Qualifying Infrastructure Plant Surcharge

2) Code Citation: 83 Ill. Adm. Code 556

3)

Section Numbers:	Adopted Action:
556.10	New Section
556.20	New Section
556.30	New Section
556.40	New Section
556.50	New Section
556.60	New Section
556.70	New Section
556.80	New Section
556.90	New Section
556.100	New Section
556.110	New Section
556.120	New Section
556.130	New Section

4) Statutory Authority: Implementing Section 9-220.3 and authorized by Sections 9-220.3 and 10-101 of the Public Utilities Act [220 ILCS 5/16-128A and 10-101]

5) Effective Date of Rule: December 27, 2013

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 Commission's Springfield office and is available for public inspection.

9) Notice of Proposal Published in the *Illinois Register*: August 16, 2013; 37 Ill. Reg. 12950

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version:

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Section 556.10, a definition of "Illinois Commerce Commission" was added, and the definition of "depreciation expense" was modified.

Section 556.60, after the formula, the definition of "NetQIP" was modified.

Section 556.90(e)(2), a revision was made to the description of the projects for which specified information must be provided.

Section 556.100(a)(2), a revision was made to the description of the items for which information must be provided.

Section 556.100(c), after the formula, the definition of "ActNetQIP" was modified.

Section 556.100(e), the description of when the first reconciliation year takes effect was revised.

A number of stylistic changes were made.

12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreement letter issued by JCAR? JCAR suggested a number of stylistic changes, and these have been made.

13) Will this rulemaking replace an emergency rule currently in effect? Yes

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Section 9-220.3 of the Public Utilities Act, which took effect in July 2013, directs the Commission to draft, adopt, and put into effect rules carrying out the provisions of the new section. Section 9-220.3 authorizes the Commission to approve tariffs that allow natural gas utilities of a certain size to recover, through tariffs, the costs of certain infrastructure improvements without seeking a general rate increase. The rules found in Part 556 define the relevant terms, explain the operation of the tariff, describe the types of projects that satisfy the statutory criteria, establish the procedure that utilities may use to seek approval of a tariff to recover the costs of qualifying projects, establish the procedure for the required annual reconciliation and audit process for a utility that has a tariff under the new provisions, and set out the required annual update that a utility with a tariff must submit to the Commission.

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

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Brian W. Allen
Office of General Counsel
Illinois Commerce Commission
527 East Capitol Avenue
Springfield, IL 62701

217/558-2387

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

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NOTICE OF ADOPTED RULE

TITLE 83: PUBLIC UTILITIES
CHAPTER I: ILLINOIS COMMERCE COMMISSION
SUBCHAPTER d: GAS UTILITIES

PART 556
QUALIFYING INFRASTRUCTURE PLANT SURCHARGE

Section

556.10 Definitions
556.20 Applicability
556.30 Terms and Conditions
556.40 Qualifying Infrastructure Plant, or QIP
556.50 Recoverable Costs – Return on QIP
556.60 Determination of the QIP Surcharge Percentage
556.70 Application for QIP Surcharge Tariff
556.80 Approval or Withdrawal of QIP Surcharge Tariff
556.90 Information Sheet Filings to Amend the QIP Surcharge
556.100 Annual Reconciliation
556.110 Annual Internal Audit
556.120 Gas Utility Commitments
556.130 Annual QIP Plan Update

AUTHORITY: Implementing Section 9-220.3 and authorized by Sections 9-220.3 and 10-101 of the Public Utilities Act [220 ILCS 5/9-220.3 and 10-101].

SOURCE: Emergency rules adopted at 37 Ill. Reg. 13567, effective August 5, 2013, for a maximum of 150 days; adopted at 38 Ill. Reg. 1998, effective December 27, 2013

Section 556.10 Definitions

Terms defined in Section 9-220.3 of the Public Utilities Act shall have the same meaning for purposes of this Part as they have under that Section of the Act, unless further defined in this Part. The following terms, when used in this Part, shall have the meaning ascribed to them in this Section.

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

"Base rate revenues" means the utility's revenues recovered through base rates, as determined in the utility's last rate case proceeding, excluding:

revenues recovered under negotiated contract rates authorized by Section 9-102.1 of the Act;

revenues recovered under billing services offered to alternative gas suppliers or application charges assessed to alternative gas suppliers; and

revenues recovered under cost recovery riders that recover specific costs outside of rate cases, including, by way of example and not limitation, costs recovered under the rider authorized by this Part, gas costs recovered under 83 Ill. Adm. Code 525, manufactured gas plant remediation costs, costs for implementing energy efficiency and on-bill financing programs under Sections 8-104 and 19-140 of the Act, and add-on taxes.

Base rate revenues may include costs and revenues associated with uncollectible expense automatic adjustment clause tariffs authorized by Section 19-145 of the Act, revenue decoupling mechanisms, and base rate storage cost recovery.

"Baseline amount" means an amount equal to the utility's average of total depreciation expense, as reported on page 336, column (b) of the utility's ILCC Form 21, for the calendar years 2006 through 2010. [220 ILCS 5/9-220.3(d)(4)]

"Commission" means the Illinois Commerce Commission.

"Costs associated with investments in qualifying infrastructure plant" shall include a return on qualifying infrastructure plant and recovery of depreciation and amortization expense on qualifying infrastructure plant, net of the depreciation included in the utility's base rates on any plant retired in conjunction with the installation of the qualifying infrastructure plant. [220 ILCS 5/9-220.3(b)]

"Depreciation expense" shall be calculated by applying the utility's approved depreciation rates, including removal and salvage, to the end-of-month QIP balance, for each category of QIP identified in Section 556.40(a)(1) through (a)(7). The resulting depreciation expense for QIP shall be reduced by *the depreciation included in the utility's base rates on any plant retired in conjunction with the installation of the qualifying infrastructure plant.* [220 ILCS 5/9-220.3(b)]

"Difficult to locate main" refers to a main from which a utility cannot obtain a reliable locating signal.

"Difficult to locate service pipe" means a service pipe from which a utility cannot obtain a reliable locating signal.

"Information sheet" means a tariff sheet filed in accordance with this Part to initiate or modify a QIP surcharge percentage.

"Qualifying infrastructure plant" or "QIP" is the qualifying infrastructure plant eligible to be recovered through the QIP surcharge as described in Section 556.40. It *includes only plant additions placed in service not reflected in the rate base used to establish the utility's delivery base rates.* [220 ILCS 5/9-220.3(b)]

"Qualifying infrastructure investment" means QIP and "costs associated with investments in qualifying infrastructure plant". It *shall not include costs or expenses incurred in the ordinary course of business for the ongoing or routine operations of the utility, including, but not limited to:*

operating and maintenance costs; and

costs of facilities that are revenue-producing, which means facilities that are constructed or installed for the purpose of serving new customers. [220 ILCS 5/9-220.3(c)]

"QIP surcharge percentage" is the percentage determined in accordance with Section 556.60 for filing in an information sheet.

"Rate zone" means the entire service area to which a particular base rate applies.

"Reconciliation year" means the calendar year period for which actual costs associated with QIP and the QIP surcharge revenues are reconciled.

Section 556.20 Applicability

a) Pursuant to Section 9-220.3 of the Act*, a natural gas utility serving more than 700,000 customers may file a tariff for a* qualifying infrastructure plant *surcharge* (QIP surcharge) *which adjusts rates and charges to provide for recovery of costs*

associated with investments in qualifying infrastructure plant, independent of any other matters related to the utility's revenue requirement. [220 ILCS 5/9-220.3(a)(1)]

b) The QIP surcharge shall be applied to gas bills of customers of natural gas utilities having an effective QIP surcharge and information sheet in effect and on file with the Illinois Commerce Commission (Commission).

Section 556.30 Terms and Conditions

a) *The cumulative amount of increases billed under the QIP surcharge, since the utility's most recent delivery service rate order, shall not exceed an annual average 4% of the utility's delivery base rate revenues, but shall not exceed 5.5% in any given year* for any utility. [220 ILCS 5/9-220.3(g)] If, pursuant to Section 556.80(a), a different QIP surcharge percentage is ordered by the Commission to be applied to the rate zones of a utility, then the above maximum thresholds established in this subsection shall apply to each rate zone of the utility.

b) The QIP surcharge percentage shall apply only to base rate revenues.

c) *On the effective date of new delivery base rates, the* QIP *surcharge shall be reduced to zero with respect to qualifying infrastructure investment that is transferred to the rate base used to establish the utility's delivery base rates, provided that the utility may continue to charge or refund any reconciliation adjustment determined* in a Commission reconciliation order. [220 ILCS 5/9-220.3(g)]

d) The utility shall provide notice of the QIP surcharge and of subsequent filings and billing to its customers in the following manner:

1) The utility shall maintain and keep open to public inspection a copy of each filing of a QIP surcharge tariff and subsequent information sheets and shall post public notice in each office of the utility in accordance with 83 Ill. Adm. Code 255.20(a).

2) For the initial filing of a QIP surcharge tariff, the utility, regardless of size, shall provide notice by newspaper publication in accordance with 83 Ill. Adm. Code 255.20(f)(1). For the initial filing of the QIP percentage information sheet, the utility shall provide notice of the filing of the initial

billing of the QIP surcharge percentage to each customer in the form of a message on the customer's bill, an insert included with the bill, or a separately mailed notification.

3) The utility shall provide customers with a general explanation of the QIP surcharge. The explanation shall appear on or be included with the initial billing of the new QIP surcharge percentage. The explanation may be provided as a message on the customer's bill, as a separately mailed notification, or as information on the back of the customer's bill, as included in the utility's form of bill on file with the Commission.

4) Except as provided in this subsection (d), or by law or by Commission order, no other notice of the filing or billing of the QIP surcharge or an information sheet is required.

e) The QIP surcharge shall be presented as a separate line item on customers' bills as the "Qualified Infrastructure Plant" charge, or as an abbreviation that clearly conveys its meaning, and shall show the applicable percentage.

f) The revenues resulting from a QIP surcharge shall be recorded by the utility with a separate revenue identifier or in a separate revenue subaccount.

Section 556.40 Qualifying Infrastructure Plant, or QIP

a) QIP shall be related to one or more of the following:

1) *The installation of facilities to retire and replace underground natural gas facilities, including facilities appurtenant to facilities constructed of those materials such as meters, regulators, and services, and that are constructed of cast iron, wrought iron, ductile iron, unprotected coated steel, unprotected bare steel, mechanically coupled steel, copper, Cellulose Acetate Butyrate (CAB) plastic, pre-1973 DuPont Aldyl "A" polyethylene, PVC, or other types of materials identified by a State or federal governmental agency as being prone to leakage;*

2) *The relocation of meters from inside customers' facilities to outside;*

3) *The upgrading of the gas distribution system from a low pressure to a medium pressure system, including installation of high-pressure facilities to support the upgrade;*

4) *Modernization investments by a combination utility as defined in Section 16-108.5(b) of* the *Act to install:*

A) *Advanced gas meters in connection with the installation of advanced electric meters pursuant to Sections 16-108.5 and 16-108.6 of* the *Act; and*

B) *The communications hardware and software and associated system software that creates a network between advanced gas meters and utility business systems and allows the collection and distribution of gas-related information to customers and other parties in addition to providing information to the utility itself;*

5) *Replacing high-pressure transmission pipelines and associated facilities identified as having a higher risk of leakage or failure or installing or replacing high-pressure transmission pipelines and associated facilities to establish records and maximum allowable operating pressures;*

6) *Replacing difficult to locate mains and service pipes and associated facilities; and*

7) *Replacing or installing transmission and distribution regulator stations, regulators, valves, and associated facilities to establish over-pressure protection.* [220 ILCS 5/9-220.3(b)(1) through (b)(7)]

b) *With respect to the installation of the facilities identified in* subsection (a)(1), *the natural gas utility shall determine priorities for such installation with consideration of projects either:*

1) *Integral to a general government public facilities improvement program, or*

2) *ranked in the highest risk categories in the utility's most recent Distribution Integrity Management Plan where removal or replacement is the remedial measure.* [220 ILCS 5/9-220.3(b)]

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c) *A natural gas utility that is subject to its delivery base rates being fixed at their current rates pursuant to a Commission order entered in Docket No. 11-0046, notwithstanding the effective date of its tariff shall reflect in a* QIP *surcharge only those projects placed in service after the fixed rate period of the merger agreement has expired by its terms.* [220 ILCS 5/9-220.3(a)(5)]

d) *The amount of qualifying infrastructure investment eligible for recovery under the* QIP surcharge *in the applicable calendar year is limited to the lesser of:*

1) *The actual qualifying infrastructure plant placed in service in the applicable calendar year; and*

2) *The difference by which total plant additions in the applicable calendar year exceed the baseline amount, and subject to the limitation in* Section 556.30(a). [220 ILCS 5/9-220.3(d)(3)]

e) *A natural gas utility can recover the costs of qualifying infrastructure investments through an approved* QIP *surcharge tariff from the beginning of each calendar year subject to the reconciliation initiated under* Section 556.100, *during which the Commission may make adjustments to ensure that the limits defined* in this Part *are not exceeded. Further, if total plant additions in a calendar year do not exceed the baseline amount in the applicable calendar year, the Commission, during the reconciliation for the applicable calendar year, shall adjust the amount of qualifying infrastructure investment eligible for recovery under the tariff to zero.* [220 ILCS 5/9-220.3(d)(3)]

Section 556.50 Recoverable Costs – Return on QIP

a) The pre-tax return (PTR) is the return on the QIP. The pre-tax return shall be calculated using the weighted cost of debt and weighted cost of equity determined in the utility's last gas rate case proceeding. The weighted cost of equity shall be multiplied by the gross revenue conversion factor (GRCF). The product shall be added to the weighted cost of debt to obtain the pre-tax return.

b) The pre-tax return shall be calculated by using the following formulas:

$$PTR = ((WCCE + WCPE) \times GRCF) + WCLTD + WCSTD$$

$$GRCF = \frac{1}{(1 - (PPTRIT + SIT)) \times (1 - FIT)}$$

Where:

GRCF	=	Gross Revenue Conversion Factor.
PPTRIT	=	Illinois Personal Property Tax Replacement Income Tax rate in effect at the time of the filing.
SIT	=	Illinois State income tax rate in effect at the time of the filing.
FIT	=	Federal income tax rate in effect at the time of the filing.
PTR	=	Pre-tax return.
WCCE	=	Weighted cost of common equity approved in the utility's last rate case proceeding.
WCPE	=	Weighted cost of preferred equity approved in the utility's last rate case proceeding.
WCLTD	=	Weighted cost of long term debt and credit facilities fees approved in the utility's last rate case proceeding.
WCSTD	=	Weighted cost of short term debt approved in the utility's last rate case proceeding.

Section 556.60 Determination of the QIP Surcharge Percentage

a) The QIP surcharge percentage shall be expressed as a percentage carried to two decimal places. The QIP surcharge percentage shall be applied to the charges billed to each customer that represent base rate revenues as defined in Section 556.10. In calculating the QIP surcharge percentage, the utility may choose the number of billing periods for which the QIP surcharge percentage shall be in effect when the tariffs are submitted to the Commission for approval.

b) The QIP surcharge percentage shall be calculated by using the following formula:

$$S\% = \frac{(NetQIP \times PTR \times NBP/12) + (NetDep \times NBP/12) + (R) + (O + INT)/NBPo}{PBR} \times 100$$

Where:

S%	=	QIP surcharge percentage.
NetQIP	=	Actual cost of QIP less accumulated depreciation and any accumulated deferred income tax liabilities net of deferred tax assets resulting from the additional QIP.
PTR	=	Pre-tax return as described in Section 556.50.
NetDep	=	Annualized depreciation expense applicable to NetQIP less the annualized depreciation expense applicable to the plant being retired as defined in Section 556.10.
R	=	Utility-determined reconciliation component calculated as described in Section 556.100(c). The reconciliation component shall be collected or refunded over the nine-month period from April through December. For S% in effect from April through December, R shall reflect 1/9 of the total R for each month.
O	=	Commission-ordered adjustment.
INT	=	The calculated interest attributable to the O component. This interest shall be calculated at the rate established by the Commission under 83 Ill. Adm. Code 280.7(e)(1). The interest shall accrue from the end of the reconciliation year to the order date in the reconciliation proceeding.
PBR	=	The projected gas base rate revenues for the applicable billing periods that S% will be in effect.
NBP	=	Number of billing periods that S% will be effective prior to the scheduled recalculation.
NBPo	=	Number of billing periods (O + INT) will be collected or refunded.

Section 556.70 Application for QIP Surcharge Tariff

A filing by a utility that seeks approval of a QIP surcharge tariff shall include testimony and the following exhibits:

a) The utility shall provide a history of the installation, relocation, upgrading, modernization, and replacement rates of qualifying infrastructure plant. The

utility shall provide five years of data by year for each of the categories, if applicable, found in Section 9-220.3(b)(1) through (b)(7) of the Act, based on projects that the utility plans to include in the QIP surcharge. If data or records are not available, the utility may use estimates. If the utility relies on estimates, the utility shall explain why the actual data was not available and how the estimate was determined.

b) The utility shall provide specific plans for its initial year of qualified infrastructure investment, and an estimate of qualified infrastructure investment for the two years following the initial year, including future replacements of underground natural gas facilities. The utility shall provide a schedule showing the qualified infrastructure investment listed by priority as defined in Section 9-220.3(b)(1) of the Act. The schedule shall explain the prioritization and provide the rationale for the investments to be included as QIP, which may include a history of leaks, or incidents of damage by location.

c) The utility shall provide an explanation for the proposed rate of replacement identified in subsection (b), relative to the rates identified in subsection (a), if applicable. The utility shall include specific data to justify the replacement rate for each of the categories of investment provided for in Sections 9-220.3(b)(1) through (b)(7) of the Act.

d) The utility shall provide any other information requested by the Commission that demonstrates that the proposed QIP surcharge tariff complies with Section 9-220.3 of the Act.

Section 556.80 Approval or Withdrawal of QIP Surcharge Tariff

a) *The Commission shall issue an order approving, or approving with modification to ensure compliance with* Section 9-220.3 of the Act, *the* QIP surcharge *tariff no later than 120 days after such filing of the tariffs filed pursuant to this* Part. *The utility shall have 7 days following the date of service of the order to notify the Commission in writing whether it will accept any modifications so identified in the order or whether it has elected not to proceed with the tariff. If the order includes no modifications or if the utility notifies the Commission that it will accept such modifications, the* QIP surcharge *tariff shall take effect on the first day of the calendar year in which the Commission issues the order, subject to petitions for rehearing and appellate procedures.* [220 ILCS 5/9-220.3(a)(3)]

b) In approving the QIP surcharge tariff for a utility having more than one rate zone, the Commission may determine that it is appropriate for different QIP surcharge tariffs to be applied in the different rate zones of the utility.

c) *After the* QIP surcharge *tariff takes effect, the utility may, upon 10 days' notice to the Commission, file to withdraw the* QIP surcharge *tariff at any time, and the Commission shall approve such filing without suspension or hearing, subject to a final reconciliation as provided in* Section 556.100. [220 ILCS 5/9-220.3(a)(3)]

d) *When a natural gas utility withdraws the* QIP surcharge *tariff, the utility shall not recover any additional charges through the* QIP *surcharge approved pursuant to this* Part, *subject to the resolution of the final reconciliation. The utility's qualifying infrastructure investment net of accumulated depreciation may be transferred to the natural gas utility's rate base in the utility's next general rate case. The utility's delivery base rates in effect upon withdrawal of the* QIP *surcharge tariff shall not be adjusted at the time the* QIP *surcharge tariff is withdrawn.* [220 ILCS 5/9-220.3(a)(4)]

Section 556.90 Information Sheet Filings to Amend the QIP Surcharge

a) *The amount of qualifying infrastructure investment shall be shown on an Information Sheet supplemental to the* QIP *surcharge tariff and filed with the Commission monthly or some other time period at the option of the utility. The Information Sheet shall be accompanied by data showing the calculation of the qualifying infrastructure investment adjustment. Unless otherwise ordered by the Commission, each qualifying infrastructure investment adjustment shown on an Information Sheet shall become effective pursuant to the utility's approved* QIP surcharge *tariffs.* [220 ILCS 5/9-220.3(e)(1)]

b) After a QIP surcharge tariff is in effect, the QIP surcharge percentage shall be filed with the Commission or postmarked on an information sheet with supporting data no later than the 20th day of the month preceding the effective date of the QIP surcharge percentage. An information sheet with supporting data filed after that date, but prior to the effective date, shall be accepted only if it corrects an error or errors from a timely filed information sheet for the same effective date. Any other information sheet with supporting data shall be accepted only if it is submitted as a special permission request to become effective on less than 45 days' notice under Section 9-201(a) of the Act.

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c) A new QIP surcharge percentage may become effective on the first day of the billing cycle or the first day of the calendar month, with a new R component becoming effective, if required, on the first billing cycle effective for April or the first day of April. A QIP surcharge percentage shall continue in effect until replaced by a subsequent information sheet filing pursuant to subsection (a).

d) A utility shall file an information sheet each period in accordance with the utility's tariff and shall reflect the continuing aggregation of qualifying infrastructure investment costs, regardless of whether the QIP surcharge percentage changes.

e) A utility shall submit with each information sheet the following documentation:

1) A calculation of the QIP surcharge percentage, PTR and GRCF;

2) A detailed schedule providing the following information for each completed QIP-eligible project:

A) Plant account number and title;

B) Category of project;

C) Project name;

D) Description of project;

E) Dollar amount in the month of closing; and

F) Month and year of closing;

3) A schedule showing the calculation of accumulated depreciation on associated QIP;

4) A schedule showing the calculation of accumulated deferred income taxes associated with QIP; and

5) A detailed schedule showing the calculation of depreciation expense.

f) If the utility has already provided data responsive to subsection (c)(2), in a prior information sheet filing, the utility may incorporate the data by reference and need not provide duplicative data with each filing.

Section 556.100 Annual Reconciliation

a) A utility that has a QIP surcharge in effect shall file with the Commission an annual petition to initiate a reconciliation proceeding. The petition shall comply with the following provisions:

1) *For each calendar year in which a surcharge tariff is in effect, the natural gas utility shall file a petition* on or before March 20 of the following year *with the Commission to initiate hearings to reconcile amounts billed under each surcharge authorized with the actual prudently incurred costs recoverable under this tariff in the preceding year. The petition filed by the natural gas utility shall include testimony and schedules that support the accuracy and the prudence of the qualifying infrastructure investment for the calendar year being reconciled.* [220 ILCS 5/9-220.3(e)(2)]

2) *The petition filed shall also include the number of jobs attributable to the* qualifying infrastructure investments whose costs are recovered through the QIP *surcharge tariff.* [220 ILCS 5/9-220.3(e)(2)] The utility shall describe in its petition how it determined the number of jobs.

3) As required by this Section, the annual reconciliation shall include a calculation of the R component necessary to adjust revenue collected under the QIP surcharge in effect during the reconciliation year to an amount equivalent to the actual level of prudently-incurred qualified infrastructure investment for the reconciliation year.

b) After a hearing on the petition, the Commission shall determine the amount of the adjustment, if any, that should be made through the O component to the level of revenue collected by operation of the QIP surcharge during the reconciliation year. The adjustment shall be calculated so that the amount of the revenue equals the actual level of prudently incurred qualified infrastructure investment costs for the reconciliation year, to the extent that the adjustment has not already been reflected through an adjustment made by the utility to the R component of the QIP surcharge percentage.

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c) The R component shall be calculated by using the following formula:

$$R = (ActNetQIP \times PTR) + ActNetDep - QIPRev + Rpy + Opy$$

Where:

R	=	Utility-determined reconciliation component.
ActNetQIP	=	The average actual cost of the investment in QIP for the reconciliation year net of the actual accumulated depreciation and accumulated deferred income tax liabilities net of deferred tax assets resulting from the additional QIP associated with the investment in QIP based on the 13-month average for the reconciliation year.
PTR	=	Pre-tax *overall rate of return authorized by the Commission in the utility's last rate case* calculated as described in Section 556.50 [220 ILCS 5/9-220.3(f)].
ActNetDep	=	Actual depreciation expense related to the investment in QIP for the reconciliation year. Depreciation expense shall be net of depreciation expense applicable to the plant being retired, as defined in Section 556.10.
QIPRev	=	Actual QIP revenues collected during the reconciliation year through the QIP surcharge.
Rpy	=	The R component from the previous reconciliation year.
Opy	=	The sum of the O components and the calculated interest attributable to the O components included in the calculation of the QIP surcharge percentage during the reconciliation year.

d) Each annual reconciliation shall include the following schedules:

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1) A schedule showing the actual monthly costs associated with the qualified infrastructure investment for the reconciliation year;

2) A schedule showing the actual monthly revenues arising from the application of the QIP surcharge during the reconciliation year;

3) A schedule showing the reconciliation component determined by the utility of the amount to be recovered or refunded over a nine-month period commencing on April 1; and

4) A schedule showing the utility's calculation of actual operating income and 13-month average rate base for the reconciliation year. The calculation of actual operating income and 13-month average rate base shall be adjusted for the impact of adjustments accepted by the Commission in the utility's last rate case represented by the pro rata percentages of net plant and operating expenses approved by the Commission compared to the net plant and operating expenses requested by the utility in its initial filing. In calculating the amount of federal and State income tax expense reflected in operating income, the utility shall show as deductible interest expense for tax purposes the product that results when the weighted embedded cost-of-debt reflected in the overall rate of return calculation used in the utility's last rate proceeding is multiplied by the rate as shown in the annual reconciliation.

e) The first reconciliation year shall take effect on the first day of the calendar year in which the Commission issues an order approving the QIP surcharge tariff and shall end on December 31 of the same calendar year. Subsequent reconciliation years shall end on December 31.

f) When the utility files its annual reconciliation petition, the utility shall provide to the Commission's Manager of the Accounting Department electronic copies of the following items:

1) Copies of all work papers pertaining to the reconciliation;

2) A summary of all work orders or projects that support the costs claimed for recovery through the QIP surcharge;

3) The total annual amounts invested, for each of the categories described in Section 9-220.3(b)(1) through (b)(7) of the Act, for qualifying infrastructure investment that support the costs claimed for recovery through the QIP surcharge;

4) Copies of the applicable general ledger or comparable material supporting the recovery of the QIP surcharge;

5) A detailed worksheet showing the calculation of any utility-determined reconciliation component (R component) amount based upon the annual reconciliation; and

6) Information regarding the prudence of the utility's investment in QIP.

g) The annual reconciliation shall be verified by an officer of the utility.

Section 556.110 Annual Internal Audit

The utility shall submit annually to the Commission's Manager of the Accounting Department, no later than July 31 for the previous calendar year, an internal audit report that determines whether the QIP surcharge and information provided under the Annual Reconciliation in Section 556.100 have been calculated in accordance with this Part and Section 9-220.3 of the Act. The initial internal audit shall be submitted no later than July 31 of the year following the effective date of the QIP surcharge tariff. Internal audits conducted under this Part shall determine whether:

a) Internal controls are effectively preventing the double recovery of costs through the QIP surcharge and other approved tariffs;

b) The QIP surcharge percentage is being properly billed to customer bills;

c) QIP surcharges are properly calculated;

d) Costs recovered through the QIP surcharge are recorded in the appropriate accounts; and

e) Costs recovered through the QIP surcharge are properly reflected in the calculation of the QIP surcharge percentage and the annual reconciliation.

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Section 556.120 Gas Utility Commitments

A natural gas utility that has in effect a QIP *surcharge tariff* shall*:*

a) *Recognize that the General Assembly identifies improved public safety and reliability of natural gas facilities as the cornerstone upon which Section* 9-220.3 of the Act *is designed, and qualifying projects should be encouraged, selected, and prioritized based on these factors; and* [220 ILCS 5/9-220.3(d)(1)]

b) *Provide information to the Commission as requested to demonstrate that:*

1) *The projects included in the* QIP surcharge *tariff are indeed qualifying projects; and*

2) *The projects are selected and prioritized taking into account improved public safety and reliability*. [220 ILCS 5/9-220.3(d)(2)]

Section 556.130 Annual QIP Plan Update

Beginning in 2015, a utility with an approved QIP surcharge tariff shall file with the Commission by April 1 of each year an annual QIP plan update on e-Docket in the docket that approved the utility's QIP surcharge tariff, with copies provided to the Commission's Director of the Financial Analysis Division and Director of the Safety and Reliability Division. The annual QIP plan update shall provide the specific plan for that calendar year's qualified infrastructure investment, including planned replacements of underground natural gas facilities during the year. The initial annual QIP plan update shall be submitted no later than April 1 of the year following the effective date of the initial QIP surcharge tariff. The annual QIP plan update shall include the following information for projects included in the update for which costs are anticipated to be incurred during the calendar year of the update:

a) A schedule showing each QIP project included in the update by the classification of the project as defined in Section 556.40(a), with the following information:

1) The project title;

2) The priority of the project;

3) The accumulated cost of the project at the beginning of the calendar year;

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4) The projected cost to be incurred during the calendar year;

5) The anticipated total cost of the project to have been incurred by the end of the calendar year; and

b) A listing of each QIP project included in the update by priority, with the following information:

1) An explanation and justification for the prioritization of the project;

2) A brief description of the project;

3) An indication of whether the project was ranked within the highest risk categories in the utility's most recent Distribution Integrity Management Program; and

4) The rationale for the investment to be included as QIP, which may include a history of leaks, or incidents of damage by location.

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1) Heading of the Part: Residential Mortgage License Act of 1987

2) Code Citation: 38 Ill. Ad. Code 1050

3)

Section Numbers:	Adopted Action:
1050.210	Amendment
1050.1010	Amendment
1050.1175	Amendment

4) Statutory Authority: Implementing and authorized by the Residential Mortgage License Act of 1987 [205 ILCS 635/4-1(g)]

5) Effective Date of Rule: December 27, 2013

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 rule, including any material incorporated by reference, is on file in the Agency's principal office and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 15590; October 4, 2013

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version: None

12) Have all the changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: The Division of Banking adopted changes to the fee Section of this Part to add an exempt entity registration fee pursuant to recently revised statutory authority found in PA 98-492 together with non-substantive updates to fee references pursuant to PA 97-891. We also converted the requirement to include a Mortgage Loan Originators Illinois License number to the use of a nationwide

identification number instead. This change appears in both the Loan Brokerage Agreements Section and Loan Logs Section. This change was suggested by industry and we are able to include it with our fee amendments.

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

Department of Financial and Professional Regulation
Attention: Craig Cellini
320 West Washington, 3rd Floor
Springfield IL 62786

217/785-0813 Fax: 217/557-4451

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

DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

NOTICE OF ADOPTED AMENDMENTS

TITLE 38: FINANCIAL INSTITUTIONS
CHAPTER II: DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

PART 1050
RESIDENTIAL MORTGAGE LICENSE ACT OF 1987

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Section
1050.100 High Risk Home Loan Definitions; Applicability
1050.110 Definitions
1050.115 Administrative Decision (Repealed)
1050.120 Assisting (Repealed)
1050.125 Commissioner (Repealed)
1050.130 Control (Repealed)
1050.132 Conviction or Convicted (Repealed)
1050.135 Document (Repealed)
1050.140 Employee (Repealed)
1050.145 First Tier Subsidiary (Repealed)
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1050.155 High Risk Home Loan (Repealed)
1050.157 Licensee (Repealed)
1050.160 Material (Repealed)
1050.165 Other Regulatory Agencies (Repealed)
1050.170 Party (Repealed)
1050.175 Principal Place of Business (Repealed)
1050.180 Repurchase a Loan (Repealed)
1050.185 State (Repealed)
1050.190 Servicer (Repealed)
1050.195 Points and Fees (Repealed)
1050.197 Total Loan Amount (Repealed)
1050.198 Approved Credit Counselor (Repealed)
1050.199 Home Equity Loan (Repealed)

SUBPART B: FEES

Section
1050.210 Fees
1050.220 License Fees (Repealed)

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1050.230 Amended License Fees – Corporate Changes (Repealed)
1050.240 Duplicate Original License Fees (Repealed)
1050.245 Loan Originator Registration Application Fee (Repealed)
1050.246 Loan Originator Registration Transfer Fee (Repealed)
1050.247 Loan Originator Registration Reactivation Fee (Repealed)
1050.248 Duplicate Loan Originator Certificate of Registration or Pocket Card Fee (Repealed)
1050.250 Examination Fees (Repealed)
1050.255 Direct Expenses of Out-of-State Examinations (Repealed)
1050.260 Additional Full-Service Office Fees (Repealed)
1050.270 Hearing Fees (Repealed)
1050.280 Late Fees (Repealed)
1050.290 Manner of Payment (Repealed)

SUBPART C: LICENSING

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1050.310 Application for an Illinois Residential Mortgage License
1050.320 Application for Renewal of an Illinois Residential Mortgage License
1050.330 Waiver of License Fee
1050.340 Full-Service Office
1050.350 Additional Full-Service Office
1050.360 Continuing Education Requirements for Certain Employees (Repealed)
1050.370 Licensing of Mortgage Loan Originators

SUBPART D: OPERATIONS AND SUPERVISION

Section
1050.410 Net Worth
1050.420 Line of Credit (Repealed)
1050.425 Examination
1050.430 Late Audit Reports
1050.440 Escrow
1050.450 Audit Workpapers
1050.460 Selection of Independent Auditor (Repealed)
1050.470 Proceedings Affecting a License
1050.475 Change in Business Activities
1050.480 Change of Ownership, Control or Name or Address of Licensee
1050.490 Bonding Requirements

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SUBPART E: ANNUAL REPORT OF MORTGAGE ACTIVITY, MORTGAGE BROKERAGE ACTIVITY, PURCHASING ACTIVITY, AND MORTGAGE SERVICING ACTIVITY

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1050.610 Filing Requirements
1050.620 Reporting Forms
1050.630 Annual Report of Mortgage Activity
1050.640 Annual Report of Brokerage Activity
1050.650 Annual Report of Servicing Activity
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1050.740 Foreclosure Rate Hearing
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1050.830 Real Property Tax and Hazard Insurance Payments
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1050.950 Misleading and Deceptive Advertising Prohibition

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1050.1010 Loan Brokerage Agreement
1050.1020 Loan Brokerage Disclosure Statement
1050.1030 Prohibited Practice

SUBPART J: LOAN APPLICATION PRACTICES

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1050.1510 Applicability
1050.1520 Definitions (Repealed)
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SUBPART R: REGISTRATION OF LOAN ORIGINATORS

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1050.2250 Issuance of Provisional Certificate of Registration; Effective Date; Conditions
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1050.APPENDIX A Estimated Monthly Income and Expenses Worksheet
1050.APPENDIX B Mortgage Ratio Worksheet

AUTHORITY: Implementing and authorized by the Residential Mortgage License Act of 1987 [205 ILCS 635/4-1(g)].

SOURCE: Filed January 18, 1974; amended at 2 Ill. Reg. 2, p. 1, effective January 16, 1978; codified at 8 Ill. Reg. 4524; amended at 9 Ill. Reg. 17393, effective October 24, 1985; Part repealed by emergency rule at 12 Ill. Reg. 3041, and new Part adopted by emergency rule at 12 Ill. Reg. 3079, effective January 13, 1988, for a maximum of 150 days; Part repealed at 12 Ill. Reg. 8683, and new Part adopted at 12 Ill. Reg. 8685, effective May 10, 1988; emergency amendment at 12 Ill. Reg. 9721, effective May 18, 1988, for a maximum of 150 days; amended at 13 Ill. Reg. 17056, effective October 20, 1989; amended at 15 Ill. Reg. 8580, effective May 28, 1991; emergency amendment at 16 Ill. Reg. 2915, effective February 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 10463, effective June 23, 1992; emergency amendment at 16 Ill. Reg. 12634, effective August 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 20179, effective December 9, 1992; amended at 17 Ill. Reg. 3513, effective March 2, 1993; transferred from Chapter III, 38 Ill. Adm. Code 450 (Commissioner of Savings and Loan Associations) to Chapter VIII, 38 Ill. Adm. Code 1050 (Commissioner of Savings and Residential Finance) pursuant to Savings Bank Act [205 ILCS 205] at 17 Ill. Reg. 4475; emergency amendment at 19 Ill. Reg. 11080, effective July 13, 1995, for a maximum of 150 days; emergency expired December 11, 1995; amended at 19 Ill. Reg. 15465, effective October 31, 1995; amended at 20 Ill. Reg. 388, effective January 1, 1996; recodified from Chapter VIII, Commissioner of Savings and Residential Finance, to Chapter II, Office of Banks and Real Estate, pursuant to PA 89-508, at 20 Ill. Reg. 12645; amended at 21 Ill. Reg. 10972, effective August 1, 1997; amended at 22 Ill. Reg. 230, effective December 19, 1997; amended at 24 Ill. Reg. 64, effective January 1, 2000; emergency amendment at 24 Ill. Reg. 19322, effective December 15, 2000, for a maximum of 150 days; emergency repealed at 25 Ill. Reg. 3696, effective January 30, 2001 in response to an objection of the Joint Committee on Administrative Rules at 25 Ill. Reg. 1857; amended at 25 Ill. Reg. 6174, effective May 17, 2001; emergency amendment at 27 Ill. Reg. 10783, effective July 1, 2003, for a maximum of 150 days; emergency expired November 27, 2003; amended at 28 Ill. Reg. 797, effective December 29, 2003; emergency amendment at 28 Ill. Reg. 7137, effective April 30, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 10352, effective June 29, 2004; amended at 28 Ill. Reg. 13351, effective September 21, 2004; amended at 29 Ill. Reg. 14808, effective September 26, 2005;

amended at 29 Ill. Reg. 19187, effective November 10, 2005; amended at 34 Ill. Reg. 17339, effective October 29, 2010; amended at 36 Ill. Reg. 250, effective January 1, 2012; amended at 38 Ill. Reg. 2019, effective December 27, 2013

SUBPART B: FEES

Section 1050.210 Fees

a) Method of Payment of Fees
The fees listed in this Section shall be payable to the Department, or to the Nationwide Mortgage Licensing System and Registry for transfer to the Department as approved by the Director. The Director may specify the form of payment to the Department or to the Nationwide Mortgage Licensing System and Registry, which may include certified check, money order, credit card, or other forms authorized by the Director. The Director may specify that fees be paid separately or combined, and may pro-rate fees for implementation of the Nationwide Mortgage Licensing System and Registry. The Nationwide Mortgage Licensing System and Registry shall be authorized to collect and process transaction fees or other fees related to licensees or other persons subject to the Act.

b) Residential Mortgage License

1) Investigation Fee: The applicant shall pay a non-refundable fee of $1,500~~$1,135~~ or such non-refundable amount as authorized by the Director that, when combined with the license fee set forth in subsection (b)(2)(A), totals an amount equal to $2,700~~$2,043~~ annually or the~~such~~ amount authorized by Section 2-2 of the Act.

2) License Fee:

A) Initial Licensure: For each application for an initial Illinois Residential Mortgage License on which the Director has made the findings that a license shall be issued, the applicant shall pay a non-refundable license fee of $1,200~~$908~~, plus the investigation fee set forth in subsection (b)(1), or such non-refundable amount as authorized by the Director that, when combined with the investigation fee set forth in subsection (b)(1), totals an amount equal to $2,700~~$2,043~~ annually or the~~such~~ amount authorized by

Section 2-2 of the Act.

B) License Renewal: For each application for an annual renewal of an Illinois Residential Mortgage License, the applicant shall pay a non-refundable license fee of $2,700~~$2,043~~, or the total amount set forth in subsections (b)(1) and (b)(2)(A).

C) Amended License: The licensee shall pay a non-refundable fee of $500 for each Notice of Change of Ownership or Control amended license that is required by Subpart D~~ of this Part~~.

D) Notice of Change: The licensee shall pay a non-refundable fee of $50 with each Notice of Change of Officers or Directors or Change of Name or Address or Change of Activity.

E) Duplicate License: The licensee shall pay a non-refundable fee of $50 for each duplicate original license issued.

F) Returned Payment: Any licensee or person who delivers a check or other payment to the Department that is returned unpaid by the financial institution upon which it is drawn shall pay to the Department, in addition to the amount already owed, a fee of $50.

3) Exempt Registration Fee: For each application for initial registration or annual renewal of registration as authorized by Section 1-3(a-1) of the Act, the applicant or registrant shall pay the Department a non-refundable registration fee of $2,700.

c) Mortgage Loan Originator License

1) Application Fee: An applicant for a Mortgage Loan Originator license shall pay a non-refundable fee of $200 for each individual licensed on the initial application and $150 annually for each individual renewal, plus an additional $75 late fee for any renewal that is received after the expiration date of the preceding license.

2) License Transfer Fee: There shall be paid by or on behalf of the Mortgage Loan Originator a non-refundable fee of $50 for each license transferred.

3) License Reactivation Fee: There shall be paid by or on behalf of the applicant a non-refundable fee of $150 for reactivating each or license on Inactive or Inoperative Status.

4) Duplicate Documents: The licensee shall pay a non-refundable fee of $50 for each duplicate document.

5) Returned Payment: Any person who delivers a check or other payment to the Department that is returned to the Department unpaid by the financial institution upon which it is drawn shall pay to the Department, in addition to the amount already owed to the Department, a fee of $50.

d) Examination

1) Fees: Time expended in the conduct of any examination of the affairs of any licensee or its affiliates pursuant to the provision of Section 4-2 of the Act shall be billed by the Department at a rate of $510 per examiner day. Fees will be billed following completion of the examination and shall be paid within 30 days after receipt of the billing.

2) Out-of-State Travel: When out-of-state travel occurs in the conduct of any examination, the licensee shall make arrangements to reimburse the Department all charges for services such as travel expenses, including airfare, hotel and per diem incurred by the employee. These expenses are to be in accord with applicable travel regulations published by the Department of Central Management Services and approved by the Governor's Travel Control Board (80 Ill. Adm. Code 2800).

e) Additional Full-Service Office:

1) Initial Fee: The licensee shall pay a non-refundable fee of $250 for each Notice of Intent to Establish an Additional Full-Service Office required by Subpart C ~~of this Part~~.

2) Annual Fee: After the notice filed under subsection (e)(1), the licensee shall pay an annual non-refundable Additional Full-Service Office fee of $250 on the initial license anniversary date.

f) Hearing Fees: Each party that requests a hearing pursuant to Section 4-1(n) of the

Act shall pay a non-refundable fee of $500, except that a Mortgage Loan Originator requesting a hearing shall pay a non-refundable fee of $250, unless the fee is waived by the Director. In determining whether to waive the fee, the Director shall consider the financial hardship imposed on the party.

(Source: Amended at 38 Ill. Reg. 2019, effective December 27, 2013

SUBPART I: LOAN BROKERAGE PRACTICES

Section 1050.1010 Loan Brokerage Agreement

Before a mortgage loan applicant (also referred to in this Section as "borrower" or "customer") signs a completed residential mortgage loan application or gives the licensee any consideration, whichever comes first, a loan brokerage agreement shall be required and shall be in writing and signed by both the mortgage loan applicant and a licensee whose services to the customer shall be loan brokering as defined at Section 1-4(o) of the Act.

a) The loan brokerage agreement shall carry a clear and conspicuous statement that, upon request, a copy of the agreement shall be made available to the borrower or the borrower's attorney for review prior to signing.

b) Both the licensee's authorized representative and the borrower shall sign and date the loan brokerage agreement at the same time, and a copy of the executed agreement shall be given to the customer at the time of signing.

c) The loan brokerage agreement shall contain an explicit description of the services the licensee agrees to perform for the borrower and a good faith estimate of all consideration and remuneration to be exchanged in connection with those services. In the same section of the agreement shall be language, of prominence equal to or greater than the estimate, listing the types of situations or conditions that could materially affect the amounts indicated as a result of details that could not be known by the licensee at the time of signing the loan brokerage agreement. Examples of such situations or conditions include, but are not limited to, an appraised value different from that estimated by the borrower or credit obligations that the borrower fails to report.

d) The loan brokerage agreement shall carry a clear and conspicuous statement as to the conditions under which the borrower is obligated to pay the licensee.

e) The loan brokerage agreement shall provide that, if the licensee makes false or misleading statements in the agreement, the borrower may, upon written notice:

1) void the agreement;

2) recover monies paid to the broker for which no services have been performed; and

3) recover actual costs, including attorney fees for enforcing the borrower's rights under the loan brokerage agreement.

f) The loan brokerage agreement shall incorporate by reference the Loan Brokerage Disclosure Statement described in Section 1050.1020~~ of this Subpart~~.

g) Except for a Rate-Lock Fee Agreement in accordance with Section 1050.1335, the loan brokerage agreement shall be the only agreement between the borrower and licensee with respect to a single loan; provider, however, that the licensee also shall provide to the customer any disclosure statement necessary to comply with Federal and State requirements, including, but not limited to, the Consumer Protection Credit Act (15 USC 1601), Equal Credit Opportunity Act (Title VII), and Truth in Lending Act (Title I) and Consumer Fraud and Deceptive Business Practices Act [815 ILCS 505].

h) The loan brokerage agreement shall contain the name and Unique Identifier in the Nationwide Mortgage Licensing System~~registration number~~ of any Mortgage Loan Originator assisting the licensee in performing services for the borrower.

(Source: Amended at 38 Ill. Reg. 2019, effective December 27, 2013

SUBPART J: LOAN APPLICATION PRACTICES

Section 1050.1175 Loan Log

a) Broker/Origination Loan Log. Each licensee engaged in loan brokerage or loan origination shall maintain a Broker/Origination Loan Log that contains the following for each loan application received, except that a Broker/Origination Log for reverse mortgages shall contain the information in subsection (c):

1) Application date (sort loan log by application date);

2) Borrower name or names;

3) Borrower or borrowers employer name;

4) Borrower or borrowers employer address;

5) Property seller name or names (indicate NA in the event of a refinance);

6) Property address;

7) Loan amount;

8) APR loan program;

9) Mortgage Loan Originator~~originator~~ name;

10) Mortgage Loan Originator Unique Identifier (Nationwide Mortgage Licensing System)~~originator license/registration number~~;

11) Processor name or names;

12) Appraiser name or names;

13) Appraiser or appraisers license number;

14) Statement of whether the loan application was cancelled, rejected or closed or is pending and, if the loan application was closed, the closing date and name of the owner and servicer of the loan;

15) Loan closer name and employer name; and

16) Loan closing location.

b) Servicer Loan Log. Each licensee engaged in loan servicing shall maintain a Servicer Loan Log that contains the following for each loan serviced:

1) Loan number;

2) Note date;

3) Borrower name or names;

4) Property address;

5) Loan type;

6) Lien position;

7) Original principal balance;

8) Unpaid principal balance;

9) Total monthly payment;

10) Principal/interest;

11) Property tax; and

12) Hazard insurance.

c) Reverse Mortgage Loan Log shall include the information in subsection (a) for items 1, 2 (add ages), 6, 8 (add lump sum, monthly payment, line of credit), 9, 10, 11, 12, and add information for new items of appraised value, loan to value, and counseling (yes or no; if yes, add name of agency and HUD approval status).

d) Secondary Market Loan Log. Each licensee that sells, assigns or purchases any loans on the secondary market shall maintain a Secondary Market Loan Log that contains the following for each loan sold, assigned or purchased:

1) Name of loan seller or assignor;

2) Name of loan buyer or assignee;

3) Date of transaction;

4) Name of borrower or borrowers for underlying property;

5) Amount financed on underlying loan; and

6) Name of Loan Servicer.

e) High Risk Home Loans. If a licensee performs licensable acts with respect to a loan subject to the High Risk Home Loan Act, then the licensee shall maintain a separate High Risk Home Loan Log with the information required in subsection (a)~~ of this Section~~ with respect to each loan application received during the previous 60 months and shall maintain the respective loan files for 60 months from the date of closing or other termination of loan processing.

(Source: Amended at 38 Ill. Reg. 2019, effective December 27, 2013

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Construction and Filing of Accident and Health Insurance Policy Forms

2) Code Citation: 50 Ill. Adm. Code 2001

3)

Section Numbers:	Adopted Action:
2001.1	Amendment
2001.2	Amendment
2001.4	New
2001.5	New
2001.6	New
2001.7	New
2001.8	New
2001.9	New
2001.10	Renumbered/Amend
2001.11	New
2001.12	New
2001.20	Renumbered
2001.30	Renumbered
2001.110	Renumbered/Amend
2001.120	Renumbered/Amend
2001.130	Renumbered/Amend
2001.210	New
2001.220	New

4) Statutory Authority: Implementing Sections 143, 355, 356a and Articles IX and XX of the Illinois Insurance Code [215 ILCS 5/143, 355, 356a, Arts. IX and XX] and Section 4-13 of the Health Maintenance Organization Act [215 ILCS 125/4-13] and authorized by Section 401 of the Code [215 ILCS 5/401]

5) Effective Date of Rule: January 2, 2014

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? Yes

8) A copy of the adopted rulemaking, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 14404; September 13, 2013

10) Has JCAR issued a Statement of Objection to this Rulemaking? No

11) Differences between Proposal and Final Version:

Table of Contents: 2001.2, after "Definitions" added "and Cross-References".
2001.2: 1st line, after "**Definitions**" added "**and Cross-References**"; 3rd line, before "The" added "a)".

2001.2, definition of "Excepted Benefits": 12st line, deleted ", specified in regulations,"; 27th line, added "and" after "benefits;"; 29th line, changed semicolon to a period; 31st line, deleted all text; line 39, after "period" added "or per event".

2001.2, after definition of "Excepted Benefits": added ""Health Benefits Exchange" means the Illinois Health Benefits Exchange established pursuant to 42 USC 18031(b) and 215 ILCS 122/5-5, also known as the Illinois Health Insurance Marketplace."

2001.2, after definition of "HHS": added ""Network Plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer."

2001.2, after definition of "Waiting Period", added "b) In this Part, parenthetical cross-references following rule text are to the federal statutes or regulations relating to that Illinois rule provision.".

2001.4(b)(1)(A): 10th line, changed "applicable Illinois law" to "215 ILCS 97/30(B)(3)".

2001.4(e): 2nd line, changed "laws" to "law", deleted "any applicable" and "regulations"; 3rd line, deleted "and".

2001.8(a)(1)(D)(i): 2nd line, after "in" added "this"; 5th and 6th lines, changed "such" to "those" and after "guidelines" added "allowed".

2001.8(c): 3rd line, changed "Unite" to "United"

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2001.9(l)(1)(A): 9th line and 2001.9(m): 4th line, changed "State" to "Illinois"

2001.10(a)(2)(D): lines 5-6, deleted "and its implementing regulations"

2001.10(b)(1)(A): lines 3-4, deleted "in accordance with guidance as specified by the Secretary"

2001.10(b)(1)(B): 2nd line, deleted "identified by the Secretary in guidance" and deleted the commas.

2001.10(b)(2): 2nd and 3rd lines, deleted "specified by the Secretary in guidance"

2001.10(b)(2)(B): deleted the last sentence.

2001.10(b)(2)(C): 4th and 5th lines, deleted "in accordance with guidance issued by the Secretary"; 9th line, deleted ", as specified by the Secretary in guidance"

2001.10(c): deleted the first sentence.

2001.10(d)(3)(C): 3rd line, deleted comma after "(b)"; 4th line, deleted "as specified in guidance published by the Secretary,"

2001.10(g)(2): 2nd and 3rd lines, deleted ", specified by the Secretary in guidance,"

2001.10(g)(2)(B): 4th line, deleted ", as specified in guidance"

2001.10(g)(3): 2nd line, deleted "provide the"; 3rd-4th lines, deleted all text; 5th line, deleted "guidance to"

2001.12(b)(4): 1st line, capitalized "manner" and deleted the period; 5th line, added a period at the end.

2001.12(g): 2nd line, changed "In accordance with guidelines developed by the Secretary, there" to "There"

2001.12(j): 2nd and 4th lines, added "Health Benefits" before "Exchange"

2001.110(g): deleted all text; renumbered "h" through "ff" as "g" through "ee", respectively.

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2001.110(m): 2nd and 3rd lines, removed capitalization of "Insuring Provisions"

2001.110(bb)(3): lines 3-4, deleted "so that the forms will comply with the requirements of the Code or regulations of the Department,"

2001.120(aa)

2001.120(k), 2nd-4th lines and 6th-9th lines, replaced the blanks with "(a specific number of)" in 4 places.

2001.130(a)(3): after "submission" added ", or provide the following information in the Filing Description field under the General Information tab in the System for Electronic Rate and Form Filing (SERFF),"

2001.130: renumbered (b) to (c) and added a new subsection (b), "Copies of the policy forms, riders and endorsements will be retained in the files of the Department. The Department will provide notice of approval through SERFF."

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Part 2001 is being amended to adopt the market reform provisions of the Patient Protection and Affordable Care Act with respect to individual and group policies that guaranty availability and renewability of coverage, and prohibit preexisting conditions, lifetime or annual limits and rescissions. The changes also require coverage of preventive health services, prohibit health status discrimination, require certain essential health benefits, and adopt federal limits on cost-sharing.

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

James Rundblom, Deputy General Counsel
Department of Insurance
320 West Washington, 4th Floor
Springfield, Illinois 62767-0001

DEPARTMENT OF INSURANCE

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217/785-8559
217/524-9033 (fax)

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

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
~~FINANCIAL AND PROFESSIONAL REGULATION~~
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2001
CONSTRUCTION AND FILING OF ACCIDENT AND
HEALTH INSURANCE POLICY FORMS

SUBPART A: PROVISIONS APPLICABLE TO INDIVIDUAL AND GROUP POLICIES

Section
2001.1 Applicability
2001.2 Definitions and Cross-References
2001.3 Discretionary Clauses Prohibited
2001.4 Guaranteed Availability and Renewability of Coverage
2001.5 Prohibition of Preexisting Condition Exclusions
2001.6 No Lifetime or Annual Limits
2001.7 Prohibition on Rescissions
2001.8 Coverage of Preventive Health Services
2001.9 Prohibiting Discrimination Against Participants and Beneficiaries Based on Health Status
2001.10 Summary of Benefits and Coverage and Uniform Glossary
2001.11 Essential Health Benefits
2001.12 Cost-Sharing

SUBPART B: PROVISIONS APPLICABLE TO INDIVIDUAL POLICIES

Section
2001.20 Construction of Accident and Health Insurance Policy Forms (Renumbered)
2001.30 Filing of Policy Forms (Renumbered)
2001.110~~2001.10~~ Applicability
2001.120~~2001.20~~ Construction of Accident and Health Insurance Policy Forms
2001.130~~2001.30~~ Filing of Policy Forms

SUBPART C: PROVISIONS APPLICABLE TO GROUP POLICIES

2001.210 Applicability
2001.220 Ban on Excessive Waiting Periods

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

AUTHORITY: Implementing Sections 143, 355 and 356a and Articles IX and XX of the Illinois Insurance Code [215 ILCS 5/143, 355, 356a, Arts. IX and XX] and Section 4-13 of the Health Maintenance Organization Act [215 ILCS 125/4-13] and authorized by Section 401 of the Code [215 ILCS 5/401].

SOURCE: Filed and effective April 1, 1952; codified at 7 Ill. Reg. 3471; amended at 20 Ill. Reg. 14405, effective October 25, 1996; amended at 29 Ill. Reg. 10172, effective July 1, 2005; amended at 31 Ill. Reg. 8472, effective May 31, 2007; amended at 38 Ill. Reg. 2037, effective January 2, 2014.

SUBPART A: PROVISIONS APPLICABLE TO INDIVIDUAL AND GROUP POLICIES

Section 2001.1 Applicability

Unless otherwise provided, this ~~This~~ Subpart is applicable to all individual and group accident and health policies~~, disability insurance policies,~~ and group accident and health certificates, including coverage provided by a Health Maintenance Organization, except to the extent that such policies, certificates or coverage provides for excepted benefits~~,regardless of whether they provide disability benefits~~. Section 2001.3 applies to all individual and group policies regardless of whether those policies provide excepted benefits.

(Source: Amended at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.2 Definitions and Cross-References

a) The following definitions shall apply to this Part:

"ACA" means the Patient Protection and Affordable Care Act (42 USC 18001 et seq.).

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

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

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

"EHB" means essential health benefit or benefits.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended (29 USC 1001 et seq.).

"Excepted benefits", as defined at 26 USC 9832, means benefits under one or more (or any combination) of the following:

Benefits not subject to requirements:

Coverage only for accident, disability income insurance, or any combination thereof;

Coverage issued as a supplement to liability insurance;

Liability insurance, including general liability insurance and automobile liability insurance;

Workers' compensation or similar insurance;

Automobile medical payment insurance;

Credit-only insurance;

Coverage for on-site medical clinics;

Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Benefits not subject to requirements if offered separately:

Limited scope dental or vision benefits; and

Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Benefits not subject to requirements if offered as independent, noncoordinated benefits:

Coverage only for a specified disease or illness;

Hospital indemnity or other fixed indemnity insurance under which benefits are paid as a fixed dollar amount per day, or other period, or per event, regardless of the amount of expenses incurred.

Benefits not subject to requirements if offered as a separate insurance policy: Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act (42 USC 1395ss(g)(1)), coverage supplemental to the coverage provided under 10 USC 55, and similar supplemental coverage provided to coverage under a group health plan.

"Health Benefits Exchange" means the Illinois Health Benefits Exchange established pursuant to 42 USC 18031(b) and 215 ILCS 122/5-5, also known as the Illinois Health Insurance Marketplace.

"HHS" means the United States Department of Health and Human Services.

"Network Plan" means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

"PHS Act" means the Public Health Service Act (42 USC 201 et seq.).

"Preexisting condition exclusion" means a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR 148), whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any limitation or exclusion of benefits (including a denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage (or if coverage is denied, the date of the denial) under a group health plan, or group or individual health insurance coverage (or other coverage provided to federally eligible individuals pursuant to 45 CFR 148), such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or

review of medical records relating to the pre-enrollment period. (45 CFR 144.103)

"SBC" means summary of benefits and coverage.

"Secretary" means the Secretary of the United States Department of Health and Human Services, except when specified otherwise within this Part.

"Waiting period" means, with respect to a group health plan and an individual who is a potential participant or beneficiary in the plan, the period of time that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the plan. (42 USC 300gg(b)(4))

b) In this Part, parenthetical cross-references following rule text are to the federal statutes or regulations relating to that Illinois rule provision.

(Source: Amended at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.4 Guaranteed Availability and Renewability of Coverage

a) Guaranteed Availability of Coverage in the Individual and Group Market
Subject to subsections (b) through (d), a health insurance issuer that offers health insurance coverage in the individual or group market in this State must offer to any individual or employer in this State all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products. (45 CFR 147.106)

b) Enrollment Periods
A health insurance issuer may restrict enrollment in health insurance coverage to open or special enrollment periods.

1) Open Enrollment Periods

A) Group Market
A health insurance issuer in the group market must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. In the case of health insurance coverage offered in the small group market, a health insurance issuer may limit the availability of coverage to an annual

enrollment period that begins November 15 and extends through December 15 of each year in the case of a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules as defined in 45 CFR 147.106(b)(3), pursuant to 215 ILCS 97/30(B)(3) and, in the case of a QHP offered in the Small Business Health Option Program (SHOP), as permitted by 45 CFR 156.285(c). With respect to coverage in the small group market, and in the large group market if such coverage is offered in a SHOP in a state, coverage must become effective consistent with the dates described in 45 CFR 155.725(h).

B) Individual Market
A health insurance issuer in the individual market must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods described in 45 CFR 155.410(b) and (e). Coverage must become effective consistent with the dates described in 45 CFR 155.410(c) and (f).

2) Limited Open Enrollment Periods
A health insurance issuer in the individual market must provide a limited open enrollment period for the events described in 45 CFR 155.420(d), excluding paragraphs (d)(3) (concerning citizenship status), (d)(8) (concerning Indians), and (d)(9) (concerning exceptional circumstances). In addition, a health insurance issuer in the individual market must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

3) Special Enrollment Periods
A health insurance issuer in the group and individual market must establish special enrollment periods for qualifying events as defined under section 603 of ERISA. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and Illinois law.

4) Length of Enrollment Periods

With respect to the group market, enrollees must be provided 30 calendar days after the date of the qualifying event described in subsection (b)(3) to elect coverage. With respect to the individual market, enrollees must be provided 60 calendar days after the date of an event described in subsections (b)(2) and (b)(3) to elect coverage.

5) Effective Date of Coverage for Limited Open and Special Enrollment Periods
With respect to an election made under subsection (b)(2) or (b)(3), coverage must become effective consistent with the dates described in 45 CFR 155.420(b). (45 CFR 147.106)

c) Special Rules for Network Plans

1) In the case of a health insurance issuer that offers health insurance coverage in the group and individual market through a network plan, the issuer may do the following:

A) Limit the employers that may apply for the coverage to those with eligible individuals in the group market who live, work or reside in the service area for the network plan, and limit the individuals who may apply for the coverage in the individual market to those who live or reside in the service area for the network plan.

B) Within the service area of the plan, deny coverage to employers and individuals if the issuer has demonstrated to the Director the following:

i) It will not have the capacity to deliver services adequately to enrollees of any additional groups or any additional individuals because of its obligations to existing group contract holders and enrollees.

ii) It is applying this subsection (c)(1) uniformly to all employers and individuals without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any

health status-related factor relating to such individuals, employees, and dependents.

2) An issuer that denies health insurance coverage to an individual or an employer in any service area, in accordance with subsection (c)(1)(B), may not offer coverage in the individual or group market, as applicable, within the service area to any individual or employer, as applicable, for a period of 180 calendar days after the date the coverage is denied. This subsection (c)(2) does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

3) Coverage offered within a service area after the 180-day period specified in subsection (c)(2) is subject to the requirements of this Section. (45 CFR 147.106)

d) Application of Financial Capacity Limits

1) A health insurance issuer may deny health insurance coverage in the group or individual market if the issuer has demonstrated to the Director the following:

A) It does not have the financial reserves necessary to offer additional coverage.

B) It is applying this subsection (d)(1) uniformly to all employers or individuals in the group or individual market, as applicable, in this State consistent with applicable Illinois law and without regard to the claims experience of those individuals, employers and their employees (and their dependents) or any health status-related factor relating to those individuals, employees and dependents.

2) An issuer that denies health insurance coverage to any employer or individual in this State under subsection (d)(1) may not offer coverage in the group or individual market, as applicable, in this State before the later of either of the following dates:

A) The 181st day after the date the issuer denies coverage;

B) The date the issuer demonstrates to the Director, if required under applicable Illinois law, that the issuer has sufficient financial reserves to underwrite additional coverage.

3) Subsection (d)(2) does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

4) Coverage offered after the 180-day period specified in subsection (d)(2) is subject to the requirements of this Section.

5) The Director may provide for the application of this subsection (d) on a service-area-specific basis. (45 CFR 147.106)

e) Marketing
A health insurance issuer and its officials, employees, agents and representatives must comply with Illinois law regarding marketing by health insurance issuers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. (45 CFR 147.106)

f) Guaranteed Renewability of Coverage General Rule.
Subject to subsections (g) through (i), a health insurance issuer offering health insurance coverage in the individual or group market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable. (45 CFR 147.106)

g) Exceptions
An issuer may nonrenew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following:

1) Nonpayment of Premiums
The plan sponsor or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

2) Fraud
The plan sponsor or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.

3) Violation of Participation or Contribution Rules
In the case of group health insurance coverage, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable Illinois law. For purposes of this subsection (g)(13), the following apply:

A) The term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

B) The term "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

4) Termination of Plan
The issuer is ceasing to offer coverage in the market in accordance with subsection (h) or (i) and applicable Illinois law.

5) Enrollees' Movement Outside Service Area
For network plans, there is no longer any enrollee under the plan who lives, resides or works in the service area of the issuer (or in the area for which the issuer is authorized to do business) and, in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under 45 CFR 147.104(c)(1)(i).

6) Association Membership Ceases
For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the bona fide association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual. (45 CFR 147.106)

h) Discontinuing a Particular Product
In any case in which an issuer decides to discontinue offering a particular product offered in the group or individual market, that product may be discontinued by the issuer in accordance with applicable Illinois law in the applicable market only if the following occurs:

1) The issuer provides notice in writing to each plan sponsor or individual, as applicable, provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 calendar days before the date the coverage will be discontinued.

2) The issuer offers to each plan sponsor or individual, as applicable, provided that particular product the option, on a guaranteed availability basis, to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan or individual health insurance coverage in that market.

3) In exercising the option to discontinue that product and in offering the option of coverage under subsection (h)(2), the issuer acts uniformly without regard to the claims experience of those sponsors or individuals, as applicable, or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage. (45 CFR 147.106)

i) Discontinuing All Coverage

1) An issuer may elect to discontinue offering all health insurance coverage in the individual or group market, or all markets, in this State in accordance with applicable Illinois law only if:

A) The issuer provides notice in writing to the Director and to each plan sponsor or individual, as applicable, (and all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 calendar days prior to the date the coverage will be discontinued; and

B) All health insurance policies issued or delivered for issuance in this State in the applicable market (or markets) are discontinued and not renewed.

2) An issuer that elects to discontinue offering all health insurance coverage in a market (or markets) in this State as described in this subsection (i) may not issue coverage in the applicable market (or markets) in this State during the 5-year period beginning on the date of discontinuation of the last coverage not renewed. (45 CFR 147.106)

j) Exception for Uniform Modification of Coverage
Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan in the following:

1) Large group market;

2) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with Illinois law and is effective uniformly among group health plans with that product. (45 CFR 147.106)

k) Application to Coverage Offered Only Through Associations
In the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, the reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. (45 CFR 147.106)

l) Applicability Date
The provisions of this Section apply for plan years (in the individual market, policy years) beginning on or after January 1, 2014. (45 CFR 147.106)

m) Grandfathered Health Plans
This Section does not apply to grandfathered health plans in accordance with 45 CFR 147.140. (45 CFR 147.106)

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.5 Prohibition of Preexisting Condition Exclusions

a) No Preexisting Condition Exclusions

1) In General
A group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not impose any preexisting condition exclusion (as defined in Section 2001.2). (45 CFR 147.108(a))

2) Subsection (a) is illustrated by the examples appearing in 45 CFR 147.108.

b) Applicability

1) General Applicability Date
Except as provided in subsection (b)(2), this Section applies for plan years beginning on or after January 1, 2014; in the case of individual health insurance coverage, for policy years beginning, or applications denied, on or after January 1, 2014.

2) Early Applicability Date for Children
This Section applies with respect to enrollees, including applicants for enrollment, who are under 19 years of age for plan years beginning on or after September 23, 2010; in the case of individual health insurance coverage, for policy years beginning, or applications denied, on or after September 23, 2010.

3) Applicability to Grandfathered Health Plans
See 45 CFR 147.140 for determining the application of this Section to grandfathered health plans (providing that a grandfathered health plan that is a group health plan or group health insurance coverage must comply with the prohibition against preexisting condition exclusions; however, a grandfathered health plan that is individual health insurance coverage is not required to comply with PHS Act section 2704). (45 CFR 147.108(b))

4) Subsection (b) is illustrated by the examples appearing in 45 CFR 147.108.

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.6 No Lifetime or Annual Limits

a) Prohibition

1) Lifetime Limits
Except as provided in subsection (b), a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any lifetime limit on the dollar amount of benefits for any individual.

2) Annual Limits

A) General Rule
Except as provided in subsections (a)(2)(B), (b) and (d), a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may not establish any annual limit on the dollar amount of benefits for any individual.

B) Exception for Health Flexible Spending Arrangements
A health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code (26 USC 106(c)(2)) is not subject to the requirement in subsection (a)(2)(A). (45 CFR 147.126)

b) Construction

1) Permissible Limits on Specific Covered Benefits
This Section does not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that such limits are otherwise permitted under applicable federal or Illinois law. (The scope of essential health benefits is addressed in subsection (c)).

2) Condition-Based Exclusions
This Section does not prevent a group health plan, or a health insurance issuer offering group or individual health insurance coverage, from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the requirements of this Section apply.

Other requirements of federal or Illinois law may require coverage of certain benefits. (45 CFR 147.126)

c) Definition of Essential Health Benefits
Essential health benefits shall be as defined in Section 2001.11(c).

d) Restricted Annual Limits Permissible Prior to 2014

1) In General
With respect to plan years (in the individual market, policy years) beginning prior to January 1, 2014, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, may establish, for any individual, an annual limit on the dollar amount of benefits that are essential health benefits, provided the limit is no less than the amounts in the following schedule:

A) For a plan year (in the individual market, policy year) beginning on or after September 23, 2010, but before September 23, 2011, $750,000.

B) For a plan year (in the individual market, policy year) beginning on or after September 23, 2011, but before September 23, 2012, $1,250,000.

C) For plan years (in the individual market, policy years) beginning on or after September 23, 2012, but before January 1, 2014, $2,000,000.

2) Only Essential Health Benefits Taken Into Account
In determining whether an individual has received benefits that meet or exceed the applicable amount described in subsection (d)(1), a plan or issuer must take into account only essential health benefits.

3) Waivers
For plan years (in the individual market, policy years) beginning before January 1, 2014, the requirements of subsection (d)(1) relating to annual limits may be waived (for such period as is specified by the Secretary) for a group health plan or health insurance coverage that has an annual dollar limit on benefits below the restricted annual limits provided under

subsection (d)(1) if compliance with subsection (d)(1) would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage. (45 CFR 147.126)

e) Transitional Rules for Individuals Whose Coverage or Benefits Ended by Reason of Reaching a Lifetime Limit

1) In General
The relief provided in the transitional rules of subsection (e) applies with respect to any individual:

A) Whose coverage or benefits under a group health plan or group or individual health insurance coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits for any individual (which, under this Section, is no longer permissible); and

B) Who becomes eligible (or is required to become eligible) for benefits not subject to a lifetime limit on the dollar value of all benefits under the group health plan or group or individual health insurance coverage on the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, by reason of the application of this Section.

2) Notice and Enrollment Opportunity Requirements

A) If an individual described in subsection (e)(1) is eligible for benefits (or is required to become eligible for benefits) under the group health plan, or group or individual health insurance coverage, described in subsection (e)(1), the plan and the issuer are required to give the individual written notice that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan and issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The

notices and enrollment opportunity required under this subsection (e)(2)(A) must be provided beginning not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010.

B) The notices required under subsection (e)(2)(A) may be provided to an employee on behalf of the employee's dependent (in the individual market, to the primary subscriber on behalf of the primary subscriber's dependent). In addition, for a group health plan or group health insurance coverage, the notices may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For either notice, with respect to a group health plan or group health insurance coverage, if a notice satisfying the requirements of subsection (e)(2) is provided to an individual, the obligation to provide the notice with respect to that individual is satisfied for both the plan and the issuer.

3) Effective Date of Coverage
In the case of an individual who enrolls under subsection (e)(2), coverage must take effect not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010.

4) Treatment of Enrollees in a Group Health Plan
Any individual enrolling in a group health plan pursuant to subsection (e)(2) must be treated as if the individual were a special enrollee, as provided under 45 CFR 146.117(d). Accordingly, the individual (and, if the individual would not be a participant once enrolled in the plan, the participant through whom the individual is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The individual also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of reaching a lifetime limit on the dollar value of all benefits. (45 CFR 147.126)

5) This subsection (e) is illustrated by the examples appearing in 45 CFR 147.126.

f) Applicability Date
This Section applies for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See 45 CFR 147.140 for determining the application of this Section to grandfathered health plans (providing that the prohibitions on lifetime and annual limits apply to all grandfathered health plans that are group health plans and group health insurance coverage, including the special rules regarding restricted annual limits, and the prohibition on lifetime limits apply to individual health insurance coverage that is a grandfathered health plan but the rules on annual limits do not apply to individual health insurance coverage that is a grandfathered health plan). (45 CFR 147.126)

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.7 Prohibition on Rescissions

a) Prohibition on Rescissions

1) A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this subsection (a)(1), regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (This subsection (a)(1) applies regardless of any contestability period that may otherwise apply.)

2) For purposes of this Section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if:

A) The cancellation or discontinuance of coverage has only a prospective effect; or

B) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. (45 CFR 147.128)

3) This subsection (a) is illustrated by the examples appearing in 45 CFR 147.128.

b) Compliance with Other Requirements
Other requirements of federal or Illinois law may apply in connection with a rescission of coverage. (45 CFR 147.128)

c) Applicability Date
This Section applies for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See 45 CFR 147.140 for determining the application of this Section to grandfathered health plans (providing that the rules regarding rescissions and advance notice apply to all grandfathered health plans). (45 CFR 147.128)

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.8 Coverage of Preventive Health Services

a) Services

1) In General
Beginning at the time described in subsection (b), and subject to 45 CFR 147.131, a group health plan, or a health insurance issuer offering group or

individual health insurance coverage, must provide coverage stated both in the policy and certificate (for group coverage) for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance or deductible) with respect to those items or services:

A) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in subsection (c));

B) Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

C) With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

D) With respect to women, to the extent not described in subsection (a)(1)(A), preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration.

i) In developing the binding health plan coverage guidelines specified in this subsection (a)(1)(D), the Health Resources and Services Administration shall be informed by evidence and may establish exemptions from those guidelines allowed with respect to group health plans established or maintained by religious employers and health insurance

coverage provided in connection with group health plans established or maintained by religious employers with respect to any requirement to cover contraceptive services under such guidelines.

ii) For purposes of this subsection (a)(1)(D), a "religious employer" is an organization that meets all of the following criteria: The inculcation of religious values is the purpose of the organization; the organization primarily employs persons who share the religious tenets of the organization; the organization serves primarily persons who share the religious tenets of the organization; the organization is a nonprofit organization as described in section 6033(a)(1) and (a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended (26 USC 6033).

2) Office Visits

A) If an item or service described in subsection (a)(1) is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

B) If an item or service described in subsection (a)(1) is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

C) If an item or service described in subsection (a)(1) is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.

D) This subsection (a)(2) is illustrated by the examples appearing in 45 CFR 147.130.

3) Out-of-Network Providers
Nothing in this Section requires a plan or issuer that has a network of providers to provide benefits for items or services described in subsection (a)(1) that are delivered by an out-of-network provider. Moreover, nothing in this Section precludes a plan or issuer that has a network of providers from imposing cost-sharing requirements for items or services described in subsection (a)(1) that are delivered by an out-of-network provider.

4) Reasonable Medical Management
Nothing prevents a plan or issuer from using reasonable medical management techniques to determine the frequency, method, treatment or setting for an item or service described in subsection (a)(1) to the extent not specified in the recommendation or guideline.

5) Services Not Described
Nothing in this Section prohibits a plan or issuer from providing coverage for items and services in addition to those recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or provided for by guidelines supported by the Health Resources and Services Administration, or from denying coverage for items and services that are not recommended by that task force or that advisory committee, or under those guidelines. A plan or issuer may impose cost-sharing requirements for a treatment not described in subsection (a)(1), even if the treatment results from an item or service described in subsection (a)(1). (45 CFR 147.130)

b) Timing

1) In General
A plan or issuer must provide coverage pursuant to subsection (a)(1) for plan years (in the individual market, policy years) that begin on or after September 23, 2010, or, if later, for plan years (in the individual market, policy years) that begin on or after the date that is one year after the date the recommendation or guideline is issued.

2) Changes in Recommendations or Guidelines

A plan or issuer is not required under this Section to provide coverage for any items and services specified in any recommendation or guideline described in subsection (a)(1) after the recommendation or guideline is no longer described in subsection (a)(1). Other requirements of federal or Illinois law may apply in connection with a plan or issuer ceasing to provide coverage for any such items or services, including PHS Act section 2715(d)(4), which requires a plan or issuer to give 60 days advance notice to an enrollee before any material modification will become effective. (45 CFR 147.130)

c) Recommendations not Current
For purposes of subsection (a)(1)(A), and for purposes of any other provision of law, recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography and prevention issued in or around November 2009 are not considered to be current. (45 CFR 147.130)

d) Applicability Date
This Section applies for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See 45 CFR 147.140 for determining the application of this Section to grandfathered health plans (providing that the provisions of this Section regarding coverage of preventive health services do not apply to grandfathered health plans). (45 CFR 147.130)

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.9 Prohibiting Discrimination Against Participants and Beneficiaries Based on Health Status

a) Health Factors

1) The term health factor means, in relation to an individual, any of the following health status-related factors:

A) Health status;

B) Medical condition (including both physical and mental illnesses), as defined in 45 CFR 144.103;

C) Claims experience;

D) Receipt of health care;

E) Medical history;

F) Genetic information, as defined in 45 CFR 146.122(a);

G) Evidence of insurability; or

H) Disability.

2) Evidence of insurability includes:

A) Conditions arising out of acts of domestic violence; and

B) Participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

3) The decision whether health coverage is elected for an individual (including the time chosen to enroll, such as under special enrollment or late enrollment) is not, itself, within the scope of any health factor. (However, under 45 CFR 146.117, a plan or issuer must treat special enrollees the same as similarly situated individuals who are enrolled when first eligible.) (45 CFR 146.121)

b) Prohibited Discrimination in Rules for Eligibility

1) In General

A) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not establish any rule for eligibility (including continued eligibility) of any individual to enroll for benefits under the terms of the plan or group health insurance coverage that discriminates based on any health factor that relates to that individual or a dependent of that individual. This rule is subject to the provisions of subsection (b)(2) (explaining how this Section applies to benefits), subsection (b)(3) (allowing plans to impose certain

preexisting condition exclusions), subsection (d) (containing rules for establishing groups of similarly situated individuals), subsection (e) (relating to nonconfinement, actively-at-work, and other service requirements), subsection (f) (relating to wellness programs), and subsection (g) (permitting favorable treatment of individuals with adverse health factors).

B) For purposes of this Section, rules for eligibility include, but are not limited to, rules relating to:

i) Enrollment;

ii) The effective date of coverage;

iii) Waiting (or affiliation) periods;

iv) Late and special enrollment;

v) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages);

vi) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles), as described in subsections (b)(2) and (b)(3);

vii) Continued eligibility; and

viii) Terminating coverage (including disenrollment) of any individual under the plan. (45 CFR 146.121)

C) This subsection (b)(1) is illustrated by the examples appearing in 45 CFR 146.121(b)(1)(iii).

2) Application to Benefits

A) General Rule

i) Under this Section, a group health plan or group health insurance issuer is not required to provide coverage for any particular benefit to any group of similarly situated individuals.

ii) However, benefits provided under a plan or through group health insurance coverage must be uniformly available to all similarly situated individuals (as described in subsection (d)). Likewise, any restriction on a benefit or benefits must apply uniformly to all similarly situated individuals and must not be directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries (determined based on all the relevant facts and circumstances). Thus, for example, a plan or issuer may limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In addition, a plan or issuer may impose annual, lifetime or other limits on benefits and may require the satisfaction of a deductible, copayment, coinsurance or other cost-sharing requirement in order to obtain a benefit if the limit or cost-sharing requirement applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. In the case of a cost-sharing requirement, see also subsection (b)(2)(B), which permits variances in the application of a cost-sharing mechanism made available under a wellness program. (Whether any plan provision or practice with respect to benefits complies with this subsection (b)(2)(A) does not affect whether the provision or practice is permitted under any other provision of ERISA, the Americans With Disabilities Act (42 USC 12101 et seq.), or any other law, whether State or federal.)

iii) For purposes of this subsection (b)(2)(A), a plan amendment applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries.

iv) This subsection (b)(2)(A) is illustrated by the examples appearing in 45 CFR 146.121(b)(2)(i)(D).

B) Exception for Wellness Programs
A group health plan or group health insurance issuer may vary benefits, including cost-sharing mechanisms (such as a deductible, copayment or coinsurance), based on whether an individual has met the standards of a wellness program that satisfies the requirements of subsection (f).

C) Specific Rule Relating to Source-of-Injury Exclusions

i) If a group health plan or group health insurance coverage generally provides benefits for a type of injury, the plan or issuer may not deny benefits otherwise provided for treatment of the injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions). This rule applies in the case of an injury resulting from a medical condition even if the condition is not diagnosed before the injury.

ii) This subsection (b)(2)(C) is illustrated by the examples appearing in 45 CFR 146.121(b)(2)(iii)(B).

3) Relationship to 45 CFR 146.111

A) A preexisting condition exclusion is permitted under this Section if it :

i) Complies with 45 CFR 146.111;

ii) Applies uniformly to all similarly situated individuals (as described in subsection (d)); and

iii) Is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries. For purposes of this subsection (b)(3)(A)(iii), a plan amendment relating to a preexisting condition exclusion applicable to all individuals in one or more groups of similarly situated individuals under the plan and made effective no earlier than the first day of the first plan year after the amendment is adopted is not considered to be directed at any individual participants or beneficiaries. (45 CFR 146.121)

B) This subsection (b)(3) is illustrated by the examples appearing in 45 CFR 146.121(b)(3)(ii).

c) Prohibited Discrimination in Premiums or Contributions

1) In General

A) A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual, as a condition of enrollment or continued enrollment under the plan or group health insurance coverage, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual (described in subsection (d)) enrolled in the plan or group health insurance coverage based on any health factor that relates to the individual or a dependent of the individual.

B) Discounts, rebates, payments in kind, and any other premium differential mechanisms are taken into account in determining an individual's premium or contribution rate. (For rules relating to cost-sharing mechanisms, see subsection (b)(2) (addressing benefits).)

2) Rules Relating to Premium Rates

A) Group Rating Based on Health Factors Not Restricted Under This Section
Nothing in this Section restricts the aggregate amount that an employer may be charged for coverage under a group health plan. But see 45 CFR 146.122(b), which prohibits adjustments in group premium or contribution rates based on genetic information.

B) List Billing Based on a Health Factor Prohibited
However, a group health insurance issuer, or a group health plan, may not quote or charge an employer (or an individual) a different premium for an individual in a group of similarly situated individuals based on a health factor. (But see subsection (l) permitting favorable treatment of individuals with adverse health factors.)

C) This subsection (c)(2) is illustrated by the examples appearing in 45 CFR 146.121(c)(2)(iii).

3) Exception for Wellness Programs
Notwithstanding subsections (c)(1) and (c)(2), a plan or issuer may vary the amount of premium or contribution it requires similarly situated individuals to pay based on whether an individual has met the standards of a wellness program that satisfies the requirements of subsections (f) through (k). (45 CFR 146.121)

d) Similarly Situated Individuals
The requirements of this Section apply only within a group of individuals who are treated as similarly situated individuals. A plan or issuer may treat participants as a group of similarly situated individuals separate from beneficiaries. In addition, participants may be treated as two or more distinct groups of similarly situated individuals and beneficiaries may be treated as two or more distinct groups of similarly situated individuals in accordance with this subsection (d). Moreover, if individuals have a choice of two or more benefit packages, individuals choosing one benefit package may be treated as one or more groups of similarly situated individuals distinct from individuals choosing another benefit package.

1) Participants
Subject to subsection (d)(3), a plan or issuer may treat participants as two or more distinct groups of similarly situated individuals if the distinction

between or among the groups of participants is based on a bona fide employment-based classification consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is determined on the basis of all the relevant facts and circumstances. Relevant facts and circumstances include whether the employer uses the classification for purposes independent of qualification for health coverage (for example, determining eligibility for other employee benefits or determining other terms of employment). Subject to subsection (d)(3), examples of classifications that, based on all the relevant facts and circumstances, may be bona fide include full-time versus part-time status, different geographic location, membership in a collective bargaining unit, date of hire, length of service, current employee versus former employee status, and different occupations. However, a classification based on any health factor is not a bona fide employment-based classification unless the requirements of subsection (l) are satisfied (permitting favorable treatment of individuals with adverse health factors).

2) Beneficiaries

A) Subject to subsection (d)(3), a plan or issuer may treat beneficiaries as two or more distinct groups of similarly situated individuals if the distinction between or among the groups of beneficiaries is based on any of the following factors:

i) A bona fide employment-based classification of the participant through whom the beneficiary is receiving coverage;

ii) Relationship to the participant (for example, as a spouse or as a dependent child);

iii) Marital status;

iv) With respect to children of a participant, age or student status; or

v) Any other factor if the factor is not a health factor.

B) Subsection (d)(2)(A) does not prevent more favorable treatment of individuals with adverse health factors in accordance with subsection (g).

3) Discrimination Directed at Individuals
Notwithstanding subsections (d)(1) and (d)(2), if the creation or modification of an employment or coverage classification is directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries, the classification is not permitted under this subsection (d) unless it is permitted under subsection (g) (permitting favorable treatment of individuals with adverse health factors). Thus, if an employer modified an employment-based classification to single out, based on a health factor, individual participants and beneficiaries and deny them health coverage, the new classification would not be permitted under this Section. (45 CFR 146.121)

4) This subsection (d) is illustrated by the examples appearing at 45 CFR 146.121(d)(4).

e) Nonconfinement and Actively-at-Work Provisions

1) Nonconfinement Provisions

A) General Rule
Under subsections (b) and (c), a plan or issuer may not establish a rule for eligibility (as described in subsection (b)(1)(B)) or set any individual's premium or contribution rate based on whether an individual is confined to a hospital or other health care institution. In addition, under subsections (b) and (c), a plan or issuer may not establish a rule for eligibility or set any individual's premium or contribution rate based on an individual's ability to engage in normal life activities, except to the extent permitted under subsections (e)(2)(B) and (e)(3) (permitting plans and issuers, under certain circumstances, to distinguish among employees based on the performance of services).

B) This subsection (e)(1)(A) is illustrated by the examples appearing at 45 CFR 146.121(e)(1)(ii).

2) Actively-at-Work and Continuous Service Provisions

A) General Rule

i) Under subsections (b) and (c) and subject to the exception for the first day of work described in subsection (e)(2)(B), a plan or issuer may not establish a rule for eligibility (as described in subsection (b)(1)(B)) or set any individual's premium or contribution rate based on whether an individual is actively at work (including whether an individual is continuously employed), unless absence from work due to any health factor (such as being absent from work on sick leave) is treated, for purposes of the plan or health insurance coverage, as being actively at work.

ii) This subsection (e)(2)(A)(i) is illustrated by the examples appearing at 45 CFR 146.121(e)(2)(B).

B) Exception for the First Day of Work

i) Notwithstanding the general rule in subsection (e)(2)(A), a plan or issuer may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan (or, in the case of a multiemployer plan, to begin a job in covered employment) before coverage becomes effective, provided that such a rule for eligibility applies regardless of the reason for the absence.

ii) This subsection (e)(2)(B) is illustrated by the examples appearing at 45 CFR 146.121(e)(2)(ii)(B).

3) Relationship to Plan Provisions Defining Similarly Situated Individuals

A) Notwithstanding subsections (e)(1) and (e)(2), a plan or issuer may establish rules for eligibility or set any individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in subsection (d). Accordingly, a plan or issuer may distinguish in rules for eligibility under the plan between full-time and part-time employees, between permanent and temporary

or seasonal employees, between current and former employees, and between employees currently performing services and employees no longer performing services for the employer, subject to subsection (d). However, other federal or Illinois laws (including the COBRA continuation provisions and the Family and Medical Leave Act of 1993 (29 USC 2601 et seq.)) may require an employee or the employee's dependents to be offered coverage and set limits on the premium or contribution rate even though the employee is not performing services. (45 CFR 146.121)

B) This subsection (e)(3)(A) is illustrated by the examples appearing at 45 CFR 146.121(e)(3)(ii).

f) Nondiscriminatory Wellness Programs – In General
A wellness program is a program of health promotion or disease prevention. Subsections (b)(2)(B) and (c)(3) provide exceptions to the general prohibitions against discrimination based on a health factor for plan provisions that vary benefits (including cost-sharing mechanisms) or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of subsections (f) through (k). The following definitions govern in applying the provisions of subsections (f) through (k):

1) Reward
Except where expressly provided otherwise, references in this Section to an individual obtaining a reward include both obtaining a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and avoiding a penalty (such as the absence of a premium surcharge or other financial or nonfinancial disincentive). References in this Section to a plan providing a reward include both providing a reward (such as a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive) and imposing a penalty (such as a surcharge or other financial or nonfinancial disincentive).

2) Participatory Wellness Programs
If none of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness

program is a participatory wellness program. Examples of participatory wellness programs are:

A) A program that reimburses employees for all or part of the cost for membership in a fitness center;

B) A diagnostic testing program that provides a reward for participation in that program and does not base any part of the reward on outcomes;

C) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits. (Note that, with respect to non-grandfathered plans, 45 CFR 147.130 requires benefits for certain preventive health services without the imposition of cost sharing.);

D) A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking;

E) A program that provides a reward to employees for attending a monthly, no-cost health education seminar; and

F) A program that provides a reward to employees who complete a health risk assessment regarding current health status, without any further action (educational or otherwise) required by the employee with regard to the health issues identified as part of the assessment. (See also 45 CFR 146.122 for rules prohibiting collection of genetic information.)

3) Health-Contingent Wellness Programs
A health-contingent wellness program is a program that requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward). A health-contingent wellness program may be an activity-only wellness program or an outcome-based wellness program.

4) Activity-Only Wellness Programs
An activity-only wellness program is a type of health-contingent wellness program that requires an individual to perform or complete an activity related to a health factor in order to obtain a reward but does not require the individual to attain or maintain a specific health outcome. Examples include walking, diet or exercise programs, which some individuals may be unable to participate in or complete (or have difficulty participating in or completing) due to a health factor, such as severe asthma, pregnancy or a recent surgery. See subsection (h) for requirements applicable to activity-only wellness programs.

5) Outcome-Based Wellness Programs
An outcome-based wellness program is a type of health-contingent wellness program that requires an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. To comply with the rules of subsections (f) through (k), an outcome-based wellness program typically has two tiers. That is, for individuals who do not attain or maintain the specific health outcome, compliance with an educational program or an activity may be offered as an alternative to achieve the same reward. This alternative pathway, however, does not mean that the overall program, which has an outcome-based component, is not an outcome-based wellness program. That is, if a measurement, test or screening is used as part of an initial standard and individuals who meet the standard are granted the reward, the program is considered an outcome-based wellness program. For example, if a wellness program tests individuals for specified medical conditions or risk factors (including biometric screening such as testing for high cholesterol, high blood pressure, abnormal body mass index, or high glucose level) and provides a reward to individuals identified as within a normal or healthy range for these medical conditions or risk factors, while requiring individuals who are identified as outside the normal or healthy range (or at risk) to take additional steps (such as meeting with a health coach, taking a health or fitness course, adhering to a health improvement action plan, complying with a walking or exercise program, or complying with a health care provider's plan of care) to obtain the same reward, the program is an outcome-based wellness program. See subsection (i) for requirements applicable to outcome-based wellness programs. (45 CFR 146.121)

g) Requirement for Participatory Wellness Programs
A participatory wellness program, as described in subsection (f)(2), does not violate the provisions of this Section only if participation in the program is made available to all similarly situated individuals, regardless of health status.

h) Requirements for Activity-Only Wellness Programs
A health-contingent wellness program that is an activity-only wellness program, as described in subsection (f)(4), does not violate the provisions of this Section only if all of the following requirements are satisfied:

1) Frequency of Opportunity to Qualify
The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

2) Size of Reward
The reward for the activity-only wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage (as defined in subsection (j)) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the wellness program, the reward must not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled. For purposes of this subsection (h)(2), the cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage.

3) Reasonable Design
The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease. This determination is based on all the relevant facts and circumstances.

4) Uniform Availability and Reasonable Alternative Standards
The full reward under the activity-only wellness program must be available to all similarly situated individuals.

A) Under this subsection (h)(4), a reward under an activity-only wellness program is not available to all similarly situated individuals for a period unless the program meets both of the following requirements:

i) The program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

ii) The program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

B) While plans and issuers are not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in either subsection (h)(4)(A)(i) or (ii), a reasonable alternative standard must be furnished by the plan or issuer upon the individual's request or the condition for obtaining the reward must be waived.

C) All the facts and circumstances are taken into account in determining whether a plan or issuer has furnished a reasonable alternative standard, including but not limited to the following:

i) If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program;

ii) The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable);

iii) If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee;

iv) If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

D) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an activity-only wellness program, it must comply with the requirements of this subsection (h) in the same manner as if it were an initial program standard. (Thus, for example, if a plan or issuer provides a walking program as a reasonable alternative standard to a running program, individuals for whom it is unreasonably difficult due to a medical condition to complete the walking program (or for whom it is medically inadvisable to attempt to complete the walking program) must be provided a reasonable alternative standard to the walking program.) To the extent that a reasonable alternative standard under an activity-only wellness program is, itself, an outcome-based wellness program, it must comply with the requirements of subsection (i), including subsection (i)(4)(D).

E) If reasonable under the circumstances, a plan or issuer may seek verification, such as a statement from an individual's personal physician, that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard of an

activity-only wellness program. Plans and issuers may seek verification with respect to requests for a reasonable alternative standard for which it is reasonable to determine that medical judgment is required to evaluate the validity of the request.

5) Notice of Availability of Reasonable Alternative Standard
The plan or issuer must disclose in all plan materials describing the terms of an activity-only wellness program the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in subsection (k), as well as in certain examples of this Section. (45 CFR 146.121)

6) The provisions of this subsection (h) are illustrated by the example appearing at 45 CFR 146.121(f)(4)(vi).

i) Requirements for Outcome-Based Wellness Programs
A health-contingent wellness program that is an outcome-based wellness program, as described in subsection (f)(5), does not violate the provisions of this Section only if all of the following requirements are satisfied:

1) Frequency of Opportunity to Qualify
The program must give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

2) Size of Reward
The reward for the outcome-based wellness program, together with the reward for other health-contingent wellness programs with respect to the plan, must not exceed the applicable percentage (as defined in subsection (j)) of the total cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses, or spouses and dependent children) may participate in the wellness program, the reward must not exceed the applicable percentage of the total cost of the coverage in which an employee and any dependents are enrolled. For

purposes of this subsection (i)(2), the cost of coverage is determined based on the total amount of employer and employee contributions towards the cost of coverage for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage.

3) Reasonable Design
The program must be reasonably designed to promote health or prevent disease. A program satisfies this standard if it has a reasonable chance of improving the health of, or preventing disease in, participating individuals, and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease. This determination is based on all the relevant facts and circumstances. To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a measurement, test or screening that is related to a health factor, as explained in subsection (i)(4).

4) Uniform Availability and Reasonable Alternative Standards
The full reward under the outcome-based wellness program must be available to all similarly situated individuals.

A) Under this subsection (i)(4), a reward under an outcome-based wellness program is not available to all similarly situated individuals for a period unless the program allows a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual who does not meet the initial standard based on the measurement, test or screening, as described in this subsection (i)(4).

B) While plans and issuers are not required to determine a particular reasonable alternative standard in advance of an individual's request for one, if an individual is described in subsection (i)(4)(A), a reasonable alternative standard must be furnished by the plan or issuer upon the individual's request or the condition for obtaining the reward must be waived.

C) All the facts and circumstances are taken into account in determining whether a plan or issuer has furnished a reasonable alternative standard, including but not limited to the following:

i) If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.

ii) The time commitment required must be reasonable (for example, requiring attendance nightly at a one-hour class would be unreasonable).

iii) If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.

iv) If an individual's personal physician states that a plan standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

D) To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, an activity-only wellness program, it must comply with the requirements of subsection (h) in the same manner as if it were an initial program standard. To the extent that a reasonable alternative standard under an outcome-based wellness program is, itself, another outcome-based wellness program, it must comply with the requirements of this subsection (i), subject to the following special rules:

i) The reasonable alternative standard cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances. For example, if the initial standard is to achieve a BMI less than 30, the reasonable alternative standard cannot be to achieve a BMI less than 31 on that same date. However, if the initial standard is to achieve a BMI less than 30, a reasonable alternative standard for the individual could be to reduce the individual's BMI by a small amount or small percentage, over a realistic period of time, such as within a year.

ii) An individual must be given the opportunity to comply with the recommendations of the individual's personal physician as a second reasonable alternative standard to meeting the reasonable alternative standard defined by the plan or issuer, but only if the physician joins in the request. The individual can make a request to involve a personal physician's recommendations at any time and the personal physician can adjust the physician's recommendations at any time, consistent with medical appropriateness.

E) It is not reasonable to seek verification, such as a statement from an individual's personal physician, under an outcome-based wellness program that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy, the otherwise applicable standard as a condition of providing a reasonable alternative to the initial standard. However, if a plan or issuer provides an alternative standard to the otherwise applicable measurement, test or screening that involves an activity that is related to a health factor, then the rules of subsection (h) for activity-only wellness programs apply to that component of the wellness program and the plan or issuer may, if reasonable under the circumstances, seek verification that it is unreasonably difficult due to a medical condition for an individual to perform or complete the activity (or it is medically inadvisable to attempt to perform or complete the activity). (For example, if an outcome-based wellness program requires participants to maintain a certain healthy weight and provides a

diet and exercise program for individuals who do not meet the targeted weight, a plan or issuer may seek verification, as described in subsection (i)(4)(D), if reasonable under the circumstances, that a second reasonable alternative standard is needed for certain individuals because, for those individuals, it would be unreasonably difficult due to a medical condition to comply, or medically inadvisable to attempt to comply, with the diet and exercise program, due to a medical condition.)

5) Notice of Availability of Reasonable Alternative Standard
The plan or issuer must disclose in all plan materials describing the terms of an outcome-based wellness program, and in any disclosure that an individual did not satisfy an initial outcome-based standard, the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard), including contact information for obtaining a reasonable alternative standard and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required. Sample language is provided in subsection (k), as well as in certain examples of this Section. (45 CFR 146.121)

6) This subsection (i) is illustrated by the examples at 45 CFR 146.121(f)(4).

j) Applicable Percentage

1) For purposes of subsections (f) through (k), the applicable percentage is 30 percent, except that the applicable percentage is increased by an additional 20 percentage points (to 50 percent) to the extent that the additional percentage is in connection with a program designed to prevent or reduce tobacco use. (45 CFR 146.121)

2) This subsection (j) is illustrated by the examples located at 45 CFR 146.121(f)(5)(ii).

k) Sample Language
The following language, or substantially similar language, can be used to satisfy the notice requirement of subsection (h)(5) or (j)(5): "Your health plan is

committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status." (45 CFR 146.121)

l) More Favorable Treatment of Individuals with Adverse Health Factors Permitted

1) In Rules for Eligibility

A) Nothing in this Section prevents a group health plan or group health insurance issuer from establishing more favorable rules for eligibility (described in subsection (b)(1)) for individuals with an adverse health factor, such as disability, than for individuals without the adverse health factor. Moreover, nothing in this Section prevents a plan or issuer from charging a higher premium or contribution with respect to individuals with an adverse health factor if they would not be eligible for the coverage were it not for the adverse health factor. (However, other laws, including Illinois insurance laws, may set or limit premium rates; these laws are not affected by this Section.)

B) This subsection (l)(1) is illustrated by the examples appearing at 45 CFR 146.121(g)(1)(ii).

2) In Premiums or Contributions

A) Nothing in this Section prevents a group health plan or group health insurance issuer from charging individuals a premium or contribution that is less than the premium (or contribution) for similarly situated individuals if the lower charge is based on an adverse health factor, such as disability. (45 CFR 146.121)

B) This subsection (l)(2) is illustrated by the examples appearing at 45 CFR 146.121(g)(2)(ii).

m) No Effect on Other Laws

Compliance with this Section is not determinative of compliance with any other provision of the PHS Act (including the COBRA continuation provisions) or any other Illinois or federal law, such as the Americans With Disabilities Act. Therefore, although this Section would not prohibit a plan or issuer from treating one group of similarly situated individuals differently from another (such as providing different benefit packages to current and former employees), other federal or Illinois laws may require that two separate groups of similarly situated individuals be treated the same for certain purposes (such as making the same benefit package available to COBRA qualified beneficiaries as is made available to active employees). In addition, although this Section generally does not impose new disclosure obligations on plans and issuers, this Section does not affect any other laws, including those that require accurate disclosures and prohibit intentional misrepresentation. (45 CFR 146.121)

n) Applicability Dates

1) Generally
This Section applies for plan years beginning on or after July 1, 2007.

2) Special Rule for Self-Funded Nonfederal Governmental Plans Exempted Under 45 CFR 146.180

A) If coverage has been denied to any individual because the sponsor of a self-funded nonfederal governmental plan has elected under 45 CFR 146.180 to exempt the plan from the requirements of this Section, and the plan sponsor subsequently chooses to bring the plan into compliance with the requirements of this Section, the plan:

i) Must notify the individual that the plan will be coming into compliance with the requirements of this Section, specify the effective date of compliance, and inform the individual regarding any enrollment restrictions that may apply under the terms of the plan once the plan is in compliance with this Section (as a matter of administrative convenience, the notice may be disseminated to all employees);

ii) Must give the individual an opportunity to enroll that continues for at least 30 days;

iii) Must permit coverage to be effective as of the first day of plan coverage for which an exemption election under 45 CFR 146.180 (with regard to this Section) is no longer in effect; and

iv) May not treat the individual as a late enrollee or a special enrollee.

B) For purposes of this subsection (n)(2), an individual is considered to have been denied coverage if the individual failed to apply for coverage because, given an exemption election under 45 CFR 146.180, it was reasonable to believe that an application for coverage would have been denied based on a health factor. (45 CFR 146.121)

C) This subsection (n)(2) is illustrated by the examples appearing at 45 CFR 146.121(i)(2)(iii).

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.10 Summary of Benefits and Coverage and Uniform Glossary ~~Applicability~~

a) Summary of Benefits and Coverage in General
A group health plan (and its administrator as defined in section 3(16)(A) of ERISA), and a health insurance issuer offering group or individual health insurance coverage, is required to file for the Director's approval prior to use a written summary of benefits and coverage (SBC) for each benefit package and provide the SBC without charge to entities and individuals described in this subsection (a) in accordance with this Section.

1) SBC Provided by a Group Health Insurance Issuer to a Group Health Plan

A) Upon Application
A health insurance issuer offering group health insurance coverage must provide the SBC to a group health plan (or its sponsor) upon application for health coverage, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

B) By First Day of Coverage (If There Are Changes)
If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a current SBC to the plan (or its sponsor) no later than the first day of coverage.

C) Upon Renewal
If the issuer renews or reissues the policy, certificate or contract of insurance (for example, for a succeeding policy year), the issuer must provide a new SBC as follows:

i) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must be provided no later than the date the written application materials are distributed.

ii) If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

D) Upon Request
If a group health plan (or its sponsor) requests an SBC or summary information about a health insurance product from a health insurance issuer offering group health insurance coverage, an SBC must be provided as soon as practicable, but in no event later than seven business days following receipt of the request.

2) SBC Provided by a Group Health Insurance Issuer and a Group Health Plan to Participants and Beneficiaries

A) In General

A group health plan (including its administrator, as defined under section 3(16) of ERISA), and a health insurance issuer offering group health insurance coverage, must provide an SBC to a participant or beneficiary (as defined under sections 3(7) and 3(8) of ERISA), and consistent with subsection (a)(3) of this Section, with respect to each benefit package offered by the plan or issuer for which the participant or beneficiary is eligible.

B) Upon Application
The SBC must be provided as part of any written application materials that are distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute written application materials for enrollment, the SBC must be distributed no later than the first date on which the participant is eligible to enroll in coverage for the participant or any beneficiaries.

C) By First Day of Coverage (If There Are Changes)
If there is any change to the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC to a participant or beneficiary no later than the first day of coverage.

D) Special Enrollees
The plan or issuer must provide the SBC to special enrollees (as described in 45 CFR 146.117) no later than the date by which a summary plan description is required to be provided under the timeframe set forth in ERISA section 104(b)(1)(A), which is 90 days from enrollment.

E) Upon Renewal
If the plan or issuer requires participants or beneficiaries to renew in order to maintain coverage (for example, for a succeeding plan year), the plan or issuer must provide a new SBC when the coverage is renewed, as follows:

i) If written application is required for renewal (in either paper or electronic form), the SBC must be provided no

later than the date on which the written application materials are distributed.

ii) If renewal is automatic, the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year; however, with respect to an insured plan, if the policy, certificate, or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

F) Upon Request
A plan or issuer must provide the SBC to participants or beneficiaries upon request for an SBC or summary information about the health coverage, as soon as practicable, but in no event later than seven business days following receipt of the request.

3) Special Rules to Prevent Unnecessary Duplication with Respect to Group Health Coverage

A) An entity required to provide an SBC under subsection (a) with respect to an individual satisfies that requirement if another party provides the SBC, but only to the extent that the SBC is timely and complete in accordance with this Section. Therefore, for example, in the case of a group health plan funded through an insurance policy, the plan satisfies the requirement to provide an SBC with respect to an individual if the issuer provides a timely and complete SBC to the individual.

B) If a single SBC is provided to a participant and any beneficiaries at the participant's last known address, then the requirement to provide the SBC to the participant and any beneficiaries is generally satisfied. However, if a beneficiary's last known address is different than the participant's last known address, a separate SBC is required to be provided to the beneficiary at the beneficiary's last known address.

C) With respect to a group health plan that offers multiple benefit packages, the plan or issuer is required to provide a new SBC automatically upon renewal only with respect to the benefit package in which a participant or beneficiary is enrolled; SBCs are not required to be provided automatically upon renewal with respect to benefit packages in which the participant or beneficiary is not enrolled. However, if a participant or beneficiary requests an SBC with respect to another benefit package (or more than one other benefit package) for which the participant or beneficiary is eligible, the SBC (or SBCs, in the case of a request for SBCs relating to more than one benefit package) must be provided upon request as soon as practicable, but in no event later than seven business days following receipt of the request.

4) SBC Provided by a Health Insurance Issuer Offering Individual Health Insurance Coverage

A) Upon Application
A health insurance issuer offering individual health insurance coverage must provide an SBC to an individual covered under the policy (including every dependent) upon receiving an application for any health insurance policy, as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application.

B) By First Day of Coverage (If There Are Changes)
If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the issuer must update and provide a current SBC to the individual no later than the first day of coverage.

C) Upon Renewal
The issuer must provide the SBC to policyholders annually at renewal. The SBC must reflect any modified policy terms that would be effective on the first day of the new policy year. The SBC must be provided as follows:

i) If written application is required (in either paper or electronic form) for renewal or reissuance, the SBC must

be provided no later than the date on which the written application materials are distributed.

ii) If renewal or reissuance is automatic, the SBC must be provided no later than 30 days prior to the first day of the new policy year; however, if the policy, certificate or contract of insurance has not been issued or renewed before such 30-day period, the SBC must be provided as soon as practicable but in no event later than seven business days after issuance of the new policy, certificate or contract of insurance, or the receipt of written confirmation of intent to renew, whichever is earlier.

D) Upon Request
A health insurance issuer offering individual health insurance coverage must provide an SBC to any individual or dependent anytime an individual requests an SBC or summary information about a health insurance product as soon as practicable, but in no event later than seven business days following receipt of the request. For purposes of this subsection (a)(4)(D), a request for an SBC or summary information about a health insurance product includes a request made both before and after an individual submits an application for coverage.

5) Special Rule to Prevent Unnecessary Duplication with Respect to Individual Health Insurance Coverage
If a single SBC is provided to an individual and any dependents at the individual's last known address, then the requirement to provide the SBC to the individual and any dependents is generally satisfied. However, if a dependent's last known address is different than the individual's last known address, a separate SBC is required to be provided to the dependent at the dependent's last known address.

b) Summary of Benefits and Coverage − Content

1) In General
Subject to subsection (b)(3), the SBC must include the following:

A) Uniform definitions of standard insurance terms and medical terms so that consumers may compare health coverage and understand the terms of (or exceptions to) their coverage;

B) A description of the coverage, including cost sharing, for each category of benefits;

C) The exceptions, reductions and limitations of the coverage;

D) The cost-sharing provisions of the coverage, including deductible, coinsurance and copayment obligations;

E) The renewability and continuation of coverage provisions;

F) Coverage examples, in accordance with subsection (b)(2);

G) With respect to coverage beginning on or after January 1, 2014, a statement about whether the plan or coverage provides minimum essential coverage as defined under section 5000A(f) of the Internal Revenue Code (26 USC 5000A(f)) and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable requirements;

H) A statement that the SBC is only a summary and that the plan document or the policy, certificate or contract of insurance should be consulted to determine the governing contractual provisions of the coverage;

I) Contact information for questions and obtaining a copy of the plan document or the insurance policy, certificate or contract of insurance (such as a telephone number for customer service and an Internet address for obtaining a copy of the plan document or the insurance policy, certificate or contract of insurance);

J) For plans and issuers that maintain one or more networks of providers, an Internet address (or similar contact information) for obtaining a list of network providers;

K) For plans and issuers that use a formulary in providing prescription drug coverage, an Internet address (or similar contact information) for obtaining information on prescription drug coverage; and

L) An Internet address for obtaining the uniform glossary, as described in subsection (c), as well as a contact phone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

2) Coverage Examples
The SBC must include coverage examples that illustrate benefits provided under the plan or coverage for common benefits scenarios (including pregnancy and serious or chronic medical conditions) in accordance with this subsection (b)(2).

A) Number of Examples
The Secretary may identify up to six coverage examples that may be required in an SBC.

B) Benefits Scenarios
For purposes of this subsection (b)(2), a benefits scenario is a hypothetical situation, consisting of a sample treatment plan for a specified medical condition during a specific period of time, based on recognized clinical practice guidelines as defined by the National Guideline Clearinghouse, Agency for Healthcare Research and Quality.

C) Illustration of Benefit Provided
For purposes of this subsection (b)(2), to illustrate benefits provided under the plan or coverage for a particular benefits scenario, a plan or issuer simulates claims processing to generate an estimate of what an individual might expect to pay under the plan, policy or benefit package. The illustration of benefits provided will take into account any cost sharing, excluded benefits, and other limitations on coverage.

3) Coverage Provided Outside the United States
In lieu of summarizing coverage for items and services provided outside the United States, a plan or issuer may provide an Internet address (or

similar contact information) for obtaining information about benefits and coverage provided outside the United States. In any case, the plan or issuer must provide an SBC in accordance with this Section that accurately summarizes benefits and coverage available under the plan or coverage within the United States. (45 CFR 147.200)

c) Summary of Benefits and Coverage – Appearance
The SBC must be presented in a uniform format, use terminology understandable by the average plan enrollee (or, in the case of individual market coverage, the average individual covered under a health insurance policy), not exceed four double-sided pages in length, and not include print smaller than 12-point font. A health insurance issuer offering individual health insurance coverage must provide the SBC as a stand-alone document. (45 CFR 147.200)

d) Summary of Benefits and Coverage – Form

1) An SBC provided by an issuer offering group health insurance coverage to a plan (or its sponsor) may be provided in paper form. Alternatively, the SBC may be provided electronically (such as by email or an Internet posting) if the following three conditions are satisfied:

A) The format is readily accessible by the plan (or its sponsor);

B) The SBC is provided in paper form free of charge upon request; and

C) If the electronic form is an Internet posting, the issuer timely advises the plan (or its sponsor) in paper form or email that the documents are available on the Internet and provides the Internet address.

2) An SBC provided by a group health plan or health insurance issuer to a participant or beneficiary may be provided in paper form. Alternatively, for non-federal governmental plans, the SBC may be provided electronically if the plan conforms to either the substance of the ERISA provisions at 29 CFR 2590.715-2715(a)(4)(ii), or the provisions governing electronic disclosure for individual health insurance issuers set forth in subsection (d)(3).

3) An issuer offering individual health insurance coverage must provide an SBC in a manner that can reasonably be expected to provide actual notice in paper or electronic form.

A) An issuer satisfies the requirements of subsection (d)(3) if the issuer:

i) Hand-delivers a printed copy of the SBC to the individual or dependent;

ii) Mails a printed copy of the SBC to the mailing address provided to the issuer by the individual or dependent;

iii) Provides the SBC by email after obtaining the individual's or dependent's agreement to receive the SBC or other electronic disclosures by email;

iv) Posts the SBC on the Internet and advises the individual or dependent in paper or electronic form, in a manner compliant with subsections (d)(3)(A)(i) through (iii), that the SBC is available on the Internet and includes the applicable Internet address; or

v) Provides the SBC by any other method that can reasonably be expected to provide actual notice.

B) An SBC may not be provided electronically unless:

i) The format is readily accessible;

ii) The SBC is placed in a location that is prominent and readily accessible;

iii) The SBC is provided in an electronic form that can be electronically retained and printed;

iv) The SBC is consistent with the appearance, content and language requirements of this Section;

v) The issuer notifies the individual or dependent that the SBC is available in paper form without charge upon request and provides it upon request.

C) Deemed Compliance
A health insurance issuer offering individual health insurance coverage that provides the content required under subsection (b) to the federal health reform Web portal described in 45 CFR 159.120 will be deemed to satisfy the requirements of subsection (a)(4)(D) with respect to a request for summary information about a health insurance product made prior to an application for coverage. However, nothing in this subsection (d)(3)(D) should be construed as otherwise limiting such issuer's obligations under this Section. (45 CFR 147.200)

e) Summary of Benefits and Coverage – Language
A group health plan or health insurance issuer must provide the SBC in a culturally and linguistically appropriate manner. For purposes of this subsection, a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of 45 CFR 147.136(e) are met as applied to the SBC. (45 CFR 147.200)

f) Notice of Modification
If a group health plan, or health insurance issuer offering group or individual health insurance coverage, makes any material modification (as defined under section 102 of ERISA) in any of the terms of the plan or coverage that would affect the content of the SBC, that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, the plan or issuer must provide notice of the modification to enrollees (or, in the case of individual market coverage, an individual covered under a health insurance policy) not later than 60 days prior to the date on which the modification will become effective. The notice of modification must be provided in a form that is consistent with subsection (d). (45 CFR 147.200)

g) Uniform Glossary

1) In General
A group health plan, and a health insurance issuer offering group health insurance coverage, must make available to participants and beneficiaries,

and a health insurance issuer offering individual health insurance coverage must make available to applicants, policyholders and covered dependents, the uniform glossary described in subsection (g)(2) in accordance with the appearance and form and manner requirements of subsections (g)(3) and (g)(4).

2) Health-Coverage-Related Terms and Medical Terms
The uniform glossary must provide uniform definitions of the following health-coverage-related terms and medical terms:

A) Allowed amount, appeal, balance billing, co-insurance, complications of pregnancy, co-payment, deductible, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, in-network co-insurance, in-network co-payment, medically necessary, network, non-preferred provider, out-of-network co-insurance, out-of-network co-payment, out-of-pocket limit, physician services, plan, preauthorization, preferred provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, reconstructive surgery, rehabilitation services, skilled nursing care, specialist, usual customary and reasonable (UCR), and urgent care; and

B) Such other terms as the Secretary determines are important to define so that individuals and employers may compare and understand the terms of coverage and medical benefits (including any exceptions to those benefits).

3) Appearance
A group health plan, and a health insurance issuer, must ensure the uniform glossary is presented in a uniform format and uses terminology understandable by the average plan enrollee (or, in the case of individual market coverage, an average individual covered under a health insurance policy).

4) Form and Manner

A plan or issuer must make the uniform glossary described in subsection (g) available upon request, in either paper or electronic form (as requested), within seven business days after receipt of the request. (45 CFR 147.200)

h) Preemption
For purposes of this Section, the provisions of PHS Act section 2724 continue to apply with respect to preemption of Illinois law. In addition, Illinois laws that require a health insurance issuer to provide an SBC that supplies less information than required under subsections (a), (b), (c), (d) and (e) are preempted by federal law. (45 CFR 147.200)

i) Failure to Provide
A health insurance issuer or a non-federal governmental health plan that willfully fails to provide information required under this Section is subject to a fine of not more than $1,000 for each such failure. A failure with respect to each covered individual constitutes a separate offense for purposes of this subsection (i). The Department and HHS will enforce these provisions in a manner consistent with 45 CFR 150.101 through 150.465. (45 CFR 147.200)

j) Applicability Date

1) This Section is applicable to group health plans and group health insurance issuers in accordance with this subsection (j). (See 45 CFR 147.140(d), providing that this Section applies to grandfathered health plans.)

A) For disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including re-enrollees and late enrollees), this Section applies beginning on the first day of the first open enrollment period that begins on or after September 23, 2012; and

B) For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), this Section applies beginning on the first day of the first plan year that begins on or after September 23, 2012.

2) For disclosures with respect to plans, and to individuals and dependents in the individual market, this Section is applicable to health insurance issuers beginning September 23, 2012. (45 CFR 147.200)

(Source: Old Section 2001.10 renumbered to Section 2001.110 and new Section 2001.10 added at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.11 Essential Health Benefits

a) Coverage for Essential Health Benefits Package
A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes an essential health benefits (EHB) package in accordance with the requirements in subsections (b) and (c). (42 USC 300gg-6(a))

b) Essential Health Benefits Package
In this Section, the term "essential health benefits package" means, with respect to any health plan, coverage that:

1) provides for the essential health benefits defined under subsection (c);

2) limits cost-sharing for such coverage in accordance with Section 2001.12(a); and

3) subject to Section 2001.12(i), provides either the bronze, silver, gold or platinum level of coverage described in Section 2001.12(b). (42 USC 18022(a) and (b))

c) Essential Health Benefits

1) In General
Subject to subsection (c)(3), essential health benefits shall include at least the following general categories and the items and services covered within the categories:

A) Ambulatory patient services;

B) Emergency services;

C) Hospitalization;

D) Maternity and newborn care;

E) Mental health and substance use disorder services, including behavioral health treatment;

F) Prescription drugs;

G) Rehabilitative and habilitative services and devices;

H) Laboratory services;

I) Preventive and wellness services and chronic disease management; and

J) Pediatric services, including oral and vision care. (42 USC 18022(a) and (b))

2) Background

A) In August 2012, the Governor's Office convened a workgroup of representatives from a number of State agencies to develop a recommendation to the Healthcare Reform Implementation Council on Essential Health Benefits for qualified health plans in Illinois. This workgroup met several times over the course of two months.

B) The Patient Protection and Affordable Care Act defined 10 EHB that must be included in all Qualified Health Plans sold inside and outside the Health Benefits Exchange starting in 2014.

C) The 10 EHB are:

i) ambulatory patient services;

ii) emergency services;

iii) hospitalization;

iv) maternity and newborn care;

v) mental health and substance use disorder services, including behavioral health treatment;

vi) prescription drugs;

vii) rehabilitative and habilitative services and devices;

viii) laboratory services;

ix) preventive and wellness services and chronic disease management; and

x) pediatric services, including oral and vision care.

D) The purpose of recommending a benchmark plan is to ensure that individuals who purchase health insurance will have a plan that covers the EHB and services outlined by the ACA.

E) HHS set specific guidelines to establish EHB. HHS requires that states look at the insurance plans already sold in their markets and identify a "benchmark" plan that is representative of a "typical employer plan". This will help ensure that state insurance mandates are included, since any benchmark plan must already be available in a state.

F) The authority to select a benchmark plan falls with the HHS Secretary, but the State was required to make a recommendation. HHS also facilitated a public comment period on the benchmark plan that the State recommends. It is the services that are provided by this particular plan that make up the EHB for Illinois. All insurers that sell products that are not excepted benefits in Illinois are required to include, at a minimum, the value of benefits and services dictated by the benchmark plan.

G) The Health Care Reform Implementation Council intends to continuously review the benchmark selection over the next two

years, at which point the State might have the option to change or amend the benchmark plan. The Council envisions an open process for feedback that engages stakeholders and ensures the minimum coverage offered in Illinois meets the needs of our residents.

3) Specific Requirements
Essential health benefits shall include those specific benefits and limits described in the Illinois EHB Benchmark Plan, as of September 1, 2013, published by the Centers for Medicare & Medicaid Services, 755 Security Boulevard, Baltimore, Maryland 21244 (http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html). This regulation does not include any later amendments or editions, if any, to the Illinois EHB benchmark.

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.12 Cost-Sharing

a) Cost-Sharing Under Group Health Plans
A group health plan shall ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under subsections (a)(1) and (2). (42 USC 300gg-6(b)) Requirements relating to cost-sharing are:

1) Annual Limitation on Cost-Sharing

A) 2014
The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under 26 USC 223(c)(2)(A)(ii) for self-only and family coverage, respectively, for taxable years beginning in 2014.

B) 2015 and Later
In the case of any plan year beginning in a calendar year after 2014, the limitation under this subsection (a)(1)(B) shall:

i) in the case of self-only coverage, be equal to the dollar amount under subsection (a)(1)(A) for self-only coverage for plan years beginning in 2014, increased by an amount

equal to the product of that amount and the premium adjustment percentage under subsection (a)(4) for the calendar year; and

ii) in the case of other coverage, twice the amount in effect under subsection (a)(1)(B)(i).

C) If the amount of any increase under subsection (a)(1)(B)(i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

2) Annual Limitation on Deductibles for Employer-Sponsored Plans

A) In General

i) In the case of a health plan offered in the small group market, the deductible under the plan shall not exceed $2,000 in the case of a plan covering a single individual and $4,000 in the case of any other plan.

ii) The amounts under subsection (a)(3)(A)(i) may be increased by the maximum amount of reimbursement that is reasonably available to a participant under a flexible spending arrangement described in 26 USC 106(c)(2) (determined without regard to any salary reduction arrangement).

B) Indexing of Limits
In the case of any plan year beginning in a calendar year after 2014:

i) the dollar amount under subsection (a)(1)(A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under subsection (a)(4) for the calendar year; and if the amount of any increase under subsection (a)(2)(B)(i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

ii) the dollar amount under subsection (a)(1)(A)(ii) shall be increased to an amount equal to twice the amount in effect under subsection (a)(1)(A)(i) for plan years beginning in the calendar year, determined after application of subsection (a)(2)(B)(i).

C) Actuarial Value
The limitation under this subsection (a) shall be applied in such a manner so as to not affect the actuarial value of any health plan, including a plan in the bronze level.

D) Coordination with Preventive Limits
Nothing in this subsection (a) shall be construed to allow a plan to have a deductible under the plan apply to benefits described in section 2713 of the federal Public Health Service Act (45 CFR 130).

3) Cost-Sharing

A) In general, the term "cost-sharing" in this Section includes:

i) deductibles, coinsurance, copayments or similar charges; and

ii) any other expenditure required of an insured individual that is a qualified medical expense (within the meaning of 26 USC 223(d)(2)) with respect to EHB covered under the plan.

B) Exceptions
The term "cost-sharing" in this Section does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

4) Premium Adjustment Percentage
For purposes of subsections (a)(1)(B)(i) and (a)(2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the

Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary). (42 USC 18022(c))

b) Levels of Coverage
The levels of coverage described in this subsection (b) are as follows:

1) Bronze Level
A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

2) Silver Level
A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.

3) Gold Level
A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

4) Platinum Level
A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan. (42 USC 18022(d))

c) Actuarial Value (AV) Calculation for Determining Level of Coverage

1) Calculation of AV
Subject to subsection (c)(2), to calculate the AV of a health plan, the issuer must use the AV Calculator developed and made available by HHS.

2) Exception to the Use of the AV Calculator
If a health plan's design is not compatible with the AV Calculator, the issuer must meet the following:

A) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in subsection (c)(2)(B) or (C).

B) Calculate the plan's AV by:

i) Estimating a fit of its plan design into the parameters of the AV Calculator; and

ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies.

C) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries, calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator.

D) The calculation methods described in subsections (c)(2)(B) and (C) may include only in-network cost-sharing, including multi-tier networks.

3) Employer Contributions to Health Savings Accounts and Amounts Made Available Under Certain Health Reimbursement Arrangements
For plans other than those in the individual market that at the time of purchase are offered in conjunction with a Health Savings Account (HSA) or with integrated Health Reimbursement Accounts (HRAs) that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly made available under such HRAs for the current year are:

A) Counted towards the total anticipated medical spending of the standard population that is paid by the health plan; and

B) Adjusted to reflect the expected spending for health care costs in a benefit year so that:

i) Any current year HSA contributions are accounted for; and

ii) The amounts newly made available under such integrated HRAs for the current year are accounted for.

4) Use of State-Specific Standard Population for the Calculation of AV
Beginning in 2015, if submitted by the State and approved by HHS, a State-specific data set will be used as the standard population to calculate AV in accordance with subsection (c)(1). The data set may be approved by HHS if it is submitted in accordance with subsection (c)(5) and:

A) Supports the calculation of AVs for the full range of health plans available in the market;

B) Is derived from a non-elderly population and estimates those likely to be covered by private health plans on or after January 1, 2014;

C) Is large enough that:

i) The demographic and spending patterns are stable over time; and

ii) It includes a substantial majority of the State's insured population, subject to the requirement in subsection (c)(4)(B);

D) Is a statistically reliable and stable basis for area-specific calculations; and

E) Contains claims data on health care services typically offered in the then-current market.

5) Submission of State-Specific Data
AV will be calculated using the default standard population described in subsection (c)(6), unless a data set in a format specified by HHS that can support the use of the AV Calculator as described in subsection (c)(1) is submitted by a State and approved by HHS consistent with subsection (c)(4) by a date specified by HHS.

6) Default Standard Population
The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in subsection (c)(1). (45 CFR 156.135)

d) Actuarial Value Levels of Coverage

1) General Requirement for Levels of Coverage
AV, calculated as described in subsection (c), and within a de minimis variation as defined in subsection (d)(3), determines whether a health plan offers a bronze, silver, gold or platinum level of coverage.

2) The levels of coverage are:

A) A bronze health plan is a health plan that has an AV of 60 percent.

B) A silver health plan is a health plan that has an AV of 70 percent.

C) A gold health plan is a health plan that has an AV of 80 percent.

D) A platinum health plan is a health plan that has as an AV of 90 percent.

3) De Minimis Variation
The allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is ±2 percentage points. (45 CFR 146.140)

e) Determination of Minimum Value

1) Acceptable Methods for Determining Minimum Value
An employer-sponsored plan provides minimum value (MV) if the percentage of the total allowed costs of benefits provided under the plan is no less than 60 percent. An employer-sponsored plan may use one of the following methods to determine whether the percentage of the total allowed costs of benefits provided under the plan is not less than 60 percent:

A) The MV Calculator to be made available by HHS and the Internal Revenue Service. The result derived from the calculator may be modified under subsection (e)(2).

B) Any safe harbor established by HHS and the Internal Revenue Service.

C) If the plan is a group health plan, it may seek certification by an actuary to determine MV if the plan contains non-standard features that are not suitable for either of the methods described in subsections (e)(1)(A) or (B). The determination of MV must be made by a member of the American Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

D) If the plan is in the small group market that meets any of the levels of coverage, as described in subsection (d), it satisfies MV.

2) Benefits that May Be Counted Towards the Determination of MV

A) In the event that a group health plan uses the MV Calculator and offers an EHB outside of the parameters of the MV Calculator, the plan may seek an actuary, who is a member of the American Academy of Actuaries, to determine the value of that benefit and adjust the result derived from the MV Calculator to reflect that value.

B) For the purposes of applying the options described in subsection (e)(1) in determining MV, a group health plan will be permitted to take into account all benefits provided by the plan that are included in any one of the EHB benchmarks.

3) Standard Population
The standard population for MV determinations described in subsection (e)(1) is the standard population developed by HHS for such use and described through summary statistics issued by HHS. The standard population for MV must reflect the population covered by self-insured group health plans.

4) Employer Contributions to Health Savings Accounts and Amounts Made Available Under Certain Health Reimbursement Arrangements
For employer-sponsored self-insured group health plans and insured group health plans that at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly made available under such HRAs for the current year are:

A) Counted towards the total anticipated medical spending of the standard population that is paid by the health plan; and

B) Adjusted to reflect the expected spending for health care costs in a benefit year so that:

i) Any current year HSA contributions are accounted for; and

ii) The amounts newly made available under such integrated HRAs for the current year are accounted for. (45 CFR 156.145)

f) Application
In determining the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage that are provided by such plan or coverage, this Section shall apply. (42 USC 18022(d)(2)(C))

g) Allowable Variance
There may be a de minimis variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates. (42 USC 18022(d)(3))

h) Plan Reference
In this Section, any reference to a bronze, silver, gold or platinum plan shall be treated as a reference to a qualified health plan providing a bronze, silver, gold or platinum level of coverage, as the case may be. (42 USC 18022(d)(4))

i) Catastrophic Plan

1) In General

A health plan not providing a bronze, silver, gold or platinum level of coverage shall be treated as meeting the requirements of subsection (b) with respect to any plan year if:

A) the only individuals who are eligible to enroll in the plan are individuals described in subsection (c)(2); and

B) the plan provides:

i) except as provided in subsection (c)(1)(B)(ii) of this Section, the essential health benefits determined under Section 2001.11(c), except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under subsection (a)(1) of this Section for the plan year (except as provided for in PHS Act section 2713); and

ii) coverage for at least three primary care visits.

2) Individuals Eligible for Enrollment
An individual is described in this subsection (i)(2) for any plan year if the individual:

A) has not attained the age of 30 before the beginning of the plan year; or

B) has a certification in effect for any plan year under this Part that the individual is exempt from the requirement under 26 USC 5000A by reason of:

i) 26 USC 5000A(e)(1) (relating to individuals without affordable coverage); or

ii) 26 USC 5000A(e)(5) (relating to individuals with hardships).

3) Restriction to Individual Market

If a health insurance issuer offers a health plan described in this subsection (i), the issuer may only offer the plan in the individual market. (42 USC 18022(e))

j) Child-Only Plans
If a qualified health plan is offered through the Health Benefits Exchange in any level of coverage specified under subsection (c), the issuer shall also offer that plan through the Health Benefits Exchange in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year, have not attained the age of 21, and such plan shall be treated as a qualified health plan. (42 USC 18022(f))

k) Payments to Federally-Qualified Health Centers
If any item or service covered by a qualified health plan is provided by a federally-qualified health center (as defined in 42 USC 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under 42 USC 1396a(bb)) for such item or service. (42 USC 18022(g))

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

SUBPART B: PROVISIONS APPLICABLE TO INDIVIDUAL POLICIES

Section 2001.20 Construction of Accident and Health Insurance Policy Forms (Renumbered)

(Source: Section 2001.20 renumbered to Section 2001.120 at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.30 Filing of Policy Forms (Renumbered)

(Source: Section 2001.30 renumbered to Section 2001.l30 at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.110~~2001.10~~ Applicability

This Subpart shall apply to:

a) Individual accident and health policy, certificate, endorsement, rider and application forms filed with the Department ~~Division~~ by both foreign and domestic companies with respect to Section 143, Article IX and Article XX of the Code ~~[215 ILCS 5/143, Art. IX and Art. XX]~~.

b) This Part shall also apply to individual policy, certificate, endorsement, rider and application forms filed in accordance with Section 356a of the Code ~~[215 ILCS 5/356a]~~.

c) The filing procedure for accident and health forms as required by Section 355 of the Code ~~[215 ILCS 5/355]~~.

d) The filing procedure for accident and health insurance policy forms prescribed by 50 Ill. Adm. Code 916.

(Source: Old Section 2001.10 renumbered to Section 2001.110 and amended at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.120~~2001.20~~ Construction of Accident and Health Insurance Policy Forms

a) Section 356a – Form of Policy~~.~~
Each policy form of a domestic company that is issued for delivery to a person residing in another state~~,~~ must be approved by the Director unless that~~such~~ policy form is subject to approval or disapproval by the~~such~~ other state.

b) Section 357.1 – Accident and Health Policy Provisions Required~~.~~

1) In order to expedite departmental action on policies submitted for approval, it is requested that companies adhere to the statutory wording and order of the required provisions. Policies submitted that include variations from the statutory words and order must be accompanied by a complete list of all variations and a justification for each. Extensive variations, without adequate justification, will only result in delay in the processing of the~~such~~ policies. The companies' cooperation in keeping ~~such~~ variations to a minimum is essential.

2) Each provision of Sections~~Section~~ 357.2 through 357.113 of the Code ~~[215 ILCS 5/357.2 through 357.113]~~ must be preceded by a caption and, if the captions differ in any respect from the captions appearing in the law,

changes must be clearly indicated and justified pursuant to subsection ~~2001.20~~(b)(1).

3) Numbering of the "Required Provisions" will not be required.

c) Section 359a – Application~~.~~

1) When~~Where~~ an Industrial Accident and Health policy is issued upon signed application of the person to be insured, the application shall conform with Section 359a of the Code ~~[215 ILCS 5/359a]~~.

2) The Application~~:~~

A) When~~Where~~ changes are made on the application for administrative purposes only, the changes must be clearly indicated.

B) When~~Where~~ the application is subject to being changed for administrative purposes by the insurer, the application shall clearly indicate that any changes are not to be ascribed to the applicant.

d) Section 361a – Age Limit~~.~~
Any policy form containing an "age limit" shall contain in substance a provision setting forth the limitations of Section 361a of the Code ~~[215 ILCS 5/361a]~~.

e) Section 362a – Non-Application to Certain Policies~~.~~
Section 362a(3) of the Code ~~[215 ILCS 5/362a(3)]~~ does not apply to group accident and health insurance provided for under Section 356a(1)(c) of the Code ~~[215 ILCS 5/356a(1)(c)]~~.

f) Section 368 – Industrial Accident and Health Insurance~~.~~
The Department ~~Division~~ will require Industrial Accident and Health policy forms to be of the same form and content as other accident and health insurance policy forms required to be filed pursuant to Section 355 of the Code ~~[215 ILCS 5/355]~~, except Industrial Accident and Health Policies shall be issued on a weekly premium basis and contain the words "Industrial Policy" printed on each form.

~~g) All provisions of the Third Edition of the Official Guide that are consistent with the statute will be required.~~

g~~h~~) Accident and Health Insurance~~:~~

1) Accident and health insurance may~~May~~ only be defined as insurance against bodily injury, disablement or death by accident and against disablement resulting from sickness or old age and every insurance appertaining thereto.

2) Terms such as "external" and "violent" in connection with the definition of accident and health insurance are not acceptable.

h~~i~~) The information required in Section 356a(1)(a) and (b) of the Code ~~[215 ILCS 5/356a(1)(a) and (b)]~~ must appear in the policy form itself or on its schedule page and cannot be added to the policy by rider, endorsement~~,~~ or supplement. Although riders, endorsements and supplements, when attached to the policy form, become a part of the contract, it is evident the law intends that the ~~aforementioned~~ information required by Section 356a(1)(a) and (b) be made a part of the policy form itself, since this Section specifically refers to the policy and distinguishes between the policy forms, riders and endorsements.

i~~j~~) Funeral benefits will not be permitted in accident and health contracts.

j~~k~~) If hospitals are defined in accident and health contract forms presented for use in this State, then an appropriate definition must be used. A term such as "legally operated hospital", or any other definition that is definite and applicable in this State, will be accepted.

k~~l~~) Waiting period provisions in accident and health insurance contracts that stipulate the contract must be maintained in "continuous force" or "in force for (a specified number of) _____ months after the effective date of the policy" or "in force for (a specified number of) _____ months prior to the date of the loss~~,~~" will not be accepted. Those~~Such~~ provisions do not adequately and clearly cover reinstatements and, therefore, waiting periods must be based upon the loss occurring (a specified number of) _____ months after the effective date of the policy and read similar to: No indemnity will be paid for loss that occurs, or commences, prior to (a specified number of) _____ months after the effective date of the policy.

l~~m~~) Additional waiting periods for certain designated diseases or illnesses based upon

inception beyond the usual customary 15 to 30 days provided for in the insuring provisionsInsuring Provisions are not permissible. If additional waiting periods are deemed necessary by the company for certain diseases and illnesses, then the Department Division requires that waiting periods be based upon the loss occurring so many months after the effective date of the policy, rather than being based on the inception of the illness or disease.

mn) "Strict compliance provisions" in accident and health insurance contracts will not be acceptable for use in this State.

no) Any specific requirement for medical attendance by a licensed physician, other than that attendance that is normally and customarily required for the disease or accident resulting in loss for which claim is made, will not be acceptable.

op) In accident and health insurance contracts that include "medical attendance benefits" and "surgical benefits" and limits liability to only one, provision must be made for the payment of the greater benefit.

pq) Broad, indefinite, ambiguous and inconsistent language must be excluded from all accident and health insurance forms. Examples of such wording are:

1) The use of the words "indirectly" and "partly" in connection with Exclusions, Limitations and Reductions;,

2) The use of the word "reasonable" when used in connection with medical attendance or any other condition or requirement included in the policy form, unless use of thatsuch word results in the provision being more favorable to the insured;.

3) The use of such words as "appendages", "involving", "affecting", etc., in connection with specified physical conditions. Medical terms should be definite. For, for instance, various types of hernia should be spelled out, or the forms should provide a general statement that all types of hernia are meant.

qr) Surgical Benefit Provisions in accident and health insurance contracts must include and provide either:

1) That all operations will be covered not to exceed a stipulated amount for

any operation that may be performed;~~,~~ or

2) A~~The inclusion of a~~ schedule of operations that includes:

A) Comparable benefits for operations of comparable severity;

B) A provision that requires the company to pay a benefit for any operation not listed in the schedule, based on an amount equivalent to that specified for a listed operation of comparable severity; and

C) A provision that requires the company to pay for that operation that~~which~~ provides the largest benefit when the company's liability is limited to one operation when~~where~~ more than one is performed, under named or enumerated conditions.

r~~s~~) Surgical benefit provisions that are contingent upon payment of a hospital confinement benefit will not be approved.

s~~t~~) Benefits for hospital room that are based upon the actual expense incurred~~,~~ may be made contingent only upon a charge being made by the hospital. Benefits payable on a stated or flat rate basis, regardless of the amount of expense incurred, may make the benefit contingent upon hospital confinement of so many hours.

t~~u~~) Premium, Cancellation and Renewal Provisions~~:~~

1) Waiver of Premium Provisions must include a statement of coverage and of the insured's rights and obligations regarding the resumption of premium payments after the period of total disability has terminated, during which the premium has been waived. This statement must read similarly to: After the termination of the period of total disability, during which a premium has been waived, the insurance afforded in this contract shall continue in full force and effect until the next premium due date, at which time the insured shall have the right to resume the payment of premiums as provided in the contract.

2) If a premium is to be charged for the period from the expiration of the period of total disability during which a premium has been waived and the expiration date of the policy, then a statement of this fact must be added to

the provision, together with a provision that the insurer will notify the insured of the premium due.

3) A policy that contains a cancellable provision may add at the end of the provision in (u)(2)~~,~~ "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof~~.~~".

4) A policy in which the insurer reserves the right to refuse any renewal premiums~~,~~ shall add~~,~~ "unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by records of the insurer, written notice of its intention not to renew this policy beyond the period for which the premium has been waived~~.~~".

u~~v~~) Requirements for the so-called "franchise insurance" are different from those for individual contracts in the following respects: Termination either by cancellation or refusal to renew any individual contracts of the group is prohibited, unless all like contracts of the group are terminated at the expiration of the contracts and upon at least ten days' notice in advance. The only other termination conditions that may be included in these~~such~~ contracts are those that terminate coverage because of nonpayment of premium, discontinuance of employment of the insured by the named employer, or the discontinuance of membership in the designated organization or association, and, in addition, coverage may be automatically terminated at a designated attained age.

v~~w~~) Policy forms that, in the opinion of the Department~~Division~~, will invite misrepresentations in the advertising and sale of the policy~~same~~, due to the restrictive nature of the forms as a result of unusual and/or over-lapping exclusions, limitations, reductions~~,~~ or conditions, will not be accepted for use in this State.

w~~x~~) Time limitations, when included in benefit provisions, must be explained in terms such as hours, days, weeks, months or years. Terms such as "immediately" or "reasonably" are not acceptable, unless use of those words makes~~make~~ the provision more favorable to the insured.

x~~y~~) Policy contracts issued by assessment companies must include a provision setting forth the contingent liability of the insured and should be based upon the regular premium provided in the policy~~,~~ and, in addition~~ thereto~~, such premium payments

as may be required by the company from time to time. This provision should be placed in the contract with equal prominence to the benefit provisions.

yz) When~~Where~~ a contingent liability provision is included in a contract issued by a mutual company as provided for in Section 55 of the Code~~ [215 ILCS 5/55]~~, the contingent liability of the policyholder must be based upon not less than one nor more than ten times the amount of the premium expressed in the continuation paragraph of the policy. This provision should be placed in the contract with equal prominence to the benefit provisions.

zaa) Limited policy contracts will not be approved that, in the opinion of the Director, set forth in a more prominent manner the provisions for relatively large benefits for specified accidents of rare occurrence than provisions for relatively low benefits for accidents of more frequent occurrence. Accumulative indemnities benefits are permissible, but schedules showing those benefits will not be approved in accident and health contracts.

aa~~bb~~) Riders, Endorsements and Exclusions~~:~~

1) Riders and endorsements that are not complete in themselves must be accompanied by the fill-in~~fill in~~ material to be used with the riders and endorsements~~,~~ to be acceptable.

2) Exclusion of coverage riders and endorsements, executed subsequent to the issuance of the policy, must provide for the signed acceptance of the insured in addition to a statement to the effect that the rider or endorsement is not valid unless signed by the insured. Policy forms that unilaterally reduce benefits must be formally approved by the Director prior to the date they are attached to a policy issued or delivered in this State.

3) Riders or endorsements submitted for the purpose of amending forms submitted in accordance with Section 355 of the Code~~ [215 ILCS 5/355], so that such forms will comply with the requirements of the Code or regulations of the Division,~~ will not be accepted for approval, unless the Director is given an adequate justification, in writing, for the use of the riders or endorsements.

bb~~cc~~) Application~~:~~

1) Questions in an application pertaining to diseases or conditions must be broken down so that applicants may insert their answer at least after every four or five diseases or conditions listed, unless questions are grouped as to related diseases or conditions.

2) Application forms that are completed by individuals for themselves and others cannot include a certification as to the correctness of the answers in the application without some qualifications, preferably in the Attestation Provision, and should read similar to "to the best of your knowledge", or "to the best of your knowledge and belief". The courts have held that answers to the questions are given to the best of the applicant's belief, and the Department ~~Division~~ sees no reason why the aforementioned qualification should not be contained in the application.

3) The receipt and/or application or policy provisions may provide that the insurance shall be effective upon issuance and the payment of the first premium while the insured is in good health. Provisions that provide the insurance shall not become effective until delivery of the policy while the insured is in good health~~,~~ will not be acceptable.

cc~~dd~~) When~~Where~~ the application provides for a written proxy, that~~such~~ proxy must be executed over the separate signature of the applicant. The signature required for the application in accordance with Section 359a of the Code ~~[215 ILCS 5/359a]~~ may not be used to satisfy this requirement.

dd~~ee~~) Advertising appearing on an application form, or any other form that requires the approval of the Director, is reviewed and filed by the Director in conjunction with the approval of the form. This is in conformity with Section 143 of the Code ~~[215 ILCS 5/143]~~.

ee~~ff~~) The Director requires that any form, previously approved and subsequently revised, must be submitted under a new form number, and be approved in accordance with Section 143 of the Code. This applies to advertising appearing on applications or other forms approved by the Director. The only exception to this is advertising that contains statistical information, such as the amount of claims paid or assets. For changes of this kind, the insurer need not submit a new form number, but only advise the Department~~Division~~ in writing as to the change in the statistical information and the date of change. Advertising is not subject to

approval but is filed for informational purposes only. See 50 Ill. Adm. Code 916 for appropriate transmittal sheets and instructions.

(Source: Section 2001.120 renumbered from 2001.20 and amended at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.130~~2001.30~~ Filing of Policy Forms

a) Policy forms, riders and endorsements must be formally filed pursuant to 50 Ill. Adm. Code 916 as follows:

1) Two copies of all forms shall be submitted in blank. If the form does not clearly indicate the place for the name of the insured, the time the insurance becomes effective, and the benefits, it will be required that the forms be completed at the time of issuance.

2) Each form must bear an identifying form number in the lower left corner of the first page. The form number is limited to 30 characters. No other date, except the inclusion of a printing date and/or designation of a state~~,~~ where a special edition is required~~,~~ will be permitted in this~~such~~ space.

3) The insurer shall file a letter of submission, or provide the following information in the Filing Description field under the General Information tab in the System for Electronic Rate and Form Filing (SERFF), containing:

A) The name of the form, if any, and identifying form number;~~.~~

B) Whether the submission is a new form;~~.~~

C) If the form is intended to supersede another, the form number of the form replaced and the date it was approved by the Department~~Division~~, with all changes from the previously approved form highlighted. Any changes not highlighted will not be deemed to be approved.

b) Copies of the policy forms, riders and endorsements will be retained in the files of the Department~~Division~~. The Department will provide notice of approval through SERFF.

c) Under no circumstances will copies of forms be returned to the company with the Department's ~~Division's~~ stamp of approval on the copies. Notice of approval will be given by letter or copy of the submitted transmittal form with the Department's ~~Division's~~ stamp affixed.

(Source: Section 2001.130 renumbered from Section 2001.30 and amended at 38 Ill. Reg. 2037, effective January 2, 2014

SUBPART C: PROVISIONS APPLICABLE TO GROUP POLICIES

Section 2001.210 Applicability

This Subpart is applicable to all group accident and health policies except to the extent that they provide excepted benefits.

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

Section 2001.220 Ban on Excessive Waiting Periods

A group health plan, and a health insurance issuer offering group health insurance coverage, must not apply any waiting period that exceeds 90 days (42 USC 300gg-7).

(Source: Added at 38 Ill. Reg. 2037, effective January 2, 2014

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Advertising of Accident and Sickness Insurance

2) Code Citation: 50 Ill. Adm. Code 2002

3)

Section Numbers:	Adopted Action:
2002.30	Amend
2002.40	Amend
2002.180	Amend

4) Statutory Authority: Implementing Article XXVI and Section 149 and authorized by Section 401 of the Insurance Code [215 ILCS 5/Art. XXVI, 149 and 401]; 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201

5) Effective Date of Rule: January 2, 2014

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted rulemaking, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 14494; September 13, 2013

10) Has JCAR issued a Statement of Objection to this Rulemaking? No

11) Differences between Proposal and Final Version: Authority note: 2nd line, added "; 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201" at the end, at JCAR's request.

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

15) Summary and Purpose of Rulemaking: Part 2002 is being amended to make it clear that the existing advertising requirements apply to the Illinois Health Insurance Exchange.

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

James Rundblom, Deputy General Counsel
Department of Insurance
320 West Washington, 4th Floor
Springfield IL 62767-0001

217/785-8559
Fax: 217/524-9033

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

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2002
ADVERTISING OF ACCIDENT AND SICKNESS INSURANCE

Section
2002.10 Authority
2002.20 Purpose
2002.30 Applicability
2002.40 Definitions
2002.50 Method of Disclosure of Required Information
2002.60 Form and Content of Advertisements
2002.70 Advertisements of Benefits Payable, Losses Covered or Premiums Payable
2002.80 Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination
2002.90 Testimonials or Endorsements by Third Parties
2002.100 Use of Statistics
2002.110 Identification of Plan or Number of Policies
2002.120 Disparaging Comparisons and Statements
2002.130 Jurisdictional Licensing and Status of Insurer
2002.140 Identity of Insurer
2002.150 Group or Quasi-Group Implications
2002.160 Introductory, Initial or Special Offers
2002.170 Statements About an Insurer
2002.180 Enforcement Procedures
2002.190 Severability Provision
2002.APPENDIX A Guidelines
2002.ILLUSTRATION A Guideline to Section 2002.20
2002.ILLUSTRATION B Guideline to Section 2002.30 (a)
2002.ILLUSTRATION C Guideline to Section 2002.30 (b)
2002.ILLUSTRATION D Guideline to Section 2002.40 (a)
2002.ILLUSTRATION E Guideline to Section 2002.40 (h)
2002.ILLUSTRATION F Guideline to Section 2002.50
2002.ILLUSTRATION G Guideline to Section 2002.60 (a)
2002.ILLUSTRATION H Guideline to Section 2002.60 (b)
2002.ILLUSTRATION I Guideline to Section 2002.70 (a) (1)
2002.ILLUSTRATION J Guideline to Section 2002.70 (a) (2)

2002.ILLUSTRATION K	Guideline to Section 2002.70 (a) (3)
2002.ILLUSTRATION L	Guideline to Section 2002.70 (a) (4)
2002.ILLUSTRATION M	Guideline to Section 2002.70 (a) (5)
2002.ILLUSTRATION N	Guideline to Section 2002.70 (a) (8)
2002.ILLUSTRATION O	Guideline to Section 2002.70 (b) (1)
2002.ILLUSTRATION P	Guideline to Section 2002.70 (b) (2)
2002.ILLUSTRATION Q	Guideline to Section 2002.70 (b) (3)
2002.ILLUSTRATION R	Guideline to Section 2002.70 (c) (1)
2002.ILLUSTRATION S	Guideline to Section 2002.70 (c) (2)
2002.ILLUSTRATION T	Guideline to Section 2002.70 (c) (3)
2002.ILLUSTRATION U	Guideline to Section 2002.80
2002.ILLUSTRATION V	Guideline to Section 2002.90 (a)
2002.ILLUSTRATION W	Guideline to Section 2002.90 (b)
2002.ILLUSTRATION X	Guideline to Section 2002.90 (c)
2002.ILLUSTRATION Y	Guideline to Section 2002.90 (d)
2002.ILLUSTRATION Z	Guideline to Section 2002.100 (a)
2002.ILLUSTRATION AA	Guideline to Section 2002.100 (b)
2002.ILLUSTRATION BB	Guideline to Section 2002.100 (c)
2002.ILLUSTRATION CC	Guideline to Section 2002.110 (a) and (b)
2002.ILLUSTRATION DD	Guideline to Section 2002.120
2002.ILLUSTRATION EE	Guideline to Section 2002.130 (a)
2002.ILLUSTRATION FF	Guideline to Section 2002.130 (b)
2002.ILLUSTRATION GG	Guideline to Section 2002.140 (a) and (b)
2002.ILLUSTRATION HH	Guideline to Section 2002.150
2002.ILLUSTRATION II	Guideline to Section 2002.160 (a) (1)
2002.ILLUSTRATION JJ	Guideline to Section 2002.160 (a) (2)
2002.ILLUSTRATION KK	Guideline to Section 2002.160 (a) (4)
2002.ILLUSTRATION LL	Guideline to Section 2002.160 (b)
2002.ILLUSTRATION MM	Guideline to Section 2002.160 (c)
2002.ILLUSTRATION NN	Guideline to Section 2002.170

AUTHORITY: Implementing Article XXVI and Section 149 and authorized by Section 401 of the Insurance Code [215 ILCS 5/Art. XXVI, 149 and 401]; 42 USC 300gg-22; and 45 CFR 150.101(b)(2) and 150.201.

SOURCE: Amended March 31, 1975; codified at 8 Ill. Reg. 5194; amended at 28 Ill. Reg. 4595, effective March 1, 2004; amended at 38 Ill. Reg. 2124, effective January 2, 2014

Section 2002.30 Applicability

a) This Part shall apply to any accident and sickness insurance "advertisement" as that term is hereinafter defined in Section 2002.40, unless otherwise specified in this Part, intended for presentation, distribution or dissemination in this State when such presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer, agent or broker as those terms are defined in the Insurance Code of this State and this Part. The Guideline for this subsection~~paragraph~~ (a) is found in Appendix A, Illustration B.

b) Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all advertisements of its policies. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurer whose policies are so advertised. The Guideline for this subsection~~paragraph~~ (b) is found in Appendix A, Illustration C.

c) This Part shall apply to advertisements both inside and outside the Illinois Health Insurance Marketplace. Policies and rates shall not be constructed or marketed in a way that discourages use of the Illinois Health Insurance Marketplace. A certificate of compliance with this Part must be submitted annually to the Illinois Department of Insurance (Department) in accordance with Section 2002.180.

(Source: Amended at 38 Ill. Reg. 2124, effective January 2, 2014

Section 2002.40 Definitions

~~a)~~ An "advertisement," for the purpose of this Part, shall include:

~~1)~~ printed and published material, audio-visual material, and descriptive literature of an insurer used in direct mail, email, internet pages, blogs, social media, newspapers, magazines, radio scripts, TV scripts, billboards and similar displays; and

~~2)~~ descriptive literature and sales aids of all kinds issued by an insurer, agent or broker for presentation to members of the insurance buying public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and

~~3)~~ prepared sales talks, presentations and material for use by agents, brokers

and solicitors. The Guideline for this definition~~paragraph (a)~~ is found in Appendix A, Illustration D.

~~b)~~ "Exception," for the purpose of this Part, shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

"Health Insurance Marketplace" means the Illinois Health Benefits Exchange established in accordance with 215 ILCS 122/5-5 and 42 USC 18031.

~~c)~~ "Institutional Advertisement~~,~~", for the purpose of this Part, shall mean an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of accident and sickness insurance~~,~~ or the promotion of the insurer.

~~d)~~ "Insurer~~,~~", for the purpose of this Part, shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, and any other legal entity that~~which~~ is defined as an "insurer" in the Insurance Code of Illinois and is engaged in the advertisement of a policy, as "policy" is ~~herein~~ defined in this Section.

~~e)~~ "Invitation to Contract~~,~~", for the purpose of this Part, shall mean an advertisement that~~which~~ is neither an invitation to inquire nor an institutional advertisement.

~~f)~~ "Invitation to Inquire~~,~~", for the purpose of this Part, shall mean an advertisement having as one of its objectives, but not necessarily the main objective, the creation of a desire to inquire further about the product or products and that~~which~~ is limited to a brief description of the loss or losses for which the benefit is payable, and that~~which~~ may contain~~:1)~~ the~~The~~ dollar amount of benefit payable~~;~~ and/or ~~2)~~ the~~The~~ period of time during which the benefit is payable, provided the advertisement does not refer to cost.~~3)~~ An ad that~~which~~ is an invitation to inquire and that~~which~~ contains a dollar amount of benefit payable,~~;~~ and/or the period of time during which a benefit is payable, shall contain a provision in effect as follows:

"For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your agent or write to the company."

~~g)~~ "Limitation~~,~~", for the purpose of this Part, shall mean any provision that~~which~~ restricts coverage under the policy other than an exception or a reduction.

~~h)~~ "Policy~~,~~", for the purpose of this Part, shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement that~~which~~ provides accident or sickness benefits, or medical, surgical or hospital expense benefits, whether on an indemnity, reimbursement, service or prepaid basis, except when issued in connection with another kind of insurance other than life, and except disability, waiver of premium and double indemnity benefits included in life insurance and annuity contracts. The Guideline for this definition~~paragraph (h)~~ is found in Appendix A, Illustration E.

~~i)~~ "Reduction~~,~~", for the purpose of this Part, shall mean any provision that~~which~~ reduces the amount of the benefit. A~~; a~~ risk of loss is assumed, but payment upon the occurrence of the~~such~~ loss is limited to some amount or period less than would be otherwise payable had the~~such~~ reduction not been used.

(Source: Amended at 38 Ill. Reg. 2124, effective January 2, 2014

Section 2002.180 Enforcement Procedures

a) Advertising File. Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state whether or not licensed in that~~such~~ other state, with a notation attached to each ~~such~~ advertisement that~~which~~ shall indicate the manner and extent of distribution and the form number of any policy advertised. The~~Such~~ file shall be subject to regular and periodic inspection by the~~this~~ Department. All such advertisements shall be maintained in the~~said~~ file for a period of either four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time.

b) Certificate of Compliance. With respect to those health insurance policies offered on the Illinois Health Insurance Marketplace, each ~~Each~~ insurer shall prepare and maintain a certificate of compliance that will be filed with the Department annually on or before March 15 of the year immediately following the year pertaining to the certificate. With respect to those health insurance policies not

offered on the Illinois Health Insurance Marketplace, each insurer shall prepare and maintain a certificate of compliance that will be placed on file with the insurer, together with the materials identified in subsection (a) ~~placed on file with the company, together with the materials identified in subsection (a)~~. The certificates ~~certificate~~ shall be executed by an authorized officer of the insurer. The certificate shall state ~~wherein it is stated~~ that, to the best of the authorized officer's~~his~~ knowledge, information and belief, the advertisements ~~which were~~ disseminated by the insurer during the preceding statement year complied, or were made to comply in all respects, with the provisions of this Part and the Insurance Laws of this State as implemented and interpreted by this Part.

(Source: Amended at 38 Ill. Reg. 2124, effective January 2, 2014

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Pre-Existing Illness

2) Code Citation: 50 Ill. Adm. Code 2005

3)

Section Numbers:	Adopted Action:
2005.20	Amend
2005.40	Amend

4) Statutory Authority: Implementing Sections 143, 154, 355a(3) and 359a, and authorized by Section 401, of the Illinois Insurance Code [215 ILCS 5/143, 154, 355a(3), 359a and 401]; 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201

5) Effective Date of Rule: January 2, 2014

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 rule, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 14502; September 13, 2013

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version:

Authority note: 1st line, added ", 355a(3)" after "154" and "of" after "359(a); 2nd line, moved comma from before to after "of"; added ", 355a(3)," after "154" and added "; 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201" at the end.
2005.20(b)(1)(H), changed "regulations" to "this Chapter".
2005.20(b)(2)(C), changed "regulations" to "rules".
2005.20(b)(3)(B), added "[215 ILCS 97/20]" after "insurance".
2005.20(b), italicized this and the remainder of the Section with the exception of "Part" in line 2, "this Chapter" in (b)(1)(H), "or" in several locations, and the citations in (b)(3)(B).
2005.40(a)(2): 1st line, add "sickness," after "illness,"
2005.40(a)(3): 1st line, added "for insurance" after "application".
2005.40(c)(2): after "restricting" add "(i.e., decreasing)".

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

2005.40(c)(3): 1st line, after "up" add "(i.e., increasing)".

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Part 2005 is being amended to ensure that the applicability of the Department's rules on pre-existing illnesses remains in effect for policies and plans providing excepted benefits and for those not subject to the prohibition of preexisting condition exclusions provisions of 50 Ill Adm. Code 2001.5 or the Department's rule on Minimum Standards for Individual and Group Medicare Supplement Insurance found at 50 Ill Adm. Code 2008.

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

Barbara Delano, Assistant General Counsel
Illinois Department of Insurance
122 S. Michigan Ave., 19th Floor
Chicago, IL 60603

312/814-0919
Fax: 312/814- 2826

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

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2005
PRE-EXISTING ILLNESS

Section
2005.10 Authority
2005.20 Applicability
2005.30 The Minimum Definition of Pre-existing Illness or Pre-existing Condition
2005.40 Application of the Definition
2005.50 Policy Form Requirements
2005.60 Effective Date

AUTHORITY: Implementing Sections 143, 154, 355a(3) and 359a of, and authorized by Section 401 of, the Illinois Insurance Code [215 ILCS 5/143, 154, 355a(3), 359a and 401]; 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201.

SOURCE: Filed October 16, 1974, effective October 30, 1974; codified at 7 Ill. Reg. 3009; amended at 14 Ill. Reg. 19892, effective December 4, 1990; amended at 38 Ill. Reg. 2132, effective January 2, 2014.

Section 2005.20 Applicability

a) This Part shall apply to individual and group accident and health insurance policies to the extent that they provide benefits and coverage that fall under an excepted benefits plan and to all other individual and group insurance policies that are not subject to 50 Ill. Adm. Code 2001.5 or 50 Ill. Adm. Code 2008.

b) *For purposes of this* Part, *the term "excepted benefits" means benefits under one or more* (or any combination) *of the following*:

1) *Benefits not subject to requirements:*

A) *Coverage only for accident, or disability income insurance, or any combination thereof;*

B) *Coverage issued as a supplement to liability insurance;*

C) *Liability insurance, including general liability insurance and automobile liability insurance;*

D) *Workers' compensation or similar insurance;*

E) *Automobile medical payment insurance;*

F) *Credit-only insurance;*

G) *Coverage for on-site medical clinics;* or

H) *Other similar insurance coverage, specified in* this Chapter, *under which benefits for medical care are secondary or incidental to other insurance benefits.*

2) *Benefits not subject to requirements if offered separately:*

A) *Limited scope dental or vision benefits;*

B) *Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;* or

C) *Such other similar, limited benefits as are specified in rules.*

3) *Benefits not subject to requirements if offered as independent, noncoordinated benefits:*

A) *Coverage only for a specified disease or illness;* or

B) *Hospital indemnity or other fixed indemnity insurance.* [215 ILCS 97/20] (26 USC 9832)

~~This Rule shall apply to all companies transacting in this State the kinds of business enumerated in Clause (b) of Class 1 and Clause (a) of Class 2 of Section 4 of the Illinois Insurance Code (Ill. Rev. Stat. 1981, ch. 73, par. 616) and to all other "persons" as defined in Section 422 of the Code (Ill. Rev. Stat. 1981, ch. 73, par. 1029) who are engaging in accident and health insurance business in this State.~~

(Source: Amended at 38 Ill. Reg. 2132, effective January 2, 2014)

Section 2005.40 Application of the Definition

a) In applying Section 2005.30~~this definition~~ to determine if an insured received consultation, advice or treatment from a physician for a disease, illness, sickness, malady or condition, the~~such~~ consultation, advice or treatment must be clearly indicated in the insured's medical records or from the statements of the insured's legally qualified physician or other relevant evidence.

~~b)~~1) If an application contains conflicting answers, or if an answer is clearly incomplete, the insurer has an obligation to investigate further. For example, if a question about medical history is answered with the name of a physician, but there is no statement concerning the condition treated or the reason for the visit, the insurer has an obligation to investigate further.~~,~~ An ~~an~~ insurer failing to make that~~such an~~ investigation and then taking appropriate action would be estopped from using a "pre-existing condition" or "pre-existing illness" as ~~a~~ grounds for denying the claim or rescinding the policy for the particular disease, illness, sickness, malady or condition.

2) If a particular disease, illness, sickness, malady or condition was not diagnosed by a legally qualified physician before the effective date of the coverage for the insured, but symptomatology was evident regardless of consultation, advice or treatment by a legally qualified physician, the disease or condition will not be considered pre-existing if there were interrogatories appropriate to the~~such~~ symptoms on the application for insurance and if the symptoms were disclosed on the application for insurance and the insurer did not make an investigation and take appropriate action.

3) If there was no application or the interrogatories on any application for insurance were not appropriate to the~~such~~ symptoms, a legally qualified physician must decide if the symptomatology was sufficient prior to the effective date of the policy to make a diagnosis and demonstrate manifestation of the disease, illness, sickness, malady or condition.

4) In the administration of this Section, ~~the Rule~~ if the Medical Director, similar employee or other physician retained by the insurer who qualifies

as a legally qualified physician decides the medical questions of Section~~Sections~~ 2005.30(a)(2) or ~~2005.30~~(a)(3), the ~~then said~~ physician shall notify either the insured or his or her attending physician or other legally qualified physician of the insured of all of the relevant facts supporting the decision. If the attending physician or other legally qualified physician of the insured offers facts that~~which~~ demonstrate there is good reason that the disease, illness, sickness, malady or condition did not exist prior to the effective date of coverage for the insured, the definition of a pre-existing illness must be construed favorably for the insured.

b~~e~~) A legally qualified physician is a physician as defined and licensed under the Medical Practice~~Practices~~ Act [225 ILCS 60]~~(Ill. Rev. Stat. 1981, ch. 111, par. 4401 et seq.)~~.

c~~d~~) The insurer may rescind a policy only if it can demonstrate the insured has withheld material information or answered material questions incorrectly on an application that~~which~~ would have resulted in the insurer, at the time of original application:

1) denying coverage;~~,~~ or

2) restricting (i.e., decreasing) the level or coverage ~~as~~ applied for;~~,~~ or

3) rating up (i.e., increasing) the premium normally charged for the coverage ~~as~~ applied for.

d~~e~~) No answers to questions in an application for insurance such as "Are you in good health?" or "Are you free from disease or impairment?" shall be used alone to rescind the policy unless the false answers to those~~such~~ questions, along with the other evidence, clearly demonstrates justification for rescission~~recision~~ of the policy.

e~~f~~) After the coverage for the insured has been in effect for two years, the coverage may not be rescinded except for fraud. To establish fraud, the insurer must meet the requirements of Illinois law in this regard.

(Source: Amended at 38 Ill. Reg. 2132, effective January 2, 2014)

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Minimum Standards of Individual Accident and Health Insurance

2) Code Citation: 50 Ill. Adm. Code 2007

3)

Section Numbers:	Adopted Action:
2007.50	Amend
2007.60	Amend
2007.70	Amend
2007.80	Amend
2007.90	Amend

4) Statutory Authority: Implementing Section 355a and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/355a and 401] and 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201

5) Effective Date of Rule: January 2, 2014

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 rule, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 15191; September 20, 2013

10) Has JCAR issued a Statement of Objection to this Rulemaking? No

11) Differences between Proposal and Final Version:

Authority note: 2nd line, added "and 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201" before the period.

2007.50: definition of "Excepted Benefits", 22nd line, deleted ", specified in regulations,"; 28th line, after the semicolon added "and"; 31st line, changed "; or" to a period; deleted 33rd line; 40th line, after "period" added ", or per event,".

2007.50: definition of Sickness, 2nd line, changed "who" to "that".

2007.60(e)(5)(B): deleted all text and renumbered (C) to (B) and (D) to (C).

2007.60(e)(1): added ", with respect to excepted benefit policies and grandfathered health plans," after "surgery or".

2007.70(b)(1)(B): changed "The" to "With respect to excepted benefit policies and grandfathered health plans, the".

2007.70(b)(1)(H): deleted all text and renumbered (I), (J), (K), (L), (M), (N), (O) and (P) to (H), (I), (J), (K), (L), (M), (N) and (O), respectively.

2007.70(b)(8)(C)(viii): 4th line, struck "the following" and added "subsections (b)(8)(C)(ix) through (b)(8)(C)(xvi)".

2007.80(f)(2): struck "below" and added "in subsections (f)(3) through (f)(6)".

2007.80(g)(2): 5th line, added a comma after "surgical services".

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Part 2007 will be amended regarding the minimum standards for individual health and accident insurance, so that the state mandates contained in the regulation only apply to certain excepted benefit and grandfathered policies. This is being done so that the state regulation is consistent with the limits of the ACA market reforms which do not apply to certain policies having limited benefits, such as auto liability, credit insurance, and workers' compensation, and those health plans grandfathered under the ACA that were existing on March 23, 2010.

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

James Rundblom, Deputy General Counsel
Department of Insurance
320 West Washington, 4th Floor

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

Springfield IL 62767-0001

217/785-8559
217/524-9033 (fax)

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

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2007
MINIMUM STANDARDS OF INDIVIDUAL ACCIDENT
AND HEALTH INSURANCE

Section
2007.10 Authority
2007.20 Purpose
2007.30 Applicability
2007.40 Revision of Noncomplying Policy Form and Subscriber Contracts Certificate of Compliance Required
2007.50 Definitions
2007.60 Prohibited Policy Provisions
2007.70 Accident and Health Minimum Standards for Benefits
2007.80 Required Disclosure Provisions
2007.90 Requirements for Replacement
2007.100 Severability

AUTHORITY: Implementing Section 355a and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/355a and 401] and 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201.

SOURCE: Adopted at 2 Ill. Reg. 30, p. 41, effective August 1, 1978; amended at 4 Ill. Reg. 45, p. 102, effective March 1, 1981; amended at 6 Ill. Reg. 7072, effective May 27, 1982; codified at 7 Ill. Reg. 10591; amended at 12 Ill. Reg. 6921, effective April 1, 1988; amended at 15 Ill. Reg. 7658, effective May 7, 1991; amended at 19 Ill. Reg. 16555, effective December 5, 1995; amended at 38 Ill. Reg. 2138, effective January 2, 2014

Section 2007.50 Definitions

Except as provided hereafter, no individual accident or health insurance policy delivered or issued for delivery to any person in this State shall contain definitions respecting the matters set forth in this Part~~below~~ unless the ~~such~~ definitions comply with the requirements of this Section.

"ACA" means the Patient Protection and Affordable Care Act" (42 USC 18001 et seq.).

"Accident and Accidental Injury" shall be defined to employ "result" language and shall not include words that ~~which~~ establish an accidental means test or use words such as "external~~,~~", "violent~~,~~", "visible" or similar words of description or characterization. The definition shall not be more restrictive than the following: "Injury or injuries, for which benefits are provided, means accidental bodily injuries sustained by the insured person which are the direct cause of loss, independent of disease cause of loss, independent of disease or bodily infirmity and occurring while the insurance is in force."

~~(~~AGENCY NOTE: The fact that the injury combined with other factors to produce the loss does not necessarily relieve the insurer of liability. Each claim must be judged on the basis of its particular facts and in light of the court decisions, to determine whether the injury is to be considered as the cause of the loss.~~)~~

The ~~Such~~ definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment~~,~~ or occupation for wage or profit.

"Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services.

A definition of the ~~such~~ home or facility shall not be more restrictive than one requiring that it:

be operated pursuant to law;

be approved for payment of Medicare benefits or be qualified to receive ~~such~~ approval, if so requested;

be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

provide continuous 24 hours a day nursing service by or under the

supervision of a registered graduate professional nurse (R.N.); and

maintains a daily medical record of each patient.

The definition of a ~~such~~ home or facility may provide that the ~~such~~ term shall not be inclusive of:

any home, facility or part thereof used primarily for rest;

a home or facility for the aged or for the care of drug addicts or alcoholics; or

a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

"Excepted Benefits", for purposes of this Part, means benefits under one or more (or any combination thereof) of the following:

Benefits not subject to requirements:

Coverage only for accident or disability income insurance, or any combination thereof;

Coverage issued as a supplement to liability insurance;

Liability insurance, including general liability insurance and automobile liability insurance;

Workers' compensation or similar insurance;

Automobile medical payment insurance;

Credit-only insurance;

Coverage for on-site medical clinics; or

Other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits.

Benefits not subject to requirements if offered separately:

Limited scope dental or vision benefits; and

Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

Benefits not subject to requirements if offered as independent, noncoordinated benefits:

Coverage only for a specified disease or illness; or

Hospital indemnity or other fixed indemnity insurance paid as a fixed dollar amount per day or other period, or per event, regardless of the amount of expenses incurred.

Benefits not subject to requirements if offered as separate insurance policy Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act (42 USC 1395ss(g)(1))), coverage supplemental to the coverage provided under 10 USC 55, and similar supplemental coverage provided to coverage under a group health plan. (26 USC 9832)

"Grandfathered Health Plan" means any group health plan or health insurance coverage in which an individual was enrolled on the date of the enactment of the ACA and shall have the same meaning as set forth in section 18011 of the Public Health and Welfare Act (42 USC 18011).

"Home Health Care Agency" shall not be defined more restrictively than a public agency or private organization that provides skilled nursing services and meets the following requirements:

It is primarily engaged in providing home health care services;

Its policies are established by a group of professional personnel (including at least one physician and one registered nurse (R.N.));

Supervision of home health care services is provided by a physician or a registered nurse (R.N.);

It maintains clinical records on all patients; and

It has a full time administrator.

"Home Health Care" shall not be defined more restrictively than skilled nursing care or services provided to a person at a residence according to a plan of treatment for illness or infirmity prescribed by a physician. These ~~Such~~ services shall include, but are not limited to, the following:

Part time and intermittent skilled nursing services − Services given to a patient at least once every 60 days or as frequently as a few hours per day, several days per week.

Therapeutic Services:

Physical Therapy;

Occupational Therapy;

Speech and Hearing Therapy;

Medical social services, medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services and laboratory services to the extent the ~~such~~ charges or costs would have been covered under the policy if the insured person had remained in the hospital.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission ~~on Accreditation of Hospitals~~.

The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

be an institution operated pursuant to the law; and

be primarily and continuously engaged in providing or operating medical and diagnostic facilities, with major surgical facilities either on its premises or in facilities available to the hospital on a

prearranged basis, under the supervision of a staff of duly licensed physicians, for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

provide 24 hours nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

The definition of the term "hospital" may state that such term shall not be inclusive of:

convalescent, rest~~,~~ or nursing homes or facilities;

facilities primarily affording custodial or educational care or care or treatment for persons suffering from mental diseases or disorders;

facilities for the aged, mentally ill, drug addicts or alcoholics (except for a unit of a hospital dedicated to the treatment of drug addicts or alcoholics or the mentally ill); or

any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for those ~~such~~ services.

"Medicare" shall be defined in any hospital, surgical or medical expense policy that ~~which~~ relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Subchapter XVIII of the Social Security Amendments of 1965 as then constituted or later amended (42 USC~~U.S.C.~~ 1395 et seq.)," or "Title I, Part I of Public Law~~Laws~~ 89-97, as enacted~~Enacted~~ by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act (42 USC~~U.S.C.~~ 395 et seq.), as then constituted and any later amendments or substitutes thereof" or words of similar import.

"Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental

or emotional disease, ~~or~~ disorder or condition, including serious mental illness and substance use disorder or condition~~of any kind~~.

"Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as a registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse~~,~~", "trained nurse" or "registered nurse" are used without specific instruction, then the use of those ~~such~~ terms requires the insurer to recognize the services of any individual who qualifies under that ~~such~~ terminology in accordance with the applicable statutes or administrative rules of the state licensing or registry board ~~of the state~~.

"One Period ~~period~~ of Confinement ~~confinement~~ or Continuous Hospital Confinement ~~continuous hospital confinement~~" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days, whichever is greater.

"Partial Disability" shall be defined in relation of the individual's inability to perform one or more, but not all, of the "major~~,~~", "important~~,~~", or "essential" duties of employment or occupation or may be related to a percentage of time worked, to a specified number of hours or to compensation. When~~Where~~ a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

"Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician~~.~~". The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the~~such~~ services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws dealing with physician licensure.

"Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential" duties of employment or occupation, or to the inability to perform all usual business for as long as is usually required. A policy that ~~which~~ provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before

residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability~~,~~", the insurer may use "proportionate disability" or other term of similar import that, ~~which~~ in the opinion of the Director, adequately and fairly describes the benefit.

"Sickness" shall not be defined to be more restrictive than the following: "Sickness means sickness or disease of an insured person that~~which~~ first manifests itself after the effective date of insurance and while the insurance is in force." A definition of sickness may provide for a probationary period that~~which~~ will not exceed ~~thirty (~~30~~)~~ days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

"Total Disability"

A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any ~~such~~ employment or occupation that ~~which~~ he or she could, giving due consideration of his education, training or experience be reasonably expected to engage in and is not in fact engaged in any employment or occupation for wage or profit.

Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

Perform "any occupation whatsoever~~,~~", "any occupational duty~~,~~", or "any and every duty of his or her occupation~~;~~,"

Engage in any training or rehabilitation program.

An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his or her regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

When through a specific provision of a policy, disability coverage is provided to a retired person, the ~~such~~ definition shall not require more than the insured be completely unable to engage in the normal activities of a retired person of like age and good health.

(Source: Amended at 38 Ill. Reg. 2138, effective January 2, 2014

Section 2007.60 Prohibited Policy Provisions

a) Except as provided in the Section 2007.50 definition of "sickness", no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy. ~~subject to the further exception that a~~ An excepted benefit policy may specify a probationary or waiting period not to exceed six ~~(6)~~ months for specified diseases or conditions and losses resulting therefrom for hernia, varicose veins, adenoids, appendix and tonsils. However, the permissible six ~~(6)~~ months exception shall not be applicable when the ~~where such~~ specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain a probationary or waiting period.

b) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to the ~~such~~ dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six ~~(6)~~ months.

c) A disability policy, hospital confinement indemnity policy or specified disease policy may contain a "return of premium" or "cash value benefit" so long as:

1) The policy provides for a return of 100% of all premiums paid less the claims incurred by the time the insured attains age 65. A percentage of less than 100%, but greater than 50%, is permissible if the "return of premium" or "cash value benefit" has been in force for 10 years or less;

2) The policy contains a reasonable nonforfeiture benefit and provides for the value to be paid automatically upon lapse or death;

3) The surrender value percentages are not less than those calculated assuming 1958 Commissioners Standard Ordinary Mortality, 5% interest and 5 year preliminary term;

4) An acceptable method of reserving is approved by the Director concurrent with approval of the policy. Reserves should exceed or equal the cash value at all durations;

5) The surrender value percentages are calculated assuming a zero percent future claim offset;

6) The surrender value percentages are defined for all policy years (surrender value percentages may be shown only for the first 20~~twenty~~ policy years, but under these conditions the contract shall define the method used to determine the surrender value percentages after the 20th~~twentieth~~ contract year);

7) The interim surrender value percentages are defined when premiums are paid within a contract year;

8) The policy does not tie the return of premium to anything less than 100% of the premiums paid less claims paid.

d) When a liability exists for charges made to or on behalf of the insured or covered dependents, Accident and Health policies shall not contain provisions excluding coverage for:

1) Confinement in a hospital operated by a federal~~Federal~~, state~~State~~ or local government~~Local Government~~;

2) Charges for medical services provided by a federal~~Federal~~, state~~State~~ or local government~~Local Government~~.~~;~~

~~where a liability exists for charges made to or on behalf of the insured or covered dependents.~~

e) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

1) With respect to excepted benefit policies and grandfathered health plans, preexisting ~~Preexisting~~ conditions or diseases;

2) With respect to excepted benefit policies and grandfathered health plans,

mental ~~Mental~~ or emotional disorders, alcoholism, intoxication and drug addiction (policies that ~~which~~ exclude benefits for alcoholism or intoxication shall provide the following definition: "That which is defined and determined by the laws of the state where the loss or cause of the loss was incurred");

3) With respect to excepted benefit policies and grandfathered health plans, pregnancy~~Pregnancy~~, except for complications of pregnancy;

4) With respect to excepted benefit policies and grandfathered health plans, rehabilitative ~~Rehabilitative~~ care, except that when~~where~~ benefits, in whole or in part, would be payable for the ~~such~~ care under the terms of coverage, those benefits shall not be denied on the basis that the~~such~~ care or treatment was provided, in whole or in part, in a rehabilitation institution, if the ~~such~~ institution was a fully accredited hospital as defined in Section 2007.50~~ of this Part~~ at the time care or treatment was provided;

5) Injury, illness, treatment or medical condition arising out of:

A) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or auxiliary units~~ auxiliary thereto~~;~~,~~

~~B) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury,~~

B)~~C)~~ aviation;~~,~~

C)~~D)~~ with respect to short-term nonrenewable policies, interscholastic sports;

6) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when the ~~such~~ service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

7) With respect to excepted benefit policies and grandfathered health plans, foot ~~Foot~~ care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

8) Benefits provided under Medicare, any state or federal worker's compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;

9) Dental care or treatment for adults;

10) Eye glasses, hearing aids and examination for the prescription or fitting of eye glasses or hearing aids~~thereof~~ for adults;

11) Rest cures, custodial care, transportation and routine physical examinations;

12) Territorial limitations;

13) Sex change surgery, with respect to excepted benefit policies and grandfathered health plans, or surgical sterilization;

14) Tests or x-rays not related to diagnosis;

15) With respect to excepted benefit policies and grandfathered health plans, infertility~~Infertility~~;

16) Drugs, therapies, procedures or treatments that ~~which~~ are determined in coordination with the attending physician to not be medically necessary;

17) With respect to excepted benefit policies and grandfathered health plans, weight ~~Weight~~ reduction procedures, treatments or classes (except for morbid obesity);

18) With respect to excepted benefit policies and grandfathered health plans, smoking ~~Smoking~~ cessation classes or patches.

f) No provision of this Part shall prohibit the use of any policy provision that ~~which~~ is required or permitted by statute. With respect to excepted benefit policies and grandfathered health plans, other ~~Other~~ provisions of this Part shall not impair or

limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. When~~Where~~ waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy, or unless notice of the waiver appears on the first page or specification page.

g) No policy, rider or endorsement providing benefits for loss due to an accident or accidental injury shall contain a provision or clause limiting, reducing or excluding liability for a loss resulting from purely accidental circumstances (e.g., involuntary or unintentional ingestion of poison or inhalation of poisonous gases or fumes). This restriction shall not preclude the exclusion of loss due to suicide or attempted suicide by properly drawn language nor shall it preclude approval of a benefit for loss from defined accidents, such as travel, sport and student accident insurance.

h) No policy, rider or endorsement shall limit or exclude coverage for illness, accident, treatment or medical condition by using a general exclusion for complications arising from a covered condition or the treatment of a covered condition. This restriction shall not preclude the exclusion of loss due to ~~such~~ complications that ~~which~~ are specifically named.

i) Policy provisions precluded in this Section shall not be construed as a limitation on the authority of the Director to disapprove other policy provisions in accordance with Section 143(1) of the Illinois Insurance Code [215 ILCS 5/143(1)] that~~, which~~, in the opinion of the Director, are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

(Source: Amended at 38 Ill. Reg. 2138, effective January 2, 2014

Section 2007.70 Accident and Health Minimum Standards for Benefits

a) The following minimum standards for benefits are prescribed for the categories of coverage noted in ~~the following~~ subsection (b). No individual policy of accident and health insurance shall be delivered or issued for delivery in this State that ~~which~~ does not meet the required minimum standards for the specified categories, except that, if ~~unless~~ the Director finds that the ~~such~~ policies are Limited Benefit

Health Insurance, ~~in which case~~ the Outline of Coverage shall comply with Section 2007.80(c)~~ of this Part~~.

b) Nothing in this Section shall preclude the issuance of any policy combining two or more categories of coverage as set forth in Section 355a(4) of the Illinois Insurance Code [215 ILCS 5/355a(4)~~(a)(4)~~].

1) General Rules

A) With respect to excepted benefit policies and grandfathered health plans, a ~~A~~ "noncancellable~~,~~", "guaranteed renewable~~,~~", or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

B) With respect to excepted benefit policies and grandfathered health plans, the~~The~~ terms "noncancellable~~,~~", "guaranteed renewable~~,~~", or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 2007.80(a)(1)~~ of this Part~~. The terms "noncancellable" or "noncancellable and guaranteed renewable" shall be defined as in 50 Ill. Adm. Code 2003.

C) With respect to excepted benefit policies and grandfathered health plans, in ~~In~~ a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force by the younger spouse to the age or for the durational period as specified in the~~said~~ definition.

D) With respect to excepted benefit policies and grandfathered health plans, if ~~If~~ a policy contains a status-type military service

exclusion of a provision that ~~which~~ suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to that ~~such~~ person on a pro rata~~rate~~ basis.

E) Policies providing normal pregnancy benefits shall provide that, in the event the insurer cancels or refuses to renew the policy, there shall be an extension of benefits for pregnancy commencing while the policy is in force and at the same level for which benefits would have been payable had the policy remained in force.

F) Policies providing convalescent or extended care benefits following hospitalization shall not condition those ~~such~~ benefits upon admission to the convalescent or extended care facility within a period of less than ~~fourteen (~~14~~)~~ days after discharge from the hospital.

G) With respect to excepted benefit policies and grandfathered health plans, any ~~Any~~ medical, surgical or other expense benefit for the recipient insured in a transplant operation may specify the limits for the ~~such~~ specific benefit relating to donors, or shall provide reimbursement of the ~~such~~ expense of the live donor to the extent that the ~~such~~ benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

~~H) A policy may contain a provision relating to recurrent disabilities provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.~~

H~~I~~) Preexisting condition exclusions are only allowed with respect to excepted benefits and grandfathered health plans. Any such preexisting ~~pre-existing~~ condition exclusion shall be administered in accordance with 50 Ill. Adm. Code 2005. When a definition of preexisting conditions ~~condition(s)~~ is required by 50 Ill. Adm. Code 2005.50, for purposes of readability, it may be summarized in the appropriate policy provision by a definition reading substantially as follows:

"A preexisting ~~pre-existing~~ illness (condition) means any condition that was diagnosed or treated by a physician within 24 months prior to the effective date of the coverage, or produced symptoms within 12 months prior to the effective date of coverage that would have caused an ordinarily prudent person to seek medical diagnosis or treatment."

I~~J~~) Accidental death and dismemberment benefits shall be payable if the loss occurs within ~~ninety (~~90~~)~~ days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than ~~thirty (~~30~~)~~ days after the date of accident, nor shall any policy that ~~which~~ the insurer cancels or refuses to renew require that it be in force at the time the disability commences if the accident occurred while the policy was in force.

J~~K~~) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific dismemberment benefit equals or exceeds the other benefits.

K~~L~~) Any accident only policy providing benefits that ~~which~~ vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits payable are less than the maximum amount payable under the policy.

L~~M~~) With respect to excepted benefit policies and grandfathered health plans, nonrenewal ~~Nonrenewal~~ of the policy shall be without prejudice to any continuous loss that ~~which~~ commenced while the accident and sickness policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the covered person limited to a period of one year for health care benefits, limited to the duration of the policy benefit period (if any), and/or limited to the payment of the maximum benefits. The extension of benefits requirement does not apply to single premium nonrenewal policies.

M~~N~~) "Total Disability" or "Totally Disabled", for the purposes of this Section, means the complete incapacity of the covered person as the result of an injury or sickness:

i) to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age; and

ii) that ~~which~~ requires the regular care of a physician other than a covered person.

N~~O~~) Extension and limitation of coverage means if a covered person is totally disabled on his/her coverage termination date the coverage provided for that covered person by the~~this~~ policy and any attached riders will be extended. During the extended coverage the applicable policy and rider provisions, exclusions, exceptions and limitations will be the same as would have applied had coverage not terminated for the ~~such~~ covered person. This extension is limited to confinement and/or expenses incurred:

i) for the injury or sickness that ~~which~~ caused the total disability;

ii) during the uninterrupted continuance of the total disability; and

iii) during the 12~~twelve~~ months following the covered person's coverage termination date.

O~~P~~) All policies issued, whether or not the ~~such~~ policy contains the refund provision, shall be administered to provide a refund of any unearned premiums upon death of any insured member from date of death if the company~~Company~~ receives a written request for unearned premium from the policy owner or the person entitled to the unearned premium~~thereto~~.

2) Basic Hospital Expense Coverage
"Basic Hospital Expense Coverage" is a policy of accident and health

insurance that ~~which~~ provides coverage for a period of not less than ~~thirty-one (~~31~~)~~ days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness. Coverage shall be for at least the following:

A) Daily hospital room and board in an amount not less than the lesser of:

i) 80% of the charges for semi-private room accommodations; or

ii) $1,000~~100.00~~ per day; except that $1,000~~100.00~~ may be reduced to $700~~70.00~~ outside the metropolitan area.

B) Miscellaneous charges made by the hospital for services and supplies that ~~which~~ are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80% of the charges incurred up to at least $1,000~~.00~~ or 10~~ten~~ times the daily hospital room and board benefits.

C) Hospital outpatient services consisting of:

i) hospital services on the day surgery is performed;

ii) hospital services rendered within 72 hours after accidental injury, in an amount not less than $50~~.00~~; and

iii) X-ray and laboratory tests for the purpose of a diagnosis and treatment of an accidental injury or a sickness, in an amount not less than $100~~.00~~, but only to the extent that benefits for x-ray and laboratory tests would have been provided if rendered to an in-patient of the hospital.

D) Benefits provided under subsection (b)(2)(A) and (B) ~~above~~, may be provided subject to a combined deductible amount not in excess of $100~~.00~~.

E) When combined with the basic medical-surgical expense coverage in subsection (b)(3), basic hospital expense coverage is an essential health benefit subject to the requirements described in 50 Ill. Adm. Code 2001.11.

3) Basic Medical-Surgical Expense Coverage
"Basic Medical-Surgical Expense Coverage" is a policy of accident and health insurance that ~~which~~ provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness. Coverage shall be for at least the following:

A) Surgical services:

i) in amounts not less than those provided on a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least $500~~.00~~ for any one procedure; or

ii) not less than 80% of the reasonable charges.

B) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his or her assistant) performing the surgical services:

i) in an amount not less than 80% of the reasonable charges; or

ii) 15% of the surgical service benefit.

C) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury, other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or $5.00 per day for not less than ~~twenty-one (~~21~~)~~ days during one period of confinement.

D) When combined with the basic hospital expense coverage in subsection (b)(2), basic medical expense coverage is an essential health benefit subject to the requirements of 50 Ill. Adm. Code 2001.11.

4) ~~Hospital Confinement Indemnity Coverage~~With respect to excepted benefit policies, "Hospital Confinement Indemnity Coverage" is a policy of accident and health insurance that ~~which~~ provides for not less than $30~~.00~~ per day and for not less than ~~thirty-one (~~31~~)~~ days during any one period of confinement for each person insured under the policy. The policy may contain a benefit limit less than $30~~.00~~ per day if the policy benefit period is extended to reflect a maximum amount payable under a $30~~.00~~ per day policy with a ~~thirty-one (~~31~~)~~ day maximum confinement period for any one period of confinement.

5) ~~Major Medical Expense Coverage~~"Major Medical Expense Coverage" is an accident and health insurance policy that ~~which~~ provides hospital, medical and surgical expense coverage~~,~~ to an aggregate maximum of not less than $10,000~~.00~~; co-payment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of those ~~such~~ bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case the ~~such~~ deductible may be increased by the amount of the benefits provided by the ~~such~~ underlying insurance, for each covered person. The aggregate maximum shall be increased not less than $3.00 for each $1.00 by which the deductible exceeds the minimum. Major medical expense insurance shall provide for each covered person coverage of:

A) Daily hospital room and board expenses, prior to application of the co-payment percentage, for not less than $50~~.00~~ daily or, in lieu thereof, the average daily cost of semi-private room rate in the area where the insured resides, for a period of not less than 31~~thirty-one~~ days during any period of continuous hospital confinement;

B) Miscellaneous Hospital Services, prior to application of the co-payment percentage, for an aggregate maximum of not less than

$1,500~~.00~~ or 15 times the daily room and board rate if specified in dollar amount;

C) Surgical Services, prior to application of the co-payment percentage, to a maximum of not less than $600~~.00~~ for the most severe operation with the amounts provided for other operations reasonably related to that ~~such~~ maximum amount; anesthetic services, prior to application of the co-payment percentage, of at least 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthetic services at the same unit value as used for surgical schedule;

D) Physician visits, in or out of the hospital with minimum dollar amounts per visit, prior to application of the co-payment percentage, equal to not less than $8.00 per visit, covering not less than one visit per day and for an aggregate maximum of the ~~such~~ covered charges of not less than $600~~.00~~;

E) Out of Hospital Diagnostic X-rays and Tests, prior to application of the co-payment percentage, for an aggregate maximum of the ~~such~~ covered charges of not less than $600~~.00~~;

F) Not fewer than 3 of the following additional benefits, prior to application of the co-payment percentage, for an aggregate maximum of the ~~such~~ covered charges of not less than $1,000~~.00~~:

i) private duty registered, or if not available, licensed practical nurse services performed by other than a family member while the insured is hospital confined;

ii) convalescent nursing home care;

iii) diagnosis and treatment by a radiologist or physiotherapist;

iv) rental of special medical equipment, as defined by the insurer in the policy;

v) artificial limbs or eyes, casts, splints, trusses or braces;

vi) treatment for functional nervous disorders, and mental or emotional disorders;

vii) out of hospital prescription drugs and medications;~~.~~

G) Major medical expense coverage is an essential health benefit subject to the requirements of 50 Ill. Adm. Code 2001.11.

6) ~~Disability Income Protection Coverage~~With respect to excepted benefit policies and grandfathered health plans, "Disability Income Protection Coverage" is a policy that ~~which~~ provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of sickness and injury that~~thereof which~~ has a maximum period of time for which it is payable during disability of at least six ~~(6)~~ months. A disability income protection policy may provide for reduction by the amount of Social Security benefits at inception of any claim but no benefit reduction shall be permitted to offset a Social Security benefit increase during a benefit period.

7) ~~Accident Only Coverage~~With respect to excepted benefit policies and grandfathered health plans, "Accident Only Coverage" is a policy of accident insurance that ~~which~~ provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least $1,000~~.00~~ and a single dismemberment shall be at least $500~~.00~~.

8) ~~Specified Coverages~~With respect to excepted benefit policies and grandfathered health plans, "Specified Disease Coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Any such policy shall meet the following general requirements and one of the following sets of minimum standards for benefits. Insurance covering cancer, whether cancer only or in conjunction with other conditions ~~condition(s)~~ or diseases~~disease(s)~~, shall meet the standards of subsection (b)(8)(C) or (D)~~ below~~. Insurance covering specified diseases ~~disease(s)~~ other than cancer shall meet the standards of subsections (b)(8)(B) or (D) ~~below~~.

A) General Requirements:

i) All advertising materials used in conjunction with a specified disease policy shall accompany the policy filing.

ii) Policies covering a single specified disease or combination of specified diseases shall not be sold or offered for sale other than as specified disease covered under this Section.

iii) Any policy issued pursuant to this Section that ~~which~~ conditions payment upon pathological diagnosis of a covered disease shall also provide that, if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.

iv) Notwithstanding any other provision of this Part, specified disease policies shall provide benefits to any covered person not only for the specified diseases~~disease(s)~~, but also for any other conditions ~~condition(s)~~ or diseases~~disease(s)~~ directly caused or aggravated by the specified diseases~~disease(s)~~ or the treatment of the specified diseases~~disease(s)~~.

v) Policies containing specified disease coverage shall be at least Guaranteed Renewable.

vi) No policy issued pursuant to this Section shall contain a waiting or probationary period greater than ~~thirty (~~30~~)~~ days.

vii) Payment may be conditioned upon a covered person receiving medically necessary care or treatment.

viii) Except for the uniform policy provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage available through individual health insurance.

ix) After the effective date of the coverage (or applicable

waiting period, if any) benefits shall begin with the first day of medical care or hospital confinement if the ~~such~~ care or confinement is for a covered disease, even though the diagnosis is made at some later date.

x) Skin cancer benefits within a cancer policy shall not be limited as it is a minimum standard of specified disease coverage and is a risk purported to be assumed. Skin cancer may only be excluded if it is in an additional benefit provision added to compliment underlying coverage not required by this Section.

B) The following minimum benefit standards apply to noncancer coverages: A policy that ~~which~~ provides coverage for each person insured under the policy for a specifically named disease (or diseases~~disease(s)~~) with a deductible amount not in excess of ($250~~.00~~) and an overall aggregate benefit limit, per person, of not less than ($10,000) and a benefit period of not less than two ~~(2)~~ years for at least the following incurred expenses:

i) Hospital room and board and any other hospital furnished medical services or supplies;

ii) Treatment by a legally qualified physician or surgeon;

iii) Private duty services of a registered nurse (R.N.);

iv) X-ray, radium, cobalt, nuclear medicine, and other therapeutic procedures used in diagnosis and treatment;

v) Professional ambulance for local service to or from a local hospital;

vi) Blood transfusions, including expense incurred for blood donors;

vii) Drugs and medicines prescribed by a physician;

viii) The rental of an iron lung or similar mechanical apparatus;

ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician;

x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

xi) May include coverage of any other expenses necessarily incurred for treatment of the disease.

C) A policy that ~~which~~ provides coverage for each person insured under the policy for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment that are prescribed by a physician as necessary for the treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in excess of $250~~.00~~ and an overall aggregate benefit limit, per person, of not less than $10,000 and a benefit period of not less than two ~~(2)~~ years for at least the following:

i) Treatment by, or under the direction of, a legally qualified physician or surgeon;

ii) X-ray, radium, cobalt, chemotherapy, nuclear medicine, and other therapeutic procedures used in diagnosis and treatment;

iii) Hospital room and board and any other hospital furnished medical services or supplies;

iv) Blood transfusions and their~~the~~ administration~~ thereof~~, including expense incurred for blood donors;

v) Drugs and medicines prescribed by a physician;

vi) Professional ambulance for local service to or from a local hospital;

vii) Private duty services of a registered nurse (R.N.) provided in a hospital;

viii) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, subsections (b)(8)(C)~~items~~ (i), (ii), (iv), (v) and (vi) plus at least subsections (b)(8)(C)(ix) through (b)(8)(C)(xvi) ~~the following~~ shall be included, but may be subject to copayment not to exceed 20% of covered charges when rendered on an out-patient basis;

ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease;

xi) Home Health Care, that is necessary care and treatment provided at the covered person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment must be prescribed in writing by the covered person's attending physician, who must approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required;

xii) Physical, speech, hearing and occupational therapy;

xiii) Special equipment including hospital bed, toilette, pulleys, aspirator, incontinence pants, oxygen, surgical dressings, rubber shields, colostomy and ileostomy appliances;

xiv) Reconstructive surgery when deemed necessary by the attending physician;

xv) Prosthetic devices; and

xvi) Nursing home care for non-custodial services.

D) The following minimum benefit standards apply to specified disease coverages written on a per diem indemnity basis. These ~~Such~~ coverages shall offer covered persons:

i) A fixed sum payment of at least $100 for each day of the hospital confinement for at least 365 days.

ii) A fixed sum payment equal to one-half of the hospital in-patient benefit for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy for at least 365 days of treatment.

iii) Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional; if a policy offers these benefits, they must equal the following:

A fixed sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days (approximately $25~~.00~~ per day or $2,500 minimum benefit). A fixed sum payment equal to one-fourth the hospital in-patient benefit for each day of home health care for at least 100 days ($2,500). Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in the above requirements, whether by definition or otherwise, shall be no more restrictive than those under Medicare.

E) "Specified Accident Coverage" is an accident insurance policy that ~~which~~ provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or dismemberment combined, with a benefit amount not less than $1,000 for double dismemberment and $500~~.00~~ for single dismemberment.

9) ~~Limited Benefit Health Insurance Coverage~~With respect to excepted benefit policies and grandfathered health plans, "Limited Benefit Health Insurance Coverage" is any policy or policies other than a policy or contract covering only a specified disease or diseases that ~~which~~ provide

benefits that are less than the minimum standards for benefits required under Section 2007.50(b)(2) through (7)~~ of this Part~~. The ~~Such~~ policies or contracts may be delivered or issued for delivery in this State only if the outline of coverage required by Section 2007.80(k)~~ of this Part~~ is completed and delivered as required by Section 2007.80(b)~~ of this Part~~.

10) Non-Conventional Coverage: With respect to excepted benefit policies and grandfathered health plans, nothing~~Nothing~~ contained in this subsection (b) shall prohibit the issuance of a policy that does not fall within subsections ~~subsection~~ (b)(1) through (9) ~~above~~ if the ~~such~~ policy is experimental in nature and is appropriately and prominently described in the outline of coverage required by Section 2007.80(l)~~ of this Part~~.

11) The requirements of this Section do not apply to policies issued in compliance with Section 363 of the Illinois Insurance Code [215 ILCS 5/363].

(Source: Amended at 38 Ill. Reg. 2138, effective January 2, 2014

Section 2007.80 Required Disclosure Provisions

a) General Rules

1) Each individual policy of accident and health insurance shall include a renewal, continuation~~,~~ or nonrenewal provision. The language or specifications of the ~~such~~ provision must be consistent with the requirements of 50 Ill. Adm. Code 2001.Subpart A and the type of plan ~~policy to be~~ issued. The~~Such~~ provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, when~~where~~ limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal that ~~which~~ reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or

endorsement that ~~which~~ increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to by the insured, except if the increased benefits or coverage is required by law.

3) When~~Where~~ a separate additional premium is charged for benefits provided in connection with riders or endorsements, the~~such~~ premium charge shall be set forth in the policy.

4) A policy that ~~which~~ provides for the payment of benefits based on standards described as "usual and customary~~,~~", "reasonable and customary~~,~~", or words of similar import shall include a definition of those ~~such~~ terms and an explanation of those ~~such~~ terms in its accompanying outline of coverage.

5) If a policy providing excepted benefits or a grandfathered health plan contains any limitations with respect to preexisting conditions, those ~~such~~ limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations~~.~~".

6) All accident only policies shall contain a prominent statement on the first page of the policy or attached to the policy ~~thereto~~ in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows:

> "This is an accident only policy and it does not pay benefits for loss from sickness."

7) All policies, except single premium nonrenewal policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance, that the policyholder shall have the right to return the policy within ~~ten (~~10~~)~~ days after~~of~~ its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.

8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, that ~~such~~ fact must be prominently set forth in the outline of coverage.

9) If a policy contains a conversion privilege, it shall comply, in substance,

with the following: the caption of the provision shall be "Conversion Privilege~~,~~", or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

10) All specified disease policies shall contain a prominent statement on the first page of the policy in contrasting color and in bold face type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is a limited policy. Read it carefully."

b) Outline of Coverage Requirements for Individual Coverages

1) No individual accident and health insurance policy shall be delivered or issued for delivery in this State unless an appropriate Summary of Benefits, in accordance with 50 Ill. Adm. Code 2001.10, that includes an outline of coverage as prescribed in subsections ~~paragraphs~~ (c) through (l) ~~below~~ is completed as to the ~~such~~ policy and is delivered in accordance with Section 355a(5)(a) of the Illinois Insurance Code [215 ILCS 5/355a(5)(a)] ~~as enacted or thereafter amended~~.

2) In the event that a policy is issued on a basis other than that applied for, an outline of coverage properly describing the policy must accompany the policy when it is delivered and, if an outline of coverage was delivered earlier, contain the following statement, in not less than ~~twelve (~~12~~)~~ point type, immediately above the company name:

NOTICE

Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

3) In those cases in which~~where~~ a policy designed to supplement existing coverage is approved, the outline of coverage shall prominently state that coverage is designed to supplement other health insurance policies owned

by the insured.

4) The appropriate outline of coverage for policies providing hospital coverage that ~~which~~ only meets the standards of Section 2007.70(b)(2) ~~of this Part~~ shall be that statement contained in subsection (c) of this Section~~section~~. The appropriate outline of coverage for policies providing coverage that ~~which~~ meets the standards of both Section 2007.70(b)(2) and (3) ~~of this Part~~ shall be the statement contained in subsection ~~paragraph~~ (e) of this Section. The appropriate outline of coverage for policies providing coverage that ~~which~~ meets the standards of Section 2007.70(b)(2) and (5), ~~or Section 2007.70~~(b)(3) and (5), or ~~Section 2007.70~~(b)(2), (3)~~,~~ and (5) ~~of this Part~~ shall be the statement contained in subsection ~~paragraph~~ (g) of this Section.

c) Basic Hospital Expense Coverage (Outline of Coverage)
An outline of coverage, in the form prescribed in this subsection (c)~~below~~, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(2) ~~of this Part~~. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
BASIC HOSPITAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Basic Hospital Expense Coverage – Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy in the following order:

A) daily hospital room and board;

B) miscellaneous hospital services;

C) hospital out-patient services; and

D) other benefits, if any.)

~~(~~AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.~~)~~

4) (A description of any policy provisions that ~~which~~ exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in subsection (c)(3) ~~above~~.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to charge premiums.)

d) Basic Medical-Surgical Expense Coverage (Outline of Coverage)
An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(3) ~~of this Part~~. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
BASIC MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you

READ YOUR POLICY CAREFULLY!

2) Basic Medical-Surgical Expense Coverage – Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical surgical expenses.

3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

A) surgical services;

B) anesthesia services;

C) in-hospital medical services; and

D) other benefits, if any.)

~~(~~AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.~~)~~

4) (A description of any policy provisions that ~~which~~ exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in subsection (d)(3) ~~above~~.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

e) Basic Hospital and Medical Surgical Expense Coverage (Outline of Coverage) An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(2) and (3) ~~of this Part~~. The items included in the outline of coverage must appear in the sequence prescribed.

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

(COMPANY NAME)
BASIC HOSPITAL AND MEDIAL SURGICAL
EXPENSE COVERAGE OUTLINE OF COVERAGE

1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Basic Hospital and Medical Surgical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital out-patient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

A) daily hospital room and board;

B) miscellaneous hospital services;

C) hospital out-patient services;

D) surgical services;

E) anesthesia services;

F) in-hospital medical services; and

G) other benefits, if any.)

~~(~~AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.~~)~~

4) (A description of any policy provisions that ~~which~~ exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in subsection (e)(3)~~above~~.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

f) Hospital Confinement Indemnity Coverage (Outline of Coverage)
An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(4)~~of this Part~~. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
HOSPITAL CONFINEMENT INDEMNITY COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Hospital Confinement Indemnity Coverage – Policies of this category are designed to provide to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. These ~~Such~~ policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described in subsections (f)(3) through (f)(6)~~below~~.

3) (A brief specific description of the benefits contained in this policy, in the

following order:

A) daily benefit payable during hospital confinement; and

B) duration of benefit described in (A).)

~~(~~AGENCY NOTE: The ~~above~~ description of benefits in this subsection (f)(3) shall be stated clearly and concisely.~~)~~

4) (A description of any policy provisions that ~~which~~ exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (f)(3) ~~above~~.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

6) (Any benefits provided in addition to the daily hospital benefit.)

g) Major Medical Coverage (Outline of Coverage)
An outline of coverage, in the form prescribed in this subsection (g)~~below~~, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(5) ~~of this Part~~. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Major Medical Expense Coverage – Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness.

Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care, subject to any deductibles, co-payment provisions, or other limitations that ~~which~~ may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.

3) (A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:

A) daily hospital room and board;

B) miscellaneous hospital services;

C) surgical services;

D) anesthesia services;

E) in-hospital medical services;

F) out of hospital care;

G) maximum dollar amount for covered charges; and

H) other benefits, if any.)

~~(~~AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.~~)~~

4) (A description of policy provisions that ~~which~~ exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in subsection (g)(3) ~~above~~.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

h) Disability Income Protection Coverage (Outline of Coverage)
An outline of coverage, in the form prescribed below, shall be issued in

connection with policies meeting the standards of Section 2007.70(b)(6)~~ of this Part~~. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Disability Income Protection Coverage – Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3) (A brief specific description of the benefits contained in this policy:)

~~(~~AGENCY NOTE: The ~~above~~ description of benefits shall be stated clearly and concisely.~~)~~

4) (A description of any policy provisions that ~~which~~ exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in subsection (h)(3)~~ above~~.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

i) Accident Only Coverage (Outline of Coverage)
An outline of coverage in the form prescribed in this subsection (i) ~~below,~~ shall be issued in connection with policies meeting the standards of Section 2007.70(b)(7) ~~of this Part~~. The items included in the outline of coverage must appear in the sequence prescribed:

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

(COMPANY)
ACCIDENT ONLY COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Accident Only Coverage – Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3) (A brief specific description of the benefits contained in this policy:)

~~(~~AGENCY NOTE: The ~~above~~ description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. Proper disclosure of benefits that ~~which~~ vary according to accidental cause shall be made in accordance with Section 2007.70(e) ~~of this Part.)~~

4) (A description of any policy provisions that ~~which~~ exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in subsection (i)(3) ~~above~~.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

j) Specified Disease or Specified Accident Coverage (Outline of Coverage)
An outline of coverage in the form prescribed in this subsection (j) ~~below~~, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(8) ~~of this Part~~. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence

prescribed:

(COMPANY NAME)
(SPECIFIED DISEASE) (SPECIFIED ACCIDENT COVERAGE)
OUTLINE OF COVERAGE

1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) (Specified Disease) (Specified Accident) Coverage – Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of (specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3) (A brief specific description of the benefits, including dollar amounts, contained in this policy:)

~~(~~AGENCY NOTE: The ~~above~~ description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits that ~~which~~ vary according to accidental cause shall be made in accordance with ~~subsection (b)(1)(L) of~~ Section 2007.70(b)(1)(L) ~~of this Part.)~~

4) (A description of any policy provisions that ~~which~~ exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in subsection (j)(3) ~~above~~.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restriction or any reservation of right to change premiums.)

k) Limited Benefit Health Coverage (Outline of Coverage)
An outline of coverage, in the form prescribed below, shall be issued in

connection with policies that ~~which~~ do not meet the minimum standards of Section ~~Sections~~ 2007.70(b)(2) through ~~-~~(b)(7) ~~of this Part~~. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Limited Benefit Health Coverage – Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

3) (A brief specific description of the benefits, including dollar amounts, contained in this policy:)

~~(~~AGENCY NOTE: The ~~above~~ description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits that ~~which~~ vary according to accidental cause shall be made in accordance with Section 2007.70(b)(1)(L~~l~~) ~~of this Part.)~~

4) (A description of any policy provisions that ~~which~~ exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in subsection (k)(3) ~~above~~.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

l) Non-Conventional Coverage (Outline of Coverage)
The outline of coverage shall include the following information:

1) The name and principal address of the insurer.

2) An appropriate statement of identification of the type of coverage provided by the policy.

3) A description of each of the principal benefits and coverages, including the benefit amounts, duration or limits, elimination periods, inner limits and any other items appropriate to the coverage provided.

4) A description of the terms and conditions of renewability of the policy, including any limitations by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insurer).

5) A description of the principal exceptions, reductions and limitations contained in the policy, including the preexisting conditions, if any, and the circumstances under which any reduction provisions become operative.

6) A statement that the Outline of Coverage is only a brief summary of the policy and is not the contract of insurance. The policy itself sets forth the rights and obligations of the insured and insurer.

(Source: Amended at 38 Ill. Reg. 2138, effective January 2, 2014

Section 2007.90 Requirements for Replacement

a) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

b) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in subsection (d)~~ below~~. One ~~(1)~~ copy of the ~~such~~ notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in subsection (e)~~ below~~.

c) In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

d) The notice required by subsection (b) ~~above~~ for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1) Health conditions that~~which~~ you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy insofar as excepted benefit policies and grandfathered health plans are concerned. Generally, excepted benefits involve coverage only for accident or disability income insurance, or coverage issued as a supplement to liability insurance, or other separately offered coverage such as dental or vision benefits. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future

claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

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

_____
Date

_____
Applicant's Signature

e) The notice required by subsection (b) ~~above~~ for a direct response insurer shall be as follows:

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1) Health conditions that~~which~~ you may presently have~~,~~ (preexisting conditions), may not be immediately or fully covered under the new policy insofar as excepted benefit policies and grandfathered health plans are concerned. Generally, excepted benefits involve coverage only for accident or disability income insurance, or coverage issued as a supplement to liability insurance, or other separately offered coverage such as dental or vision benefits. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
Company Name

(Source: Amended at 38 Ill. Reg. 2138, effective January 2, 2014

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Long-Term Care Insurance

2) Code Citation: 50 Ill. Adm. Code 2012

3)

Section Numbers:	Adopted Action:
2012.30	Amend
2012.121	Amend
2012.123	Amend
2012.145	New
2012.EXHIBIT L	New
2012.EXHIBIT M	New

4) Statutory Authority: Implementing and authorized by Section 351A-11 of the Illinois Insurance Code [215 ILCS 5/351A-11]

5) Effective Date of Rule: January 2, 2014

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 rule, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal published in the Illinois Register: 37 Ill. Reg. 13108; September 16, 2013

10) Has JCAR issued a Statement of Objection to this Rulemaking? No

11) Differences between Proposal and Final Version:

2012.30: definition of "Maintenance or Personal Care Services", 1st line, capitalized "Internal".
2012.30: definition of "Qualified Long-Term Care Insurance Partnership Policy", 13th and 14th lines, replaced "Section" with "section" and "(P.L. 109-171)" with "(42 USC 1305)".
2012.145(a): 1st line, added "(42 USC 1305)" after "2005"; 2nd line, corrected the spelling of "Partnership".
2012.145(c)(1):7th line, changed "180 days" to "12 months".

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

2012.EXHIBIT L: replaced parentheses with brackets throughout the Exhibit.

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace an emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Part 2012 is being amended to include provisions that will ensure Illinois compliance with federal long-term care partnership requirements. Proposed changes include LTC benefit inflation protection designed to meet standards required within the Deficit Reduction Act of 2005; LTC policy "exchanges", allowing insureds to exchange policies that were issued prior to Illinois' Partnership effective date without having to go through re-underwriting on existing coverage; and an effective date consistent with the effective date of Department of Health Care and Family Services' State Plan Amendment. Also, proposed amendments would make changes to the ongoing training requirements that will help the Department and producers to better record and track continuing education compliance for the insurance producer license.

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

Louis Butler, Staff Attorney
Department of Insurance
122 S. Michigan Ave., 19th Floor
Chicago IL 60601-3251

312/814- 5398

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

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE~~FINANCIAL AND PROFESSIONAL REGULATION~~
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2012
LONG-TERM CARE INSURANCE

Section

2012.10 Purpose
2012.20 Applicability and Scope
2012.30 Definitions
2012.40 Policy Definitions
2012.50 Policy Practices and Provisions
2012.55 Unintentional Lapse
2012.60 Required Disclosure Provisions
2012.62 Required Disclosure of Rating Practices to Consumers
2012.64 Initial Filing Requirements
2012.65 Prohibition Against Post Claims Underwriting
2012.70 Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies
2012.80 Requirement to Offer Inflation Protection
2012.83 Incontestestability Period
2012.86 Nonforfeiture Benefits
2012.90 Requirements for Application Forms and Replacement Coverage
2012.95 Reporting Requirements
2012.100 Filing Requirement
2012.110 Loss Ratio
2012.112 Premium Rate Schedule Increases
2012.115 Filing Requirements for Advertising
2012.120 Reserve Standards
2012.121 Producer Training Requirements
2012.122 Standards for Marketing
2012.123 Suitability
2012.124 Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates
2012.125 Availability of New Services or Providers
2012.126 Right to Reduce Coverage and Lower Premiums
2012.127 Nonforfeiture Benefit Requirement

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

2012.128 Standards for Benefit Triggers
2012.129 Additional Standards for Benefit Triggers for Qualified Long-Term Care
2012.130 Standard Format Outline of Coverage Requirements
2012.140 Requirement to Deliver Shopper's Guide
2012.145 Long-Term Care Insurance Partnership Program
2012.150 Penalties
2012.EXHIBIT A Replacement Notice for Other Than Direct Response Solicitations
2012.EXHIBIT B Replacement Notice for Direct Response Solicitations
2012.EXHIBIT C Standard Format Outline of Coverage
2012.EXHIBIT D Rescission Reporting Format
2012.EXHIBIT E Class of Insurance – Accident and Health (Repealed)
2012.EXHIBIT F Long-Term Care Insurance Personal Worksheet
2012.EXHIBIT G Things You Should Know Before You Buy Long-Term Care Insurance
2012.EXHIBIT H Long-Term Care Insurance Suitability Letter
2012.EXHIBIT I Claims Denial Reporting: Long-Term Care Insurance Form
2012.EXHIBIT J Potential Rate Increase Disclosure
2012.EXHIBIT K Replacement and Lapse Reporting Form
2012.EXHIBIT L Long-Term Care Insurance Partnership Disclosure Notice
2012.EXHIBIT M Long-Term Care Insurance Partnership Certification Form

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

SOURCE: Adopted at 14 Ill. Reg. 10345, effective June 15, 1990; amended at 18 Ill. Reg. 2238, effective February 1, 1994; amended at 19 Ill. Reg. 2832, effective July 1, 1995; emergency amendment at 19 Ill. Reg. 8403, effective June 13, 1995; emergency expired September 1, 1995; amended at 19 Ill. Reg. 14421, effective October 3, 1995; amended at 22 Ill. Reg. 2105, effective January 6, 1998; amended at 26 Ill. Reg. 8835, effective July 1, 2002; amended at 32 Ill. Reg. 7600, effective May 5, 2008; amended at 38 Ill. Reg. 2186, effective January 2, 2014.

Section 2012.30 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

"Exceptional Increase" means only those increases filed by an insurer as exceptional for which the Director determines the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this State, or to increased and unexpected utilization that affects the majority of insurers of similar products.

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

The Director may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

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

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

One or more employers or labor organizations, or to a trust or to the trustee(s) of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

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

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

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

An association or a trust or the trustee(s) of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this State, the association or associations, or the insurer of the association or associations, shall file evidence with the Director that the association or associations have at the outset a minimum of 100 members and have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and by-laws which provide that:

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

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

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

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

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

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

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

the benefits are reasonable in relation to the premiums charged.

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

benefits provided over the life of the policy. These values shall be measured as of the date of issue.

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

"Long-Term Care Insurance", as defined in Section 351A-1 of the Code, *means any accident and health insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. The term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of function capacity. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization, to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income* or related asset-*protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may include benefits for care and treatment in accordance with the tenets and practices of any established church or religious denomination which teaches reliance on spiritual treatment through prayer for healing.*

"Maintenance or Personal Care Services", within the meaning of the Internal~~internal~~ Revenue Code of 1986, as amended (26 USC 7702B(c)(3)), means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a chronically ill individual (including the protection from threats to health and safety due to severe cognitive impairment).

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

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

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

"Qualified Long-Term Care Insurance Partnership Policy" means a policy that meets all of the following requirements:

It covers an insured who was a resident of Illinois when coverage first became effective under the policy;

It is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986 issued not earlier than the effective date of the State plan amendment;

It meets the model regulations and requirements of the National Association of Insurance Commissioners model specified in paragraph (5) of Title VI, section 6021 of the federal Deficit Reduction Act of 2005 (42 USC 1305), and the Director of the Department of Insurance certifies it as meeting these requirements; and

If the policy is sold to an individual who:

has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

has attained age 61 but has not attained age 76 as of the date of purchase, the policy provides some level of inflation protection; or

has attained age 76 as of the date of purchase, the policy may, but is not required to, provide some level of inflation protection.

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

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

"Similar Policy Forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition of "Group Long-Term Care Insurance" found in Section 351A-1(e)(1) of the Code are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications. For purposes of determining similar policy forms, long-term care benefit classifications are defined as follows: institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

~~*Long-Term Care Insurance,* as defined in Section 351A-1 of the Code [215 ILCS 5/351A-1], *means any accident and health insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders*~~

~~*which provide directly or which supplement long-term care insurance. Such term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of function capacity. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization, to the extent they are otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income*~~ or related asset ~~*protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may include benefits for care and treatment in accordance with the tenets and practices of any established church or religious denomination which teaches reliance on spiritual treatment through prayer for healing.*~~

(Source: Amended at 38 Ill. Reg. 2186, effective January 2, 2014)

Section 2012.121 Producer Training Requirements

a) Long-Term Care Training Required

1) An individual may not sell, solicit or negotiate long-term care insurance unless the individual is licensed as an insurance producer for accident and health and has completed a one-time training course. The training shall meet the requirements set forth in subsection (b).

2) An individual already licensed and selling, soliciting or negotiating long-term care insurance on July 1, 2008 may not continue to sell, solicit or negotiate long term care insurance unless the individual has completed a one-time training course, as set forth in subsection (b), by July 1, 2009.

3) In addition to the one-time training course required in subsection (a)(1) and (2), an individual who sells, solicits or negotiates long-term care insurance shall complete ongoing training as set forth in subsection (b).

4) The training requirements of subsection (b) may be approved as continuing education courses under Section 500-35(b)(1) of the Code.

b) Minimum Education and Training Requirements

1) The one-time training required by this Section shall be no less than 8 hours. The ~~and the~~ ongoing training required by this Section shall be no less than 4 hours and must be completed before each subsequent license renewal. A producer who fails to complete the 4 hours ongoing training prior to license renewal will have 12 months from that renewal date to complete the ongoing training without having to complete the 8 hour course again~~in 24 months~~.

2) The training required under subsection (b)(1) shall consist of topics related to long-term care insurance, long-term care services and, if applicable, qualified state long-term care insurance Partnership programs as prescribed in 42 USC 1396p, including, but not limited to:

A) State and federal regulations and requirements and the relationship between qualified state long-term care insurance Partnership programs and other public and private coverage of long-term care services, including Medicaid;

B) Available long-term care services and providers;

C) Changes or improvements in long-term care services or providers;

D) Alternatives to the purchase of private long-term care insurance;

E) The effect of inflation on benefits and the importance of inflation protection; and

F) Consumer suitability standards and guidelines.

3) The training required by this Section shall not include training that is insurer or company product specific or that includes any sales or marketing information, materials, or training, other than those required by State or federal law.

c) Verification of Training

1) Insurers subject to this Part shall obtain verification that a producer receives training required by subsection (a) ~~of this Section~~ before a producer is permitted to sell, solicit or negotiate the insurer's long-term care insurance products, maintain records subject to the state's record retention requirements, and make that verification available to the Director upon request.

2) Insurers subject to this Part shall maintain records with respect to the training of their producers concerning the distribution of their Partnership policies that will allow the state insurance department to provide assurance to the state Medicaid agency that producers have received the training contained in subsection (b)(2)(A) as required by subsection (a) and that producers have demonstrated an understanding of the Partnership policies and their relationship to public and private coverage of long-term care, including Medicaid, in this State. These records shall be maintained in accordance with the state's record retention requirements and shall be made available to the Director upon request.

d) The satisfaction of these training requirements in any state shall be deemed to satisfy the training requirements in this State.

(Source: Amended at 38 Ill. Reg. 2186, effective January 2, 2014)

Section 2012.123 Suitability

a) This Section shall not apply to life insurance policies that accelerate benefits for long-term care.

b) Every insurer, health care service plan or other entity marketing long-term care insurance (the "issuer") shall:

1) Develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

2) Train its insurance producers in the use of its suitability standards; and

3) Maintain a copy of its suitability standards and make them available for inspection upon request by the Director.

c) To determine whether the applicant meets the standards developed by the issuer:

1) The insurance producer and issuer shall develop procedures that take the following into consideration:

A) The ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;

B) The applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and

C) The values, benefits and costs of the applicant's existing insurance, if any, when compared to the values, benefits and costs of the recommended purchase or replacement.

2) The issuer, and where an insurance producer is involved, the insurance producer shall make reasonable efforts to obtain the information referenced in subsection (c)(1)~~ of this Section~~. The efforts shall include presentation to the applicant, at or prior to application, of the " Long-Term Care Insurance Personal Worksheet". The personal worksheet used by the issuer shall contain, at a minimum, the information in the format contained in Exhibit F~~ of this Part~~, in not less than 12 point type. The issuer may request the applicant to provide additional information to comply with its suitability standards. A copy of the issuer's personal worksheet shall be filed with the Director.

3) A completed personal worksheet shall be returned to the issuer prior to the issuer's consideration of the applicant for coverage, except the personal worksheet need not be returned for sales of employer group long-term care insurance to employees and their spouses.

4) The sale or dissemination outside the company or agency by the issuer or insurance producer of information obtained through the personal worksheet in Exhibit F~~ of this Part~~ is prohibited.

d) The issuer shall use the suitability standards it has developed pursuant to this Section in determining whether issuing long-term care insurance coverage to an

applicant is appropriate.

e) Insurance producers shall use the suitability standards developed by the issuer in marketing long-term care insurance.

f) At the same time as the personal worksheet is provided to the applicant, the disclosure form entitled "Things You Should Know Before You Buy Long-Term Care Insurance" shall be provided. The form shall be in the format found in Exhibit G~~ of this Part~~, in not less than 12 point type.

g) If the issuer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the issuer may reject the application. In the alternative, the issuer shall send the applicant a suitability letter similar to the one found in Exhibit H~~ of this Part~~. However, if the applicant has declined to provide financial information, the issuer may use some other method to verify the applicant's intent. Either the applicant's returned letter or a record of the alternative method of verification shall be made part of the applicant's file.

h) The issuer shall report annually by June 30 to the Director the total number of applications received from residents of this State, the number of those who declined to provide information on the personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

(Source: Amended at 38 Ill. Reg. 2186, effective January 2, 2014)

Section 2012.145 Long-Term Care Insurance Partnership Program

a) In accordance with section 6021 of the Deficit Reduction Act of 2005 (42 USC 1305) and the Illinois Long-Term Care Partnership Program Act [215 ILCS 132], in addition to the applicable provisions of this Part, the provisions of this Section shall apply to any qualified State long-term care insurance partnership policy.

b) The policy provides the following inflation protections:

1) If the policy is sold to an individual who has not attained age 61 as of the date of purchase, the policy shall provide compound annual inflation protection at a rate of at least 3%, or at a rate based on the changes in the

Consumer Price Index for All Urban Consumers: U.S. city average as determined by the Bureau of Labor Statistics of the U.S. Department of Labor.

2) If the policy is sold to an individual who has attained age 61 but has not attained age 76 as of the date of purchase, the policy shall provide inflation protection expressed in simple or compound interest annually at a rate of at least 3% or at a rate based on the changes in the Consumer Price Index for All Urban Consumers: U.S. city average as determined by the Bureau of Labor Statistics of the U.S. Department of Labor.

3) If the policy is sold to an individual who has attained age 76 as of the date of purchase, the policy may, but is not required to, provide some level of inflation protection.

c) Offers of Exchange

1) An insurer shall offer, on a onetime basis, in writing, to all existing policyholders that were issued a long-term care policy on or after May 5, 2008, the date of the last long-term care (LTC) regulation revision, the option to exchange their existing LTC coverage for coverage that is intended to qualify under Illinois' Long-Term Care Partnership Program (LTCPP). The insurer shall provide written notification of this onetime offer within 12 months from the date on which the company begins to offer partnership coverage in this State. The offer shall be made on a nondiscriminatory basis without regard to the age or health status of the insured and shall remain open for a minimum of 90 days from the date of mailing by the insurer.

2) The mandatory offer of an exchange shall only apply to products issued by the insurer that are comparable to the type of policy form, such as group policies and individual policies, and on the policy series that the company has certified as partnership qualified. This exchange may be subject to underwriting.

3) Premiums may be adjusted based on the results of the underwriting process or the exchange may be denied by the insurer.

4) A policy received in an exchange after the effective date of Illinois' LTCPP is treated as newly issued and is eligible for qualified policy status. For purposes of applying the Medicaid rules relating to qualified LTC partnership policies, the addition of a rider, endorsement or change in schedule page for a policy may be treated as giving rise to an exchange. The effective date of the LTC partnership policy shall be the date the policy was exchanged.

d) Filing Requirements for Long-Term Care Insurance Partnership Policies

1) A partnership policy shall not be issued or issued for delivery in this State unless filed with and approved by the Director in accordance with the procedures set forth in Section 143 of the Code. Any policy submitted for approval as a partnership policy shall be accompanied by a properly executed Partnership Certification Form (Exhibit M).

2) Insurers requesting to make use of a previously approved policy form as a qualified State LTC partnership policy shall submit to the Director a Partnership Certification Form signed by an officer of the company. The Partnership Certification Form shall be accompanied by a copy of the policy or certificate form listed, the approval date, and a bookmark for each of the requirements listed in sections II and III of the form. A Partnership Certification Form shall be required for each policy form submitted for partnership qualification.

e) Partnership Disclosure Notice
A partnership policy issued or issued for delivery in this State shall include a Partnership Disclosure Notice (Exhibit L) explaining the benefits associated with a partnership policy and indicating that, at the time issued, the policy is a qualified State LTC insurance partnership policy. The Partnership Disclosure Notice shall also include a statement indicating that, by purchasing this partnership policy, the insured does not automatically qualify for Medicaid.

f) Producer Training Requirements
The training requirements for a producer to sell, solicit or negotiate LTC insurance, which includes the LTCPP, are listed in Section 2012.121. The training requirements must be met before any producer attempts to sell, solicit or negotiate an LTC partnership policy.

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

(Source: Added at 38 Ill. Reg. 2186, effective January 2, 2014)

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

Section 2012.EXHIBIT L Long-Term Care Insurance Partnership Disclosure Notice

Long-Term Care Insurance Partnership Disclosure Notice
(Company Name)
(Company Address)

(Policyholder/Certificateholder) Name:
(Policy/Certificate) Number/Identifier:
Effective Date:

Important Information Regarding Your Policy's (Certificate's)
Long-Term Care Insurance Partnership Status

NOTE: Please keep this notice with your long term care insurance policy (certificate)

Partnership Policy (Certificate) Status. Your long-term care insurance policy (certificate) is intended to qualify as a Partnership Policy (Certificate) under the Illinois Long-Term Care Partnership Program as of your Policy's (Certificate's) effective date.

The long-term care insurance policy (certificate) recently purchased and enclosed qualifies for the Illinois Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long term care insurance coverage that meets certain state and federal requirements. Long-Term Care Insurance Policies (Certificates) that qualify as Partnership Policies (Certificates) may protect your assets through a feature known as "Asset Disregard" under Illinois' Medicaid Program.

Asset Disregard means that an amount of the policyholder's (certificateholder's) assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy (Certificate) will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy (Certificate) without affecting the person's eligibility for Medicaid. **In addition, the purchase of this Partnership Policy does not automatically qualify you for Medicaid.**

What Could Disqualify Your Policy (Certificate) as a Partnership Policy. If you make any changes to your policy (certificate), such changes could affect whether your policy (certificate) continues to be a Partnership Policy (Certificate). ***Before you make any changes, you should consult with (carrier name) to determine the effect of a proposed change.*** In addition, if you

move to a state that does not maintain a Partnership Program or does not recognize your policy (certificate) as a Partnership Policy (Certificate), you would not receive beneficial treatment of your policy (certificate) under the Medicaid program of that state. The information contained in this disclosure is based on current Illinois and Federal law. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy (certificate) under Illinois' Medicaid Program.

Additional Information. If you have questions regarding long-term care insurance policies (certificates), please contact (carrier name). If you have questions regarding current laws governing Medicaid eligibility, you should contact the Illinois Department of Healthcare and Family Services.

(Source: Added at 38 Ill. Reg. 2186, effective January 2, 2014)

Section 2012.EXHIBIT M Long-Term Care Insurance Partnership Certification Form

Long-Term Care Insurance Partnership Certification Form

NOTE: This Form must be completed and submitted with each long-term care policy or certificate form for which the insurer is seeking Partnership qualification. A separate form must be completed for each policy form and a specimen copy of the form, including all riders and endorsements, must be attached. A long-term care insurance policy or certificate form may not be issued in Illinois as a partnership policy or certificate unless and until this form has been submitted to and approved by the Illinois Department of Insurance.

Under section 1917(b)(5)(B)(iii) of the Social Security Act (42 USC 1396p(b)(5)(B)(iii)), the state insurance commissioner of a state implementing a qualified state long-term care insurance partnership ("Qualified Partnership") may certify that long-term care insurance policies (including certificates issued under a group insurance contract) covered under the Qualified Partnership meet certain consumer protection requirements, and policies so certified are deemed to satisfy those requirements. These consumer protection requirements are set forth in section 1917(b)(5)(A) of the Social Security Act (42 USC 1396p(b)(5)(A)) and principally include certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act", respectively).

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

_____
_____
_____
_____

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:

_____
_____
_____
_____

C. Policy form numbers (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form:

_____
_____
_____
_____

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

II. QUESTIONS REGARDING APPLICABLE PROVISIONS

Please answer each of the questions below with respect to the policy forms identified in section I.C above. For purposes of answering the questions below, any provision of the 2000 Model Regulation or 2000 Model Act listed below shall be treated as including any other provision of the 2000 Model Regulation or 2000 Model Act necessary to implement the provision.

NAIC Model Regulation Requirement	Identify Policy Page # and Provision OR use this space to explain if requirement is inapplicable
Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5), and the requirements of Section 6B of the 2000 Model Act relating to Section 6A	
Section 6B (relating to prohibitions on limitations and exclusions), other than paragraph (7)	
Section 6C (relating to extension of benefits)	
Section 6D (relating to continuation or conversion of coverage)	

Section 6E (relating to discontinuance and replacement of policies)	
Section 7 (relating to unintentional lapse)	
Section 8 (relating to disclosure), other than Sections 8F, 8G, 8H and 8I	
Section 9 (relating to required disclosure of rating practices to consumer)	
Section 11 (relating to prohibitions against post-claims underwriting)	
Section 12 (relating to minimum standards)	
Section 14 (relating to application forms and replacement coverage)	
Section 15 (relating to reporting requirements)	
Section 22 (relating to filing requirements for marketing)	
Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6) and (9) of Section 23C	
Section 24 (relating to suitability)	
Section 25 (relating to prohibition against pre-existing conditions and probationary periods in replacement policies or certificates)	
Section 26 (relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in section 7702B(g)(4) of the Internal Revenue Code of 1986 (26 USC 7702B(g)(4))	

Section 29 (relating to standard format outline of coverage)	
Section 30 (relating to requirement to deliver shopper's guide)	

NAIC Model Act Requirements	**Identify Policy Page # and Provision OR use this space to explain if requirement is inapplicable**
Section 6C (relating to pre-existing conditions)	
Section 6D (relating to prior hospitalization)	
Section 8 (relating to contingent nonforfeiture benefits)	
Section 6F (relating to right to return)	
Section 6G (relating to outline of coverage)	
Section 6H (relating to requirements for certificates under group plans)	
Section 6J (relating to policy summary)	
Section 6K (relating to monthly reports on accelerated death benefits)	
Section 7 (relating to incontestability period)	

Part III. INFLATION PROTECTION

Identify the policy provision or provide form number of endorsement or amendment form (and date of approval) for inflation protection coverage in compliance with 50 Ill. Adm. Code 2012.145(b)(1) through (b)(3).

_____

_____

_____

Part IV. Certification

I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct and complete and the policy [certificate] satisfies the requirements necessary for a qualified State long-term care insurance partnership policy in the State of Illinois.

Date	Name and Title of Officer of the Insurer
	Signature of Officer of the Insurer

(Source: Added at 38 Ill. Reg. 2186, effective January 2, 2014)

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED REPEALER

1) Heading of the Part: Small Employer Group Health Insurance

2) Code Citation: 50 Ill. Adm. Code 2014

3)

Section Numbers:	Adopted Action:
2014.10	Repeal
2014.20	Repeal
2014.30	Repeal
2014.40	Repeal
2014.EXHIBIT A	Repeal

4) Statutory Authority: Implementing Article XIXB of the Illinois Insurance Code [215 ILCS 5/351B-1]

5) Effective Date of Rule: January 2, 2014

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 rule, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 14509; September 13, 2013

10) Has JCAR issued a Statement of Objection to this Rulemaking? No

11) Differences between Proposal and Final Version: None

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? There were none.

13) Will this rulemaking replace any emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Part 2014 implements the Small Employer Group Health Insurance Law Article XIXB. The rule is being repealed because the Department

no longer accepts policy form filings under this statute since the implementation of HIPAA.

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

Anne Marie Skallerup
Assistant General Counsel
Illinois Department of Insurance
122 S. Michigan Ave, 19th Floor
Chicago IL 60603

312/814-5410
312/814-2862 (fax)

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED RULES

1) Heading of the Part: Premium Increase Justification and Reporting

2) Code Citation: 50 Ill. Adm. Code 2026

3)

Section Numbers:	Adopted Action:
2026.5	New
2026.10	New
2026.20	New
2026.30	New
2026.40	New
2026.50	New
2026.60	New

4) Statutory Authority: Implementing Section 355 and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/355 and 401]; 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201

5) Effective Date of Rule: January 2, 2014

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 rule, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 14515; September 13, 2013

10) Has JCAR issued a Statement of Objection to this Rulemaking? No

11) Differences between Proposal and Final Version:

Table of Contents: 2026.30, 2026.40, 2026.50, 2026.60, added capitalizations; 2026.50, removed period after "justification".

Authority note: 2nd line, added "; 42 USC 300gg-22; and 45 CFR 150.101(b)(2) and 150.201".

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED RULES

2026.5(a): 2nd line, delete "[215 ILCS 5/355]".

2026.10: throughout this Section, capitalized the terms being defined and placed them in quotation marks.

2026.10: definition of "Affordable Care Act", add " "or "ACA""; change brackets to parentheses; add a period at the end.

2026.10: after definition of "Affordable Care Act", added " "Code" means the Illinois Insurance Code [215 ILCS 5]."".

2026.10: in definition of "CMMS", changed "CMMS" to "CMS" and changed the ampersand to "and".

2026.10: definition of Federal Medical Loss Ratio Standard, 3rd line, deleted "Part".

2026.10: definition of "Health Insurance Coverage", changed the second "the" to "that", changed "in Section" to "in PHS Act section" and deleted "of the Public Health Service Act".

2026.10: in the definition of "Health Insurance Issuer", changed the second "the" to "that", changed "in Section" to "in PHS Act section" and deleted "of the Public Health Service Act".

2026.10: change the first 7 lines in the definition: "Individual Market" has the meaning given in PHS Act section 2791(e)(1)(A). Coverage that would be regulated as individual market coverage, as defined in PHS Act section 2791(e)(1)(A), if it were not sold through an"

2026.10: definition of "PHS Act", change the brackets to parentheses.

2026.10: definition of "Product", 2nd line, change "State" to lower case.

2026.10: change the first 3 lines of the definition to " "Small Group Market" has the meaning ascribed in PHS Act section 2791(e)(5)"; 5th line, change "under Section" to "in section"; 8th line, changed "Section" to "section".

2026.10: definition of "Unreasonable Rate Increase", 2nd line, changed "Section 40 of this Part" to "Section 2026.40".

2026.20(a): 1st line, capitalized "general"; 2nd line, capitalized "part".

2026.20(b): 2nd line, capitalized "part"; 3rd and 4th lines, changed to "as defined in 45 CFR 147.140 or to excepted benefits as described in PHS Act section 2791(c).".

2026.30: 1st line, changed to "A rate increase filed on or after January 1, 2014, or effective on or after January 1, 2014, is".

2026.30(a): 1st line, deleted the comma and "that"; 2nd line, deleted "begins on September 1" and changed "paragraph (b) of this Section;" to "subsection (b).".

2026.30(b): 1st and 2nd lines, changed "paragraph (a) of this Section" to "subsection (b)".

2026.30(c): 2nd line, changed "paragraph (b) of this Section" to "subsection (b)"; 5th line, changed "review and such" to "review. The"

2026.40(a): 1st line, changed "increase he" to "increase, he or she".

2026.40(b): 3rd line, changed "as required in" to "(see" and after "b)" added ")".

2026.40(b)(1): 2nd and 4th lines, changed "Federal" to "federal".

2026.50(b)(1): 1st and 2nd lines, change "paragraph (d) of this section" to "subsection (d)".

2026.50(b)(2): 2nd line, change "paragraph (e) of this section" to "subsection (e)".

2026.50(b)(3): change "paragraph (f) of this section" to "subsection (f)".

2026.50(c): 2nd line, change "paragraphs (b)(1) and (b)(3) of this section" to "subsections (b)(1) and (b)(3)"; 4th line, delete "then"; 5th line, change "paragraph (b)(2) and (b)(3) of this section" to "subsections (b)(1) and (b)(3)".

2026.50(d): 2nd line, after "following" added a comma.

2026.50(e): 4th line, changed "and including" to "and must include".

2026.50(e)(1): 3rd line, changed the comma to a semicolon.

2026.50(f): 5th line, after the second "and" added "to".

2026.50(g): 1st and 2nd lines, changed "paragraphs (d) and (f) of this section" to "subsections (d) and (f)"; 3rd and 4th lines, deleted extra spaces after "increase" and "his", added a comma after "increase", changed "his" to "a" and changed "per" to "as allowed by".

2026.60(a):1st line, deleted the subsection symbol; 3rd line, after the first "increase" added a comma; 4th line, changed "his" to "that" and changed "CMS" to "CMMS".

2026.60(b): 1st line, changed "CMS" to "CMMS"; 3rd line, changed "CMS's receipt thereof" to "CMMS receipt of the final determination".

2026.60(c)(3): 3rd line, changed "Sections" to "sections".

2026.60(c)(4): 3rd line, changed "Affordable Care Act" to "ACA".

2026.60(d): 2nd line, after "factors" added a comma.

2026.60(d)(5): 2nd and 3rd lines, changed "Section 2701 of the Public Health Service Act" to "PHS Act section 2701".

2026.60(d)(6): 1st line, change "trend" to "trends".

2026.60(d)(15); 2nd line, changed "Sections" to lower case and changed "Affordable Care Act" to "ACA".

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace an emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: The ACA directs the Secretary of DHHS to establish a process for the annual review of unreasonable increases in premiums for long–term care health insurance coverage and to adopt a State's determination of whether a rate increase is an unreasonable rate increase when a State meets certain requirements specified by the ACA. The DHHS has determined that Illinois meets these requirements,

and therefore will adopt its determinations of unreasonable rate increases. In accordance with the ACA this new rule provides that health insurance issuers file with the DOI justifications for unreasonable premium increases prior to the implementation of the increases. Neither the new Department of Insurance rule nor the ACA prohibit use of the rate if it is found to be unreasonable.

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

Mary Jane Adkins
Assistant General Counsel
Illinois Department of Insurance
122 S. Michigan Ave, 19th Fl.
Chicago, IL 60603

312/814-5411
312/814-2862 (fax)

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

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED RULES

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2026
PREMIUM INCREASE JUSTIFICATION AND REPORTING

Section
2026.5 Purpose and Scope
2026.10 Definitions
2026.20 Applicability
2026.30 Rate Increases Subject to Review
2026.40 Unreasonable Rate Increases
2026.50 Submission of Rate Filing Justification
2026.60 Determination of an Unreasonable Rate Increase

AUTHORITY: Implementing Section 355 and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/355 and 401]; 42 USC 300gg-22; and 45 CFR 150.101(b)(2) and 150.201.

SOURCE: Adopted at 38 Ill. Reg. 2213, effective January 2, 2014

Section 2026.5 Purpose and Scope

a) Purpose
This Part describes the Director's authority to review rate filings pursuant to Section 355 of the Illinois Insurance Code.

b) Scope
This Part establishes the requirements for health insurance issuers offering health insurance coverage in the small group or individual markets to report information concerning unreasonable rate increases to the Director. This Part further establishes the process by which it will be determined whether the rate increases are unreasonable rate increases as defined in this Part.

Section 2026.10 Definitions

"Affordable Care Act" or "ACA" means the Patient Protection and Affordable Care Act (42 USC 18001 et seq.).

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

"Department" means the Illinois Department of Insurance.

"Director" means the Director of the Illinois Department of Insurance.

"CMMS" means the Centers for Medicare and Medicaid Services.

"Federal Medical Loss Ratio Standard" means the applicable medical loss ratio standard for the State and market segment involved, determined under subpart B of 45 CFR 158.

"Health Insurance Coverage" has the meaning given that term in PHS Act section 2791(b)(1).

"Health Insurance Issuer" has the meaning given that term in PHS Act section 2791(b)(2).

"Individual Market" has the meaning given in PHS Act section 2791(e)(1)(A). Coverage that would be regulated as individual market coverage, as defined in PHS Act section 2791(e)(1)(A), if it were not sold through an association, is subject to rate review as individual market coverage.

"PHS Act" means the Public Health Service Act (42 USC 201 et seq.).

"Product" means a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a state.

"Rate Increase" means any increase of the rates for a specific product offered in the individual or small group market.

"Rate Increase Subject to Review" means a rate increase that meets the criteria set forth in Section 2026.30.

"Secretary" means the Secretary of the Department of Health and Human Services.

"Small Group Market" has the meaning ascribed in PHS Act section 2791(e)(5); provided, however, that for the purpose of this definition, "50" employees applies in place of "100" employees in the definition of "small employer" in section 2791(e)(4). "Coverage" that would be regulated as small group market coverage (as defined in section 2791(e)(5)) if it were not sold through an association is subject to rate review as small group market coverage.

"Unreasonable Rate Increase" means a rate increase that the Director determines under Section 2026.40 to be excessive, unjustified or unfairly discriminatory.

Section 2026.20 Applicability

a) In General
The requirements of this Part apply to health insurance issuers offering health insurance coverage in the individual market and small group market, as defined in 45 CFR 154.103.

b) Exceptions
The requirements of this Part do not apply to grandfathered health plan coverage as defined in 45 CFR 147.140 or to excepted benefits as described in PHS Act section 2791(c).

Section 2026.30 Rate Increases Subject to Review

A rate increase filed on or after January 1, 2014, or effective on or after January 1, 2014, is subject to review if, as required by 45 CFR 154.200:

a) The rate increase is 10 percent or more and applicable to a 12-month period as calculated under subsection (b).

b) A rate increase meets or exceeds the applicable threshold set forth in subsection (a) if the average increase for all enrollees weighted by premium volume meets or exceeds the applicable threshold.

c) If a rate increase that does not otherwise meet or exceed the threshold under subsection (b) meets or exceeds the threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to

meet or exceed the threshold and is subject to review. The review shall include a review of the aggregate rate increases during the applicable 12-month period.

Section 2026.40 Unreasonable Rate Increases

a) When the Director reviews a rate increase, he or she will determine that the rate increase is an unreasonable rate increase if the increase is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase, as required and defined by 45 CFR 154.205.

b) The rate increase is an excessive rate increase if the increase causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage (see 45 CFR 154.205(b)). In determining whether the rate increase causes the premium charged to be unreasonably high in relationship to the benefits provided, the Director will consider:

1) Whether the rate increase results in a projected medical loss ratio below the federal medical loss ratio standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under federal law;

2) Whether one or more of the assumptions on which the rate increase is based is not supported by substantial evidence; and

3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable.

c) The rate increase is an unjustified rate increase (as defined in 45 CFR 154.205(c)) if the health insurance issuer provides data or documentation to the Director in connection with the increase that is incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

d) The rate increase is an unfairly discriminatory rate increase (as defined in 45 CFR 154.205(d)) if the increase results in premium differences between insureds within similar risk categories that do not reasonably correspond to differences in expected costs.

Section 2026.50 Submission of Rate Filing Justification

a) If any product is subject to a rate increase, a health insurance issuer must submit a Rate Filing Justification for all products in the single risk pool, including new or discontinuing products, to the Director on a form and in a manner prescribed by the Secretary in 45 CFR 154.215(a).

b) The Rate Filing Justification must consist of the following Parts (as required in 45 CFR 154.205(b)):

1) Unified rate review template (Part I), as described in subsection (d).

2) Written description justifying the rate increase (Part II), as described in subsection (e).

3) Rating filing documentation (Part III), as described in subsection (f).

c) A health insurance issuer must complete and submit Parts I and III of the Rate Filing Justification described in subsections (b)(1) and (b)(3) to the Director as required by 45 CFR 154.215(c). If a rate increase is subject to review, the health insurance issuer must also complete and submit to the Director Part II of the Rate Filing Justification described in subsection (b)(2).

d) Content of unified rate review template (Part I): The unified rate review template must include the following, as determined appropriate by the Director and in accordance with 45 CFR 154.215(d):

1) Historical and projected claims experience.

2) Trend projections related to utilization, and service or unit cost.

3) Any claims assumptions related to benefit changes.

4) Allocation of the overall rate increase to claims and non-claims costs.

5) Per enrollee per month allocation of current and projected premium.

6) Three year history of rate increases for the product associated with the rate increase.

e) Content of written description justifying the rate increase (Part II): The written

description of the rate increase must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase and must include the following as required by 45 CFR 154.215(e):

1) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary; and

2) Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

f) Content of rate filing documentation (Part III) as required by 45 CFR 154.215(f): The rate filing documentation must include an actuarial memorandum that contains the reasoning and assumptions supporting the data contained in Part I of the Rate Filing Justification. Parts I and III must be sufficient to conduct an examination satisfying the requirements of 45 CFR 154.301(a)(3) and (4) and to determine whether the rate increase is an unreasonable increase.

g) If the level of detail provided by the issuer for the information under subsections (d) and (f) does not provide sufficient basis for the Director to determine whether the rate increase is an unreasonable rate increase, the Director will request the additional information necessary to make a determination, as allowed by 45 CFR 154.215(g).

Section 2026.60 Determination of an Unreasonable Rate Increase

a) As required by 45 CFR 154.225(a), when the Director receives a Rate Filing Justification for a rate increase subject to review and the Director reviews the rate increase, the Director will make a timely determination whether the rate increase is an unreasonable rate increase, and submit that decision to CMMS.

b) If the Director determines that the rate increase is unreasonable, CMMS will provide the Director's final determination and brief explanation to the health insurance issuer within five business days following CMMS receipt of the final determination.

c) The Director's rate review process includes an examination of the following as required by 45 CFR 154.301(a)(3):

1) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions;

2) The health insurance issuer's data related to past projections and actual experience;

3) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act; and

4) The health insurance issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the ACA.

d) As required by 45 CFR 154.301(a)(4), the examination must take into consideration the following factors, to the extent applicable to the filing under review:

1) The impact of medical trend changes by major service categories;

2) The impact of utilization changes by major service categories;

3) The impact of cost-sharing changes by major service categories, including actuarial values;

4) The impact of benefit changes, including essential health benefits and non-essential health benefits;

5) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under PHS Act section 2701;

6) The impact of any overestimate or underestimate of medical trends for prior year periods related to the rate increase;

7) The impact of changes in reserve needs;

8) The impact of changes in administrative costs related to programs that improve health care quality;

9) The impact of changes in other administrative costs;

10) The impact of changes in applicable taxes, licensing or regulatory fees;

11) Medical loss ratio;

12) The health insurance issuer's capital and surplus;

13) The impacts of geographic factors and variations;

14) The impact of changes within a single risk pool to all products or plans within the risk pool; and

15) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the ACA.

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED RULES

1) Heading of the Part: Navigator, In-Person Counselor and Certified Application Counselor Certification

2) Code Citation: 50 Ill. Adm. Code 3125

3)

Section Numbers:	Adopted Action:
3125.10	New
3125.20	New
3125.30	New
3125.40	New
3125.50	New
3125.60	New
3125.70	New
3125.80	New
3125.90	New
3125.100	New
3125.110	New
3125.120	New
3125.130	New
3125.140	New

4) Statutory Authority: Implementing and authorized by the Navigator Certification Act [215 ILCS 121] and 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201

5) Effective Date of Rule: January 3, 2014

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 rule, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 15238; September 20, 2013

10) Has JCAR issued a Statement of Objection to this Rulemaking? No

11) Differences between Proposal and Final Version:

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED RULES

Header, 4th line: changed "REGISTERED FIRMS" to "TRAINING PROVIDERS".

Table of contents: renumbered 3125.30, 3125.40, 3125.50, 3125.60, 3125.70 and 3125.80 to 3125.90, 3125.100, 3125.110, 3125.120, 3125.130, and 3125.140, respectively, and added the following new Sections: 3125.30 Certification Required; 3125.40 Exemption from Certification; 3125.50 Application for Certification; 3125.60 Certification Renewal; 3125.70 Navigator, In-Person Counselor and Certified Application Counselor Prohibited Conduct; and 3125.80 Reporting to the Director.

Table of Contents, Section 3125.90: added "Training" before "Provider Responsibilities".

Table of Contents, Section 3125.100: added "the" before "Navigator".

Table of Contents, Section 3125.110: changed "Requirements" to "Course Design".

Table of Contents, Section 140: changed "Felony" to "Disqualifying Offense".

Authority note: added comma after [215 ILCS 121] and added "42 USC 300gg-22; and 45 CFR 150.101(b)(2) and 150.201" before the period.

3125.10, first line: added "establish certification criteria for Navigator, In-Person Counselor or Certified Application Counselor certification;" after "Part is to".

3125.10, 3rd line: changed "and" to "or".

3125.10, 4th line: changed "providers" to "Training Providers".

3125.10, 6th line: changed "felony" to "disqualifying offense", changed "education providers" to "Training Providers", and "In-person" to "In-Person".

3125.20, 1st line: added ""Certification" means the issuance by the Director of a license or authorization pursuant to this Part.".

3125.20, definition of "Certified Application Counselor", 1st line: changed "a person who provides information" to "any employee or volunteer of a Certified Application Counselor Organization that enters into an agreement with the Marketplace to have its employees or volunteers provide information to individuals and employees"; 2nd line, added "qualified health plan" before "coverage options; 2nd and 3rd lines, changed "assists and facilitates" to "assist"; 4th line, changed "marketplace" to "Marketplace" and "helps" to "help"; 5th line, changed "individual" to "individuals".

3125.20, following the definition of "Certified Application Counselor": added ""Certified Application Counselor Organization" means any organization designated by the Marketplace to certify its staff members or volunteers to act as certified application counselors and includes those organizations described in 45 CFR 155.225."

3125.20, deleted definition of "Contact Instruction".

3125.20, deleted definition of "Date of Original Issue.

3125.20, definition of "In-Person Counselor", 1st line: changed "person" to "individual". 2nd line, after "identified in", deleted all remaining text in the definition and added: "45 CFR 155.205 or is described or designated by a Marketplace, the State, or the United States Department of Health and Human Services, or could reasonably be described or designated as "non-Navigator assistance personnel" as described in 45 CFR 155.215. An In-Person Counselor would engage in the activities and meet the standards described in 45 CFR 155.215, including, but not limited to:

conduct public education activities to raise awareness of the availability of qualified health plans;

distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under 26 USC 36B and cost-sharing reductions under 42 USC 18071;

facilitate enrollment in qualified health plans;

provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Services Act (42 USC 300gg-93), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under a plan or coverage; and

provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Marketplace."

3125.20, definition of "Interactive Online Course, 1st line: deleted "self-study" and changed "presented only" to "only presented". After that, added ""Marketplace" means any health benefit exchange authorized under the federal Patient Protection and Affordable Care Act and established or operating in this State, including any exchange established or operated by the United States Department of Health and Human Services."

3125.20, definition of "Marketplace": 3rd line, changed "state" to "State".

3125.20, definition of "Navigator", 1st line: changed "person" to "individual"; after "entity who", added "is certified as a "Navigator" under the federal Patient Protection and Affordable Care Act, and means any individual or entity, other than an insurance producer licensed by the Department,". 3rd line: added "who" after "Department"; 6th line: changed "18031(i)," to "18031(i)(3) or is described or designated by a Marketplace, the State, or the United States Department of Health and Human Services, or could

reasonably be described or designated, as Navigators, as described in 45 CFR 155.210. A Navigator would engage in the activities and meet the standards described in 45 CFR 155.210 and 45 CFR 155.215,"; added a colon after "limited to"; and deleted "maintain". Replaced all remaining text in the definition with:

conduct public education activities to raise awareness of the availability of qualified health plans;

distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under 26 USC 36B and cost-sharing reductions under 42 USC 18071;

facilitate enrollment in qualified health plans;

provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Services Act (42 USC 300gg-93), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under a plan or coverage; and

provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Marketplace.

3125.20, deleted definition of "Provider".
3125.20, added definition ""Qualified health plan" has the meaning given that term in 42 USC 18021(a)."
3125.20, definition of "Successful Completion": 1st line, changed "70" to "80"; 2nd line, added "in no more than three attempts" after "above"; 2nd and 3rd lines changed "provider and certified by the Director" to "Training Provider".
3125.20, added definition ""Training Provider" means any organization duly authorized by the Department to offer courses to individuals seeking certification by the Director pursuant to this Part."
3125.30: renumbered to 3125.90.
3125.40: renumbered to 3125.100; added "the" before "Navigator".
3125.50: renumbered to 3125.110; changed "Requirements" to "Course Design".
3125.60: renumbered to 3125.120.
3125.70: renumbered to 3125.130.
3125.80: renumbered to 3125.140; changed "Felony" to "Disqualifying Offense".

Added new Sections 3125.30 Certification Required, 3125.40 Exemption from Certification, 3125.50 Application for Certification; 3125.60 Certification Renewal; 3125.70 Navigator, In-Person Counselor and Certified Application Counselor Prohibited Conduct; and 3125.80 Reporting to the Director.

3125.90: changed "Provider Responsibilities" to "Training Provider Responsibilities".

3125.90(a): deleted all text and replace with "a) Training shall be provided in a manner duly authorized by the Director.".

3125.90(b): 1st line, changed "provider" to "Training Provider"; deleted "a certification"; after "Director" added "or his or her designee for certification"; and deleted "for"; 3rd line, changed "Department" to "Director or his or her designee"; 4th and 5th lines, deleted "be accompanied by the appropriate fee (see 215 ILCS 5/500-135(a)(6) or (7))."; 5th line, changed "provider" to "Training Provider" and "providers" to "Training Provider"s"; 10th and 11th lines, deleted "(see 215 ILCS 5/500-35(b)(1))".

3125.90(c): deleted all text and renumbered (d) through (j) to (c) through (i), respectively. 3125.90(c): 1st line, changed "Each provider" to "The Training Provider"; 2nd and 3rd lines, changed "provider" to "Training Provider" twice.

3125.90(d): 1st line, renumbered(e) to (d); changed "Each provider" to "The Training Provider".

3125.90(d)(1): 1st line, changed "seminar" to "online course"; 2nd line, changed "students" to "student" and added "and" before "the date"; 3rd and 4th lines, changed the comma after "attendance" to a period and deleted all remaining text.

3125.90(d)(2): deleted all text and replaced with "2) Records of any examinations given.".

3125.90(d)(3): deleted all text and replaced with "3) Original course content provided in initial training that is appropriately updated may be used in continuing education training."

3125.90(e): 1st line, changed "f)" to "e)"; changed "Each provider" to "The Training Provider"; and "provide" to "submit"; 4th line, changed "provider" to "Training Provider"; 8th and 9th lines, deleted "and in the specifications established by the Director"; 12th line, changed "provider" to "Training Provider"; deleted "Other than the original course fee," and changed "no" to "No".

3125.90(f): 2nd line, added "Training" before "Providers" and changed "the" to "those".

3125.90(g): added "Training" before "Providers"; 2nd line, changed "provider" to "Training Provider".

3125.90(h): 3rd line, changed "providers" to "Training Providers" and changed "the arrangement" to "such an arrangement"; 4th line, changed "required" to "requirements"; changed "provider" to "Training Provider".

3125.90(i): added "Training" before "Providers".

3125.100(a): renumbered to (b) and added new subsection (a), "a) Prior to receiving approval for a Navigator, In-Person Counselor or Certified Application Counselor certification, the applicant must complete approved State and federal training courses prescribed by the Director. Initial courses for Navigators and In-Person Counselors will be at least 24 hours and may be provided in-person or online. Initial courses for Certified Application Counselors will be at least 6 hours and may be provided in-person or online. An applicant for a Navigator, In-Person Counselor or Certified Application Counselor must complete the Director prescribed State and federal training courses within 12 months prior to certification."

3125.100(b)(1): 1st line, deleted comma and added "or" after "Each Navigator"; deleted "or Certified Application Counselor"; 2nd line, changed "24" to "12" and added "requirements" after "education"; 3rd line, changed "Three" to "Two" and "24" to "12"; 4th through 11th lines, changed "an ethics training classroom course" to "ethics" and deleted all remaining text in this Section.

3125.100(b): after (1) add "2) Each Certified Application Counselor shall complete a minimum of 4 hours of continuing education requirements prior to requesting an extension of a certification. One of the 4 hours of continuing education must consist of ethics.

c) Each Navigator, In-Person Counselor or Certified Application Counselor shall maintain a record of each course completed for 3 years from the date of completion. The record shall include the name of the Training Provider, the course title, and the date of completion. Courses initiated or completed prior to the original issue date of the certificate shall not be used to meet continuing education requirements."

3125.110(a): 1st line, added "of a continuing education course" after "certification".

3125.110(b): 2nd line, changed "provider" to "Training Provider".

3125.110(c): 1st line, added "private and public" after "understanding of"; 2nd line, deleted "and coverages"; added "and" after "laws" and deleted ", insurance"; added "Medicaid and Marketplace policies and operations, and outreach and education skills." after "regulations," 3rd line, deleted "agency management, customer service and sales.".

3125.110(d), changed "seminar" to "on-line course".

3125.110(e), changed "contact" to "online".

3125.110(f)(1) and (f)(2), changed "provider" to "Training Provider" in two places.

3125.110(g)(1): deleted all text and added "The course must provide an exam at the end of each course;"

3125.110(g)(3): 2nd line, added "prior to the examination" after "time".
3125.120(a)(2): 2nd line, changed "commissioner" to "Director".
3125.120(a)(12): added "Illinois" before "State" in two places and added "Illinois" before "Department" in the 4th line.
3125.120(b) renumbered to (c) and added new subsection (b): "If an action by the Director is to nonrenew, suspend, or revoke a certificate or to deny an application for a certificate, then the Director shall notify the applicant or certificate holder and advise, in writing, the applicant or certificate holder of the reason for the suspension, revocation, or denial or nonrenewal of the applicant"s or certificate holder"s certificate. The applicant or certificate holder may make written demand upon the Director within 30 days after the date of mailing for a hearing before the Director to determine the reasonableness of the Director"s action. The hearing must be held within not fewer than 20 days nor more than 30 days after the mailing of the notice of hearing and shall be held pursuant to 50 Ill. Adm. Code 2402."
3125.130(d): 2nd line, added "Illinois insurance laws," after "violations of".
3125.140: 2nd line, added "Section 30(a) of the Illinois Navigator Act allows the Director to place on probation, suspend, revoke or refuse to issue or renew a Navigator, In-Person Counselor and Certified Application Counselor certification, levy a civil penalty, or take any combination of the preceding actions as established by rule. Section 3125.120 of this Part allows the Director to place on probation, suspend, revoke, or refuse to issue or renew a Navigator, In-Person Counselor or Certified Application Counselor"s certificate or levy a civil penalty or take any combination of these actions, when the Navigator, In-Person Counselor, Certified Application Counselor or applicant has been convicted of a felony. (See Section 3125.120(6))." before "When reviewing".
3125.140(g): 1st line, changed "Successful" to "Satisfactory".

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Part 3125 (new rule) implements 215 ILCS 121, The Insurance Navigator Act. It establishes pre-certification education requirements for applicants for Navigator, In-Person Counselor and Certified Application Counselors and establishes requirements for providers and instructors of continuing education courses. It

also establishes disqualification and non-compliance penalty provisions and felony review standards for education providers, Navigators, In-Person Counselors and Certified Application Counselors.

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

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312/814-5410
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The full text of the Adopted Rules begins on the next page:

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED RULES

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER ii: NAVIGATOR, IN-PERSON COUNSELOR, CERTIFIED APPLICATION COUNSELOR AND TRAINING PROVIDERS

PART 3125
NAVIGATOR, IN-PERSON COUNSELOR AND CERTIFIED APPLICATION COUNSELOR CERTIFICATION

Section
3125.10 Purpose
3125.20 Definitions
3125.30 Certification Required
3125.40 Exemption from Certification
3125.50 Application for Certification
3125.60 Certification Renewal
3125.70 Navigator, In-Person Counselor and Certified Application Counselor Prohibited Conduct
3125.80 Reporting to the Director
3125.90 Training Provider Responsibilities
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3125.120 Certification Denial, Nonrenewal or Revocation
3125.130 Regulatory Examinations
3125.140 Disqualifying Offense Review

AUTHORITY: Implementing and authorized by the Navigator Certification Act [215 ILCS 121]; 42 USC 300gg-22; and 45 CFR 150.101(b)(2) and 150.201.

SOURCE: Adopted at 38 Ill. Reg. 2226, effective January 3, 2014.

Section 3125.10 Purpose

The purpose of this Part is to establish certification criteria for Navigator, In-Person Counselor or Certified Application Counselor certification; establish pre-certification education requirements for applicants for Navigators, In-Person Counselors or Certified Application Counselors certification; establish continuing education requirements for Navigators, In-Person Counselors or Certified Application Counselors; and establish requirements for Training Providers and

instructors of continuing education courses. Additionally, this Part establishes disqualification and non-compliance penalty provisions and disqualifying offense review standards for Training Providers, Navigators, In-Person Counselors or Certified Application Counselors regardless of residency.

Section 3125.20 Definitions

"Certification" means the issuance by the Director of a license or authorization pursuant to this Part.

"Certified Application Counselor" means any employee or volunteer of a Certified Application Counselor Organization that enters into an agreement with the Marketplace to have its employees or volunteers provide information to individuals and employees about insurance affordability programs and qualified health plan coverage options; assist individuals and employees to apply for coverage in a qualified health plan through the Marketplace and for insurance affordability programs; and help to facilitate enrollment of eligible individuals in qualified health plans and insurance affordability programs.

"Certified Application Counselor Organization" means any organization designated by the Marketplace to certify its staff members or volunteers to act as certified application counselors and includes those organizations described in 45 CFR 155.225.

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

"Course" means any course of study certified to the Director that meets the requirements of this Part, including but not limited to seminar, classroom, and self-study formats.

"Department" means the Illinois Department of Insurance.

"Director" means the Director of the Illinois Department of Insurance or anyone to whom the Director's responsibilities and authority are lawfully delegated.

"In-Person Counselor" means any individual or entity who receives grant funds from the State of Illinois to perform the activities and duties identified in 45 CFR 155.205 or is described or designated by a Marketplace, the State, or the United States Department of Health and Human Services, or could reasonably be described or designated as "non-Navigator assistance personnel" as described in

45 CFR 155.215. An In-Person Counselor would engage in the activities and meet the standards described in 45 CFR 155.215, including, but not limited to:

conduct public education activities to raise awareness of the availability of qualified health plans;

distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under 26 USC 36B and cost-sharing reductions under 42 USC 18071;

facilitate enrollment in qualified health plans;

provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Services Act (42 USC 300gg-93), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under a plan or coverage; and

provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Marketplace.

"Interactive Online Course" means courses only presented on the Internet that do not require a proctored final exam.

"Marketplace" means any health benefit exchange authorized under the federal Patient Protection and Affordable Care Act and established or operating in this State, including any exchange established or operated by the United States Department of Health and Human Services.

"Navigator" means any individual or entity who is certified as a "Navigator" under the federal Patient Protection and Affordable Care Act, and means any individual or entity, other than an insurance producer licensed by the Department, who receives grant funds from the United States Department of Health and Human Services to perform any of the activities and duties identified in 42 USC 18031(i)(3) or is described or designated by a Marketplace, the State, or the United States Department of Health and Human Services, or could reasonably be described or designated, as Navigators, as described in 45 CFR 155.210. A

Navigator would engage in the activities and meet the standards described in 45 CFR 155.210 and 45 CFR 155.215, including, but not limited to:

conduct public education activities to raise awareness of the availability of qualified health plans;

distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under 26 USC 36B and cost-sharing reductions under 42 USC 18071;

facilitate enrollment in qualified health plans;

provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Services Act (42 USC 300gg-93), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding his or her health plan, coverage, or a determination under a plan or coverage; and

provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Marketplace.

"Qualified health plan" has the meaning given that term in 42 USC 18021(a).

"Successful Completion" means passing an examination with a score of 80% or above in no more than three attempts in accordance with criteria established by the Training Provider.

"Supervised Examination" means a proctored, timed and closed book examination.

"Training Provider" means any organization duly authorized by the Department to offer courses to individuals seeking certification by the Director pursuant to this Part.

Section 3125.30 Certification Required

a) No individual or entity shall act as, offer to act as, or advertise any service as a Navigator, In-Person Counselor, Certified Application Counselor or Certified Application Counselor Organization in this State unless the individual or entity is certified by the Department pursuant to this Part.

B) The Director shall determine the length, no less than 12 months, of the effectiveness of any certification issued pursuant to this Part.

Section 3125.40 Exemption from Certification

a) Government employees and their agents performing activities related to the Marketplace are exempt from certification. Those individuals and entities may not engage in Navigator, In-Person Counselor and Certified Application Counselor prohibited conduct.

b) The distribution of educational and informational materials relating to the Marketplace authored or provided by a governmental authority is exempt from certification.

c) The collection from the public of requests for information or assistance relating to the Marketplace in a manner approved by a governmental authority or a certified Navigator, In-Person Counselor, Certified Application Counselor or Certified Application Counselor Organization is exempt from certification.

d) The referral of inquiries from the public relating to the Marketplace to an appropriate governmental authority or certified Navigator, In-Person Counselor, Certified Application Counselor or Certified Application Counselor Organization is exempt from certification.

e) The exercise in good faith by journalists and persons other than a certified Navigator, In-Person Counselor or Certified Application Counselor of such person's U.S. and Illinois constitutional right to speak, write and publish freely with regard to the Marketplace is exempt from certification. The rights of a certified Navigator, In-Person Counselor or Certified Application Counselor to engage in Navigator, In-Person Counselor and Certified Application Counselor prohibited conduct are expressly restricted.

Section 3125.50 Application for Certification

a) An individual applying for a Navigator, In-Person Counselor or Certified Application Counselor certification shall make application to the Department on a form developed or accepted by the Director and declare under penalty of refusal, suspension, or revocation of the certification that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the Director shall find that the individual:

1) Is at least 18 years of age;

2) Maintains his or her principal place of business in the State;

3) Is not disqualified for having committed any act that would be a ground for denial, suspension, or revocation of a certification;

4) Has not had an insurance producer license, Navigator certification, In-Person Counselor certification, or Certified Application Counselor certification, or equivalent license or certification denied, suspended, or revoked in any state, province, district, or territory or by the United States Department of Health and Human Services;

5) Has successfully passed the applicable federal training program for Navigators, In-Person Counselors or Certified Application Counselors;

6) Unless otherwise determined by the Director, other than an applicant for Certified Application Counselor certification, has submitted a full set of fingerprints to the Department and successfully completed a criminal background check in a manner prescribed by the Director. The Director may accept an equivalent criminal background check performed by the Navigator entity, In-Person Counselor entity or Certified Application Counselor Organization;

7) When applicable, has the written consent of the Director pursuant to 18 USC 1033 or any successor statute regulating crimes by or affecting persons engaged in the business of insurance whose activities affect interstate commerce;

8) Possesses the requisite character and integrity; and

9) Has identified the entity with which the individual is affiliated and supervised, if any.

b) An entity that acts as a Navigator, supervises or is responsible for the activities of individual Navigators, or receives funding to perform those activities shall obtain a Navigator entity certification. An entity applying for Navigator entity certification shall:

1) Make application on a form containing the information prescribed by the Director; and

2) Designate an individual registered as a Navigator to be responsible for the entity's compliance with this Chapter.

c) An entity that acts as an In-Person Counselor, supervises or is responsible for the activities of individual In-Person Counselors, or receives funding to perform these activities shall obtain an In-Person Counselor entity certification. An entity applying for In-Person Counselor entity certification shall:

1) Make application on a form containing the information prescribed by the Director; and

2) Designate an individual registered as an In-Person Counselor to be responsible for the entity's compliance with this Chapter.

d) An entity that acts as a Certified Application Counselor Organization, supervises or is responsible for the activities of individual Certified Application Counselors, or receives funding to perform those activities shall obtain a Certified Application Counselor certification. An entity applying for a Certified Application Counselor certification shall:

1) Make application on a form containing the information prescribed by the Director; and

2) Designate an individual registered as a Certified Application Counselor to be responsible for the entity's compliance with this Chapter.

e) The Director may require any documents deemed necessary to verify the information contained in an application submitted.

f) Entities certified as Navigators shall, in a manner prescribed by the Director, provide the Director with a list of all individual Navigators that it employs, supervises, or is affiliated with on a quarterly basis.

g) Entities certified as In-Person Counselors shall, in a manner prescribed by the Director, provide the Director with a list of all individual In-Person Counselors that it employs, supervises, or is affiliated with on a quarterly basis.

h) Entities certified as Navigators, In-Person Counselors or Certified Application Counselor Organizations shall, in a manner prescribed by the Director, provide the Director with a list of all individual Navigators, In-Person Counselors or Certified Application Counselors that it employs, supervises, or is affiliated with on a quarterly basis.

Section 3125.60 Certification Renewal

a) A Navigator, In-Person Counselor, Certified Application Counselor and Certified Application Counselor Organization certification shall be valid for one year. A Navigator, In-Person Counselor, Certified Application Counselor and Certified Application Counselor Organization certification shall expire 12 months after certification.

b) Thirty days prior to the end of the 12 month period, a Navigator, In-Person Counselor, Certified Application Counselor or Certified Application Counselor Organization may file an application for renewal on the application prescribed by the Director.

c) Prior to the filing date for application for renewal of a certification, an individual Navigator, or In-Person Counselor shall complete 12 hours, and an individual Certified Application Counselor shall complete 4 hours, of continuing education requirements approved by the Director. The individual shall file with the Director, by a method prescribed by the Director, satisfactory certification of completion of the continuing education requirements. Any failure to fulfill the ongoing continuing education requirements shall result in the expiration of the certification. Individual Navigators, In-Person Counselors or Certified Application Counselors whose certification has expired for failing to complete the continuing education requirements may not apply for a certification until they have provided satisfactory proof to the Director that they have completed the

required continuing education requirements and have filed an application for certification.

Section 3125.70 Navigator, In-Person Counselor and Certified Application Counselor Prohibited Conduct

a) A Navigator, In-Person Counselor, Certified Application Counselor and Certified Application Counselor Organization may not:

1) sell, solicit, or negotiate, as these terms are defined in Section 500-10 of the Illinois Insurance Code, any of the classes of insurance enumerated in Section 4 of the Illinois Insurance Code;

2) offer advice about which health plan is better or worse for a particular individual or employer;

3) recommend or endorse a particular health plan or advise consumers about which health plan to choose;

4) provide any information or services related to health benefit plans or other insurance products not offered in the exchange, except for health care providers when furnishing information or services related to a patient's existing health benefit plan or other existing health insurance coverage;

5) accept any compensation or consideration, directly or indirectly, from any issuer of accident and health insurance or stop-loss insurance that is dependent, in whole or in part, on whether a person enrolls in or purchases a particular private health benefit plan; or

6) engage in any unfair method of competition or any fraudulent, deceptive or dishonest act or practice with respect to the Marketplace or with respect to that individual's or entity's absence of a conflict of interest in connection with the enrollment of any individuals or employees in a particular private health benefit plan.

b) Subsections (a)(1) through (a)(5) do not apply to Navigators, In-Person Counselors, Certified Application Counselors or Certified Application Counselor Organizations when assisting individuals with the enrollment process in the State Medicaid program or other public programs.

c) A Navigator or In-Person Counselor may not:

1) Be a health insurance issuer or issuer of stop-loss insurance;

2) Be a subsidiary of a health insurance issuer or issuer of stop-loss insurance;

3) Be an association that includes members of, or lobbies on behalf of, the insurance industry; or

4) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop-loss insurance in connection with the enrollment of any individuals or employees in a Qualified Health Plan or Non-Qualified Health Plan.

Section 3125.80 Reporting to the Director

a) Each certified Navigator, In-Person Counselor, Certified Application Counselor and Certified Application Counselor Organization shall report to the Director any administrative action taken by a governmental agency against that person in this State or in any other jurisdiction within 30 calendar days after the final disposition of the matter. This report shall include a copy of the order, consent order, or other relevant legal documents.

b) Each certified Navigator, In-Person Counselor, Certified Application Counselor and Certified Application Counselor Organization shall immediately report to the Director any criminal prosecution of that person taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing, and any other relevant legal documents. Failure to report within 30 days following the hearing date shall be considered a violation of this Section.

c) An entity certified under this Part as a Navigator, In-Person Counselor or Certified Application Counselor Organization that terminates the employment, engagement, affiliation, or other relationship with an individual Navigator, In-Person Counselor or Certified Application Counselor shall notify the Director within 30 days following the effective date of the termination, using a format prescribed by the Director, if the reason for termination is one of the reasons set forth in Section 3125.70 or 3125.120, or the entity has knowledge the navigator or

certified application counselor was found by a court or government body to have engaged in any of the activities in Section 3125.70 or 3125.120. Upon the written request of the Director, the entity shall provide additional information, documents, records, or other data pertaining to the termination or activity of the individual.

Section 3125.90 Training Provider Responsibilities

a) Training shall be provided in a manner duly authorized by the Director.

b) Each Training Provider shall submit to the Director or his or her designee for certification each course it intends to offer for continuing education credit. Certification is to be submitted to the Director or his or her designee at least 30 days prior to the first date the course will be offered. Certification must be signed and dated by the Training Provider and contain: the Training Provider's name; Federal Employer Identification Number (FEIN) and/or Social Security number of the individual Training Provider; contact person and that person's telephone number; published Training Provider telephone number; course title; first date course will be offered; whether the course is for public education; class of insurance to which the course is applicable; and type of course instruction. The certification format and content are available on the Department's website at: www.insurance.illinois.gov/Producer/producer_information.asp and will be made available by the Department upon request.

c) The Training Provider shall maintain a copy of all instructional materials for each course. If the Training Provider ceases to offer a course or makes a significant change in the course materials, the Training Provider shall maintain the original material for one year from the date the course was terminated or significantly changed.

d) The Training Provider shall maintain the following records for 3 years at a central location:

1) Classroom or online course – roster for each classroom course or online course identifying the instructors, the student, the course, the location, and the date and hours of attendance.

2) Records of any examinations given.

3) Original course content provided in initial training that is appropriately updated may be used in continuing education training.

e) The Training Provider shall submit to the Director a list of students who have successfully completed a continuing education course. The list shall contain course number; credit hours; course title; reporting week being submitted; Training Provider name; FEIN and/or Social Security number for the individual navigator or in-person counselor; and student data (including student name and Social Security number, date course completed and credit hours for continuing education). The information shall be submitted by an electronic method of transfer prescribed by the Director. Each list shall be received by the Director within 10 days following the end of the week in which the course was completed. The date of completion for a course with an examination shall be the date the examination is graded by the Training Provider. No additional fee shall be charged to the student for reporting the student's successful completion to the Department. If the initial report contains an error, no additional charge shall be given for re-reporting the credits to the Department.

f) Instructors shall have either a Bachelor's degree or 3 years experience in the course subject matter. Training Providers must maintain evidence of those qualifications while the instructor is actively engaged in instructing the course and for one year thereafter.

g) Training Providers shall, upon the request of the Director, provide a copy of all course material, Training Provider records, and evidence of instructor's qualifications to the Director. All such requests shall be subject to a warrant of the Director and for the express purpose of gauging compliance with the Code and Department regulations pertaining to the Code.

h) The Director may make arrangements, including contracting with an outside service administrator, for the purpose of administrating and collecting the educational data from the Training Providers. Under such an arrangement, all or a portion of the reporting requirements of the Training Provider shall be made to the servicing administrator.

i) Training Providers may not advertise a training course or continuing education course unless it has been approved by the Department.

Section 3125.100 Responsibilities of the Applicant for the Navigator, In-Person Counselor or Certified Application Counselor Certification

a) Prior to receiving approval for a Navigator, In-Person Counselor or Certified Application Counselor certification, the applicant must complete approved State and federal training courses prescribed by the Director. Initial courses for Navigators and In-Person Counselors will be at least 24 hours and may be provided in-person or online. Initial courses for Certified Application Counselors will be at least 6 hours and may be provided in-person or online. An applicant for a Navigator, In-Person Counselor or Certified Application Counselor must complete the Director prescribed State and federal training courses within 12 months prior to certification.

b) Certified Navigator, In-Person Counselor or Certified Application Counselor

1) Each Navigator or In-Person Counselor shall complete 12 hours of continuing education requirements prior to requesting an extension of a certification. Two of the 12 hours of continuing education must consist of ethics.

2) Each Certified Application Counselor shall complete a minimum of 4 hours of continuing education requirements prior to requesting an extension of a certification. One of the 4 hours of continuing education must consist of ethics.

c) Each Navigator, In-Person Counselor or Certified Application Counselor shall maintain a record of each course completed for 3 years from the date of completion. The record shall include the name of the Training Provider, the course title, and the date of completion. Courses initiated or completed prior to the original issue date of the certificate shall not be used to meet continuing education requirements.

Section 3125.110 Continuing Education Course Design

a) The certification of a continuing education course must be received by the Director at least 30 days prior to any course being offered.

b) For purposes of this Section, "full credit" shall mean the reasonable amount of time, as certified by the Training Provider, that is necessary for a student to study

for and pass an examination or, in the case of a course with no examination, the number of documented classroom attendance hours.

c) Courses shall be intended to increase the knowledge and understanding of private and public insurance principles, applicable laws and regulations, Medicaid and Marketplace policies and operations, and outreach and education skills. The following courses shall not be considered for continuing education:

1) Courses used for pre-certification training or insurance qualifying examination preparation.

2) Courses with less than one hour of certified continuing education credit.

d) For purposes of this Section, the minimum number of hours may be made up of any combination of classroom, on-line course, or self-study hours.

e) One credit will be awarded for each 50 minutes of online instruction.

f) No credit shall be given for a self-study course if the student does not successfully complete the examination. If the student fails an examination and successive examinations are given, the successive examinations must be substantially different from each other. Self-study courses are subject to the following additional requirements:

1) No students shall evaluate their own examination. The evaluation of the examination must be completed by the Training Provider;

2) No Training Provider shall furnish the answers to an examination prior to the student completing the examination;

3) Self-study exams must contain at least 25 questions. The number of questions must increase proportionately as the amount of material increases;

4) No more than a third of the questions shall be true/false; and

5) Credit hours shall be determined by the time it may take a student to study the material using 10 8½" by 11" full pages per credit hour (10-12 point font text), single line spacing with 1" margins.

g) Interactive Online Courses
Interactive online is a type of self-study course. Interactive online courses are, by definition, only presented on the Internet and do not require a proctored final exam. To be eligible for certification under Section 3125.90, an interactive online course must meet the following additional requirements:

1) The course must provide an exam at the end of each course;

2) The course must provide clear instructions on how to navigate through the course;

3) The course must provide the ability to go back and review any unit at any time prior to the examination;

4) The course must provide online viewing access to the Department at all times;

5) The course must include a statement that the student information will not be sold or distributed to any third party without prior written consent of the student. Taking the course shall not constitute consent;

6) The course must provide some type of encryption. All personal information, including credit card number and name and address of the student must be encrypted so that the information cannot be read as it passes across the Internet;

7) Students must affirm that they, and only they, completed the course; and

8) The course must include the ability to contact an instructor (i.e., automated e-mail).

Section 3125.120 Certification Denial, Nonrenewal or Revocation

a) The Director may place on probation, suspend, revoke, or refuse to issue or renew a Navigator, In-Person Counselor or Certified Application Counselor's certificate or may levy a civil penalty in accordance with this Section or take any combination of actions, for any one or more of the following causes:

1) Providing incorrect, misleading, incomplete, or materially untrue information in the certificate application;

2) Violating any insurance laws, or violating any rule, subpoena, or order of the Director or of another state's insurance Director;

3) Obtaining or attempting to obtain a certificate through misrepresentation or fraud;

4) Obtaining or attempting to obtain any monies or properties from Illinois consumers while conducting navigator business;

5) Intentionally misrepresenting the terms of an actual or proposed insurance contract;

6) Having been convicted of a felony;

7) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this State or elsewhere;

9) Having a Navigator, In-Person Counselor or Certified Application Counselor certificate, or its equivalent, denied, suspended, or revoked in any other state, province, district or territory;

10) Forging a name to an application for insurance or to a document related to an insurance transaction;

11) Failing to comply with an administrative or court order imposing a child support obligation;

12) Failing to pay Illinois state income tax or penalty or interest or comply with any administrative or court order directing payment of Illinois state income tax or failing to file a return or to pay any final assessment of any tax due to the Illinois Department of Revenue; or

13) Failing to make satisfactory repayment to the Illinois Student Assistance Commission for a delinquent or defaulted student loan.

b) If an action by the Director is to nonrenew, suspend, or revoke a certificate or to deny an application for a certificate, then the Director shall notify the applicant or certificate holder and advise, in writing, the applicant or certificate holder of the reason for the suspension, revocation, or denial or nonrenewal of the applicant's or certificate holder's certificate. The applicant or certificate holder may make written demand upon the Director within 30 days after the date of mailing for a hearing before the Director to determine the reasonableness of the Director's action. The hearing must be held within not fewer than 20 days nor more than 30 days after the mailing of the notice of hearing and shall be held pursuant to 50 Ill. Adm. Code 2402.

c) In addition to, or instead of, any applicable denial, suspension or revocation, a person may be subject to a civil penalty of up to $10,000 for each cause for denial, suspension or revocation; however, the civil penalty may total no more than $100,000.

Section 3125.130 Regulatory Examinations

a) The Director may examine any applicant for or holder of a Navigator, In-person Counselor or Certified Application Counselor certificate or Navigator or In-Person Counselor entity certificate.

b) All Navigators, In-Person Counselors or Certified Application Counselors being examined must provide to the Director convenient and free access, at all reasonable hours, at their offices, and/or comply with any requests, to all books, records, documents and other papers relating to the persons' navigator business affairs. The Navigator, In-Person Counselor or Certified Application Counselor and employees must facilitate and aid the Director in the examinations, as much as it is in their power to do so.

c) The Director may designate an examiner or examiners to conduct any examination under this Section. The Director or his or her designee may administer oaths and examine under oath any individual relative to the business of the person being examined.

d) The examiners designated by the Director under this Section may make reports to the Director. A report alleging substantive violations of Illinois insurance laws, this Part or any rules prescribed by the Director must be in writing and be based upon facts ascertained from the books, records, documents, papers, and other evidence obtained by the examiners or from sworn or affirmed testimony of or written affidavits from the Navigator, In-Person Counselor or Certified Application Counselor employees or other individuals, as given to the examiners. The report of an examination must be verified by the examiners.

Section 3125.140 Disqualifying Offense Review

Review Standards
Section 30(a) of the Illinois Navigator Act allows the Director to place on probation, suspend, revoke or refuse to issue or renew a Navigator, In-Person Counselor and Certified Application Counselor certification, levy a civil penalty, or take any combination of the preceding actions as established by rule. Section 3125.120 of this Part allows the Director to place on probation, suspend, revoke, or refuse to issue or renew a Navigator, In-Person Counselor or Certified Application Counselor's certificate or levy a civil penalty or take any combination of these actions, when the Navigator, In-Person Counselor, Certified Application Counselor or applicant has been convicted of a felony. (See Section 3125.120(a)(6).) When reviewing Navigator, In-Person Counselor and Certified Application Counselor certifications or applications involving Navigators, In-Person Counselors or Certified Application Counselors who have been convicted of a felony, the Director shall consider the following factors in determining the appropriate action:

a) Nature and severity of the criminal activity. Violent criminals or sex offenders may be denied certification privileges, as well as those convicted of crimes which are insurance related and/or involve untrustworthiness;

b) Time elapsed since the prior criminal conduct. The greater the time period since the criminal conduct, the more leniency is appropriate. When making this determination, the duration since the criminal activity should be proportionate to the severity of the criminal conduct;

c) Absence of additional criminal conduct since the reported felony. Continued criminal conduct of a lesser or greater nature should not be tolerated;

d) Multiple offenses or pattern of criminal conduct. Those engaged in repeated criminal conduct are a greater risk to the public;

e) Restitution. Payment to the victim of the felony is necessary to both satisfy the court order and to demonstrate penitence;

f) Proper disclosure. Failure to fully cooperate or properly report the criminal activity to the Department does not reflect favorably on the applicant's character;

g) Satisfactory completion of sentence and probationary period. The debt to society must be fully satisfied before the applicant is granted any further privileges;

h) Rehabilitation. Post-conviction community service or charitable activity may serve as evidence of rehabilitation;

i) Nature of work performed. There is less risk when the work to be performed does not involve money transactions or direct contact with the public; and

j) Any other facts or circumstances deemed relevant by the Director. Letters of recommendation addressed to the Director attesting to the character and reputation of the applicant or certificate holder may be considered by the Director.

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Managed Care Reform & Patient Rights

2) Code Citation: 50 Ill. Adm. Code 5420

3)

Section Numbers:	Adopted Action:
5420.40	Amend
5420.50	Amend
5420.70	Amend
5420.90	Amend
5420.110	Amend
5420.EXHIBIT A	Repeal
5420.EXHIBIT B	Repeal
5420.EXHIBIT C	Amend

4) Statutory Authority: Implementing the Managed Care Reform and Patient Rights Act [215 ILCS 134] and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401] and 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201

5) Effective Date of Rule: January 2, 2014

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 rule, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal published in the Illinois Register: 37 Ill. Reg. 15251; September 20, 2013

10) Has JCAR issued a Statement of Objection to this Rulemaking? No

11) Differences between Proposal and Final Version:

Authority note, added "; 42 USC 300gg-22; and 45 CFR 150.101(b)(2) and 150.201" before the period.
5420.110(b); 7th line, changed "that" to "than" after "restrictive".

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Part 5420 is being amended with regard to managed care and patient rights to replace the description of coverage disclosure standards, including those for notice of policy modification, summaries of benefits and uniform glossaries, with those that are consistent with the Summary of Benefits requirements of the ACA. The reforms take effect for non-grandfathered plans on a rolling basis beginning January 1, 2014, in connection with plans purchased both on and off the exchange.

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

Simone Arthur
Assistant General Counsel
Illinois Department of Insurance
122 S. Michigan Ave, 19th Fl
Chicago IL 60603

312/814-8580
Fax: 312/814-2862

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

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER kkk : HEALTH CARE SERVICE PLANS

PART 5420
MANAGED CARE REFORM & PATIENT RIGHTS

Section
5420.10 Purpose
5420.20 Applicability and Scope
5420.30 Definitions
5420.40 Provision of Information
5420.50 Notice of Nonrenewal or Termination
5420.60 Transition of Services
5420.70 Health Care Services, Appeals, Complaints and External Independent Reviews
5420.80 Joint Resolution of Complaints – Department of Insurance and Department of Public Health − Notification and Resolution Process
5420.90 Record of Complaints
5420.100 Access and Quality of Care from Providers Without Primary Care Physician Referral or Authorization
5420.110 Emergency Services
5420.120 Post Stabilization Services
5420.130 Registration of Utilization Review Organizations
5420.140 Operational Requirements
5420.EXHIBIT A Description of Coverage – Cover Page (Repealed)
5420.EXHIBIT B Description of Coverage – Worksheet (Repealed)
5420.EXHIBIT C Complaint Reporting Column Descriptions
5420.EXHIBIT D Application for Registration of a Utilization Review Organization
5420.EXHIBIT E Utilization Review Organization Officers and Directors Biographical Affidavit
5420.EXHIBIT F NAIC Utilization Review Organization Officers and Directors Biographical Affidavit

AUTHORITY: Implementing the Managed Care Reform and Patient Rights Act [215 ILCS 134] and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/401]; 42 USC 300gg-22; and 45 CFR 150.101(b)(2) and 150.201.

SOURCE: Emergency rules adopted at 23 Ill. Reg. 12466, effective September 27, 1999, for a maximum of 150 days; adopted at 24 Ill. Reg. 3374, effective February 10, 2000; amended at 24

Ill. Reg. 9429, effective July 1, 2000; amended at 28 Ill. Reg. 13711, effective September 28, 2004; amended at 30 Ill. Reg. 6368, effective March 29, 2006; amended at 34 Ill. Reg. 6879, effective April 29, 2010; amended at 38 Ill. Reg. 2253, effective Janury 2, 2014.

Section 5420.40 Provision of Information

~~a)~~Description of Coverage
~~1)~~A written summary of benefits and coverage (SBC) in accordance with 50 Ill. Adm. Code 2001.10,~~So that a person can compare the attributes of various health care plans, both a description of coverage cover page and worksheet~~ must be ~~completed~~ provided to the enrollee by the health care plan. ~~The cover page and worksheet shall follow substantially the same format as prescribed in Exhibits A and B respectively of this Part. Each shall be printed in no less than 12 point type.~~

~~A) Copayments and/or deductibles which vary within a specific benefit category must be listed individually for each item (e.g., copayments for prescription drugs should be listed separately based upon the drug being brand name or generic equivalent).~~

~~B) The category entitled "Other Services" may be modified to include additional headings as may be appropriate. If the contract does not provide coverage for listed "Other Services", the description of coverage worksheet should so indicate by stating "Not Applicable" for each such item.~~

~~C) A health care plan specific description of coverage worksheet shall contain financial information specific to the enrollee's plan. A generic description of coverage worksheet will be applicable to all of the health care plan's plans and include a general description of financial information.~~

~~D) All description of coverage worksheets shall include a notice of the enrollee's right to request a description of the financial relationships between the health care plan and any health care provider, the percent of copayments, deductibles and total premiums spent on health care related and administrative expenses, as well as a notice of the enrollee's right to request health care provider information from their provider as set forth in Section 15(c) of the Managed Care Reform and Patient Rights Act.~~

~~E) All description of coverage worksheets shall clearly disclose that referral arrangements through the enrollee's participating primary care physician may limit the enrollee's ability to seek services from certain participating specialist physicians or participating health care providers. To obtain clarification on such referral arrangements, the enrollees must be instructed to contact their participating primary care physician's office. If a referral arrangement does not exist between the enrollee's participating primary care physician and the desired participating specialist physician or participating health care provider, then the enrollees must be informed of their ability to designate a new participating primary care physician with whom such referral arrangement does exist.~~

~~F) The description of coverage worksheet for point of service products, defined within 50 Ill. Adm. Code 5421.20, must include a specific description of coverages, limitations, exclusions, deductibles and copayments specific to the indemnity contract.~~

~~2) A plan specific description of coverage cover page, worksheet and a list of participating health care providers shall be given to all new enrollees. Annually thereafter, a generic description of coverage cover page and worksheet must be mailed to enrollees. Only one enrollee per household must be furnished this material unless otherwise requested by the enrollee. For group contracts, the plan may satisfy this requirement by giving the required material to the contract holder, for distribution to their members.~~

~~3) Enrollees must be advised annually of their right to request a plan specific description of coverage cover page, worksheet and an updated list of participating health care providers. The enrollee shall be given the choice of requesting this information through a local telephone number or long distance toll-free telephone number and a prepaid postcard.~~

~~4) The plan specific description of coverage cover page, worksheet and list of participating health care providers shall be given to all prospective enrollees upon request. Availability of this information shall be prominently communicated within the health care plan's marketing materials. Prospective enrollees shall be able to request this information~~

~~through a local telephone number or a long distance toll-free telephone number.~~

~~5)~~ ~~Health care plans are encouraged to make a generic description of coverage cover page, worksheet and list of participating health care providers available on their web sites. This will not act as a substitute for other forms of required disclosure.~~

~~6)~~ ~~Health care plans issuing contracts or evidences of coverage for delivery in this State shall not issue such contract or evidence of coverage unless a specific description of coverage cover page and worksheet are provided.~~

~~7)~~ ~~All health care plans must clearly communicate their procedure for the filing of complaints pursuant to Section 45 of the Act. When a health care plan is permitted by statute to require complaints be filed in writing, the appropriate complaint form must be made available to the enrollee.~~

~~b)~~ ~~Within the group contract, evidence of coverage, individual contract and enrollee handbook, the health care plan shall provide a notice of the enrollees' right to request a description of the financial relationships between the health care plan and any health care provider, the percent of copayments, deductibles and total premiums spent on health care related and administrative expenses as well as the right to obtain health care provider information from their provider as set forth in Section 15(c) of the Managed Care Reform and Patient Rights Act.~~

~~c)~~ ~~Each health care plan shall clearly disclose, within the group contract, evidence of coverage, individual contract, enrollee handbook and provider directory that referral arrangements through the enrollee's participating primary care physician may limit the enrollee's ability to seek services from certain participating specialist physicians or participating health care providers. To obtain clarification on such referral arrangements, the enrollees must be instructed to contact their participating primary care physician's office. If a referral arrangement does not exist between the enrollee's participating primary care physician and the desired participating specialist physician or participating health care provider, then the enrollee must be informed of his ability to designate a new participating primary care physician with whom such referral arrangement does exist.~~

~~d)~~ ~~Within the group contract, evidence of coverage, individual contract and enrollee handbook, all health care plans must clearly communicate their procedure for the~~

~~filing of complaints pursuant to Section 45 of the Act. When a health care plan is permitted by statute to require complaints be filed in writing, the appropriate complaint form must be made available to the enrollee.~~

(Source: Amended at 38 Ill. Reg. 2253, effective Janury 2, 2014

Section 5420.50 Notice of Nonrenewal or Termination

a) All provider agreements shall provide for at least 60 days notice by the provider for termination with cause, as defined in the~~such~~ provider agreement, and at least 90 days notice by the provider for termination without cause. Upon receipt of the~~such~~ notice, the health care plan shall notify enrollees within 30 days after the termination and the proper steps to be taken for selecting a new health care provider. In the event the provider violates the provider agreement and does not give a notice of termination in the appropriate timeframe, the health care plan must provide immediate notice to the enrollees. The health care plan must inform the Department~~Division of Insurance of the Department of Financial and Professional Regulation~~ immediately of any known or intended termination, with or without cause, of an MCO.

b) A health care plan must give at least 60 days notice of nonrenewal or termination of a health care provider to the health care provider and to the enrollees served by the health care provider. The notice shall include a name and address to which an enrollee or health care provider may direct comments and concerns regarding the nonrenewal or termination. Immediate written notice may be provided without 60 days notice when a health care provider's license has been disciplined by a State licensing board. The notice shall inform the enrollee of the availability of transitional services and that the enrollee must request transitional services within 30 days from receipt of this notice.

(Source: Amended at 38 Ill. Reg. 2253, effective Janury 2, 2014

Section 5420.70 Health Care Services, Appeals, Complaints and External Independent Reviews

a) A plan shall implement an effective appeals process for appeals of coverage determinations and claims, under which the health care plan shall, at a minimum:

1) have in effect an internal claims appeal process;

2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of Department consumer assistance to assist enrollees with the appeals processes; and

3) allow an enrollee to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process. (Section 2719 of the Public Health Service Act; 42 USC 201 et seq.)

b~~a~~) A plan shall affirm or deny liability on claims within a reasonable time and shall offer payment within 30 days after affirmation of liability, if the amount of the claim is determined and not in dispute. For those portions of the claim that are not in dispute and the payee is known, the plan shall tender payment within the 30 days.

c~~b~~) If a settlement of a claim is less than the amount claimed, or if the claim is denied, the plan shall provide to the insured a reasonable written explanation of the basis of the lower offer or denial within 30 days after the investigation and determination of liability is completed. This explanation shall clearly set forth the policy definition, limitation, exclusion or condition upon which denial was based. The explanation shall clearly inform the enrollee of the right to appeal the claim reduction or denial, the process by which the enrollee (or the enrollee's designee or guardian) may initiate the appeal process and the plan's phone number to call to receive more information concerning the appeal process. Notice of Availability of the Department~~Division of Insurance~~ shall accompany this explanation.

d~~c~~) A health plan shall ensure that an enrollee (or the enrollee's designee or guardian) has a period of not less than 180 days after the date of the explanation of a denial of a claim for benefits in which to appeal the~~such~~ denial under this Section. The only exception to this requirement is~~are~~ those complaints that are handled by the Department of Healthcare and Family Services (HFS),~~IDPA~~ consistent with the requirements of Section 5420.80(a)~~ of this Part~~.

~~d) Every health care plan shall submit for the Division's review, and thereafter maintain, a mechanism for the joint selection of the external independent reviewer. Any proposed changes to the mechanism must be filed for review by the Division.~~

(Source: Amended at 38 Ill. Reg. 2253, effective Janury 2, 2014

Section 5420.90 Record of Complaints

a) Complaint, as used in this Section, means any communication primarily expressing a grievance to the health care plan by, or on behalf of, the enrollee, or by the health care provider. For purposes of this definition, "communication" shall include the following:

1) A written notice relating to the health care plan's determinations, procedures and administration as stated in Sections 45 and 50 of the Act; and

2) Written or oral notice filed under the expedited health care services appeal process or under the utilization review process.

b) The health care plan shall submit to the Director ~~of the Division of Insurance~~ a report by April 1 for the previous calendar year that shall include a record of the plan's complaints in the format prescribed in Exhibit C ~~of this Part~~. Beginning April 1, 2005, all plans or companies must electronically submit the record of complaints to the Director in a format prescribed by the Director.

c) Any plan or company failing to file a complaint report by April 1 for the previous calendar year may be subject to a late fee of $100 for each day the report is late.

(Source: Amended at 38 Ill. Reg. 2253, effective Janury 2, 2014

Section 5420.110 Emergency Services

a) For purposes of determining compliance with Section 65 of the Act, timely determination shall mean a determination is made within 30 days after the health care plan receives a claim for emergency services if no additional information is needed to determine the emergency services meet the definition of an emergency medical condition. In the event additional information is necessary to make the~~such a~~ determination, the health care plan shall request the medical record documenting the presenting symptoms at the time care was sought within 15 days after receipt of the emergency services claim and make a determination within 30 days after its receipt.

b) If a group health care plan offering group or individual health insurance, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan shall cover emergency services in a manner that those services will be provided without imposing a requirement under the plan for prior authorization of services or any limitation on coverage when the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan.

c) In addition to complying with the coverage requirements provided in 50 Ill. Adm. Code 2051.310(a)(6)(J), if emergency services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if the services were provided in-network. (Section 2719A(b) and (c)(ii) of the Public Health Service Act (42 USC 300 gg-19(1)))

(Source: Amended at 38 Ill. Reg. 2253, effective Janury 2, 2014

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

Section 5420.EXHIBIT A Description of Coverage – Cover Page (Repealed)

~~The Managed Care Reform and Patient Rights Act of 1999 established rights for enrollees in health care plans. These rights cover the following:~~

~~What emergency room visits will be paid for by your health care plan.~~

~~How specialists (both in and out of network) can be accessed.~~

~~How to file complaints and appeal health care plan decisions (including external independent reviews).~~

~~How to obtain information about your health care plan, including general information about its financial arrangements with providers.~~

~~You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. SINCE THE DESCRIPTION OF COVERAGE IS NOT A LEGAL DOCUMENT, for full benefit information please refer to your contract or certificate, or contact your health care plan at the toll free number on the next page. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.~~

~~For general assistance and information, please contact the Illinois Department of Insurance Office of Consumer Health Insurance at _____. (Please be aware that the Office of Consumer Health Insurance will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)~~

(Source: Repealed at 38 Ill. Reg. 2253, effective Janury 2, 2014

Section 5420.EXHIBIT B Description of Coverage − Worksheet (Repealed)

~~Plan:~~
~~Name:~~
~~Address:~~
~~Toll Free Telephone Number:~~
~~Web site (optional)~~

			~~*Description of Coverage*~~		
~~Basics~~	~~Your Doctor *(description of process for selection of physician, PCP and/or WPHCP)*~~				
	~~Annual Deductible (if applicable)~~				
	~~Out-of-Pocket Maximum~~	~~*Individual*~~			
		~~*Family*~~			
	~~Lifetime Maximums (if applicable)~~				
	~~Preexisting Condition Limitations~~				
			~~Description of Coverage~~	~~Health Care Plan Covers~~	~~You Pay~~
~~In the Hospital~~	~~Number of Days of Inpatient Care~~				
	~~Room & Board~~				
	~~Surgeon's Fees~~				
	~~Doctor's Visits~~				
	~~Medications~~				
	~~Other Miscellaneous Charges~~				
~~Emergency Care~~	~~Emergency Services = *(medical conditions of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in serious jeopardy of the person's health, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.)*~~				
	~~Emergency Post-stabilization Services~~				
~~In the Doctor's Office~~	~~Doctor's Office Visits~~				
	~~Routine Physical Exams~~				
	~~Diagnostic Tests and X-rays~~				
	~~Immunizations~~				
	~~Allergy Treatment & Testing~~				

	~~Wellness Care~~

~~**Medical Services**~~	~~**Outpatient Surgery**~~				
	~~**Maternity Care**~~	~~***Hospital Care***~~			
		~~***Physician Care***~~			
	~~**Infertility Services**~~				
	~~**Mental Health**~~	~~***Outpatient***~~			
		~~***Inpatient***~~			
	~~**Substance Abuse**~~	~~***Outpatient***~~			
		~~***Inpatient***~~			
	~~**Outpatient Rehabilitation Services**~~				
~~**Other Services***~~	~~**Durable Medical Equipment**~~				
	~~**Hospice**~~				
	~~**Home Health Care**~~				
	~~**Prescription Drugs**~~				
	~~**Dental Services**~~				
	~~**Vision Care**~~				

~~*Copayments and deductibles for these services may not apply to your out of pocket maximums.~~

~~**Service Area** (Boldface Type)~~

~~[A summary description of the area to be served by the health care plan.]~~

~~**Exclusions and Limitations** (Boldface Type)~~

~~[A summary description of all contract exclusions, exceptions and limitations.]~~

~~**Pre-certification and Utilization Review** (Boldface Type)~~

~~[A summary description of the procedures and requirements for pre-certification and other utilization review procedures.]~~

~~**Emergency Care** (Boldface Type)~~

~~[A summary description of requirements for and coverage of pre- and post-emergency care.]~~

~~**Primary Care Physician Selection** (Boldface Type)~~

~~[A summary description of procedures and requirements for primary care physician selection.]~~

~~**Access to Specialty Care** (Boldface Type)~~

~~[A summary description of referral policies, including standing referrals, and any limitation on access to specialists. This should include access to, and limitations on access to, out of network specialists.]~~

~~**Out-of-Area Coverage** (Boldface Type)~~

~~[A summary description of benefits available to the enrollee for out-of-area coverage.]~~

~~**Financial Responsibility** (Boldface Type)~~

~~[A summary description to the enrollee of all out-of-pocket expenses, including copayments, deductibles and premiums payable under the policy. When the entire premium is not paid directly by the enrollee, then the enrollee may need to contact the benefit administrator for the level of contribution.]~~

~~**Continuity of Treatment** (Boldface Type)~~

~~[A summary description of the health care plan's provision for continuity of treatment in the event that the enrollee's health care provider terminates from the plan during a course of care, including time frames for requesting transitional services.]~~

~~**Appeals Process** (Boldface Type)~~

~~[A summary description of the process for health care service appeals, complaints, external independent reviews, administrative complaints and utilization review complaints, including time frames and a phone number to call to receive more information from the health care plan concerning the enrollee's appeal process.]~~

~~Any enrollee not satisfied with the health care plan's resolution of any complaint may appeal the final plan decision to the Department of Insurance, through the Consumer Services Section, at one of the following locations:~~

~~320 West Washington Street~~
~~Springfield, Illinois 62767-0001~~

~~OR~~

~~100 West Randolph Street~~
~~Suite 15-100~~
~~Chicago, Illinois 60601-3251~~

~~You may electronically file your appeal with the Department at http://insurance.illinois.gov/Complaints/file_complaint.asp.~~

~~Note: External grievance determinations in most cases are not appealable through the Department of Insurance.~~

~~**IMPORTANT: In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.**~~

(Source: Repealed at 38 Ill. Reg. 2253, effective Janury 2, 2014

Section 5420.EXHIBIT C Complaint Record and Column Descriptions

1. Column A. Health Care Plan Identification Number – This is the identification number used by the health care plan to identify the complaint internally. The identification number must be unique for each complaint.

2. Column B. Complaint Origin – complaint was filed by:

   a) Consumer or enrollee;

   b) Provider;

   c) Any other individual.

3. Column C. Function Code. Complaints are to be classified by functions ~~function(s)~~ or the health care plan involved, as follows:

   a) Denial of care or treatment (dissatisfaction regarding prospective non-authorization of a request for care or treatment recommended by a provider excluding diagnostic procedures and referral requests; partial approvals and care terminations are also considered to be denials);

   b) Denial of diagnostic procedure (dissatisfaction regarding prospective non-authorization of a request for a diagnostic procedure recommended by a provider; partial approvals are also considered to be denials);

   c) Denial of referral request (dissatisfaction regarding non-authorization of a request for a referral to another provider recommended by a PCP);

   d) Sufficient choice and accessibility of health care providers (dissatisfaction by an enrollee or policyholder regarding the extent to which the health care plan has practitioners/providers of the appropriate type and number distributed geographically to meet the needs of the member; in addition, dissatisfaction by an enrollee or policyholder regarding the extent to which the enrollee or policyholder may obtain available services at the time they are needed − available~~such~~ service refers to both telephone access and ease of scheduling an appointment);

   e) Underwriting (dissatisfaction by an enrollee or policyholder regarding the health care plan's process of examining, accepting, or rejecting insurance risks and

classifying those selected in order to charge the proper premiums for each);

f) Marketing and sales (dissatisfaction regarding solicitation or the sale of a policy by the managed care organization; solicitation means any method by which information relative to the health care plan is made known to the public for the purpose of informing or influencing potential enrollees to enroll in the health care plan, regardless of the media or technique used);

g) Claims and utilization review (dissatisfaction regarding the concurrent or retrospective evaluation of the coverage, medical necessity, efficiency or appropriateness of health care services or treatment plans; prospective "Denials of care or treatment," "Denials of diagnostic procedures" and "Denials of referral requests" should not be classified in this category, but the appropriate one above);

h) Member services (dissatisfaction by an enrollee or policyholder related to response time regarding provision of information; handling of a complaint, appeal or external review; or any interaction between plan representatives and enrollee);

i) Provider relations:

I) Quality of Care (dissatisfaction regarding any aspect of care provider by an institution or organization or practitioner that provides services to a managed care organization's members; this category does not include sufficient choice or accessibility of a provider);

II) Provider complaints − Prompt Pay (complaints by providers (prompt pay, etc.), excluding those filed under "Denials of care or treatment," "Denials of diagnostic procedures" and "Denials of referral request" above);

j) Miscellaneous (any "complaint", as defined above, not falling in one of the above categories).

4. Column D. Date Received – date received by the health care plan.

5. Column E. Date Closed – date closed by the health care plan.

6. Column F. Illinois Department~~Division~~ of Insurance Complaint File Number – If the complaint was also sent to the health care plan from the Department~~Division~~, the health care plan should provide the IDOI complaint number in this column.

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

7. Column G. Illinois Department~~Division~~ of Insurance Complaint File Closed Date. The Department~~Division of Insurance~~ will provide the company with the date the complaint was closed by the Department~~Division of Insurance~~.

8. Column H. External Review – indicate by placing an "X" in the column if complaint was processed through external review procedure.

9. Column I. Disposition.

   a) Relief Granted − If the complaint was resolved in favor of the complainant;

   b) Partial Relief Granted − If the complaint was only partially resolved in favor of the complainant;

   c) Information Furnished − The complaint did not require action, only information to be provided to the enrollee;

   d) No Relief Granted − If the complaint was not resolved in favor of the complainant.

(Source: Amended at 38 Ill. Reg. 2253, effective Janury 2, 2014

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Health Maintenance Organization

2) Code Citation: 50 Ill. Adm. Code 5421

3)

Section Numbers:	Adopted Action:
5421.20	Amendment
5421.60	Amendment
5421.110	Amendment
5421.130	Amendment

4) Statutory Authority: Implementing and authorized by Sections 4-6.1, 4-17, 5-2 and 5-7 of the Health Maintenance Organization Act [215 ILCS 125/4-6.1, 4-17, 5-2 and 5-7] and 42 USC 300gg-22; 45 CFR 150.101(b)(2) and 150.201

5) Effective Date of Rule: January 2, 2014

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 rule, including any material incorporated by reference, is on file in the principal office of the Department of Insurance and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 15270; September 20, 2013

10) Has JCAR issued a Statement of Objection to this Rulemaking? No

11) Differences between Proposal and Final Version:

Authority note: 2nd line, added "; 42 USC 300gg-22; and 45 CFR 150.101(b)(2) and 150.201" before the period.
5421.20: Definition of "Director", deleted "(see Section 1-2(2) of the Act)".
5421.20: Definition of "Department of Insurance Complaint", changed "CMMS" to "CMS" in two locations.
5421.20: Definition of "Limited Insurance Representative", changed "public aid" to "Medicaid".
5421.110(i)(4): 2nd line, deleted comma and added "or" after "services".
5421.110(l)(2): 3rd line, before the period added "(2013)".

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5421.110(m)(2): 3rd line, deleted all text; 4th line, deleted "no later amendments or editions)" and "(78 FR 42322, as"; 5th line, deleted all text.

12) Have all changes agreed upon by the Agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Part 5421 is being amended to remove provisions allowing for pre-existing conditions and amends the requirements for Basic Health Care Services, so that HMO policy forms submitted for the approval of the Director are consistent with ACA requirements. The ACA prohibits provisions restricting coverage for pre-existing conditions and requires coverage for certain essential health benefits. The rule adds infertility treatment, prenatal and postnatal care, and delivery and inpatient services for maternity care to the definition of Basic Health Care Services that are required to be provided by an HMO, and adds preventive services and essential health benefits to the coverage standards.

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

James Rundblom
Deputy General Counsel
Department of Insurance
320 West Washington, 4th Floor
Springfield, Illinois 62767-0001

217/785-8559
217/524-9033 (fax)

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

DEPARTMENT OF INSURANCE

NOTICE OF ADOPTED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER kkk: HEALTH CARE SERVICE PLANS

PART 5421
HEALTH MAINTENANCE ORGANIZATION

Section
5421.10 Scope
5421.20 Definitions
5421.30 Valuation of Investments
5421.40 Grievance Procedure
5421.50 Contracts, Administrative Arrangements and Material Modifications
5421.60 Rates
5421.70 Subordinated Indebtedness
5421.80 Financial Reporting
5421.90 Conflict of Interest and Required Disclosure
5421.100 Solicitation
5421.110 Requirements for Group Contracts, Evidences of Coverage and Individual Contracts
5421.111 Cancellation
5421.112 Form Filing Requirements
5421.113 Point of Service Plan Requirements
5421.120 Internal Security Standards and Fidelity Bonds
5421.130 Basic Health Care Services
5421.131 Basic Outpatient Preventive and Primary Health Care Services for Children
5421.132 Required Coverage for Reconstructive Surgery Following Mastectomies
5421.140 General Provisions
5421.141 HMO Producer Licensing Requirements
5421.142 Limited Insurance Representative Requirements − Public Aid and Medicare Enrollers
5421.150 Severability
5421.160 Effective Date (Repealed)

AUTHORITY: Implementing and authorized by Sections 4-6.1, 4-17, 5-2 and 5-7 of the Health Maintenance Organization Act [215 ILCS 125/4-6.1, 4-17, 5-2 and 5-7]; 42 USC 300gg-22; and 45 CFR 150.101(b)(2) and 150.201.

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NOTICE OF ADOPTED AMENDMENTS

SOURCE: Filed June 16, 1976, effective July 1, 1976; codified at 7 Ill. Reg. 3016; amended at 15 Ill. Reg. 199, effective December 28, 1990; amended at 20 Ill. Reg. 10639, effective July 25, 1996; recodified at 21 Ill. Reg. 1729; emergency amendment at 21 Ill. Reg. 15262, effective November 18, 1997, for a maximum of 150 days; amended at 22 Ill. Reg. 6671, effective March 31, 1998; amended at 23 Ill. Reg. 5690, effective May 3, 1999; emergency amendment at 26 Ill. Reg. 5146, effective March 25, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 13088, effective August 19, 2002; amended at 28 Ill. Reg. 14412, effective October 19, 2004; amended at 30 Ill. Reg. 4732, effective March 2, 2006; amended at 37 Ill. Reg. 14032, effective August 26, 2013; amended at 38 Ill. Reg. 2272, effective Janury 2, 2014.

Section 5421.20 Definitions

"Act" means the Health Maintenance Organization Act [215 ILCS 125].

"Advertisement" means any printed or published material, audiovisual material and descriptive literature of the health care plan used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards and similar displays; and any descriptive literature or sales aids of all kinds disseminated by a representative of the health care plan for presentation to the public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters and prepared sales presentations (Section 1-2(1) of the Act).

"Base Rates" means the rate generated before any classification deviations are applied.

"Basic Health Care Services" means emergency care, and inpatient hospital and physician care, outpatient medical services, mental health services and care for alcohol and drug abuse, infertility treatment, prenatal and postnatal care, delivery and inpatient services for maternity care, and preventative services required pursuant to 42 USC 300gg-13~~U.S.C. including any reasonable deductibles and co-payments~~, all of which are subject to ~~such~~ limitations ~~as are~~ set forth in this Part (see Section 1-2(3) of the Act).

"Cancellation" means the termination of a group contract, evidence of coverage or individual contract by an HMO prior to the expiration date of the group contract, evidence of coverage or individual contract.

"Consumer" means any enrollee, provided that the~~such~~ individual is not or has not been, in the previous two years: an employee (including the employee's~~his~~ spouse

or dependent) of the HMO or affiliate of the HMO; or a provider furnishing health care services to the HMO or affiliate of the HMO.

"Copayment" means the amount an enrollee must pay in order to receive a specific covered service that~~which~~ is not fully prepaid.

"Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the HMO begins to pay the costs associated with treatment.

"Director" means the Director of the Illinois Department of Insurance~~ (see Section 1-2(2) of the Act)~~.

"Department" means the Illinois Department of Insurance.

"Department of Insurance Complaint" means a written complaint filed by or on behalf of an enrollee, with the Department pursuant to Section 4-6 of the Act~~ [215 ILCS 125/4-6]~~, excluding complaints filed by Illinois Department of Healthcare and Family Services~~Public Aid~~ HMO members under Section 5-11 of the Public Aid Code [305 ILCS 5/5-11] and complaints subject to handling by the Centers for Medicare and Medicaid Services (CMMS) pursuant to a contract entered into between CMMS and the HMO.

"*Enrollee" means an individual who has been enrolled in a health care plan.* (Section 1-2(4) of the Act)~~.~~

"Evidence of Coverage" means any certificate, agreement, or contract issued to enrollees setting out the coverage to which they are entitled in exchange for a per capita prepaid sum. (Section 1-2(5) of the Act)~~.~~

"Governing Body" means the board of trustees, or directors, or if otherwise designated in the basic organizational document bylaws, those individuals vested with the ultimate responsibility for the management of any organization that has been issued, or is applying for, a certificate of authority as an HMO.

"Grievance" means any written complaint submitted to the HMO by or on behalf of an enrollee regarding any aspect of the HMO relative to the enrollee, but shall not include any complaint by or on behalf of a provider.

"Grievance Committee" means individuals who have been appointed by the HMO

to respond to grievances that~~which~~ have been filed on appeal from the HMO's simplified complaint process established pursuant to Section 5421.40(d)~~ of this Part~~. At least 50% of the individuals on this committee shall be~~ composed of~~ enrollees who are consumers.

"*Group Contract*" *means a contract for health care services which by its terms limits eligibility to members of a specified group* (Section 1-2(6) of the Act).

"Health Care Plan" means any arrangement in which~~whereby~~ any organization undertakes to provide or arrange for, and pay for or reimburse the cost of, any basic health care services from providers selected by the HMO. The~~and such~~ arrangement consists of arranging for, or the provision of, the~~ such~~ health care services, as distinguished from mere indemnification against the cost of the~~such~~ services, except as otherwise authorized by Section 2-3 of the Act, on a per capita prepaid basis, through insurance or otherwise (see Section 1-2(7) of the Act). A health care plan also includes any arrangement in which~~whereby~~ an organization undertakes to provide~~,~~ or arrange for, or pay for~~,~~ or reimburse the cost of, any health care services for persons who are enrolled in the integrated health care program established under Section 5-16.3 of the Illinois Public Aid Code ~~[305 ILCS 5/5-16.3]~~ through providers selected by the organization and the arrangement consists of making provision for the delivery of health care services, as distinguished from mere indemnification. A health care plan also includes any arrangement pursuant to Section 4-17 of the Act~~ [215 ILCS 125/4-17]~~. Nothing in the definition of Health Care Plan, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

"*Health Care Services*" *means any services included in the furnishing to any individual of medical or dental care, or the hospitalization or incident to the furnishing of such care or hospitalization as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury* (Section 1-2(8) of the Act).

"HMO" means Health Maintenance Organization.

"Individual Contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber.

"Limited Insurance Representative" means an individual appointed by an HMO to represent the HMO in the enrollment of recipients of Medicaid~~public aid~~ or Medicare in the HMO.

"Managed Care Organization" or ~~(~~"MCO"~~)~~ means a partnership, association, corporation or other legal entity, including but not limited to individual practice associations (IPAs) and Physician Hospital Organizations (PHOs), that~~which~~ delivers or arranges for the delivery of health care services through providers it has contracted with or otherwise made arrangements with to furnish those~~such~~ health care services.

"Notice of Availability of the Department", as required by this Part, shall be no less informative than the following:

> The regulations of the Illinois Department of Insurance (50 Ill. Adm. Code 5421.110(n)) require that we advise you that if you wish to take this matter up with the Illinois Department of Insurance it maintains a Consumer Division in Chicago at 122 S. Michigan Avenue, 19th Floor, Chicago, Illinois 60603 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767-0001.

"Point of Service Plan" means a plan in which an eligible enrollee is covered under both an HMO evidence of coverage and an indemnity insurance policy or certificate and may select, on a point of service basis, between using the HMO or the indemnity benefit program.

"Primary Care Physician" means a provider who has contracted with an HMO to provide primary care services as defined by the contract and who is:

> a physician licensed to practice medicine in all of its branches who spends a majority of clinical time engaged in general practice or in the practice of internal medicine, pediatrics, gynecology, obstetrics or family practice;~~, or~~
>
> a chiropractic physician licensed to treat human ailments without the use of drugs or operative surgery~~ (77 Ill. Adm. Code 240.2)~~.

"Producer" means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment (see Section 1-2(13) of the Act).

"Provider" means any physician, hospital facility, or other person which is licensed or otherwise authorized to furnish health care services and also includes any other entity that arranges for the delivery or furnishing of health care services (Section 1-2(12) of the Act). For purposes of Section 5421.50~~ of this Part~~, "provider"~~Provider~~ shall also mean an MCO.

"Renewal" means the issuance and delivery by an HMO of a group contract or individual contract superseding at the end of the contract period a contract previously issued and delivered by the same HMO or the issuance and delivery of a certificate or notice extending the term of the group or individual contract beyond its contract term.

"Solicitation" means any method by which information relative to an HMO is made known to the public for the purpose of informing or influencing potential enrollees to enroll in a Health Care Plan, regardless of the media or technique used.

"State" means any governing body, department~~,~~ or agency of the State of Illinois that~~which~~ has regulatory authority under~~governing~~ the Act.

"Subscriber" means a person who has entered into a contractual relationship with the HMO for the provision of or arrangement of at least Basic Health Care Services to the beneficiaries of such contract (Section 1-2(15) of the Act).

"Supplemental Health Care Services" means any health care service other than basic health care services.

"Usual and Customary Fee" means~~ shall mean~~ the fee, as reasonably determined by the HMO, that is based on the fee ~~which~~ the provider who renders the service usually charges its patients for the same service. The~~ and the~~ fee shall be~~is~~ within the range of usual fees other providers of similar type, training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances.

(Source: Amended at 38 Ill. Reg. 2272, effective Janury 2, 2014

Section 5421.60 Rates

a) Subject to the requirements of 50 Ill. Adm. Code 2026, the~~The~~ HMO shall file all

schedules of base rates to be used in conjunction with enrollee certificates. The schedules shall be filed with the Director prior to the effective date and will be maintained as a public document by the Department.

b) When the schedules of base rates are filed, percentage change from the previous filing for the schedules of base rates shall be included.

c) Upon the request of the Director, the HMO shall submit actuarial documentation for any submitted rates, which shall be stamped "confidential" by the HMO. Documentation shall include, but not be limited to, the major cost components, experience, assumptions~~,~~ and procedures used to develop the submitted rates. The actuarial documentation shall be deemed confidential and proprietary by the Department unless specific authorization is given by the HMO.

(Source: Amended at 38 Ill. Reg. 2272, effective January 2, 2014

Section 5421.110 Requirements for Group Contracts, Evidences of Coverage and Individual Contracts

a) Any group contract, evidence of coverage, individual contract, enrollee handbook, enrollment application, identification card or other form that affects the terms and conditions applicable to the subscriber or enrollee in the provision of health care services must be filed with and approved by the Director prior to use in accordance with the requirements of Section 5421.112~~ of this Part~~ and Section 4-13 of the Act. The HMO shall issue to each subscriber or enrollee a group contract, evidence of coverage, or individual contract. Any conflicting information between the valid current document referenced in this subsection~~above~~ issued to the subscriber or enrollee and the current group contract shall be interpreted according to whichever is most beneficial to the subscriber or enrollee. Any group contract, evidence of coverage, or individual contract shall provide for the rendering of health care services as defined in that document for either a specific period of not less than 12 months from the date of issuance or for another period mutually agreed to by the HMO and the group or individual contractholder; and shall provide for renewal on a basis mutually agreed to by both parties, unless the HMO has given 31 days written notice of nonrenewal prior to the renewal date of the contract.

b) A detailed statement of any exceptions, exclusions or limitations shall be set forth in the group contract, evidence of coverage, and individual contract for any type

of health care service to be excepted. Exception, exclusions or limitations shall appear with the same prominence in the group contract, evidence of coverage and individual contract as any benefit.

c) The group contract, evidence of coverage, and individual contract shall set forth a detailed statement of the terms and conditions of maternity benefits and any related exceptions, exclusions, limitations, copayments and deductibles. Exceptions, exclusions, limitations, copayments and deductibles applicable to prenatal and post-natal care shall be covered no differently than any other covered health care services provided pursuant to the contract, with the exception of a limitation for coverage of routine prenatal care or delivery when the enrollee is outside the service area against medical advice, except when the enrollee is outside of the service area due to circumstances beyond her control, may be included in the group contract and evidence of coverage.

d) Entire Contract. The group contract, evidence of coverage and individual contract shall contain a statement that the group contract evidence of coverage and individual contract, all applications, and any amendments shall constitute the entire agreement between the parties. No portion of the charter, by-laws or other document of the HMO shall be part of a contract or evidence of coverage unless set forth in full in the document or attached to it.

e) Eligibility Requirements. The group contract, evidence of coverage and individual contract shall contain eligibility requirements indicating the conditions that must be met to enroll in a health care plan, the limiting age for enrollees and eligible dependents including the effects of Medicare eligibility, and a clear statement regarding coverage of newborn children as set forth in Sections 4-8 and 4-9 of the Act.

f) Benefits and Services Within the Service Area. The group contract, evidence of coverage and individual contract shall contain a specific description of benefits and services available within the HMO's designated service area.

g) Emergency Care Services. The group contract, evidence of coverage and individual contract shall contain a specific description of benefits and services available for emergencies 24-hours a day, 7 days a week, including disclosure of any restrictions on emergency care services. No group contract, evidence of coverage or individual contract shall limit the coverage of emergency services within the service area to those providers having a contract with the HMO.

h) Out of Area Benefits and Services. The group contract, evidence of coverage and individual contract shall contain a specific description of benefits and services available out of the HMO's designated service area.

i) Deductibles and Copayments

1) An HMO may require deductibles and copayments of enrollees as a condition for the receipt of specific health care services, including basic health care services. Deductibles and copayments shall be the only allowable charge, other than premiums, assessed enrollees. Nothing within this subsection (i) shall preclude the provider from charging reasonable administrative fees, such as service fees for checks returned for non-sufficient funds and missed appointments.

2) Copayments and deductibles appearing in the policy shall be for specific dollar amounts or for specific percentages of the cost of the health care services.

3) No combination of deductibles and copayments for ~~the receipt of~~ basic health care services may exceed the annual maximum out-of-pocket expenses of a high deductible health plan as defined in 26 USC 223.

4) Deductibles and copayments applicable to supplemental health care services or~~,~~ catastrophic-only plans as defined under the federal Affordable Care Act, ~~or pre-existing conditions~~ are not subject to the annual limitations described in this Section.

5) This subsection (i) applies to enrollees and does not limit the health care plan payment for services provided by non-participating providers.

~~j) Pre-existing Conditions. An HMO may impose deductible and copayment pre-existing condition limitations as a condition to receiving health care services. A pre-existing condition shall not be defined more restrictively than a condition for which medical advice or treatment was recommended by a physician or received from a physician within a one year period preceding the effective date of coverage under the health care plan or the existence of symptoms that, in the opinion of a legally qualified physician, would have caused an ordinarily prudent person to seek diagnosis, care or treatment within a one year period preceding the effective~~

~~date of coverage under the health care plan. The condition may only be limited for a period not to exceed one year from the effective date of coverage.~~

j~~k~~) Cancellation. The group contract, evidence of coverage, and individual contract shall contain the conditions upon which cancellation may be effected by the HMO or the enrollee as set forth in Section 5421.111.

k~~l~~) Reinstatement. The group contract, evidence of coverage, and individual contract shall contain the conditions of the enrollee's right to reinstatement.

l~~m~~) Grace Period~~.~~

1) A group contract or individual contract not involving the use of a premium tax credit shall provide for a grace period for the payment of any premium, except the first, during which coverage shall remain in effect if payment is made during the grace period. The grace period for a group contract shall not be less than 10 days. The grace period for an individual contract shall not be less than 31 days. During the grace period, the HMO shall remain liable for providing the services and benefits contracted for; the subscriber shall remain liable for the payment of the premium for the time coverage was in effect during the grace period and the enrollee shall remain liable for the payment of any applicable share of the premium, for the time coverage was in effect, as well as for any copayments owed.

2) Termination of coverage for individuals receiving advance payments of premium tax credits shall comply with the requirements of 45 CFR 155 and 45 CFR 156.270 (2013).

m~~n~~) No group contract, or evidence of coverage, or individual contract may be delivered in this State unless the subscriber and/or enrollee is provided written notice required by Section 143c of the Illinois Insurance Code [215 ILCS 5/143c].

n~~o~~) Right to Examine Contract. An individual contract, with the exception of an HMO Medicare contract entered into between the Health Care Financing Administration and the HMO under Title XVIII of the Social Security Act, as amended from time to time, shall contain a provision stating that an enrollee who has entered into an agreement with an HMO shall be permitted to return the individual contract within ten days after receiving it and to receive a refund of the premium paid if the enrollee is not satisfied with the contract for any reason. If

the individual contract is returned to the HMO or to its representative through whom it was purchased, it is considered void from the beginning. However, if services are rendered or claims are paid for the~~such~~ enrollee or dependent by the HMO during the 10 day examination period, the enrollee shall not be permitted to return the contract and receive a refund of the premium paid.

o~~p~~) An HMO Medicare contract entered into between the Health Care Financing Administration and the HMO under Title XVIII of the Social Security Act, as amended from time to time, shall be delivered to the enrollee at least 15 days prior to the effective date of the contract. The enrollee shall be permitted to return the HMO Medicare contract prior to the effective date and to receive a refund of the premium paid if the enrollee is not satisfied with the contract for any reason, provided the enrollee complies with the disenrollment procedures of Title XVIII of the Social Security Act, as amended from time to time.

p~~q~~) Every HMO will provide to every enrollee of the HMO information that generally describes the philosophy, functions and organization of the HMO and related institutions, and specific information that describes the appropriate use of the HMO's services, including a general description of benefits and limitations. The HMO shall include in its enrollee information a description of the HMO's grievance procedure, directions for filing a grievance, and a Notice of Availability of the Department.

q~~r~~) Every HMO shall provide enrollees with an identification card that must prominently display the following information:

1) the words "Health Maintenance Organization" or "HMO";

2) disclaimer language concerning an enrollee's unauthorized use of providers not selected by the HMO;

3) a current telephone number for the enrollees to use when health care services are required outside of normal office hours; and

4) the name of all enrollees entitled to coverage, along with all other mandated information, if the HMO does not issue a card to each enrollee who is entitled to coverage. In these situations, at least two cards must be issued to the primary enrollee upon enrollment and the HMO must issue additional cards to all enrollees at the request of the enrollee for no

additional charge. Notification of the right to order additional cards for no additional charge must be included with information required to be disseminated to enrollees under subsection (pq).

rs) Enrollment Application. No individual contract shall be issued except upon the signed enrollment application of the enrollee for whom coverage is being sought. Any information or statement of the applicant shall appear on the application in the form of interrogatories by the HMO and answers by the applicant. The enrollee shall not be bound by any statement made within an application for health care coverage unless a copy of the application is attached to the individual contract. Group enrollment applications must be maintained on file by the HMO; otherwise, disputes arising from statements made within the applications will be resolved in the enrollee's favor. Except for those instances involving fraud or material misrepresentation, an HMO's failure to investigate incomplete or conflicting answers on an enrollment application shall estop the HMO from subsequently denying coverage on the basis of those responses.

st) Coordination of Benefits

1) HMOs are permitted, but not required, to adopt coordination of benefits provisions to avoid over insurance and to provide for the orderly payment of claims when a person is covered by two or more group health insurance or health care plans.

2) If an HMO adopts coordination of benefits, the provision must be consistent with the coordination of benefits requirements set forth in 50 Ill. Adm. Code 2009.

3) To the extent necessary for an HMO to meet its obligations as a secondary carrier under 50 Ill. Adm. Code 2009, and where an enrollee has established a credit within the reserve bank, the HMO shall make payments for services that are:

A) received from non-participating providers;

B) provided outside its services areas; or

C) not covered under the terms of health care plan.

t~~u~~) Dependents-termination of coverage-disability and dependency, proof-application. Every group contract, evidence of coverage, or individual contract that provides that coverage of a dependent person of an enrollee shall terminate upon attainment of the limiting age for dependent persons shall comply with the requirements of Section 4-9.1 of the Act.

u~~v~~) Conversion of Coverage

1) The group contract and evidence of coverage shall contain a conversion provision that provides that each enrollee has the right to convert coverage to an individual or group HMO contract in the following circumstances:

A) upon cancellation of eligibility for coverage under a group contract;

B) upon cancellation of the group contract; or

C) upon non-renewal of the group contract.

2) The conversion contract shall cover the enrollee and his/her eligible dependents who were covered by the group contract on the date of cancellation or non-renewal of coverage. To obtain the conversion contract, an enrollee shall submit a written application and the application premium payment within 31 days after the date the enrollee's coverage is cancelled.

3) The HMO may require copayments and deductibles under a conversion contract that differ from the group contract.

4) A conversion contract shall not be required to be made available if:

A) The cancellation of the enrollee's coverage occurred for any of the reasons listed in Section 5421.111(a);

B) The enrollee is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act;

C) The enrollee is covered by similar hospital, medical, or surgical benefits under State or federal law;

D) The enrollee is covered by similar hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group whether on an insured or uninsured basis;

E) The enrollee is covered for similar benefits through individual coverage;

F) The enrollee has not been continuously covered during the three-month period immediately preceding cancellation of that person's coverage;

G) The enrollee has moved outside of the service area of the health maintenance organization;

H) The cancellation of the enrollee's coverage occurred in relation to the HMO being placed in rehabilitation or liquidation proceedings pursuant to Section 5-6 of the Act; or

I) The group contract has been discontinued in its entirety and there is a succeeding carrier providing coverage to the group in its entirety.

5) Benefits or coverage shall be considered "similar" if coverage is provided for at least 12 months under comprehensive type medical coverage.

~~6) Notwithstanding subsection (v)(4)(C), (D), (E) or (I), if the enrollee or any of his or her covered dependents has a pre-existing condition, and the enrollee is covered by similar hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis, and the coverage does not cover pre-existing conditions, then the enrollee may continue conversion coverage for the individual with the pre-existing condition until the enrollee's or dependent's pre-existing condition is covered under the succeeding plan.~~

6~~7~~) The conversion contract shall provide as a minimum to its enrollees basic health care services.

7~~8~~) The conversion contract shall begin coverage of the enrollee and any

dependents formerly covered under the group contract on the date of termination from the group or the former individual contract.

8~~9~~) Coverage shall be provided without requiring evidence of insurability and shall not impose any pre-existing condition limitations or exclusions ~~other than those remaining unexpired under the contract from which conversion is exercised~~.

9~~10~~) Prior to the issuance of a conversion contract, the enrollee must be notified in writing that the election of any conversion contract will terminate the individual's federal eligibility for coverage under the Illinois Comprehensive Health Insurance Plan.

v~~w~~) Discrimination between individuals of the same class in the terms and conditions of the health care plan, or in the amount charged for coverage under a health care plan except when the rate differential is based on sound actuarial principles, or in any other manner whatsoever is prohibited.

w~~x~~) Grievance Procedure
The group contract, evidence of coverage, and individual contract shall set forth a full description of the HMO grievance procedure required by Section 5421.40.

x) The provisions of 50 Ill. Adm. Code 2001, Subparts A and C, shall apply to this Part.

(Source: Amended at 38 Ill. Reg. 2272, effective January 2, 2014

Section 5421.130 Basic Health Care Services

The provision of Basic Health Care Services shall not discriminate against any class of physician. The following minimum standards shall meet the requirements for Basic Health Care Services, provided that services are medically necessary as determined by the enrollee's primary care physician and, if required by the HMO, are authorized on a prospective and timely basis by the HMO's Medical Director:

a) Physician services, including primary care, consultation, referral, surgical, anesthesia or other as needed by the enrollee in any level of service delivery. Physician services need not include organ transplants unless specifically authorized by a primary care physician and approved by the HMO's Medical

Director;

b) Outpatient diagnostic imaging, pathology services and radiation therapy;

c) 120 days of non-mental health inpatient services per year, including all professional services, medications, surgically implanted devices and supplies used by the enrollee while an inpatient;

d) Emergency services for accidental injury or emergency illness 24 hours per day, and 7 days per week. Emergency services are covered benefits inside and out of the plan's service area. Emergency treatment shall include outpatient visits and referrals for emergency mental health problems;

e) Maternity care, including prenatal and post-natal care and care for complication of pregnancy of mother and care with respect to a newborn child from the moment of birth, which shall include the care and treatment of illness, injury, congenital defects, birth abnormalities and premature birth;

f) Blood transfusion services, processing and the administration of whole blood and blood components and derivatives;

g) Preventive health services as appropriate for the patient population, including a health evaluation program and immunizations to prevent or arrest the further manifestation of human illness or injury including but not limited to allergy injections and allergy serum. A health evaluation program shall include at least periodic physical examinations and medical history, hearing and vision testing or screening, routine laboratory testing or screening, blood pressure testing, and uterine cervical cytological testing, and low dose mammography testing as required by Section 4-6.1 of the Act;

h) Ten days inpatient mental health care per year. Care in a day hospital, residential non-hospital or intensive outpatient mode may be substituted on a two-to-one basis for inpatient hospital services as deemed appropriate by the primary care physician. Twenty individual outpatient mental health care visits per enrollee per year, as appropriate for evaluation, short-term treatment and crisis intervention services. Group outpatient mental health care visits may be substituted on a two-to-one basis for individual mental health care visits as deemed appropriate by the primary care physician;

i) Alcoholism and Drug Abuse

1) Diagnosis, detoxification and treatment of the medical complications of the abuse of or addiction to alcohol or drugs on either an inpatient or outpatient basis. Inpatient hospital services are subject to subsection (c).

2) Rehabilitation services on an inpatient basis, for up to 10 days inpatient care per year. Care in a day hospital, residential non-hospital or intensive outpatient treatment mode may be substituted on a two-to-one basis for inpatient hospital services as deemed appropriate by the primary care physician. Twenty individual outpatient care visits per enrollee per year as appropriate for evaluation, short-term treatment, and crisis intervention services. Group outpatient care visits may be substituted on a two-to-one basis for individual outpatient visits as deemed appropriate by the primary care physician. Prolonged rehabilitation services in a specialized inpatient or residential facility need not be a part of Basic Health Care Services;

j) Outpatient Rehabilitative therapy (including but not limited to: speech therapy, physical therapy, and occupational therapy directed at improving physical functioning of the member) up to 60 treatments per year for conditions which are expected to result in significant improvement within two months as determined by the primary care physician and if required by the HMO, are authorized on a prospective and timely basis by the HMO's Medical Director;~~.~~

k) Preventive services required pursuant to 42 USC 300gg-13;

l) Essential health benefits as provided in 50 Ill. Adm. Code 2001.11.

(Source: Amended at 38 Ill. Reg. 2272, effective January 2, 2014

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

a) Heading of the Part: Dealers, Wreckers, Transporters and Rebuilders

b) Code Citation: 92 Ill. Adm. Code 1020

3) Section Number: 1020.10 — Adopted Action: Amendment

4) Statutory Authority: Implementing Chapter 5 and authorized by Section 2-104(b) of the Illinois Vehicle Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/Ch. 5 and 2-104(b)] amended by PA 97-838

5) Effective Date of Rule: December 26, 2013

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 rule, 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*: September 27, 2013, 37 Ill. Reg. 15503

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version: No substantive changes were made during the First Notice period. 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 rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: Defines procedures and penalties for licensees accused of violating the Illinois Vehicle Code and rules adopted under the authority of the Illinois Vehicle Code.

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

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

Carrie E. Leitner
Office of the General Counsel
298 Howlett Building
Springfield, IL 62756

217/785-3094
email: cleitner@ilsos.net

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

SECRETARY OF STATE

NOTICE OF ADOPTED AMENDMENT

TITLE 92: TRANSPORTATION
CHAPTER II: SECRETARY OF STATE

PART 1020
DEALERS, WRECKERS, TRANSPORTERS AND REBUILDERS

Section
1020.10 Dealers Established Place of Business
1020.20 Required Records for Automotive Parts Recyclers Rebuilders, New Vehicle Dealers, Used Vehicle Dealers, Repairers and Out-of-State Salvage Vehicle Buyers
1020.30 Records Required Upon Removal of Dash Assemblies with Vehicle Identification Number Plate Attached
1020.40 Inspection of Licensees' Records and Premises
1020.50 Consignment Sales by Dealers
1020.70 Rebuilders Not to Engage in Retail Selling of Salvage or Rebuilt Vehicles
1020.80 Inspection of Rebuilt Vehicles

AUTHORITY: Implementing Chapter 5 and authorized by Section 2-104(b) of the Illinois Vehicle Title and Registration Law of the Illinois Vehicle Code [625 ILCS 5/Ch. 5 and 2-104(b)].

SOURCE: Filed March 5, 1975; amended at 2 Ill. Reg. 33, p. 144, effective August 8, 1978; amended at 5 Ill. Reg. 3835, effective March 27, 1981; codified at 6 Ill. Reg. 12674; amended at 7 Ill. Reg. 5260, effective April 4, 1983; amended at 8 Ill. Reg. 14657, effective August 1, 1984; amended at 8 Ill. Reg. 22884, effective November 16, 1984; amended at 12 Ill. Reg. 13612, effective August 15, 1988; amended at 12 Ill. Reg. 17962, effective November 1, 1988; amended at 14 Ill. Reg. 8704, effective June 1, 1990; amended at 19 Ill. Reg. 11640, effective August 1, 1995; amended at 20 Ill. Reg. 11356, effective August 1, 1996; amended at 22 Ill. Reg. 11527, effective July 1, 1998; amended at 38 Ill. Reg. 2291, effective December 26, 2013.

Section 1020.10 Dealers Established Place of Business

a) Each person or entity seeking to be or already duly licensed as a new or used vehicle dealer under the Illinois Vehicle Code (IVC~~I.V.C.~~) [625 ILCS 5] shall maintain an established place of business that~~which~~ shall, in addition to those requirements in IVC Section 5-100~~ of the Illinois Vehicle Code (I.V.C)~~, meet the following requirements:

1) Have office facilities in a building for maintaining and keeping books and records as are required. The office facilities shall be permanently mounted on a fixed foundation and may not include a trailer with axle attached and still moveable. It may include, however, a house trailer in a licensed mobile home park or dealership lot with tires removed and utilities attached.

2) Be properly and permanently equipped with the necessary office equipment and machines~~,~~ and documents and papers adequate to properly conduct business as a dealer and must be within a permanent building or structure as required in subsection (a)(1)~~ above~~.

3) Be equipped with an operating telephone for inbound and outbound calls, ~~and~~ have the business telephone number published in the telephone directory generally available in the dealership area, and be adequately equipped with operating electric lights.

4) Have the name of the dealership posted on the front entrance door.

5) Have posted on the front entrance door a sign setting forth the days and regular and reasonable hours when open for business. A dealership shall not be deemed as being open for business unless at least one employee, who is able to conduct regular business, is on the premises and available to the public. The~~ and the~~ dealership must be operated consistent with general dealer practices. The dealership must be open for business at least ~~five (~~5~~)~~ days out of each ~~seven (~~7~~)~~ days in a week, and a minimum of ~~four (~~4~~) hours~~ consecutive hours per day. However, dealers who operate their dealerships less than 12 months shall state in the license application those months in which the dealership is closed and shall not be required to maintain regular business hours during the period of closure. The months of closure shall also be posted in a prominent place for the public to see in the dealership office.

6) Maintain a lot~~, being~~ (the area not occupied by a building) that~~, which~~ shall be surfaced with rock or better surface material, and that~~which~~ shall be properly illuminated, if open after sundown, so that vehicles for sale can be properly inspected by any prospective customer.

A) The lot used for sale of vehicles shall be separate and apart from

any other business. In addition, if~~where~~ a dealer is selling both new and used cars, the new cars shall be parked separately and apart from used cars.

B) The ~~above~~ lot requirement described in this subsection (a)(6) shall not be applicable if~~where~~ the place of business has an indoor showroom, properly illuminated, for the display of vehicles held for sale.

C) The separate lot requirement specified in subsection (a)(6)(A) ~~above~~ shall not prohibit the operation by the dealer of other businesses on the same premises, which shall include the lot, provided that the businesses are reasonably related to the sale or operation of new or used automobiles, if~~provided further that~~ the sale of new or used automobiles constitutes~~shall constitute~~ at least 50% of the gross revenues of the license~~licensed~~ holder.~~, and the sale of automobiles shall be the primary business of the licensed dealer. No business defined as reasonably related to the sale of automobiles under this Section shall exceed 50% of the gross revenue of the business entities using the lot.~~ Businesses reasonably related to the sale or operation of automobiles shall include only the sale of automobile parts and accessories, the sale of gasoline, diesel fuel, oil and lubricant, the sale of automobile tires, the leasing of automobiles, insuring automobiles, and financing of automobiles sold by the licensed dealers engaged in these businesses. Licensed dealers engaged in operating businesses other than those stated in this subsection (a)(6)(C)~~herein~~ shall remove unauthorized~~such~~ businesses or modify them to comply with this Section~~rule~~ within 60 days after~~of~~ notification by the Secretary of State, or be subject to the revocation or suspension of their dealer's~~dealers~~ license.

7) Dealership in a Department Store − When~~Where~~ a dealer maintains a place of business within a department store, the dealership shall be separated from other operations of~~within~~ the department store.

8) Sign – Display a permanent sign bearing the name of the dealership, which shall be properly illuminated if open after sundown and which shall be visible from the highway, as defined at IVC Section 1-126, leading to

the established place of business.

9) Display a federally required pricing document on all new motor vehicles held for sale.

10) If the premises are leased, the~~such~~ lease must be for at least the duration of the current licensed period.

b) Supplemental Lots
An Illinois licensed dealer may operate as an additional place of business a permanent supplemental lot that meets~~which will meet~~ all the requirements of subsection (a)~~subsections (a)(1) through (a)(10) of this Section~~, except the records required to be kept shall be maintained at the principal place of business of the dealership, as defined by IVC Section 1-164~~ of the I.V.C.~~, unless the supplemental lot is more than one mile from the main dealership~~dealerships~~. The one mile shall be measured by the most direct road between the dealership and the supplemental lot.

1) A licensed dealer shall apply for the supplemental lot authorization when he/she files the application required by IVC Section~~Sections~~ 5-101 or 5-102 ~~of the I.V.C.~~ or he or she~~he/she~~ may file an application to add a supplemental lot during the license period.

2) The fee for a license to operate a supplemental lot is $25 or $12.50 as provided in IVC Sections 5-101(b)(7) and 5-102(b)(5)~~ of the I.V.C~~.

3) No vehicle sales at supplemental lots shall be allowed on Sundays except as provided for in IVC Section 5-106~~ of the I.V.C~~.

c) Trade Show Exhibition, Display Exhibition and Off Site Sale
A licensed dealer may operate as an additional place of business an exhibition area in a trade show exhibition, display exhibition~~,~~ or off site sale, provided:

1) The trade show exhibition, display exhibition or off site sale must be conducted separately~~separate~~ and away from the licensed dealer's established and additional places of business.

2) The licensed dealer has a currently valid new or used vehicle dealer's license issued by the Secretary of State of Illinois or another state where

applicable.

3) The applicant dealer meets the requirements of subsection (c)(7), (8) or (9) ~~of this Section~~.

4) No permit granted for an additional location in a trade show exhibition, display exhibition or off site sale may be transferred or~~nor~~ removed to another location.

5) Regardless of the dates of the trade show exhibition, display exhibition or off site sale, no vehicle sales will be allowed on Sunday except as provided for in IVC Section 5-106~~ of the I.V.C~~.

6) The licensed dealer has provided the Secretary of State with a copy of:

A) the written contract with the agency,~~ or~~ person or other entity sponsoring, creating or supervising the trade show exhibition, display exhibition or off site sale; and

B) an application for the trade show exhibition, display exhibition or off site sale permit:

i) containing the name of the dealership, its license number, the location and dates of the trade show exhibition, display exhibition or off site sale;~~,~~ and

ii) signed by the licensed dealer.

7) Trade Show Exhibitions

A) A permit for an additional location granted for a trade show exhibition shall in no event be valid for more than ~~thirty (~~30~~)~~ days from the date of the first day of the trade show exhibition for which it is granted.

B) The fee for a permit to operate in a trade show exhibition shall be $10.00 per permit.

C) No vehicles may be offered for sale.

D) Each trade show exhibition must have a minimum of ~~three (~~3~~)~~ licensed participants, at least two of whom~~which~~ must be licensed under IVC Section 5-101 or 5-102~~ of the I.V.C.~~, who all meet the requirements in subsections (c)(1) through (6)~~ of this Section~~.

E) A trade show exhibition of new vehicles shall only have participants licensed as new vehicle dealers, at least two of whom~~which~~ must be licensed under IVC Section 5-101~~ of the I.V.C.,~~ and meet the requirements in subsections (c)(1) through (6) ~~of this Section~~.

8) Display Exhibitions

A) Only a new or used vehicle dealer licensed under IVC Section 5-101 or 5-102~~ of the I.V.C.~~, who also meets the requirements of subsections (c)(1) through (6)~~ of this Section~~, may participate in a display exhibition.

B) A permit for an additional location granted for a display exhibition shall in no event be valid for more than ~~thirty (~~30~~)~~ days from the date of the first day of the display exhibition for which it is granted.

C) The fee for a permit to operate in a display exhibition shall be $10.00 per permit.

D) No vehicles may be offered for sale.

9) Off Site Sales

A) Only a dealer licensed under IVC Section 5-101 or 5-102~~ of the I.V.C.~~, who also meets the requirements of subsections (c)(1) through (6)~~ of this Section~~, may conduct an off site sale.

B) The off site sale must not be conducted out of the licensed dealer's relevant market area, as defined in IVC Section 5-100~~ of the I.V.C~~. This does not apply to off site sales of motor homes or recreational vehicles.

C) A permit for an additional location granted for an off site sale shall in no event be valid for more than ~~seven (~~7~~)~~ days from the date of the first day of the off site sale for which it is granted.

D) The fee for a permit to operate an off site sale shall be $25~~.00~~ per permit.

d) Each person seeking to be or already duly licensed as a scrap processor, automotive parts recycler, rebuilder, repairer or out-of-state salvage buyer under the IVC~~I.V.C.~~ shall maintain an established place of business that meets~~which shall meet~~ the requirements of~~contained in~~ subsection (a)~~above~~, except that no lot as set forth in subsection (a)(6)~~above~~ is required. However, if open after sundown, the premises shall be adequately illuminated so that prospective purchasers may inspect the items held for sale.

e) In lieu of a criminal complaint, the Secretary of State Department of Police may issue an administrative citation to a party licensed under IVC Chapter 5 for any violation of the IVC or any administrative rule adopted by the Secretary under the IVC. If an administrative citation is issued, then a minimum of 3 separate violations must be present at the time of the investigation or inspection and any violations shall result in a $50 penalty per violation. Any party that receives an administrative citation that results in a monetary penalty may either pay the penalty or contest the administrative citation through the Secretary's administrative hearing process (see 92 Ill. Adm. Code 1000.Subpart A). If a licensee agrees to pay the administrative citation, the licensee waives his or her ability to contest the administrative citation through the administrative hearing process. If a licensee pays the penalty as a result of an administrative citation but receives subsequent administrative citations pursuant to a subsequent investigation or inspection, and the licensee disputes the subsequent administrative citations through the administrative hearing process, the Secretary may use any previous administrative citations as evidence to establish a pattern or habit of violations. A licensee shall have 90 calendar days after receiving the administrative citation to either pay the penalty or file a request for an administrative hearing. Failure to either pay the administrative citation or file a timely request for an administrative hearing may result in the denial of a license renewal until the penalty is paid in full or an administrative hearing is scheduled to adjudicate the contested administrative citations.

f~~e~~) None of the requirements of this Section shall apply to the place of business of a vehicle auctioneer licensed under IVC Chapter 5, Article VII~~ of the I.V.C~~.

(Source: Amended at 38 Ill. Reg. 2291, effective December 26, 2013)

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Firearm Owner's Identification Card Act

2) Code Citation: 20 Ill. Adm. Code 1230

3)

Section Numbers:	Proposed Action:
1230.10	Amend
1230.20	Amend
1230.30	Amend
1230.40	Amend
1230.50	Amend
1230.60	Amend
1230.70	Amend
1230.80	Repeal
1230.90	Repeal
1230.100	Repeal
1230.120	New

4) Statutory Authority: Implementing and authorized by the Firearm Owner's Identification Card Act [430 ILCS 65] and authorized by Section 2605-15 of the Civil Administrative Code of Illinois [20 ILCS 2605/2605-120]

5) Effective Date of Rule: December 31, 2013

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 is on file in the Agency's principal office and is available for public inspection.

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 15841, October 11, 2013

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between Proposal and Final Version:

In Section 1230.10, changed the definition of "Law enforcement officer" to "means an employee of a government agency who:

is authorized by law to engage in or supervise the prevention, detection, investigation, prosecution or incarceration of any person for any violation of law;

has statutory powers of arrest or custodial detention;

is authorized by the agency to carry a firearm while on duty;

is not the subject of any disciplinary action by the employing agency that could result in termination;

meets the standards established by the agency that require the employee to regularly qualify in the use of a firearm; and

is not prohibited by federal law from possessing a firearm."

In Section 1230.10, in the definition of "Law enforcement official", added "for purposes of clear and present danger reporting."

In Section 1230.20(b), added "(see Section 5 of the Act)".

In Section 1230.20(f), added "Only persons with a permanent duty assignment in Illinois qualify for a FOID Card if they are not otherwise an Illinois resident. Military personnel in Illinois on temporary duty assignment are not eligible and do not need a FOID Card."

In Section 1230.20(g), added "Persons in Illinois on a non-immigrant visa must have permission from their government and the U.S. Attorney General to possess or transport firearms."

In Section 1230.20(h), added "as part of the application process, ask any questions necessary to determine eligibility under State and federal law to possess or receive a firearm".

In Section 1230.30, deleted "The Department shall, at least 60 days prior to the expiration of a FOID Card, forward to the last known address of each person whose FOID Card is to expire a notification of the expiration and an application that may be used to apply for renewal. It is the registrant's responsibility to notify the Department in writing of the registrant's change of address."

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED AMENDMENTS

In Section 1230.40(a), changed last sentence to read "The parent or legal guardian providing consent shall file an affidavit with the Department, as prescribed by the Department, (using the form available on the Department's website), stating that the parent/guardian is not an individual prohibited by Section 4(2) of the Act from having a FOID Card.

In Section 1230.70(a), deleted items (1), (A), (B), and (C).

In Section 1230.70, changed number (2) to (1), and added "Unit within 60 days after receipt of the notice that their FOID application is denied or their FOID Card is revoked to begin the appeal process."

In Section 1230.70, changed number (3) to (2), and added "In addition to the documents required by Section 10(c-5), the".

In Section 1230.70(2), deleted item (A); changed item (B) to (A); deleted items (C), (D), and (E); changed item (F) to (B); deleted number (4); changed number (5) to (3) and added "(Section 10(f) of the Act)".

In Section 1230.70(b)(2), deleted "Division" and added "Unit within 60 days after receipt of the notice that their FOID application is denied or their FOID Card is revoked to begin the appeal process."

In Section 1230.70(b), added "5) If relief is denied by both the Director and through an administrative hearing, in order to be eligible for a FOID Card once five years have passed since the admission, the applicant must have received a mental health evaluation by a physician, clinical psychologist, or qualified examiner as defined in the Mental Health and Developmental Disabilities Code [405 ILCS 5] and received a certification that he or she is not a clear and present danger to himself or herself or others."

Changed Section 1230.70(c)(1) to read "An individual whose application for a *FOID Card is denied* or whose *FOID Card is revoked* (Section 10(a) of the Act) because of a felony conviction may petition the Department for relief unless the appeal must be directed to the circuit court in the county of his or her residence pursuant to Section 10(a) of the Act."

Changed Section 1230.70(d) to read "Other Denials or Revocation; Petition for Relief – Individuals who wish to request relief from the Department shall provide written notice to the Firearms Services Bureau, Appeals Unit within 60 days after receipt of the notice

that their FOID application is denied or their FOID Card is revoked to begin the appeal process."

Deleted Section 1230.70(d)(2).

Changed Section 1230.70(d)(3) to 1230.70(d)(2).

Changed Section 1230.70(d)(4) to 1230.70(d)(3).

Changed Section 1230.70(d)(5) to 1230.70(d)(4).

In Section 1230.70(d) added "5) Persons Revoked as a Clear and Present Danger: If a petitioner wishes to appeal the denial or revocation based upon the fact that he or she has been determined to be a clear and present danger pursuant to the Act and this Part, the petitioner must provide information refuting the finding that he or she presents a clear or present danger as defined by the Act."

Deleted Section 1230.70(m).

In Section 1230.120(b), added:

"1) Clear and present danger reporting shall be used by the Department to identify persons who pose an actual, impending, or imminent threat of substantial bodily harm to themselves or another person that is articulable and significant or who will be likely to act in a manner dangerous to public safety or contrary to the public interest if they were granted access to a weapon.

2) Clear and present danger reporting shall be made consistent with the Family Educational Rights and Privacy Act (20 USC 1232g) to assist the Department with protecting the health and safety of the public by denying persons who present a clear and present danger from having lawful access to weapons."

In Section 1230.120, added "d) The Department shall maintain a record of those persons who are determined to present a clear and present danger for the purpose of denying or revoking a FOID Card pursuant to Section 8(f) of the Act but shall not maintain a record of those persons who are not determined to present a clear and present danger for these purposes."

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED AMENDMENTS

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 rule currently in effect? No

14) Are there any rulemakings pending on this Part? No

15) Summary and Purpose of Rulemaking: The proposed amendments will update procedures associated with FOID card matters including the application process, expiration of cards, surrender and return of revoked cards, appeal process for revoked or denied cards, and methods for clear and present danger reporting. In addition, sections pertaining to judicial review, certification, and reduction of remittance are being repealed.

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

Suzanne L. Y. Bond
Chief Legal Counsel
Illinois State Police
801 South 7th Street, Suite 1000-S
Springfield IL 62703

217/782-7658

or

Lisa Freitag
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801 South 7th Street, Suite 1000-S
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The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED AMENDMENTS

TITLE 20: CORRECTIONS, CRIMINAL JUSTICE, AND LAW ENFORCEMENT
CHAPTER II: DEPARTMENT OF STATE POLICE

PART 1230
FIREARM OWNER'S IDENTIFICATION CARD ACT

Section
1230.10 Definitions
1230.20 Application Procedures
1230.30 Duration and Renewal of Identification Card
1230.40 Sponsorship of a Minor
1230.50 Return of FOID Card – Applicant~~Denial of Application or Revocation and Seizure of Identification Card~~
1230.60 Return of Revoked FOID Card – Other~~Notification of Grounds for Denial of Application and Revocation and Seizure of Identification Card~~
1230.70 Appeal
1230.80 Judicial Review (Repealed)
1230.90 Certification (Repealed)
1230.100 Reduction of Remittance (Repealed)
1230.110 Retention of Remittance
1230.120 Clear and Present Danger Reporting
1230.EXHIBIT A Application for Firearm Owner's Identification Card (Form FOID-1.2) (Repealed)
1230.EXHIBIT B Certification (Repealed)

AUTHORITY: Implementing and authorized by the Firearm Owner's Identification Card Act [430 ILCS 65] and authorized by Section 2605-120 of the Civil Administrative Code of Illinois [20 ILCS 2605/2605-120].

SOURCE: Filed March 8, 1973; codified at 7 Ill. Reg. 9557; amended at 8 Ill. Reg. 21306, effective October 10, 1984; recodified from the Department of Law Enforcement to the Department of State Police at 10 Ill. Reg. 3279; amended at 17 Ill. Reg. 18856, effective October 18, 1993; amended at 22 Ill. Reg. 16629, effective September 8, 1998; amended at 27 Ill. Reg. 10308, effective June 26, 2003; amended at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.10 Definitions

Terms defined in the Firearm Owner's Identification Card Act [430 ILCS 65/1.1] have the same meanings when used is this Part. The ~~As used in this Part, the~~ following additional definitions

also apply to this Part unless the context clearly requires a different meaning:

"Act" means Firearm Owner's Identification Card Act [430 ILCS 65].

"Antique firearm" ~~means~~ shall have the meaning ascribed to it in 18 USC 921(a)(16), i.e.:

any firearm, including any firearm with a matchlock, flintlock, percussion cap, or similar type of ignition system, manufactured in or before 1898; or

any replica of any firearm described in the previous paragraph if the replica:

is not designed or redesigned for using rimfire or conventional centerfire fixed ammunition; or

uses rimfire or conventional centerfire fixed ammunition that is no longer manufactured in the United States and that is not readily available in the ordinary channels of commercial trade; or

any muzzle loading rifle, muzzle loading shotgun, or muzzle loading pistol that is designed to use black powder or a black powder substitute and that cannot use fixed ammunition.

The term "antique firearm" shall not include any weapon that incorporates a firearm frame or receiver, any firearm that is converted into a muzzle loading weapon, or any muzzle loading weapon that can be readily converted to fire fixed ammunition by replacing the barrel, bolt, breechblock or any combination of these. ~~means, for the purpose of 430 ILCS 65/1.1(4), any firearm with a matchlock, flintlock, percussion cap, or similar type of ignition system manufactured in or before 1898, provided it is not likely to be used as a weapon.~~

"Applicant" means a person who has submitted a completed application ~~an applicant~~ for a Firearm Owner's Identification Card.

"Criminal Justice System Employee" includes law enforcement officials, courts, State's Attorneys, probation officers, parole officers, and federal law enforcement officials.

"Department" means the Department of State Police.

"Director" means the Director of State Police or his or her designee.

~~"Firearm" and "firearm ammunition" mean the terms as defined in Section 1.1 of the Act.~~

"FOID Card" means the ~~"~~Firearm Owner's Identification Card~~" means the term~~ as defined in Section 6 of the Act.

"Law enforcement officer" means an employee of a government agency who:

is authorized by law to engage in or supervise the prevention, detection, investigation, prosecution or incarceration of any person for any violation of law;

has statutory powers of arrest or custodial detention;

is authorized by the agency to carry a firearm while on duty;

is not the subject of any disciplinary action by the employing agency that could result in termination;

meets the standards established by the agency that require the employee to regularly qualify in the use of a firearm; and

is not prohibited by federal law from possessing a firearm.

"Law enforcement official", for purposes of clear and present danger reporting, means any peace officer, warden, superintendent~~,~~ or keeper of prisons, penitentiaries, jails~~,~~ and other institutions for the detention of persons accused or convicted of a criminal offense, and employees of police laboratories having a department or section of forensic firearm identification.

~~"Mental institution" means any medical facility or part of any medical facility used primarily for the care or treatment of persons for mental illness.~~

~~"Mentally retarded" means a person who has significantly subaverage general~~

~~intellectual functioning which exists concurrently with impairment in adaptive behavior and which originates before the age of 18 years.~~

"Out-of-state resident" means a person who does not qualify for an Illinois driver's license or an Illinois State identification card due to his or her establishment of a primary domicile in another state.

"Valid" means current and not suspended, revoked, expired, cancelled, invalidated, denied or disqualified.

~~"Narcotics" means any substance controlled by the Controlled Substances Act.~~

(Source: Amended at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.20 Application Procedures

a) Application for a FOID Card shall be made by completing an application form provided by the Department. These forms will be made available through the Department's website (www.isp.state.il.us/foid/foidapp.cfm).

b) All application forms shall be completed accurately and in their entirety, accompanied by the correct fee (see Section 5 of the Act) and a photograph, and submitted as indicated on the application form.

c) Any application form that is not completed accurately and in its entirety, including the correct fee and a photograph, will be denied.

d) Except as provided in subsection (e), any requirement for an Illinois driver's license number or Illinois identification card number shall mean a valid Illinois driver's license number or valid Illinois identification card number. A temporary visitor's driver's license (TVDL) will not be accepted.

e) In regard to an applicant who is employed as a law enforcement officer, an armed security officer in Illinois or by the United States military permanently assigned in Illinois and who is not an Illinois resident, any requirement for a driver's license number or State identification card number shall mean the valid driver's license number or valid state identification card number from his or her state of residence.

f) In regard to an applicant who is employed by the United States military permanently assigned in Illinois, the applicant shall also provide valid military identification and assignment orders establishing permanent assignment in Illinois. Only persons with a permanent duty assignment in Illinois qualify for a FOID Card if they are not otherwise an Illinois resident. Military personnel in Illinois on temporary duty assignment are not eligible and do not need a FOID Card.

g) In regard to an applicant who is applying under a non-immigrant visa exception, the applicant shall provide a letter from his or her foreign government stating the purpose for travel to Illinois and the date the applicant's non-immigrant visa expires. The applicant shall also explain the need for the FOID Card or submit a waiver from this Part granted by the U.S. Attorney General. Persons in Illinois on a non-immigrant visa must have permission from their government and the U.S. Attorney General to possess or transport firearms.

h) The Department shall, as part of the application process, ask any questions necessary to determine eligibility under State and federal law to possess or receive a firearm, and deny a FOID application of any applicant who is prohibited under federal law from possessing or receiving a firearm.

i) All FOID Cards issued shall remain the property of the Department.~~Application for a Firearm Owner's Identification Card will be made by completing an application form provided by the Department. These forms will be made available through the Firearms Services Bureau, P.O. Box 3677, Springfield, Illinois 62708-3677. All forms must be properly completed, accompanied by the correct fee and a photograph, and mailed to the address indicated on the application form. Other than in regard to an applicant who is employed as an armed security officer at a nuclear energy, storage, weapons, or development facility regulated by the Nuclear Regulatory Commission and who is not an Illinois resident, any requirement for a driver's license and any requirement for a driver's license number shall mean an Illinois driver's license and an Illinois driver's license number. In regard to an applicant who is employed as an armed security officer at a nuclear energy, storage, weapons, or development facility regulated by the Nuclear Regulatory Commission and who is not an Illinois resident, any requirement for a driver's license and any requirement for a driver's license number shall mean his or her driver's license number or state identification card number from his or her state of residence. All Firearm Owner's Identification Cards issued shall remain the property of the Department.~~

(Source: Amended at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.30 Duration and Renewal of Identification Card

A FOID~~Firearm Owner's Identification~~ Card shall expire 10~~five~~ years from the date of issuance. The first day of the month in which the related FOID~~Firearm Owner's Identification~~ Card Application was received is designated as the date of issuance for purposes of this Part. ~~The Department shall, at least 30 days prior to the expiration of a Firearm Owner's Identification Card, forward to the last known address of each person whose Firearm Owner's Identification Card is to expire a notification of the expiration and an application which may be used to apply for renewal. It is the registrant's responsibility to notify the Department in writing of the registrant's change of address.~~

(Source: Amended at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.40 Sponsorship of a Minor

a) Every applicant for a FOID~~Firearm Owner's Identification~~ Card~~,~~ under the age of 21~~,~~ shall have the written consent of his/her parent or legal guardian to possess and acquire firearms and firearm ammunition, prior to issuance of a FOID~~Firearm Owner's Identification~~ Card. If the consent is given by a legal guardian, a certified copy of the guardianship court order must be submitted with the application. ~~The applicant cannot have been adjudged delinquent or convicted of a misdemeanor other than a traffic offense.~~ The parent or legal guardian providing consent shall~~must~~ file an affidavit with the Department, as prescribed by the Department (using the form available on the Department's website), stating that the parent/guardian~~he/she~~ is not an individual prohibited by Section 4(2) of the Act from having a FOID~~Firearm Owner's Identification~~ Card.

b) No applicant under age 21 will be granted a FOID Card if he or she is prohibited from having a FOID Card by State or federal law.

c) If the minor is not physically capable of signing the application because of age, disability or other cause, the parent or legal guardian providing consent must submit a copy of the minor's birth certificate.

(Source: Amended at 38 Ill. Reg. 2301, effective December 31, 2013

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED AMENDMENTS

Section 1230.50 Return of FOID Card – Applicant~~Denial of Application or Revocation and Seizure of Identification Card~~

Individuals whose cards have been revoked shall surrender their FOID Cards and complete the Firearm Disposition Record required by Section 9.5 of the Act. A copy of the required Firearm Disposition Record can be found on the Department's website at www.isp.state.il.us within the FOID section or at the local law enforcement agency where the individual resides. Individuals whose FOID Cards were confiscated by law enforcement or the courts must submit documentation of the confiscation with the Firearm Disposition Record.~~The Department will deny an application for or revoke and seize a Firearm Owner's Identification Card if the Department finds that the applicant or the person to whom such a Firearm Owner's Identification Card was issued is or was at the time of issuance prohibited from acquiring or possessing firearms or firearm ammunition by any Illinois state statute or by federal law or does not otherwise qualify under Illinois statute to possess a Firearm Owner's Identification Card. Any card seized, revoked, or otherwise inappropriately possessed shall be returned to the Department of State Police, Firearms Services Bureau.~~

(Source: Amended at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.60 Return of Revoked FOID Card – Other~~Notification of Grounds for Denial of Application and Revocation and Seizure of Identification Card~~

Any criminal justice system employee or firearm or ammunition retailer who takes possession of a revoked FOID Card shall return the revoked card to the Illinois State Police, Firearms Services Bureau, within 10 business days.~~The Department shall notify, in writing to the last known address, every person whose application for a Firearm Owner's Identification Card is denied and every person whose Firearm Owner's Identification Card is revoked of the specific grounds upon which the application has been denied or the Firearm Owner's Identification Card has been revoked. In those situations for which written notification to the last known address is ineffective or unnecessarily delays revocation, additional alternative means may be used to communicate notification and effectuate revocation. Individuals whose cards have been revoked shall immediately return the revoked card to the Department of State Police, Firearms Services Bureau.~~

(Source: Amended at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.70 Appeal

a) Commitment to a Mental Health Facility; Expedited Relief Law Enforcement

Officers

1) Law enforcement officers who wish to request expedited relief from the Department shall initiate such a request by providing written notice of this intention to the Department's Firearms Services Bureau, Appeals Unit within 60 days after receipt of the notice that their FOID application is denied or their FOID Card is revoked to begin the appeal process. The officer must also sign an affidavit provided by the Department certifying that he or she meets the requirements of Section 10(c-5) of the Act for expedited relief.

2) In addition to the documents required by Section 10(c-5), the petitioner must provide to the Department the following documentation:

A) a letter from the petitioner's employer on official letterhead that provides the current status of employment, job title, any records regarding the revocation of petitioner's FOID Card, and the employer's opinion as to the suitability of the petitioner to possess a firearm; and

B) any other reasonable documentation requested by the Department related to the determination for granting relief.

3) *If it is established by a preponderance of the evidence that the person will not be likely to act in a manner dangerous to public safety and that granting relief would not be contrary to the public interest, the Director shall grant relief* (Section 10(f) of the Act).

b) Commitment to a Mental Health Facility

1) An individual whose application for a FOID Card is denied or whose FOID Card is revoked for a commitment to a mental health facility may petition the Department for relief.

2) Individuals who wish to request relief from the Department shall provide written notice of this intention to the Firearms Services Bureau, Appeals Unit within 60 days after receipt of the notice that their FOID application is denied or their FOID Card is revoked to begin the appeal process.

3) The petitioner must provide to the Department the following documentation:

A) a signed, dated and notarized statement from the petitioner detailing any and all facts and circumstances requested by the Department surrounding the admission;

B) two signed, dated and notarized statements from adults who are aware of the circumstances regarding the revocation or denial of the FOID Card, detailing their opinion as to the individual's suitability to possess firearms and the individual's current mental state;

C) a current forensic evaluation or letter from a psychiatrist, all psychiatric and counseling records from the past five years, and any and all court records that may apply; and

D) any other reasonable documentation requested by the Department related to the determination for granting relief.

4) *If it is established by a preponderance of the evidence that the person will not be likely to act in a manner dangerous to public safety and that granting relief would not be contrary to the public interest, the Director* or his or her designee may *grant relief.* (Section 10(a) of the Act)

5) If relief is denied by both the Director and through an administrative hearing, in order to be eligible for a FOID Card once five years have passed since the admission, the applicant must have received a mental health evaluation by a physician, clinical psychologist, or qualified examiner as defined in the Mental Health and Developmental Disabilities Code [405 ILCS 5] and received a certification that he or she is not a clear and present danger to himself or herself or others.

c) Felony Denials; Petition for Relief

1) An individual whose application for a *FOID Card is denied* or whose *FOID Card is revoked* (Section 10(a) of the Act) because of a felony conviction may petition the Department for relief unless the appeal must be directed to the circuit court in the county of his or her residence

pursuant to Section 10(a) of the Act.

2) Individuals who wish to request relief from the Department shall provide written notice to the Department to begin the appeal process.

3) The petitioner must provide to the Department the following documentation:

A) a signed, dated and notarized statement from the petitioner detailing any and all facts and circumstances requested by the Department surrounding the felony;

B) three signed, dated and notarized statements from adults, one of whom lives with the petitioner, detailing their opinions as to the individual's suitability to possess firearms, as well as their knowledge surrounding the felony; and

C) any other reasonable documentation requested by the Department related to the determination for granting relief.

4) Upon receiving complete documentation for the appeal, the Department will investigate the circumstances surrounding the denial or revocation action. If the Director is satisfied that substantial justice has not been done, the Director or his or her designee may grant relief.

d) Other Denials or Revocation; Petition for Relief – Individuals who wish to request relief from the Department shall provide written notice to the Firearms Services Bureau, Appeals Unit within 60 days after receipt of the notice that their FOID application is denied or their FOID Card is revoked to begin the appeal process.

1) An individual whose application for a *FOID Card is denied* or whose *FOID Card* is revoked for one or more of the felonies described in subsection (c) of the Act *may petition in writing the circuit court in the county of his or her residence for a hearing on the denial or revocation* (Section 10(a) of the Act).

2) Out-of-state Residents: If a petitioner wishes to appeal the denial or revocation based on his or her status as an out-of-state resident, the petitioner must provide to the Department documentation requested by the

Department, which shall include a copy of a valid driver's license or identification card, proof of residency, and a signed, dated and notarized statement from the petitioner detailing any and all facts and circumstances regarding the status of his or her residency and the need for a FOID Card. The petitioner must also provide any other documentation requested by the Department relating to the determination for granting relief.

3) Persons Under 21: If a petitioner wishes to appeal the denial or revocation based on the fact that he or she does not have a parent or legal guardian, the petitioner must provide two signed, dated and notarized personal references regarding his or her suitability to possess firearms and a signed, dated and notarized statement detailing his or her circumstances. If applicable, the petitioner must provide death certificates for his or her parents or legal guardians and/or any applicable court documents regarding the petitioner's circumstances.

4) Persons Unable to Provide a Driver's License or State Identification Card: If a petitioner wishes to appeal the denial or revocation based on the fact that he or she cannot provide a driver's license or State identification card other than for eligibility reasons, the petitioner must provide a signed, dated and notarized statement detailing his or her circumstances, including any medical explanations. If the petitioner is medically unable to obtain a driver's license or state identification card, the petitioner must provide a physician's statement regarding his or her condition. The petitioner must provide any and all other relevant information requested by the Department, including documentation from the Secretary of State.

5) Persons Revoked as a Clear and Present Danger: If a petitioner wishes to appeal the denial or revocation based upon the fact that he or she has been determined to be a clear and present danger pursuant to the Act and this Part, the petitioner must provide information refuting the finding that he or she presents a clear and present danger as defined by the Act.

6) Upon receiving complete documentation for the appeal, the Department will investigate the circumstances surrounding the denial or revocation action. If the Director is satisfied that substantial justice has not been done, the Director or his or her designee may grant relief.

e) The appeal process will not begin until the Department has received all the

necessary documentation.

f) In the event the Director or his or her designee desires additional information concerning the circumstances surrounding the denial or revocation action, the Director may schedule a fact-finding conference with the petitioner or request additional information.

g) The Director or his or her designee may grant or deny relief as a result of the fact-finding conference.

h) At a fact-finding conference, the petitioner may be represented by counsel or present witnesses who have direct knowledge of the circumstances of the denial or revocation and may present any evidence or information relating to the Department's action.

i) If the Director does not provide relief as a result of the investigation or a fact-finding conference, the petitioner may request an administrative hearing. The request for hearing must be in writing and sent to the Firearms Services Bureau, Appeals Unit.

j) The administrative law judge (ALJ) for contested hearings shall be an attorney licensed to practice law in Illinois appointed by the Director. The ALJ may be disqualified for bias or conflict of interest.

k) The procedures for the hearing shall be as described in Article 10 of the Administrative Procedure Act [5 ILCS 100/Art. 10] and as ordered by the ALJ.

l) In the event relief is denied, a new application from the petitioner will not be accepted until two years have passed since the date of the last denial.

~~a) An individual whose application for a Firearm Owner's Identification Card is denied or whose Firearm Owner's Identification Card is revoked may petition the Department for relief unless the denial or revocation was based upon a forcible felony, stalking, aggravated stalking, domestic battery, any violation of either the Illinois Controlled Substances Act or the Cannabis Control Act that is classified as a Class 2 or greater felony, or any felony violation of Article 24 of the Criminal Code of 1961, in which case the aggrieved party may petition the circuit court in writing in the county of his or her residence for a hearing upon such denial or revocation.~~

~~b) Individuals who wish to request relief from the Department shall initiate such a request by providing written notice of this intention to the Department.~~

~~c) Upon receiving written notice, the Department shall investigate the circumstances surrounding the denial or revocation action; and if the Director is satisfied that substantial justice has not been done, the Director may grant relief. In the event the Director desires additional information concerning the circumstances surrounding the denial or revocation action, the Director may schedule a fact finding conference with the petitioner.~~

~~d) At a fact finding conference, the petitioner may be represented by counsel or any other person and may present any evidence or information relating to the Department's action.~~

~~e) The Director may provide relief as a result of the fact finding conference.~~

~~f) If the Director does not provide relief as a result of the investigation or a fact finding conference, the petitioner may petition for a hearing.~~

~~g) The administrative law judge for contested hearings shall be the Director or an attorney licensed to practice law in Illinois appointed by the Director. The administrative law judge may be disqualified for bias or conflict of interest.~~

~~h) The procedures for the hearing shall be as described in Article 10 of the Administrative Procedure Act [5 ILCS 100/Art. 10] and as ordered by the administrative law judge.~~

~~i) In the event relief is denied, a new application from the petitioner will not be accepted until two years have passed since the date of the last denial.~~

(Source: Amended at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.80 Judicial Review (Repealed)

~~All final decisions of the Department under this Act are subject to judicial review under the provisions of the Administrative Review Law (Ill. Rev. Stat. 1991, ch. 110, par. 3-101 through 112) [735 ILCS 5/3-101 through 112].~~

(Source: Repealed at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.90 Certification (Repealed)

~~At the time of acquisition of a firearm or firearm ammunition to be used by a law enforcement official in the performance of official duties, the law enforcement official may present a certified letter from the chief administrator or his designee of the employing law enforcement agency to the seller of the firearm or firearm ammunition in lieu of a Firearm Owner's Identification Card. This letter must contain the following information:~~

~~a) A statement that the officer is a law enforcement officer;~~

~~b) A statement that the firearm or firearm ammunition described is intended for use in the performance of official law enforcement duties;~~

~~c) The acquiring officer's signature and star, badge, or other numeric identifier;~~

~~d) A description of the firearm and firearm ammunition to be acquired;~~

~~e) The date, title/rank, and signature of the chief administrator or his designee;~~

~~f) The name and address of the law enforcement agency; and~~

~~g) A statement limiting the validity of the certification to 60 days from the date of issuance.~~

(Source: Repealed at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.100 Reduction of Remittance (Repealed)

~~a) The Department may reduce by interlineation the amount of any check.~~

~~b) The drawer of the check shall be notified in writing of such reduction.~~

~~c) Any check reduced pursuant to subsection (a) shall be endorsed in a manner that shall reflect the reduction.~~

~~d) All applications upon reprinting shall contain the following authorization statement: "My signature authorizes the Department to reduce the amount of my~~

~~personal check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee.~~

(Source: Repealed at 38 Ill. Reg. 2301, effective December 31, 2013

Section 1230.120 Clear and Present Danger Reporting

a) Physicians, clinical psychologists and qualified examiners shall report determinations of a clear and present danger to the Department by making notification to the Department of Human Services in the form and manner prescribed at Section 6-103.3 of the Mental Health and Developmental Disabilities Code [405 ILCS 5].

b) Law enforcement officials and school administrators shall report determinations of a clear and present danger directly to the Department. The Department shall make a form and instruction for the reporting available to law enforcement officials and school administrators on its website.

1) Clear and present danger reporting shall be used by the Department to identify persons who pose an actual, impending, or imminent threat of substantial bodily harm to themselves or another person that is articulable and significant or who will be likely to act in a manner dangerous to public safety or contrary to the public interest if they were granted access to a weapon.

2) Clear and present danger reporting shall be made consistent with the Family Educational Rights and Privacy Act (20 USC 1232g) to assist the Department with protecting the health and safety of the public by denying persons who present a clear and present danger from having lawful access to weapons.

c) The Department shall make the final determination regarding whether a clear and present danger exists for purposes of revoking a FOID Card pursuant to Section 8(f) of the Act.

d) The Department shall maintain a record of those persons who are determined to present a clear and present danger for the purpose of denying or revoking a FOID Card pursuant to Section 8(f) of the Act but shall not maintain a record of those

persons who are not determined to present a clear and present danger for these purposes.

(Source: Added at 38 Ill. Reg. 2301, effective December 31, 2013

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

1) Heading of the Part: Firearm Concealed Carry Act Procedures

2) Code Citation: 20 Ill. Adm. Code 1231

3)

Section Numbers:	Proposed Action:
1231.10	New Section
1231.20	New Section
1231.30	New Section
1231.40	New Section
1231.50	New Section
1231.60	New Section
1231.70	New Section
1231.80	New Section
1231.90	New Section
1231.100	New Section
1231.110	New Section
1231.120	New Section
1231.130	New Section
1231.140	New Section
1231.150	New Section
1231.160	New Section
1231.170	New Section
1231.180	New Section
1231.APPENDIX A	New Section
1231.APPENDIX B	New Section
1231.APPENDIX C	New Section

4) Statutory Authority: Implements the Firearm Concealed Carry Act [430 ILCS 66] and authorized by Section 95 of that Act

5) Effective Date of Rules: December 31, 2013

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of these adopted rules, including any material incorporated by reference, is on file in the Agency's principal office and is available for public inspection.

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

9) Notice of Proposal published in the *Illinois Register*: 37 Ill. Reg. 15859; October 11, 2013

10) Has JCAR issued a Statement of Objection to these rules? No

11) Differences between Proposal and Final Version:

Added "SUBPART A: DEFINITIONS", "SUBPART B: INSTRUCTOR AND CURRICULUM", "SUBPART C: FIREARM CONCEALED CARRY LICENSURE", AND "SUBPART D: MISCELLANEOUS".

In Section 1231.10 Definitions, added "In addition to the definitions included in this Section, any additional definitions created in Section 5 of the Act apply."

In the definition of "All Applicable State and Federal Laws Relating to the Ownership, Storage, Carry and Transportation of Firearms Instruction", deleted "and the appropriate and lawful interaction with law enforcement while transporting or carrying a concealed firearm".

Added the definition "CCLRB" means the Concealed Carry Licensing Review Board."

Under the definition of "Four Basic Firearms Handling Safety Rules" added the sentence "For purposes of Section 75(e) of the Act, "hit the target" shall mean hit the scoring area of the B-27 Silhouette Target."

Added the definition of "Law Enforcement Official".

Added the definition of "United States Armed Forces".

Changed the definition "Valid" to "Valid Driver's License" or "Valid State Identification Card".

In Section 1231.20, added item (a) to read:

"a) Applicants for Concealed Carry Firearm Instructor (Instructor) approval shall meet the requirements of Section 80 of the Act and shall maintain:

1) A valid Firearms Owner's Identification (FOID) Card of, if an out-of-state resident, eligibility to obtain a FOID Card (see 20 Ill. Adm. Code 1230); and

2) After April 16, 2014, a valid FCCL, unless the applicant is not required to possess an FCCL to conceal and carry handguns in Illinois."

In Section 1231.20, changed item (a) to (b).

In Section 1231.20, changed item (b) to (c).

In Section 1231.20, changed former item (c) to (d), and added "Upon receipt of an incomplete Application, the Department shall notify the instructor applicant and advise what information is missing. If an instructor applicant has not provided the missing information in response to the Department's notification within 60 days after notice from the Department, the Application shall be denied."

In Section 1231.20, changed former item (d) to (e). Changed "apply for an Illinois Firearms Concealed Carry License" to "and, after April 16, 2014, hold an Illinois Firearms Concealed Carry License". Deleted "B) is eligible for and has applied for a FOID Card; or".

In Section 1231.20, added "f) Applicants must meet all of the requirements of Section 30 of the Act."

In Section 1231.20, changed item (e) to (g). Added the address:
"Illinois State Police
Concealed Carry Firearms Instructor Approval
P.O. Box 19333
Springfield, IL 62724"

In Section 1231.30, deleted item (a).

In Section 1231.30, changed item (b) to (a).

In Section 1231.30, changed item (c) to (b).

In Section 1231.30, added "c) The Department may, without providing prior notice, audit an Instructor's scheduled training for purposes of investigating allegations that an Instructor and/or curriculum is not in compliance with the Act and this Part. Complaints regarding Instructors may be made by calling the Illinois State Police Academy at (217) 786-0284."

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

In Section 1231.40(d), added "(see Appendix B)".

In Section 1231.40(d)(1)(D) and (d)(2)(A), added "and appropriate and lawful interaction with law enforcement while transporting or carrying a concealed firearm".

In Section 1231.50(a) and (c), added "(see Appendix C)".

Changed Section 1231.50(c)(1) to read "certify the number of hours the FCCL applicant successfully completed". Deleted "a 16 hour training course, an 8 hour training course, or a 3 hour renewal training course".

Changed Section 1231.50(3) from "provide the unique identification number assigned by the Department to the approved curriculum and the Instructor" to "identify which prior training credits the Instructor verified, as identified on the Department's Concealed Carry Firearm Training Certification form (see Appendix C)".

In Section 1231.60(c), added "no later than January 5, 2014. No later than July 1, 2014, the Department will provide an alternative to the web-based application process for Illinois residents who have limited or not access to the web-based application process."

In Section 1231.60(d), changed "State of Illinois" to "Department of Central Management Services (see 14 Ill. Adm. Code 105)".

In Section 1231.70(b), added "and LEADS information".

In Section 1231.70(b)(2), added "other than information obtained from LEADS".

In Section 1231.70(c), deleted "through the criminal history background check".

In Section 1231.80, added "b) Applicants disqualified pursuant to Section 25 of the Act shall not be referred to the Concealed Carry Licensing Review Board."

Changed Section 1231.80(b) to "c) If the applicant is subject to review pursuant to Section 20 of the Act, the Department will make the results of the applicant's State criminal history background check and federal out-of-state fingerprint-based criminal history background check, as well as any local law enforcement objections available to the Concealed Carry Licensing Review Board."

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

In Section 1231.80, changed (c) to (d).

In Section 1231.90, added "a) Applicants shall meet the requirements of Sections 25 and 30 of the Act, as well as Sections 4 and 8 of the FOID Act."

In Section 1231.90, changed (a) to "b) FCCL applicants who are Illinois residents must have a valid FOID Card. Illinois residents who have applied for a FOID card may apply for an FCCL before the FOID Card is issued. The Department will not approve the FCCL application until the applicant has been issued a FOID Card. If the FCCL applicant's FOID Card application is denied, the FCCL fee is not refundable (see Section 60(a) of the Act)."

Changed Section 1231.100(a) to read "The application shall include the information required in Sections 25 and 30 of the Act, as well as the information required in Sections 4 and 8 of the FOID Act. The application shall also include the FCCL applicant's citizenship, race, gender, phone number, e-mail address (if available) and state of residence. For Illinois residents, the application shall include the FCCL applicant's driver's license or identification card number and its expiration date."

In Section 1231.100(b), added "(e.g., training certificates; official documentation from the employing agency demonstrating that the applicant is an active law enforcement or corrections officer, has completed required firearms training, and is authorized to carry a firearm; official documentation from the Department approving the Concealed Carry Firearm Instructor's application that includes the Instructor Number; official documentation from the Illinois Law Enforcement Training and Standards Board; printouts from the Illinois Department of Financial and Professional Regulations' "License Look-up" that includes the licensee's name, license number and license status; etc.) with the training requirements of Section 75 of the Act."

In Section 1231.100, added items (d), (e), (f), and (g).

In Section 1231.110(e), added "(see 430 ILCS 65/8(i-5) and 20 Ill. Adm. Code 1231.20(g))".

In Section 1231.120(c), added "by Section 30(b)(8) of the Act".

In Section 1231.130, added item (d).

In Section 1231.140(a), added "required by Section 60 of the Act".

In Section 1231.140(b), added "which is linked to the electronic FCCL application on the DSP website".

In Section 1231.140, added items (c) and (d).

In Section 1231.150(a), added "is provided in Appendix A and is".

In Section 1231.150, added item (d).

Added new Section 1231.160 FCCL Suspension, Revocation and Invalidation per agreement with JCAR, in order to provide procedures for the handling of suspended, revoked and invalidated FCCLs.

Added new Section 1231.170 Appeals per agreement with JCAR, in order to provide procedures for individuals to appeal the denial, suspension, or revocation of his or her FCCL.

Changed Section 1231.160 Law Enforcement Fingerprinting Registration to Section 1231.180.

In Section 1231.180(c), added "as being compatible with the Department's systems (see 68 Ill. Adm. Code 1240)".

Added Section 1231.Appendix A Prohibited Area Posting, per agreement with JCAR.

Added Section 1231. Appendix B Prior Training Credit, per agreement with JCAR.

Added Section 1231.Appendix C Concealed Carry Firearm Training Certification Form, per agreement with JCAR.

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 rule currently in effect? Yes, 37 Ill. Reg. 15146; August 30, 2013

14) Are there any rulemakings pending on this Part? No

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

15) Summary and Purpose of Rules: The proposed rule will provide procedures for implementing the Firearm Concealed Carry Act, including instructor and curriculum approval, concealed carry licensure, and law enforcement fingerprinting registration.

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

Suzanne L. Y. Bond
Chief Legal Counsel
Illinois State Police
801 South 7th Street, Suite 1000-S
Springfield, Illinois 62703

217/782-7658

or

Lisa Freitag
Rules Coordinator
Illinois State Police
801 South 7th Street, Suite 1000-S
Springfield, Illinois 62703

217/782-9356

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

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

TITLE 20: CORRECTIONS, CRIMINAL JUSTICE, AND LAW ENFORCEMENT
CHAPTER II: DEPARTMENT OF STATE POLICE

PART 1231
FIREARM CONCEALED CARRY ACT PROCEDURES

SUBPART A: DEFINITIONS

Section
1231.10 Definitions

SUBPART B: INSTRUCTOR AND CURRICULUM APPROVAL

1231.20 Instructor Approval
1231.30 Instructor Approval Revocation
1231.40 Curriculum Approval
1231.50 Training Certification

SUBPART C: FIREARM CONCEALED CARRY LICENSURE

1231.60 Issuance of License
1231.70 Objections
1231.80 Review Board
1231.90 Qualifications for License
1231.100 Application
1231.110 Non-Resident Application
1231.120 Renewal
1231.130 Change Requests
1231.140 Fees
1231.150 Prohibited Areas
1231.160 FCCL Suspension, Revocation and Invalidation
1231.170 Appeals

SUBPART D: MISCELLANEOUS

1231.180 Law Enforcement Fingerprinting Registration

1231.APPENDIX A Prohibited Area Posting
1231.APPENDIX B Prior Training Credit

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

1231.APPENDIX C Concealed Carry Firearm Training Certification Form

AUTHORITY: Implements the Firearm Concealed Carry Act [430 ILCS 66] and authorized by Section 95 of that Act.

SOURCE: Adopted at 38 Ill. Reg. 2322, effective December 31, 2013.

SUBPART A: DEFINITIONS

Section 1231.10 Definitions

In addition to the definitions included in this Section, any additional definitions created in Section 5 of the Act apply.

"Act" means the Firearms Concealed Carry Act [430 ILCS 66].

"All Applicable State and Federal Laws Relating to the Ownership, Storage, Carry and Transportation of Firearms Instruction" means, at a minimum, instruction on the Act in its entirety, with emphasis on Sections 10(h) and 65 of the Act; the Firearm Owner Identification Card Act [430 ILCS 65]; relevant portions of the Criminal Code of 2012, including but not limited to, use of force in defense of a person [720 ILCS 5/7-1], use of force in defense of dwelling [720 ILCS 5/7-2], use of force in defense of other property [720 ILCS 5/7-3], and unlawful use of a weapon [720 ILCS 5/Art. 24].

"Application Verification Document" means the documents electronically generated by the Department upon submission of a completed Firearms Instructor Approval Application, which authorizes the Department to verify the answers given and confirm the validity of the information provided.

"B-27 Silhouette Target" means any target that complies with the National Rifle Association of America B-27 50 Yard Target Specifications.

"Basic Principles of Marksmanship Instruction" means, at a minimum, instruction on stance, grip, sight alignment, sight picture and trigger control.

"Care, Cleaning, Loading and Unloading of a Concealable Firearm Instruction" means, at a minimum, instruction on gun identification, ammunition identification

and selection, safety and cleaning protocols, cleaning equipment, and firearms loading and unloading.

"CCLRB" means the Concealed Carry Licensing Review Board.

"Department" means the Illinois Department of State Police.

"FCCL" means Firearms Concealed Carry License issued pursuant to the Act.

"Firearms Safety Instruction" means, at a minimum, instruction on the four basic firearms handling safety rules, home storage, vehicle storage and public storage.

"FOID Act" means the Firearm Owner's Identification Card Act [430 ILCS 65].

"Four Basic Firearms Handling Safety Rules" means:

Keep the firearm pointed in a safe direction and never at anything the shooter is not willing to destroy;

Keep finger off the trigger until the sights are aligned on target and the shooter is ready to shoot and do not press on the trigger unless the shooter intends to fire;

Treat all guns as though they are always loaded; and

Know the target and what lies beyond the target.

For purposes of Section 75(e) of the Act, "hit the target" shall mean hit the scoring area of the B-27 Silhouette Target.

"Illinois Resident" means a person who qualifies for an Illinois driver's license, other than a Temporary Visitor's Driver's License (TVDL), or an Illinois State identification card due to his or her establishment of a primary domicile in Illinois.

"In Person" means during a live, face-to-face interaction and not via video conference, webinar or any other electronic media, except that pre-recorded materials may be used by an instructor during a live presentation.

"Law Enforcement Official" means an employee of a government agency who:

is authorized by law to engage in or supervise the prevention, detection, investigation, prosecution or incarceration of any person for any violation of law;

has statutory powers of arrest or custodial detention;

is authorized by the agency to carry a firearm while on duty;

is not the subject of any disciplinary action by the employing agency that could result in termination;

meets the standards established by the agency that require the employee to regularly qualify in the use of a firearm; and

is not prohibited by federal law from possessing a firearm.

"LEADS" means the Illinois Law Enforcement Agencies Data System maintained by the Department. It is a statewide, computerized telecommunications system designed to provide services, information and capabilities to the Illinois law enforcement and criminal justice community.

"NICS" means the National Instant Criminal Background Check System maintained by the Federal Bureau of Investigation.

"NLETS" means the National Law Enforcement Telecommunications System.

"Public Storage" means storage at publicly-owned location, for example in a storage locker provided by a public or government facility, which may or may not have its own storage rules or protocols.

"Substantially Similar" means the comparable state regulates who may carry firearms, concealed or otherwise, in public; prohibits all who have involuntary mental health admissions, and those with voluntary admissions within the past 5 years, from carrying firearms, concealed or otherwise, in public; reports denied persons to NICS; and participates in reporting persons authorized to carry firearms, concealed or otherwise, in public through NLETs.

"United States Armed Forces" shall, for purposes of Section 75 of the Act, include all branches of the U.S. Military (Army, Air Force, Coast Guard, Marine Corps and Navy), as well as the Federal Reserve Components (Army, Navy, Air Force, Marine Corps and Coast Guard) and National Guard (Army and Air).

"Valid Driver's License" or "Valid State Identification Card" means current and not suspended, revoked, expired, cancelled, invalidated, denied or disqualified. It does not include a temporary visitor's driver's license (TVDL).

"Valid Firearms Instructor Certification" means certification as:

a Law Enforcement Firearms Instructor; or

a Firearms Instructor qualified to teach either handgun safety or a handgun training course that requires in-person classroom or lecture sessions totaling at least 3 hours and a live handgun firing component that was issued by:

a law enforcement entity;

a State or federal government entity (e.g., Military, Coast Guard, etc.);

the Illinois Law Enforcement Training Standards Board;

the National Rifle Association of America (NRA); or

any other entity recognized by at least 3 state or federal government agencies-as being qualified to provide education and training in the safe and proper use of firearms that maintains a program or process to certify instructors.

"Weapons Handling Instruction" means, at a minimum:

handgun fundamentals;

handgun concealment;

live fire qualification instruction; and

live fire qualification with a concealable firearm using a B-27 silhouette target consisting of a minimum of 30 rounds and 10 rounds from a distance of 5 yards, 10 rounds from a distance of 7 yards and 10 rounds from a distance of 10 yards.

"Within a Vehicle" means within the passenger compartment of a passenger or recreational vehicle or within a lockable container secured to a motorcycle.

SUBPART B: INSTRUCTOR AND CURRICULUM APPROVAL

Section 1231.20 Instructor Approval

a) Applicants for Concealed Carry Firearm Instructor (Instructor) approval shall meet the requirements of Section 80 of the Act and shall maintain:

1) A valid Firearm Owner's Identification (FOID) Card or, if an out-of-state resident, eligibility to obtain a FOID Card (see 20 Ill. Adm. Code 1230); and

2) After April 16, 2014, a valid FCCL, unless the applicant is not required to possess an FCCL to conceal and carry handguns in Illinois.

b) Application to be a Concealed Carry Firearms Instructor shall be made by first submitting a full set of fingerprints to the Department in an electronic format using a Live Scan Vendor licensed by the Department of Financial and Professional Regulation or a law enforcement agency registered by the Department. Manual fingerprints will not be accepted.

c) Upon receiving a Live Scan Fingerprint Transaction Control Number (TCN) from the Licensed Live Scan Vendor or law enforcement agency registered by the Department, the applicant shall electronically complete and submit the Department's Concealed Carry Firearms Instructor Approval Application (Application), available on the Department's website @ccl4illinois.com.

d) The Application must be complete and accurate. Incomplete Applications will not be accepted or processed. Upon receipt of an incomplete Application, the Department shall notify the instructor applicant and advise what information is missing. If an instructor applicant has not provided the missing information in

response to the Department's notification within 60 days after notice from the Department, the Application shall be denied.

e) Applicants must have read the Act in its entirety, understand the rules and requirements of this Part, and, after April 16, 2014, hold an Illinois Firearms Concealed Carry License, unless the applicant is not required to possess an FCCL to conceal and carry handguns in Illinois, and:

1) If the applicant is an Illinois resident, possess a valid FOID Card.

2) If not an Illinois resident, be eligible to obtain a valid FOID Card if the applicant were an Illinois resident.

f) Applicants must meet all of the requirements of Section 30 of the Act.

g) Upon completing and submitting the Application electronically, the applicant must print the Application Verification Document, sign it, have it notarized, attach the required Valid Firearms Instructor Certifications, and submit the Certification documents to:

Illinois State Police
Concealed Carry Firearms Instructor Approval
P.O. Box 19333
Springfield IL 62724

Section 1231.30 Instructor Approval Revocation

a) Revocation or expiration of either the FOID Card or FCCL shall result in the immediate revocation of the Instructor's approval.

b) The Department may revoke an Instructor's approval upon receiving substantiated information that the Instructor is not teaching the curriculum in a manner consistent with Section 75 of the Act.

c) The Department may, without providing prior notice, audit an Instructor's scheduled training for purposes of investigating allegations that an Instructor and/or curriculum is not in compliance with the Act and this Part. Complaints regarding Instructors may be made by calling the Illinois State Police Academy at (217)786-0284.

d) Upon revocation of an Instructor's approval, the Instructor's name and information shall be removed from the registry of approved Instructors maintained by the Department and available on its website.

e) Once an Instructor's approval is revoked and the Department issues a letter of revocation to the Instructor, the Instructor may appeal the revocation to the Director of the Department and present evidence that the factors resulting in the revocation have been resolved. If the Director determines that the revocation of approval was not warranted, or that the issues that resulted in revocation have been remedied, the Instructor's approval shall be reinstated, the Instructor shall be notified and the name of the Instructor shall be restored to the registry of approved Instructors.

Section 1231.40 Curriculum Approval

a) Application for curriculum approval shall be made by completing and submitting a Request for Approval of a Concealed Carry License Firearms Curriculum form, which is available on the Department's website.

b) The application must be complete, accurate, signed, and notarized. If the application is not completed properly, it will be returned to the applicant and will not be processed.

c) The applicant shall verify that the proposed curriculum meets the requirements set forth in the Act and that the course will be taught in person, as described in this Section.

d) Training necessary for issuance of the FCCL shall consist of 16 hours of classroom and firearm training. Pursuant to Section 75(g), (h) and (i) of the Act, fewer hours of training, or no additional training, will be acceptable in certain instances (see Appendix B) indicating prior firearms training.

1) A 16 hour training course must, at a minimum, cover the following topics:

A) Firearms Safety − a minimum of 1 hour;

B) Basic Principles of Marksmanship − a minimum of 1 hour;

C) Care, Cleaning, Loading and Unloading of a Concealable Firearm − a minimum of 1 hour;

D) All Applicable State and Federal Laws Relating to the Ownership, Storage, Carry and Transportation of a Firearm and appropriate and lawful interaction with law enforcement while transporting or carrying a concealed firearm − a minimum of 2 hours; and

E) Weapons Handling − a minimum of 1 hour.

2) An 8 hour training course must, at a minimum, cover the following topics:

A) All Applicable State and Federal Laws Relating to the Ownership, Storage, Carry and Transportation of a Firearm and appropriate and lawful interaction with law enforcement while transporting or carrying a concealed firearm − a minimum of 2 hours; and

B) Weapons Handling − a minimum of 1 hour.

3) For the topics to be included in the 16 hour and 8 hour training courses, the minimum hours established in this subsection (d) have been determined to be sufficient for the experienced shooter and shall be adjusted upward by the approved instructor based upon the skill level of those to be trained to ensure proficiency by all upon the completion of the required training component.

e) A 3 hour licensure renewal course must, at a minimum, cover the following topics:

1) Two hours to cover:

A) any updates to Illinois or federal firearms laws governing concealed carry in Illinois;

B) updates in the Criminal Code Sections listed in Section 1231.10; and

C) appropriate and lawful interaction with law enforcement while transporting or carrying a concealed firearm; and

2) One hour of instruction to include a live fire qualification with a concealable firearm using a B-27 silhouette target consisting of a minimum of 30 rounds and 10 rounds from a distance of 5 yards, 10 rounds from a distance of 7 yards and 10 rounds from a distance of 10 yards.

f) The Department may request a complete course outline and instructional notes or any additional course related information from the applicant. If the applicant refuses the request, the application will be deemed incomplete and returned to the applicant.

g) Once approved by the Department, the curriculum may only be taught by an Instructor approved by the Department under Section 1231.20 who is listed on the registry of approved Instructors.

h) Upon receiving substantiated information that a curriculum is not consistent with Section 75 of the Act, the Department may remove that curriculum from the list of approved curriculums maintained on the Department's website.

i) Once a curriculum is removed from the list of approved curricula, the decision to remove the curriculum from the list may be appealed to the Director of the Department and evidence must be presented that the factors resulting in the revocation have been resolved. If the Director determines that the removal of the curriculum from the list was not warranted, or that the issues that resulted in that removal have been remediated, the curriculum approval shall be reinstated to the list.

Section 1231.50 Training Certification

a) Approved Instructors shall complete for FCCL applicants the Department's Concealed Carry Firearms Training Certification form (see Appendix C), which is available on the Department's website.

b) The Certification form shall only be completed for those applicants who the Instructor trained in person for whom the Instructor can verify:

1) successful completion of the appropriate Department approved curriculum; or

2) that the applicant has already successfully completed training through a Department approved curriculum.

c) On the Certification form (see Appendix C), the Instructor shall:

1) certify the number of hours the FCCL applicant successfully completed; and

2) provide the unique identification number assigned by the Department to the approved curriculum and the Instructor.

d) For those applicants who provided proof of up to 8 hours of training already completed toward the 16 hours training, the Instructor shall:

1) verify the aggregate number of hours for which the applicant provided proof of instruction in Firearms Safety, Basic Principles of Marksmanship, and Care, Cleaning, Loading and Unloading of a Concealable Firearm, based upon a list provided by the Department of accepted training courses, and provide the necessary additional hours of training to equal 16 hours total;

2) certify whether the applicant successfully completed the 8 hours training required by Section 1231.40; and

3) identify which prior training credits the Instructor verified, as identified on the Department's Concealed Carry Firearm Training Certification form (see Appendix C).

e) The Instructor may certify up to 8 hours of prior training, consistent with Section 75 of the Act. The prior training may be substituted for no more than the following number of hours in any of the topics required by Section 1231.40(d)(2):

1) Firearms Safety − a maximum of 2 classroom hours;

2) Basic Principles of Marksmanship − a maximum of 3 classroom and range hours; and

3) Care, Cleaning, Loading and Unloading of a Concealable Firearm − a maximum of 3 classroom and range hours.

SUBPART C: FIREARM CONCEALED CARRY LICENSURE

Section 1231.60 Issuance of License

a) An FCCL shall expire 5 years after the date of issuance.

b) The Department shall, at least 60 days prior to the expiration of an FCCL, forward to the last known address of each person whose FCCL is to expire a notification of the expiration.

c) The Department shall make applications available via its website no later than January 5, 2014. No later than July 1, 2014, the Department will provide an alternative to the web-based application process for Illinois residents who have limited or no access to the web-based application process.

d) FCCL applicants must obtain a digital signature through the Department of Central Management Services (see 14 Ill. Adm. Code 105) before applying for an FCCL. The Department will provide a link to the digital signature application through its website.

e) Applicants submitting fingerprints shall do so electronically by submitting a full set of fingerprints to the Department in an electronic format using a Live Scan vendor licensed by the Department of Financial and Professional Regulation or a law enforcement agency registered by the Department. Manual fingerprints will not be accepted.

f) Upon receiving a Live Scan Fingerprint Transaction Control Number (TCN) from the licensed Live Scan vendor or law enforcement agency, the applicant shall electronically complete and submit the FCCL to the Department.

g) The TCN for FCCL applicants will have a unique purpose code for the FCCL application process. Concealed Carry Firearm Instructors may use the TCN previously obtained for the instructor application process. No other previously obtained TCNs may be used as they will not have the appropriate purpose code.

h) The database of FCCL applicants maintained by the Department pursuant to Section 10(i) of Act shall be exempt from FOIA pursuant to FOIA Section 7.5(v) [5 ILCS 140/7.5(v)].

1) Persons authorized to access the database shall register with the Department to obtain a unique password granting them secure access to the database.

2) The entity employing persons requesting access to the database shall appoint a person to act as the entity's point of contact and shall enter into an agreement with the Department defining the security protocols of the database and access to the database.

Section 1231.70 Objections

a) Criminal history background checks for all FCCL applicants will be conducted by the Department. Law enforcement officials who wish to raise an objection to an FCCL applicant shall not use LEADS to run background checks to determine FCCL eligibility.

b) Law enforcement officials may submit objections outside of the criminal history background check procedure via an electronic objection process available on the Department's website. Manual submissions and LEADS information will not be accepted.

1) Law enforcement officials submitting an objection shall provide a narrative outlining the detailed reason for the objection.

2) Law enforcement officials submitting an objection shall attach any available documentation, other than information obtained from LEADS, supporting their objection.

c) The Department may deny an application based upon a disqualifier identified pursuant to Section 25 of the Act; however, the local law enforcement official shall be permitted to submit objections for the duration of the objection period prescribed by Section 15 of the Act.

d) If, upon or after receiving an objection from a local law enforcement official, an FCCL applicant is disqualified through the criminal history background check

conducted under Section 25 of the Act, the Department will maintain a record of those objections. The objections will not be forwarded to the Concealed Carry Licensing Review Board for further consideration.

Section 1231.80 Review Board

a) The Concealed Carry Licensing Review Board is part of the criminal justice process responsible for reviewing an FCCL applicant's criminal history record and eligibility.

b) Applicants disqualified pursuant to Section 25 of the Act shall not be referred to the Concealed Carry Licensing Review Board.

c) If the applicant is subject to review pursuant to Section 20 of the Act, the Department will make the results of the applicant's State criminal history background check and federal and out-of-state fingerprint-based criminal history background check, as well as any local law enforcement objections, available to the Concealed Carry Licensing Review Board.

d) The Concealed Carry Licensing Review Board shall provide the Department with its final decision on each applicant in an electronic report authored by the Chairperson of the Board.

Section 1231.90 Qualifications for a License

a) Applicants shall meet the requirements of Sections 25 and 30 of the Act, as well as Sections 4 and 8 of the FOID Act.

b) FCCL applicants who are Illinois residents must have a valid FOID Card. Illinois residents who have applied for a FOID Card may apply for an FCCL before the FOID Card is issued. The Department will not approve the FCCL application until the applicant has been issued a FOID Card. If the FCCL applicant's FOID Card application is denied, the FCCL fee is not refundable (see Section 60(a) of the Act).

c) The Department shall deny the FCCL application for any FCCL applicant who is prohibited under State or federal law from possessing or receiving a firearm.

Section 1231.100 Application

a) The application shall include the information required in Sections 25 and 30 of the Act, as well as the information required in Sections 4 and 8 of the FOID Act. The application shall also include the FCCL applicant's citizenship, race, gender, phone number, e-mail address (if available) and state of residence. For Illinois residents, the application shall include the FCCL applicant's driver's license or identification card number and its expiration date.

b) As part of the application process and pursuant to Section 30(b)(10) of the Act, FCCL applicants must electronically upload proof of compliance (e.g., training certificates; official documentation from the employing agency demonstrating that the applicant is an active law enforcement or corrections officer, has completed required firearms training, and is authorized to carry a firearm; official documentation from the Department approving the Concealed Carry Firearm Instructor's application that includes the Instructor Number; official documentation from the Illinois Law Enforcement Training and Standards Board; printouts from the Illinois Department of Financial and Professional Regulations' "License Look-up" that includes the licensee's name, license number and license status; etc.) with the training requirements of Section 75 of the Act. For every certificate submitted, FCCL applicants must include the Instructor's name and contact number and the name of the approved curriculum, as well as the unique identification numbers assigned by the Department to the instructor and the curriculum.

c) All documentation required pursuant to Section 30 of the Act shall be submitted to the Department electronically by uploading it as an attachment to the FCCL application.

d) FCCL applicants shall select whether they prefer to receive Department notification via e-mail or written notification. If selecting e-mail notifications, applicants shall provide a current e-mail address to the Department as part of the application process and are responsible for checking the e-mail address provided for correspondence from the Department regarding the application.

e) If any of the FCCL applicant's contact information changes, including but not limited to his or her e-mail address, the FCCL applicant shall amend his or her application to notify the Department of the corrected contact information.

f) Upon receipt of an incomplete application, the Department shall notify the FCCL applicant and advise the applicant as to what information is missing. The application shall not be deemed complete and the provisions of Section 10(e) of the Act shall not apply until the FCCL applicant provides a complete application including the requested missing information.

g) If an FCCL applicant has not provided the missing information in response to the Department's notification within 60 days after notice from the Department, the application shall be denied.

Section 1231.110 Non-Resident Application

a) Pursuant to Section 40(b) of the Act, non-resident FCCL applications will only be accepted from persons licensed or permitted to carry firearms, concealed or otherwise, in public, in a substantially similar state.

b) The Department shall post on its website a list of all states determined to be substantially similar.

c) The Department shall determine which states are substantially similar, as defined in Section 1231.10, to Illinois in their manner of regulating concealed carry of firearms by surveying all other states.

d) Non-resident FCCL applicants shall obtain a non-resident eligibility affidavit from the Department's website.

1) The affidavit must be completed and notarized by all non-resident FCCL applicants.

2) A copy of the affidavit must be submitted as an electronic attachment to the non-resident's FCCL application through the on-line application process.

3) The original affidavit with notary stamp must be retained by the non-resident FCCL applicant and provided to the Department upon request.

e) FCCL applicants applying under the non-immigrant visa exception to the FOID Act (see 430 ILCS 65/8(i-5) and 20 Ill. Adm. Code 1231.20(g)) shall provide a letter from their foreign government stating the purpose for travel to Illinois, the

date the applicant's non-immigrant visa expires, and the need for the FOID Card, or a waiver from this provision granted by the U.S. Attorney General.

f) All documentation required by Section 40(c) and (d) of the Act shall be submitted to the Department electronically by uploading it as an attachment to the non-resident's FCCL application.

Section 1231.120 Renewal

a) All documentation required pursuant to Section 50 of the Act shall be submitted to the Department electronically by uploading it as an attachment to the FCCL renewal application.

b) FCCL renewal applicants may submit a full set of fingerprints to the Department in an electronic format using a Live Scan vendor licensed by the Department of Financial and Professional Regulation or a law enforcement agency registered by the Department if the renewal applicant did not do so at the time of his or her original FCCL application.

1) Renewal fingerprints must comply with the provisions set forth in Section 1231.60.

2) FCCL renewal applicants who submitted fingerprints at the time of their original FCCL application need not submit additional sets of fingerprints upon renewal.

c) The Department shall grant or deny an FCCL renewal application no later than 90 days after receipt of a completed application, except that the Department is granted by Section 30(b)(8) of the Act 30 days in addition to the 90 days if the applicant has not previously submitted a full set of fingerprints in electronic format.

Section 1231.130 Change Requests

The notification requirements of Section 55 of the Act shall be made by the licensee through an online process established by the Department and available on its website.

a) The notarized statements required shall be made available by the Department on its website.

b) Any required attachment or attachments shall be submitted to the Department electronically by uploading them as an attachment.

c) The original statements with notary stamp must be retained by the licensee and provided to the Department upon request.

d) Upon receipt of an incomplete change request, the Department shall notify the FCCL applicant and advise what information is missing. If an FCCL applicant has not provided the missing information in response to the Department's notification within 60 days after notice from the Department, the request shall be denied.

Section 1231.140 Fees

a) FCCL applicants shall pay the fee required by Section 60 of the Act, in full, when submitting their application.

b) All application fees shall be collected using the Illinois State Treasurer's E-Pay program, which is linked to the electronic FCCL application on the DSP website. A convenience fee will be charged in accordance with the Illinois State Treasurer's E-Pay program.

c) Application, renewal and replacement fees are non-refundable.

d) All fees collected for criminal history records checks required by Section 35 of the Act will be collected by the licensed Live Scan Vendors or local law enforcement agencies at the time of fingerprinting and transmitted to the Department for deposit in the State Police Services Fund. A convenience fee may be charged by the licensed Live Scan Vendors or local law enforcement agencies as provided by Section 31-5 of the Private Detective, Private Alarm, Private Security, Fingerprint Vendor, and Locksmith Act of 2004 [225 ILCS 447/31-5].

Section 1231.150 Prohibited Areas

Section 65 of the Act specifies areas where concealed carry of firearms is prohibited and requires posting of those areas.

a) A template for signs required pursuant to Section 65(d) of the Act is provided in Appendix A and is available on the Department's website.

b) Owners of prohibited areas may utilize signage larger in size than the template provided, at their discretion. If prohibited areas use a larger sign, the template provided shall be reproduced somewhere on the larger sign no smaller than the 4" x 6" dimension required by the Act.

c) Prohibited areas may include additional language on their signs. If prohibited areas include additional language, the template provided shall be reproduced somewhere on the larger sign no smaller than the 4" x 6" dimension required by the Act.

d) The required signs shall be clearly and conspicuously posted at the entrance of the building, premises or real property. The sign shall provide persons entering the property notice that they are entering a prohibited area in which, pursuant to the Act, they shall not carry a concealed firearm.

Section 1231.160 FCCL Suspension, Revocation and Invalidation

a) Section 70 of the Act specifies violations resulting in suspension, revocation or invalidation of an FCCL.

b) The Department will provide written notice to the licensee of a suspension, revocation or invalidation.

c) The license of a person in violation of Section 70(d) or (e) will be suspended for a period of 6 months upon conviction of the second violation and shall be permanently revoked for a third violation.

d) Surrender/Seizure of an FCCL

1) A person whose FCCL has been revoked or suspended shall surrender the FCCL to the local law enforcement agency where the person resides within 48 hours after receiving notice of the revocation or suspension.

2) If the licensee whose FCCL has been revoked or suspended fails to comply with the requirements of this subsection, the law enforcement

agency where the person resides may petition the circuit court to issue a warrant to search for and seize the FCCL.

3) The local law enforcement agency shall provide the licensee a receipt for the revoked or suspended FCCL and transmit the FCCL license to the Department of State Police, within 10 business days.

Section 1231.170 Appeals

a) Appeals to CCLRB
An individual whose application for an FCCL is denied or whose FCCL is suspended or revoked may petition the Department for relief unless the denial is based upon a determination of the CCLRB. A denial based upon a determination of the CCLRB may be appealed through petition to the circuit court in the county of the applicant's residence, pursuant to Section 87(a) of the Act.

b) Informal Relief Proceeding

1) Individuals who wish to request relief from the Department shall provide written notice to the Department within 60 days after receipt of the notice that their FCCL application is denied or their FCCL is revoked to begin the appeal process.

2) The petitioner must provide to the Department any reasonable documentation requested by the Department related to the determination for granting relief.

3) Upon receiving complete documentation for the appeal, the Department will investigate the circumstances surrounding the denial or revocation. If the Director is satisfied that substantial justice has not been done through the denial or revocation and that it is not likely that the applicant or any other party will be injured by the granting of the relief, the Director or his or her designee may grant relief.

4) The appeal process shall not begin until the Department has received all the necessary documentation.

5) In the event the Director or his or her designee desires additional information concerning the circumstances surrounding the denial or

revocation action, the Director may schedule a fact-finding conference with the petitioner or request additional information.

6) The Director or his or her designee may grant or deny relief as a result of the fact-finding conference.

7) In an informal relief proceeding, the petitioner may be represented by counsel or present witnesses who have direct knowledge of the circumstances of the denial or revocation and may present any evidence or information relating to the Department's action.

c) Formal Administrative Hearing

1) If the Director does not provide relief as a result of the investigation or a fact-finding conference, the petitioner may request a formal administrative hearing. The request for hearing must be in writing and sent to the DSP Firearms Services Bureau, Appeals Unit.

2) The administrative law judge (ALJ) for contested hearings shall be an attorney licensed to practice law in Illinois appointed by the Director. The ALJ may be disqualified for bias or conflict of interest.

3) The procedures for the hearing shall be as described in Article 10 of the Illinois Administrative Procedure Act [5 ILCS 100/Art. 10] and as ordered by the ALJ.

4) In the event relief is denied, a new application from the petitioner will not be accepted until two years have passed since the date of the last denial.

d) Administrative Review Law
All final administrative decisions of the Department or the CCLRB shall be subject to judicial review under the Administrative Review Law.

SUBPART D: MISCELLANEOUS

Section 1231.180 Law Enforcement Fingerprinting Registration

a) Law enforcement agencies that plan to submit to the Department Electronic Fingerprint Fee Applications (EFFA, the application submitted by a person being

electronically fingerprinted) for FCCL applicants shall sign a memorandum of understanding between the agency and the Department establishing the requirements of the applicable State statutes and federal laws for the submission of non-criminal justice fingerprint transactions to the Department or the Federal Bureau of Investigation (FBI).

b) Fingerprint images, a photograph of the individual being fingerprinted, and related alpha numeric identification data shall be submitted to the Department via electronic transmission utilizing Live Scan procedures and equipment approved by the Department. The photograph provision will be waived for applicants with a physical disability or ailment that could result in the taking of a photograph causing the applicant harm in any way.

c) A law enforcement agency's equipment and transmission of all types of transactions shall be certified by the Department as being compatible with the Department's systems (see 68 Ill. Adm. Code 1240).

d) All employees responsible for taking fingerprints for the purposes of the Act shall require each individual seeking to be fingerprinted to present primary or secondary identification in order to be fingerprinted by the agency.

1) Primary identification shall mean a valid driver's license or Secretary of State issued State identification card.

2) In the absence of a driver's license or State identification card, secondary identification shall mean the individual seeking to be fingerprinted shall provide at least two forms of identification within the Identity Verification Program Guide (2006) developed and available from the National Crime Prevention and Privacy Compact Council from the FBI website (http://www.fbi.gov/about-us/cjis/cc/current-initiatives/identity-verification-program-guide).

e) All FCCL applicants who submit an EFFA shall be required to sign a consent form prior to fingerprinting. The privacy statement within the consent form shall be approved by the Department.

f) Agencies must maintain a record of all documentation and non-criminal justice transactions submitted to the Department for the purpose of auditing by the Department or the FBI and make its records available for that auditing.

g) All employees responsible for taking fingerprints for non-criminal justice purposes shall successfully complete a fingerprint training course conducted or authorized by the Department.

h) Agencies will be required to establish a fiscal account with the Department of State Police-Bureau of Identification for the purpose of facilitating the payment of State and FBI background checks. The agencies will be invoiced monthly for all submissions received by the agency the prior month. The Department will not accept individual payments from the persons printed.

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

Section 1231.Appendix A Prohibited Area Posting

Pursuant to Section 65(d) of the Act, signs must be of a uniform design. The Department has adopted the following sign format. The background is white, with no text, other than the reference to 403 ILCS 66/65, and no other marking within the one-inch area surrounding the graphic design. The graphic design is a handgun in black ink surrounded by a red circle with a diagonal slash across the handgun. The circle shall be 4 inches in diameter. The black rectangle surrounding the image must measure 4 inches tall by 6 inches wide.

The image is available on the DSP website for download.

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

Section 1231.Appendix B Prior Training Credit

a) Section 75(g) and (i) of the Act provides that prior handgun training can be substituted for a portion of the training required for an FCCL. The following is a list of training courses that qualify for prior training credit and the amount of credit awarded for each.

b) It is the responsibility of the Instructor to verify successful completion of prior training and apply credit as listed. Once this credit is combined with additional training hours provided by the Instructor, the Instructor will certify that the 16 hour training requirement was met.

c) Instructors should inform applicants how much credit they will receive for their prior training and remind them the prior training certificates must be submitted with the FCCL Training Certificate (see Appendix C) when they apply.

d) The following are courses for which prior training credit can be awarded. This list will be updated as additional courses are submitted and approved by the Department.

Course Title	Acceptable Credit
Illinois Hunter Safety Course	4 hours
Utah Concealed Carry	4 hours
Florida Concealed Carry	4 hours
Nevada Concealed Carry	4 hours
Missouri Concealed Carry	4 hours
Kentucky Concealed Carry	4 hours
Michigan Concealed Carry	4 hours
Chicago Firearms Safety Course	4 hours
NRA Basic Pistol	8 hours
NRA Personal Protection in the Home	8 hours
NRA Personal Protection Outside the Home	8 hours
Active, Retired or Honorably Discharged member of the United States Armed Forces	8 hours
Prior Law Enforcement or Corrections Officer Training (see Section 75(j) of the Act)	8 hours

e) Section 75(g) of the Act requires that any hours remaining after the credit has

been granted must at least cover the classroom subject matter and range qualifications listed in Section 1231.40(d) and (e)(2).

f) To submit training for recognition by the Department, mail the following items to Illinois State Police, FCCL Prior Credit, Post Office Box 19333, Springfield IL 62794:

1) Basic course outline of the training submitted; and

2) A letter from another state indicating it recognizes the course.

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

Section 1231.Appendix C Concealed Carry Firearm Training Certification Form

Illinois State Police

CONCEALED CARRY FIREARM TRAINING CERTIFICATE

I, _____ certify that _____ has successfully completed training for
(Instructor Name Printed) (Applicant Name – First, Middle, Last)

an Illinois Concealed Carry Firearms License on _____ pursuant to the Illinois Firearm Concealed Carry Act (the Act).
(Date)

☐ I provided ____ hours of training required by Section 75(b) and (c) of the Act. ☐
(CURRICULUM ID#: CCC)

☐ I verified _____ hours of prior training and provided the additional required training to be counted towards the 16 hour requirement pursuant to Section 75(g) of the Act.
The Applicant provided documentation of the following courses for prior training credit. (CHECK ALL THAT APPLY)

- ○ Illinois Hunter Safety Course .....
- ○ Utah Concealed Carry .....
- ○ Florida Concealed Carry.....
- ○ Nevada Concealed Carry .....
- ○ Missouri Concealed Carry .....
- ○ Kentucky Concealed Carry .....
- ○ Michigan Concealed Carry .....
- ○ Chicago Firearms Safety Course .....
- ○ NRA Basic Pistol ..... 8 hours
- ○ NRA Personal Protection in the Home ..... 8 hours
- ○ NRA Personal Protection Outside the Home ..... 8 hours
- ○ Active, Retired or Honorably Discharged member of the US Armed Forces..... 8 hours
- ○ Previously qualified law enforcement or corrections officer (see 430 ILCS 75(j)) .....8 hours

I hereby certify that the above applicant has demonstrated a total of 16 hours of approved training curriculum as required by Section 75(b) and (c) of the Act.

INSTRUCTOR ID NUMBER: CCT

INSTRUCTOR BUSINESS NAME: _____

INSTRUCTOR SIGNATURE: _____

DEPARTMENT OF STATE POLICE

NOTICE OF ADOPTED RULES

APPLICANT SIGNATURE: _____

12/20/13

DEPARTMENT ON AGING

NOTICE OF EMERGENCY AMENDMENTS

1) Heading of the Part: Adult Protection and Advocacy Services

2) Code Citation: 89 Ill. Adm. Code 270

3)

Section Numbers:	Emergency Action:
270.10	Amend
270.200	Amend
270.205	Amend
270.210	Amend
270.215	Amend
270.220	Amend
270.225	Amend
270.230	Amend
270.235	Amend
270.240	Amend
270.241	New
270.245	Amend
270.250	Amend
270.255	Amend
270.260	Amend
270.265	Amend
270.270	Amend
270.275	Amend
270.280	Amend
270.285	Amend
270.290	Amend
270.295	Amend
270.300	Amend

4) Statutory Authority: Implementing Section 4.04(c) of the Illinois Act on the Aging [20 ILCS 105/4.04(c)] and Section 10 of the Adult Protective Services Act [320 ILCS 20/10] and authorized by Section 4.01(11) of the Illinois Act on the Aging [20 ILCS 105/4.01(11)]

5) Effective Date of Emergency Rulemaking: December 31, 2013

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 is not set to expire before the end of the 150-day period.

DEPARTMENT ON AGING

NOTICE OF EMERGENCY AMENDMENTS

7) Date filed with the Index Department: December 31, 2013

8) A copy of the emergency amendments, including any material incorporated by reference, is on file in the Agency's principal office and is available for public inspection.

9) Reason for Emergency: The State of Illinois has an obligation to protect its most vulnerable citizens from abuse, neglect and exploitation. The Department deems the adoption of this emergency rulemaking necessary to protect the public interest, safety and welfare of this population. These amendments are being filed to make necessary updates for the expansion and transfer of authority to the Department for investigating allegations of abuse against adults with disabilities aged 18-59 living in domestic settings previously handled by the Office of the Inspector General for the Department of Human Services as a result of Public Act 98-49. Doing so will also help build a more integrated adult protection and advocacy system for outreach, intake, early intervention, and investigatory services at the local level and thereby improve responsiveness to reported incidents.

10) A Complete Description of the Subjects and Issues Involved:

Table of Contents: Changes the name of Part 270 and the headers for Subparts C and D to reflect the name of the new enabling Act. Updates Section headings to correspond with revisions in accompanying text.

Section 270.10: Updates terminology. Adds language to explain the purpose for the various programs comprising Adult Protection and Advocacy Services and the populations being served by the Department and its provider agencies.

Section 270.200: Updates Section heading and terminology. Adds language summarizing the principles upon which the Adult Protective Services Program is modeled in Illinois.

Section 270.205: Updates Section heading and terminology. Adds "fatality review teams" to the listing of services and activities of the Adult Protective Services Program.

Section 270.210: Updates terminology. Adds definitions for the following terms: "Abuse Fatality Review Team", "Adult Protective Services Hotline", "Adult Protective Services Provider Agency", "Adult with disabilities", "APS", "Capacity to Consent", "Case worker", "Disability", "Early Intervention Services", "Emergency", "Initial interview", "Report taker", "Self-determination", "Self-neglect", "Services", and

"Suspicious death". Revises definition of other terms as follows: (1) by updating the name of the enabling Act under "Act"; (2) by eliminating an obsolete reference to board and care homes, updating an internal cross-reference to the IO/DD Community Care Act, and adding exclusions for facilities licensed under the Specialized Mental Health Rehabilitation Act and the Community Residential Alternative Act under "Domestic living situation"; (3) by adding language that describes the expanded jurisdiction of the Department to investigate allegations of abuse against adults with disabilities aged 18-58 living in domestic settings for "Alleged abuser", "Alleged victim" and "Eligible adult"; (4) by clarifying the referral function and adding "self-neglect" to listing of types of reports handled under "Intake"; (5) by adding an employee of an entity providing developmental disabilities services or service coordination funded by the Department of Human Services and updating the internal cross-references to the listing of other licensed occupations under "Mandated reporter"; and (6) by adding "self-neglect" to the types of reports under "Substantiated case". Eliminates obsolete definitions.

Section 270.215: Updates terminology. Adds a clarification that the Adult Protective Services Program is contingent upon adequate funding. Explains the transition process for the contract termination of a regional administrative agency.

Section 270.220: Updates terminology. Specifies that the Department may designate an Area Agency on Aging to serve as a regional administrative agency or hold a competitive procurement. Explains the procurement and contracting processes for a regional administrative agency. Sets forth public awareness and education role of regional administrative agencies and lists information that must be included in producing related material. Clarifies that a regional administrative agency shall not serve as a legal guardian, an agency under the Illinois Power of Attorney Act, or a representative payee for any client in the program. Allow a waiver of this prohibition by the Department when there is documented evidence that no other qualified person or entity can serve in such capacity and the regional administrative agency is willing and qualified to take on such responsibilities. States record retention responsibilities for a regional administrative agency.

Section 270.225: Updates Section heading and terminology. Specifies the work days, closures, and staffing availability for APS provider agencies. Sets forth public awareness and education role of APS provider agencies and lists information that must be included in producing related material. Clarifies that APS provider agencies shall not serve as a legal guardian, an agency under the Illinois Power of Attorney Act. States record retention responsibilities for a regional administrative agency. Directs that APS supervisors must be involved in guiding and directing ANE case and share responsibility

in the case worker's decisions and actions. Lists the qualifications for APS supervisors and APS case workers. Clarifies that the Department may suspend or remove any case worker or supervisor who fails or refuses to properly perform duties from the APS Case Worker Registry. Directs the APS provide agency to return to the Department the identification card of a case worker or supervisor who separates from employment.

Section 270.230: Updates Section heading and terminology. Explains new standard regarding mandated reporting requirement, which occurs when an eligible adult is unable to seek assistance because of a disability or other condition or impairment. Eliminates obsolete references to board and care homes. Clarifies that the identity of a person making a report of alleged or suspected abuse is confidential unless disclosure is consented to in writing or required by court order.

Section 270.235: Updates terminology. Re-arranges paragraph order to improve readability. Eliminates redundant provisions.

Section 270.240: Updates Section heading and terminology. Revises the list of agencies and hotlines that are authorized to receive ANE reports. Specifies staffing requirements for APS provider agencies.

Section 270.241: Adds a new Section. Explains reporting requirements for suspicious deaths for report takers and provider agencies.

Section 270.245: Updates Section heading and terminology.

Section 270.250: Updates Section heading and terminology. Eliminates obsolete provisions. Adds to the list of information that must be documented in a confidential case records, including referrals to law enforcement, coroners or medical examiners; notification to a probate court, and suspicious death reports. Requires preparation of a final investigative report by a provider agency in all cases without regard to whether there is a substantiated finding.

Section 270.255: Updates Section heading and terminology. Explains how the provider agency develops a care plan. Directs the provider agency to consult with appropriate professionals and service providers, including establishing working relationships with disability agencies. Requires preparation of a final investigative report by a provider agency in all cases without regard to whether there is a substantiated finding. Eliminates obsolete provisions. Sets forth reporting requirements to a law enforcement agency, the coroner or medical examiner, and the probate court with jurisdiction over a guardian

where a provider agency has reason to believe that the death of an eligible may be the result of abuse or neglect. Indicates that a case may be closed by a provider agency when the alleged victim is determined to be ineligible for services.

Section 270.260: Updates Section heading. Adds provision regarding determination to be made by a provider agency at the initial interview with an alleged victim and after an assessment of a reported incident is conducted. Sets forth the rights of an alleged victim under the Adult Protective Services Program. Explains how to determine whether an alleged victim lacks the capacity to consent and clarifies when the case worker may proceed with intervention in emergency and non-emergency situations by involving a guardian or agent; family, friends, or other caregivers; and the Illinois Guardianship and Advocacy Commission, the Office of State Guardian or other appropriate agency. Eliminates obsolete provisions.

Section 270.265: Updates Section heading and terminology. Eliminates obsolete provisions regarding the Emergency Intervention Services fund.

Section 270.270: Updates terminology. Revises the list of professions represented by volunteers on a multi-disciplinary team. Directs law enforcement agencies, coroners and medical examiners to supply records to the multi-disciplinary team as may be requested in particular cases.

Section 270.275: Updates terminology. Adds "self-neglect" to listing of types of confidential reports under the Adult Protective Services Program that cannot be disclosed except as specifically authorized by the Act once a case is closed. Clarifies that records generated as a result of such reports include, but is not limited to, referrals and intervention services. Indicates that confidential records are exempt from inspection and copying under the Freedom of Information Act. Updates the list of individuals authorized to access confidential records. Explains the record request process for releasing confidential records on the basis of a written authorization by an eligible adult or his or her legal representative or through the use of a subpoena accompanied by court order after an in camera inspection to determine relevancy.

Section 270.280-270.300: Updates terminology.

11) Are there any other proposed rulemakings to this Part pending? No

12) Statement of Statewide Policy Objectives: This emergency rulemaking does not create or enlarge any State mandate.

DEPARTMENT ON AGING

NOTICE OF EMERGENCY AMENDMENTS

13) Information and questions regarding this emergency rulemaking shall be directed to:

Karen Alice Kloppe
Deputy General Counsel
Illinois Department on Aging
One Natural Resources Way, Suite 100
Springfield, Illinois 62702-1271

217/785-3346

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

DEPARTMENT ON AGING

NOTICE OF EMERGENCY AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER II: DEPARTMENT ON AGING

PART 270
ADULT PROTECTION AND ADVOCACY SERVICES~~ELDER RIGHTS~~

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EMERGENCY

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DEPARTMENT ON AGING

NOTICE OF EMERGENCY AMENDMENTS

AUTHORITY: Implementing Section 4.04(c) of the Illinois Act on the Aging [20 ILCS 105/4.04(c)] and Section 10 of the Adult Protective Services Act [320 ILCS 20/10] and authorized by Section 4.01(11) of the Illinois Act on the Aging [20 ILCS 105/4.01(11)].

SOURCE: Adopted at 21 Ill. Reg. 8887, effective July 1, 1997; amended at 25 Ill. Reg. 5259, effective April 1, 2001; amended at 26 Ill. Reg. 3964, effective March 15, 2002; expedited correction at 26 Ill. Reg. 8482, effective March 15, 2002; amended at 30 Ill. Reg. 8913, effective April 28, 2006; amended at 35 Ill. Reg. 8180, effective May 12, 2011; emergency amendment at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days.

SUBPART A: INTRODUCTION

Section 270.10 Summary and Purpose
EMERGENCY

This Part describes the organization, standards and responsibilities of the programs that comprise the Department's Adult Protection and Advocacy Services~~Elder Rights Programs~~.

a) Services
These services include the Long Term Care Ombudsman Program, the Adult Protective Services~~Elder Abuse and Neglect~~ Program and the Senior Legal Assistance Program. ~~These programs are designed to expand and advance the rights of seniors.~~

b) Purpose

1) The Long Term Care Ombudsman Program is designed to ensure that adults aged 60 and over and persons with disabilities aged 18 through 59 receive quality services in long term care facilities or in home-and community-based settings.

2) The Adult Protective Services Program is designed to prevent abuse, neglect, financial exploitation, or self-neglect of adults with disabilities aged 18 through 59 and persons aged 60 or older who reside in a domestic living situation.

3) The Senior Legal Assistance Program is designed to provide legal assistance to persons aged 60 or older.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

SUBPART C: ADULT PROTECTIVE SERVICES ~~ELDER ABUSE AND NEGLECT~~ PROGRAM

Section 270.200 Purpose and Program Model
EMERGENCY

a) This Subpart describes the organization of the Adult Protective Services~~Elder Abuse and Neglect~~ Program administered by and through the Illinois Department on Aging.

b) The Adult Protective Services Program is modeled on the following principles:

1) advocacy intervention by APS provider agencies;

2) the right to self-determination by the alleged victim to:

A) decide where and how they will live;

B) choose whether to accept social services or other community assistance; and

C) make decisions different from those a reasonable adult would make, which are not harmful to others.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.205 Adult Protective Services~~Elder Abuse and Neglect~~ Program
EMERGENCY

The Adult Protective Services~~Elder Abuse and Neglect~~ Program is designed to respond to eligible adults~~older persons~~ who are victims of abuse, neglect, and financial exploitation (ANE). The services and activities of the program are:

a) Intake of ANE reports

b) Assessment

c) Case work

d) Follow-up

e) Early~~Emergency~~ intervention services

f) Multi-disciplinary teams

g) Fatality review teams

h) Public awareness/education.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.210 Definitions
EMERGENCY

"Abuse" means causing any physical, mental or sexual injury to an eligible adult, including exploitation of such adult's financial resources. [320 ILCS 20/2(a)]

"Abuse Fatality Review Team" means a regional interagency review team established pursuant to Section 15 of the Act. Abuse Fatality Review Team also has the same meaning as At-Risk Adult Fatality Review Team.

"Abuser" means a person who abuses, neglects, or financially exploits an eligible adult. [320 ILCS 20/2(a-5)]

"Act" means the Adult Protective Services~~Elder Abuse and Neglect~~ Act [320 ILCS 20].

"Adult Protective Services Hotline" means the 24-hour toll-free statewide telephone number that can be called to report suspected cases of abuse, neglect, or financial exploitation of eligible adults.

"Adult Protective Services Provider Agency" means any public or nonprofit agency, appointed by the regional administrative agency with prior approval by the Department, to receive and assess reports of alleged or suspected abuse, neglect and financial exploitation. "Adult Protective Services Provider Agency" has the same meaning as "designated agency".

"Adult with disabilities" means a person aged 18 through 59 who resides in a domestic living situation and whose disability impairs his or her ability to seek or obtain protection from abuse, neglect or financial exploitation. [320 ILCS 20/2(a-6)]

"Allegation" means a charge or a claim of abuse, neglect, or financial exploitation.

"Alleged abuser" means a person who is reported as abusing, neglecting, or financially exploiting an adult with disabilities or older person.

"Alleged victim" means an adult with disabilities or~~the~~ older person who is reported as being abused, neglected, or financially exploited.

"ANE" means abuse, neglect, and financial exploitation.

"APS" means adult protective services.

"Assessment" means the process of obtaining and documenting information about the case to determine if there is reason to believe abuse, neglect or financial exploitation is occurring (or has occurred), and to ascertain the level of risk to the eligible adult of future abuse or harm.

"Capacity to consent" to an assessment or services means an individual reasonably appears to be either able to receive and evaluate information related to the assessment or services; or able to communicate in any manner decisions related to the assessment of the reported incident or services (See 320 ILCS 20/9(d-5).)

"Caregiver" means a person who either as a result of a family relationship, voluntarily, or in exchange for compensation~~,~~ has assumed responsibility for all or a portion of the care of an eligible adult who needs assistance with activities of daily living. [320 ILCS 20/2(a-7)]

"Case work" is the development and implementation of a service plan for the client, which minimally includes: the identification of the needs, problems, limitations and capacities of the client; interventions to protect the health, welfare and safety of the client; assisting the client in obtaining needed services; and respecting the self-determination and independence of the client.

"Case worker" means an employee of an APS provider agency who is authorized to receive and assess reports of alleged or suspected abuse, neglect and financial exploitation and to develop and implement a service plan for a client.

"Clear and convincing" is the standard of proof that must be met to reach a "verified" substantiation decision in the Adult Protective Services~~ANE~~ Program. This standard of proof is met when the credible evidence, weighed in its entirety, creates a substantial certainty that the abuse, neglect or financial exploitation is occurring or has occurred.

"Client" is an eligible adult who is receiving services from the APS~~elder abuse~~ provider agency.

"Combined service area" means a designated service area, within a planning and service area where a single APS provider agency is responsible for providing a response, during non-business hours, to reports of alleged or suspected abuse or neglect when an eligible adult is at risk of death or serious physical injury, pursuant to a cooperative agreement among the APS provider agencies involved. The APS provider agency shall respond to reports in accordance with the time frame outlined in Section 270.240.

"Confinement" means restraining or isolating an individual~~older person~~ for other than bona fide medical reasons.

"Department" means the Department on Aging of the State of Illinois. [320 ILCS 20/2(b)]

"Director" means the Director of the Department. [320 ILCS 20/2(c)]

"Disability" means a physical or mental disability, including, but not limited to, a developmental disability, an intellectual disability, a mental illness as defined under the Mental Health and Developmental Disabilities Code [405 ILCS 5/1-

129], *or dementia as defined under the Alzheimer's Disease Assistance Act* [410 ILCS 405/3(a-5)]. [320 ILCS 20/2(c-5)]

"Domestic living situation" means a residence where the eligible adult at the time of the report lives alone or with his or her family or a caregiver, or others, or ~~a board and care home or~~ other community-based unlicensed facility, but is not:

A licensed facility as defined in Section 1-113 of the Nursing Home Care Act [210 ILCS 45/1-113];

A facility licensed under the IO/DD~~MR/DD~~ Community Care Act;

A facility licensed under the Specialized Mental Health Rehabilitation Act;

A *" life care facility" as defined in the Life Care Facilities Act* [210 ILCS 40];

A home, institution, or other place operated by the federal government or agency thereof or by the State of Illinois;

A hospital, sanitarium, or other institution, the principal activity or business of which is the diagnosis, care, and treatment of human illness through the maintenance and operation of organized facilities therefor, which is required to be licensed under the Hospital Licensing Act [210 ILCS 85];

A "community living facility" as defined in the Community Living Facilities Licensing Act [210 ILCS 35]; ~~and~~

A "community-integrated living arrangement" as defined in the Community-Integrated Living Arrangements Licensure and Certification Act [210 ILCS 135]; and

A "community residential alternative" as defined in the Community Residential Alternative Act [210 ILCS 140]. [320 ILCS 20/2(d)]

~~"Elder Abuse Hotline" means the 24-hour toll-free statewide number that can be called to report suspected cases of elder abuse, neglect, or financial exploitation.~~

~~"Elder abuse provider agency" means any public or nonprofit agency, appointed by the regional administrative agency with prior approval by the Department, to receive and assess reports of alleged or suspected abuse, neglect and financial exploitation.~~

"Early Intervention Services" are the services purchased by APS provider agencies to provide temporary short term or emergency services necessary to secure the health, welfare and/or safety of a client when other existing resources are unavailable.

"Eligible adult" means either an adult with disabilities aged 18 through 59 or a person aged 60 ~~years of age~~ or older who resides in a domestic living situation and is, or is alleged to be, abused, neglected, or financially exploited by another individual or who neglects himself or herself. [320 ILCS 20/2(e)]

"Emergency" means a situation in which an eligible adult is living in conditions presenting a risk of death or physical, mental or sexual injury and the APS provider agency has reason to believe the eligible adult is unable to consent to services which would alleviate that risk. [320 ILCS 20/2(f)]
~~"Emergency Intervention Services" are the services purchased by elder abuse provider agencies to provide temporary short term or emergency services necessary to secure the health, welfare and/or safety of a client when other existing resources are unavailable.~~

"Emotional abuse" means verbal assaults, threats of maltreatment, harassment, or intimidation.

"Financial exploitation" means the use of an eligible adult's~~older person's~~ resources by another to the disadvantage of that adult~~the older person and/~~ or the profit or advantage of a person other than that adult~~the older person~~. [320 ILCS 20/2(f-1)].

"Follow-up" means the monitoring of substantiated cases of ANE for clients of the program.

"Guardian" means a person appointed by a court of competent jurisdiction, who is legally responsible for the care of a person who has been adjudicated by the court to be incompetent to manage his or her own affairs and/or property.

"Initial interview" means the preliminary contact made by an APS provider agency to determine the level of risk to an alleged victim, the need for early intervention services in order to assure safety and welfare or otherwise reduce risk to the alleged victim, and his or her decisional capacity to consent to an assessment and/or services.

"Intake" means the point at which trained staff of the Illinois Department on Aging's Adult Protective Services Hotline, Senior HelpLine, a regional administrative agency, or APS~~an elder abuse~~ provider agency receives a report of alleged or suspected abuse, neglect, or financial exploitation or self-neglect and relays the report to a case worker for further assessment~~; screens the case to make an initial determination that the alleged victim is an eligible adult; and, if so, opens a case file to keep a record of the case~~.

"Intervention" means an action initiated by the adult protective services~~elder abuse~~ case worker or the APS~~elder abuse~~ provider agency to provide medical, social, economic, legal, housing, law enforcement, or other protective, emergency, or supportive services to, or on behalf of, the eligible adult~~elder abuse victim or alleged victim~~.

"Mandated reporter" means any of the following persons while engaged in carrying out their professional duties:

a professional or professional's delegate while engaged in:

social services,

law enforcement,

education,

the care of an eligible adult or eligible adults, or

any of the occupations required to be licensed under the Clinical Psychologist Licensing Act [225 ILCS 15], *the Clinical Social Work and Social Work Practice Act* [225 ILCS 20], *the Illinois Dental Practice Act* [225 ILCS 25], *the Dietitian~~Dietetic and Nutritionist~~~~Nutrition Services~~ Practice Act* [225 ILCS 30], *the Marriage and Family Therapy Licensing Act* [225 ILCS 55], *the*

Medical Practice Act of 1987 [225 ILCS 60], ~~*the Respiratory Care Practice Act* [225 ILCS 106]~~, *the Naprapathic Practice Act* [225 ILCS 63], *the Nurse Practice Act* [225 ILCS 65], *the Nursing Home Administrators Licensing and Disciplinary Act* [225 ILCS 70], *the Illinois Occupational Therapy Practice Act* [225 ILCS 75], *the Illinois Optometric Practice Act of 1987* [225 ILCS 80], *the Pharmacy Practice Act* [225 ILCS 85], *the Illinois Physical Therapy Act* [225 ILCS 90], *the Physician Assistant Practice Act of 1987* [225 ILCS 95], *the Podiatric Medical Practice Act of 1987* [225 ILCS 100], *the Professional Counselor and Clinical Professional Counselor Licensing and Practice Act* [225 ILCS 107], *the Respiratory Care Practice Act* [225 ILCS 106], *the Illinois Speech-Language Pathology and Audiology Practice Act* [225 ILCS 110], *the Veterinary Medicine and Surgery Practice Act of 2004~~1994~~* [225 ILCS 115], *and the Illinois Public Accounting Act* [225 ILCS 450];

an employee of an entity providing developmental disabilities services or service coordination funded by the Department of Human Services.

an employee of a vocational rehabilitation facility prescribed or supervised by the Department of Human Services;

an administrator, employee, or person providing services in or through an unlicensed community-based facility;

any religious practitioner who provides treatment by prayer or spiritual means alone in accordance with the tenets and practices of a recognized church or religious denomination, except as to information received in any confession or sacred communication enjoined by the discipline of the religious denomination to be held confidential*;*

field personnel of the Department of Healthcare and Family Services, Department of Public Health, and Department of Human Services, and any county or municipal health department;

personnel of the Department of Human Services, the Guardianship and Advocacy Commission, the State Fire Marshal, local fire departments, the Department on Aging and its subsidiary Area Agencies on Aging and APS

provider agencies, and the Office of State Long Term Care Ombudsman; provided that attorneys contracted or employed by the Area Agencies and their senior legal services providers and licensed to practice in Illinois are not mandated to report ~~elder~~ abuse, although they may voluntarily do so;

any employee of the State of Illinois not otherwise specified in this definition who is involved in providing services to eligible adults, including professionals providing medical or rehabilitation services and all other persons having direct contact with eligible adults;

a person who performs the duties of a coroner or medical examiner; or

a person who performs the duties of a paramedic or an emergency medical technician. [320 ILCS 20/2(f-5)]

"Neglect" means another individual's failure to provide an eligible adult with or willful withholding from an eligible adult the necessities of life including, but not limited to, food, clothing, shelter or health~~medical~~ care. This definition does not create any new affirmative duty to provide support to eligible adults. Nothing in the Act shall be construed to mean that an eligible adult is a victim of neglect because of health care services provided or not provided by licensed health care professionals. [320 ILCS 20/2(g)]

"Passive neglect" means the failure by a caregiver to provide an eligible adult with the necessities of life including, but not limited to, food, clothing, shelter, or medical care, because of failure to understand the eligible adult's needs, lack of awareness of services to help meet needs, or a lack of capacity to care for the eligible adult.

"Physical abuse" means the causing of physical pain or injury to an eligible adult.

"Preponderance of the evidence" is the standard of proof that must be met to reach a "some indication" substantiation decision in the Adult Protective Services~~ANE~~ Program. This standard of proof is met when the credible evidence, weighed in its entirety, creates a reasonable certainty that more likely than not the abuse, neglect or financial exploitation is occurring or has occurred.

"Provider agency" means any public or nonprofit agency in a planning and service area appointed by the regional administrative agency with prior approval

by the Department on Aging to receive and assess reports of alleged or suspected abuse, neglect, or financial exploitation. [320 ILCS 20/2(h)]

"Regional administrative agency" means any public or nonprofit agency in a planning and service area so designated by the Department, provided that the designated Area Agency on Aging shall be designated the regional administrative agency if it so requests. The Department shall assume the functions of the regional administrative agency for any planning and service area where another agency is not so designated. [320 ILCS 20/2(i)]

"Report taker" means the trained staff of the Illinois Department on Aging's Senior HelpLine, the Adult Protective Services Hotline, regional administrative agencies or APS provider agencies that performs intake of alleged or suspected abuse, neglect, financial exploitation or self-neglect.

"Reporter" means the person who calls, visits or otherwise communicates to an authorized intake agency allegations or suspicions that an eligible adult has been or is being abused, neglected, or financially exploited.

~~"Review team" means a regional interagency elder abuse fatality review team established pursuant to Section 15 of the Act. Each review team shall be comprised of representatives of the Department on Aging, the coroner's or medical examiner's office, the State's Attorney's office, local police departments, forensic units, the provider agency, and other interested parties, the purpose of which is to review suspicious or unexplained deaths of seniors in a domestic living situation.~~

~~"Senior HelpLine" means the Department's toll-free statewide number that can be called to report suspected cases of elder abuse, neglect and financial exploitation, or to obtain additional information about services available to eligible adults.~~
"Self-determination" means the right of an eligible adult with decisional capacity to:

decide where and how he or she will live;

choose whether to accept program services or other community assistance; and

make decisions different from those a reasonable adult would make, including "bad" decisions, which are not harmful to others.

"Self-neglect" means a condition that is the result of an eligible adult's inability, due to physical or mental impairments, or both, or a diminished capacity, to perform essential self-care tasks that substantially threaten his or her own health, including: providing essential food, clothing, shelter, and health care; and obtaining goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety. The term includes compulsive hoarding, which is characterized by the acquisition and retention of large quantities of items and materials that produce an extensively cluttered living space, which significantly impairs the performance of essential self-care tasks or otherwise substantially threatens life or safety. [320 ILCS 20/2(i-5)]

"Services" means medical, social, economic, legal, housing, law enforcement, or other protective, early, emergency, or supportive action provided to, or on behalf of, the eligible adult.

"Sexual abuse" means any sexual activity with an eligible adult who is unable to understand, unwilling to consent, threatened, or physically forced to engage in such sexual activity.

"Shared service area" means the designated area within a planning and service area where two or more APS provider agencies are responsible for providing a response, during non-business hours, to reports of alleged or suspected abuse or neglect when an eligible adult is at risk of death or serious physical injury, pursuant to a cooperative agreement among the APS provider agencies involved. The APS provider agencies shall respond to reports in accordance with the time frame outlined in Section 270.240.

"Source of information" means the point of origin of information about the client.

"State Triad" is a statewide, unincorporated, voluntary association of law enforcement, senior citizens and community groups, organized around the issue of senior safety, crime against the elderly, and financial exploitation of the elderly. The State Triad Council was created under the aegis of the National Association of Triads, Inc., 1450 Duke Street, Alexandria VA 22314.

"Substantiation" is the process by which an APS~~elder abuse~~ provider agency

determines, after a review of all available information, that abuse, neglect or financial exploitation of an eligible adult has occurred.

"Substantiated case" means a reported case of alleged or suspected abuse, neglect, ~~or~~ financial exploitation, or self-neglect in which an APS~~a~~ provider agency, after assessment, determines that there is reason to believe abuse, neglect, or financial exploitation has occurred. [320 ILCS 20/2(j)]

"Suspicious death" means the instance where an APS provider agency reasonably believes that the death of an individual may be the result of abuse or neglect.

"Victim" means an eligible adult who is the subject of a substantiated report of abuse, neglect, or financial exploitation.

"Willful deprivation" is the deliberate denial to an eligible adult of required medication, medical care, shelter, food, therapeutic devices, or other physical assistance, thereby exposing that person to the risk of physical, mental, or emotional harm. Willful deprivation shall not include the discontinuation of medical care or treatment when the eligible adult has expressed a desire to forego such medical care or treatment.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, for a maximum of 150 days)

Section 270.215 Organizational Standards and Responsibilities: Department on Aging EMERGENCY

a) Contingent upon adequate funding, *the~~The~~ Department shall establish, design, and manage a protective services program of response and services for eligible adults~~persons 60 years of age and older~~ who have been, or are alleged to be, victims of abuse, neglect, ~~or~~ financial exploitation, or self-neglect. The Department shall contract with or fund, or contract with and fund, regional administrative agencies, APS provider agencies, or both, for the provision of those functions, and, contingent on adequate funding, with attorneys or legal services provider agencies for the provision of legal assistance pursuant to the Act.* [320 ILCS 20/3(a)]

b) The Department shall have the overall responsibility for designing, managing and monitoring the Adult Protective Services~~Elder Abuse and Neglect~~ Program.

c) The Department shall designate regional administrative agencies and approve the designation and termination of APS~~elder abuse~~ provider agencies. Designated APS~~elder abuse~~ provider agencies are agents of the Illinois Department on Aging.

1) If a regional administrative agency terminates its contract, it must so notify the Department in writing at least 30 days in advance and cooperate in the transition of functions and records to a successor agency so as to minimize risk to clients in the program.

2) The Department shall assume the functions in the Planning and Service Area until a replacement is selected through a competitive procurement process.

d) The Department shall design and manage the programmatic and financial reporting system for the program. The Department shall develop and manage a monitoring/quality assurance system for the program.

e) The Department shall develop and implement public awareness efforts designed to publicize the purposes and mode of operation of the program through public service announcements, posters, and brochures.

f) The Department shall provide technical assistance, policy clarifications and/or interpretations to regional administrative agencies on adherence to the rules, standards, and procedures established for the program. The Department may provide technical assistance in case handling directly to the APS~~elder abuse~~ provider agencies. The technical assistance provided by the Department may include legal advice and consultation. The Department's interpretation of statutes, rules, policy and procedure shall prevail.

g) The Department shall provide training to APS~~elder abuse~~ provider agency staff who will assess reports of ANE or who will supervise staff performing the assessment function. Regional administrative agency staff working in the program shall also be trained by the Department.

h) The Department shall maintain a registry of all APS~~elder abuse~~ provider agency and regional administrative agency staff that has~~who have~~ successfully completed Department sponsored certification training and are employed in the program.

i) The Department's "Adult Protective Services Hotline~~Senior HelpLine~~" ~~and the "After Hours Line"~~ shall receive reports of ANE and relay such reports to the appropriate APS~~elder abuse~~ provider agency within the required timelines.

j) *The Department shall also be responsible for, contingent upon adequate funding, coordination of efforts with other agencies, councils, and like entities, which may impact awareness of, and response to, ~~elder~~ abuse, neglect, and financial exploitation, and promotion of prevention activities* for eligible adults. [320 ILCS 20/3.5(b)]

k) *The Department shall file with the Governor and the General Assembly, within 270 days after the end of each fiscal year, a report concerning its implementation of the Act during such fiscal year, together with any recommendations for future implementation.* [320 ILCS 20/11]

l) The Department shall reimburse APS~~elder abuse~~ provider agencies under contract at a uniform rate established by the Department. A separate rate shall be established for each of the following case activities completed by the APS~~elder abuse~~ provider agency: assessment, case work, and follow-up.

m) If a designated APS~~elder abuse~~ provider agency terminates its contract to provide services, the Department, in coordination with the regional administrative agency, shall ensure that ~~elder abuse~~ services are available without interruption to eligible adults within the terminated APS~~elder abuse~~ provider agency's service area.

n) *The Department shall establish and coordinate a training program on the unique nature of APS~~elder abuse~~ cases with other agencies and councils, including the Office of the Attorney General, the State Police, the State Triad, and other similar agencies.*[320 ILCS 20/3.5(f)]

o) The Department shall solicit *financial institutions for the purpose of making information available to the general public warning of financial exploitation of eligible adults~~the elderly~~ and related financial fraud or abuse, including such information and warning available through signage or other written materials provided by the Department on the premises of such financial institutions, provided that the manner of displaying or distributing such information is subject to the sole discretion of each financial institution.* [320 ILCS 20/3.5(g)]

p) The Department shall coordinate *efforts with utility and electric companies to*

send notices in utility bills to explain to persons 60 years of age or older their rights regarding telemarketing and home repair fraud. [320 ILCS 20/3.5(h)]

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.220 Organizational Standards and Responsibilities: Regional Administrative Agencies
EMERGENCY

a) The Department may designate an Area Agency on Aging to serve as a regional administrative agency or hold a competitive procurement for a Planning and Service Area.

b) *Each regional administrative agency* in turn *shall designate* APS *provider agencies within its planning and service area with prior approval by the Department on Aging.* [320 ILCS 20/3(b)]

c~~b~~) A procurement process shall be held by the regional administrative agency for the designation of an APS provider agency in each service area at least every six years, except as provided in subsection (g)(1).~~The standard term for designation shall be for six years, unless such designation is terminated by action of the regional administrative agency or the Department, or unless a provider agency declines to continue its designation. The contract for services in a specified geographical area shall be awarded to a designated elder abuse provider agency for a period of one year. The contract for services may be renewed annually by the regional administrative agency, with the prior approval of the Department.~~

d~~c~~) The contract for services in a specified geographical area shall be awarded to a designated APS provider agency for a period of one year. The contract for services may be renewed annually by the regional administrative agency, with the prior approval of the Department.~~A procurement process shall be held by the regional administrative agency for the designation of an elder abuse provider agency in each service area every six years, except as provided in subsection (f)(1).~~

e~~d~~) If a review of the proposals submitted during a procurement process fails to produce an acceptable APS provider agency for the service area, the regional administrative agency shall designate, with the prior approval of the Department,

a qualified agency on an emergency basis under subsection (f).

f~~e~~) The regional administrative agency, after notification to, and concurrence by, the Department, may terminate the designation of an APS~~elder abuse~~ provider agency for failure to provide services in accordance with the contract and this Part.

g~~f~~) If the designation of an APS~~elder abuse~~ provider agency has been terminated, either at the initiative of the regional administrative agency or an APS~~elder abuse~~ provider agency, the regional administrative agency shall designate, with the prior approval of the Department, a qualified agency on an emergency basis until such time that a subsequent procurement process produces an acceptable APS provider agency for the service area.

1) When an APS~~organization or~~ agency has been selected on an emergency basis, the APS agency shall be designated for the balance of the fiscal year in which such designation was awarded, and for up to one additional year.

2) Not later than two years following the emergency designation, the regional administrative agency shall conduct a procurement process for the designation of an APS~~elder abuse~~ provider agency for the specified service area.

h~~g~~) A regional administrative agency may elect, for its planning and service area, to designate APS provider agencies, from those agencies designated in accordance with subsections (a) through (f) of this Section, for the purpose of providing either a combined or shared service area response, during non-business hours, to reports of alleged or suspected abuse or neglect when an eligible adult is at risk of death or serious physical injury. Each regional administrative agency shall follow the steps outlined in subsections (a) through (f) for procuring services for non-business hours for a combined or shared service area.

i~~h~~) The regional administrative agencies shall provide technical assistance to APS~~elder abuse~~ provider agencies and shall seek from Department staff policy clarifications and interpretations of standards and procedures.

j~~i~~) Regional administrative agencies shall monitor the performance of APS~~elder abuse~~ provider agencies, according to Departmental policies.

k) The regional administrative agencies may assist the Department and APS provider agencies in raising public awareness and providing education on the issues of abuse, neglect, financial exploitation, and self-neglect. The regional administrative agencies shall include the following information when producing any public education materials:

1) identification as a part of the Adult Protective Services Program;

2) voice and teletypewriter (TTY) phone numbers for the Department on Aging's toll free 24-hour Adult Protective Services Hotline; and

3) a nondiscrimination clause.

l) The regional administrative agency shall not serve as a legal guardian, an agent under the Illinois Power of Attorney Act [755 ILCS 45], or a representative payee for any client in the program. The Department may allow a waiver only if the APS provider agency has documented evidence that no other qualified person or entity exists to serve in the foregoing capacities on behalf of a client of the program and the regional administrative agency is willing and qualified to take on such responsibilities.

m) The regional administrative agency shall retain all books, records and other documents relevant to the operation of the program for three full years after final payment on the agreement and all other pending matters are closed, unless transfer is authorized in writing by the Department. The APS provider agency must insure that records are purged by completely shredding or incinerating.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.225 Organizational Standards and Responsibilities: Adult Protective Service ~~Elder Abuse~~ Provider Agencies
EMERGENCY

a) The APS~~elder abuse~~ provider agency shall enter into a written contract with the regional administrative agency to provide services in a specific geographical area in the regional administrative agency's planning and service area.

b) The APS~~elder abuse~~ provider agency shall provide such services in accordance

with the Act and this Part.

c) The APS provider agency shall be open for business and available to receive ANE reports not less than 246 working days per calendar year under the following conditions:

1) The APS provider agency shall not be closed for more than four consecutive days, unless an alternative method of receiving ANE reports is approved by and on file with the regional administrative agency and the Department.

2) If a recorded message is activated during business hours, there must be an option to talk directly to a report taker at that time rather than leaving a message on voice mail.

3) A report taker must be available at least seven hours each working day.

d) The APS provider agencies may assist the Department by providing public awareness and education on the issues of abuse, neglect, financial exploitation, and self-neglect. The APS provider agencies shall include the following information when producing any public education materials:

1) identification as a part of the Adult Protective Services Program;

2) voice and teletypewriter (TTY) phone numbers for the Department on Aging's toll free 24-hour Adult Protective Services Hotline; and

3) a nondiscrimination clause.

e) The adult protective services agency shall not serve as a legal guardian or an agent under the Illinois Power of Attorney Act [755 ILCS 45] for any client in the program.

f) The APS provider agency shall retain all books, records and other documents relevant to the operation of the program for three full years after final payment on the agreement and all other pending matters are closed, unless transfer is authorized in writing by the Department. The APS provider agency must insure that records are purged by completely shredding or incinerating.

g) A contract to provide adult protective~~elder abuse~~ services may be terminated by the APS~~elder abuse~~ provider agency in accordance with the termination clause in the contract.

h) Pursuant to the terms of their contract, APS provider agencies shall have sufficient staff to perform all duties and responsibilities of the program for which an agreement to perform is in effect.

i) APS supervisors must be involved in guiding and directing ANE cases and share responsibility in the case workers' decisions and actions in ANE cases.

j) Qualifications:

1) APS supervisors shall have:

A) a Master's Degree in health, social sciences, social work, health care administration, gerontology, disability studies, criminal justice, or public administration, and one year experience in health or human services; or

B) a Registered Nursing license, or a Bachelor of Science in Nursing (B.S.N.) or a Bachelor of Arts (B.A.)/Bachelor of Science (B.S.) in health, social sciences, social work, health care administration, gerontology, or criminal justice and three years experience in health or human services, including either one year of supervisory experience or one year of experience in aging, adults with disabilities or domestic violence programs or services;

C) Department sponsored APS case worker certification and on-line forms training;

D) Department sponsored Phase II certification training within six months of the APS case worker certification, to be placed on the Department's APS Case Worker Registry;

E) Department sponsored APS supervisor's certification training;

F) Fourteen hours of participation by actual attendance at in-service training on abuse of eligible adults, rights of older adults and adults with disabilities, self-neglect, and domestic violence subjects within a calendar year. For partial years of employment, training shall be prorated to equal approximately 45 minutes for each full month of employment. Participation by actual attendance at regional, state, or national conferences on abuse of older adults and adults with disabilities and rights of older adults and adults with disabilities, self-neglect, and domestic violence qualify as in-service training. Participation should be documented and included in the employee's personnel file;

G) Eleven hours of qualifying recertification every three years which must be documented in the employee's personnel file; and

2) APS case workers shall have:

A) a Master's Degree in health, social services, social work, health care administration, gerontology, disability studies, criminal justice, public administration; or

B) a Registered Nursing license, or a B.S.N. or a B.A./B.S. in health, social sciences, social work, health care administration, gerontology, or criminal justice and one year experience in health or human services; or

C) a Practical Nursing license, with two years experience in health or human services; and

D) Department sponsored APS case worker certification and on-line forms training;

E) Department sponsored Phase II certification training within six months of the APS case worker certification, to be listed on the Department's APS Case Worker Registry;

F) Twelve hours of participation by actual attendance at in-service training on abuse of eligible adults, rights of older adults and adults with disabilities, self-neglect, and domestic violence subjects within a calendar year. For partial years of employment, training shall be prorated to equal approximately 45 minutes for each full month of employment. Participation by actual attendance at regional, state, or national conferences on abuse of older adults and adults with disabilities and rights of older adults and adults with disabilities, self-neglect, and domestic violence qualify as in-service training. Participation should be documented and included in the employee's personnel file.

G) Eleven hours of qualifying recertification every three years which must be documented in the employee's personnel file.

k) The Department may suspend or remove from the APS Case Worker Registry any case worker or supervisor who fails or refuses to perform the duties of a case worker or supervisor in accordance with this Part.

l) The APS provider agency must return to the Department, within 15 days, any identification card of a case worker or supervisor who separates from employment.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.230 ~~Elder~~Abuse Reporting
EMERGENCY

a) *If any mandated reporter has reason to believe that an eligible adult, who because of disability or other condition or impairment~~dysfunction~~ is unable to seek assistance for himself or herself, has, within the previous 12 months, been subjected to abuse, neglect, or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to an agency designated to receive such reports under the Act or to the Department.* [320 ILCS 20/4(a-5)]

b) *Whenever a mandated reporter is required to report under the Act in his or her capacity as a member of the staff of a medical or other public or private*

institution, facility, ~~board and care home,~~ or agency, he or she shall make a report to an agency designated to receive such reports under the Act or to the Department in accordance with the provisions of the Act and may also notify the person in charge of the institution, facility, ~~board and care home,~~ or agency or his or her designated agent that the report has been made. [320 ILCS 20/4(a-5)]

c) *Under no circumstances shall any person in charge of such institution, facility, ~~board and care home,~~ or agency, or his or her designated agent to whom the notification has been made, exercise any control, restraint, modification, or other change in the report or the forwarding of the report to an agency designated to receive such reports under the Act or to the Department. The privileged quality of communication between any professional person required to report and his or her patient or client shall not apply to situations involving abused, neglected, or financially exploited eligible adults and shall not constitute grounds for failure to report as required by the Act.* [320 ILCS 20/4(a-5)]

d) *The identity of a person making a report of alleged or suspected abuse or neglect under the Act may be disclosed by the Department or other agency provided for in the Act only with such person's written consent or by court order, but is otherwise confidential.* [320 ILCS 20/4(c)]

e) *Any mandated reporter who makes a report or any person who investigates a report under the Act shall testify fully in any judicial or administrative proceeding resulting from such report, as to any evidence of abuse, neglect, or financial exploitation or the cause thereof. No evidence shall be excluded by reason of any common law or statutory privilege relating to communications between the alleged abuser or the eligible adult subject of the report under the Act and the person making or investigating the report.* [320 ILCS 20/4.2]

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.235 Immunity
EMERGENCY

a) *Any person, institution or agency participating in the making of a report, providing information or records related to a report, assessment, or services, or participating in the investigation of a report under the Act in good faith, or taking photographs or x-rays as a result of an authorized assessment, shall have*

immunity from any civil, criminal or other liability for such actions~~in any civil, criminal or other proceeding brought in consequence of making such report or assessment or on account of submitting or otherwise disclosing such photographs or x-rays to any agency designated to receive reports of alleged or suspected abuse or neglect~~.

b) *Any person, institution or agency authorized by the Department to provide assessment, intervention, or administrative services under the Act shall, in the good faith performance of those services, have immunity from any civil, criminal or other liability in any civil, criminal, or other proceeding brought as a consequence of the performance of those services.*

c) *For the purposes of any civil, criminal, or other proceeding, the good faith of any person required to report, permitted to report, or participating in an investigation of a report of alleged or suspected abuse, neglect, or financial exploitation or self-neglect shall be presumed.* [320 ILCS 20/4(b)]

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.240 Intake of Abuse, Neglect, and Financial Exploitation~~ANE~~ Reports EMERGENCY

a) The following agencies are authorized to receive ANE reports:

1) the Department on Aging's toll free 24-hour Adult Protective Services Hotline;

2) the~~Illinois~~ Department on Aging's Senior HelpLine;~~ 2) "After Hours" Line;~~

3) Regional administrative agencies; and

4) APS~~Elder abuse~~ provider agencies.

b) An APS~~elder abuse~~ provider agency receiving a report of ANE shall assign a priority to the report in accordance with the following:

1) Priority one reports are reports of abuse or neglect where the alleged

victim~~older person~~ is reported as being~~alleged to be~~ in serious physical harm or in immediate danger of death or serious physical harm. Priority one reports include, but are not limited to, the following:

A) physical abuse such as fractures, head injuries, internal injuries, or burns, when the injury is of a serious nature, such as to require medical treatment;

B) threats of serious injury or death;

C) lack of basic physical necessities severe enough to result in freezing, serious heat stress or starvation;

D) immediate medical attention is needed to treat conditions that could result in irreversible physical damages such as unconsciousness, acute pain, or severe respiratory distress;

E) alleged sexual abuse that has occurred in the last 72 hours;

F) threats of sexual abuse where the alleged abuser has access to the alleged victim; and

G) punishment by the alleged abuser, such as locking the alleged victim in the closet.

2) Priority two reports are reports of abuse, neglect or financial exploitation where the alleged victim~~alleging that an older person~~ is reported as being abused, neglected or exploited and the report taker has reason to believe that the consequences are less serious than priority one reports. Priority two reports include, but are not limited to, the following:

A) physical abuse involving scratches or bruises;

B) inadequate attention to physical needs such as insufficient food or medicine;

C) unreasonable confinement; and

D) probability of liquidation or depletion of an alleged victim's

income and assets.

3) Priority three reports are reports of abuse, neglect or financial exploitation where the alleged victim~~alleging that an older person~~ is reported as being emotionally abused by a caregiver or the alleged victim's~~older person's~~ financial resources are being misused or withheld and the report taker has reason to believe that there is no immediate threat of harm to the alleged victim.

c) If a report includes allegations or conditions of more than one priority, the report taker~~agency~~ that has received the report assigns it to the higher priority.

d) An agency that is not an APS~~elder abuse~~ provider agency shall forward the reports of ANE~~report~~ to the appropriate APS~~elder abuse~~ provider agency within two hours~~the required time frame~~.

e) The APS~~elder abuse~~ provider agency is directed to respond to reports of ANE within required time frames, including making a good faith attempt to conduct a face-to-face visit with the alleged victim.

f) The required time frames for each priority are: for "priority one" reports, 24 hours from the receipt of the report; "priority two" reports, 72 hours from the receipt of the report; and for "priority three" reports, seven calendar days from the receipt of the report.

g) The following exceptions shall apply and extend the time frames specified by that priority:

1) The alleged victim of the "priority one" report has been admitted to the hospital, in which case the required response time for a face-to-face visit is extended from 24 hours to the following work day.

2) The report is a "priority two" or "priority three" report, the adult protective ~~elder abuse~~ case worker is likely to be in danger, and a police officer or an appropriate other individual is called to investigate or escort the worker. An ~~"~~appropriate other~~"~~ escort may be, but is not limited to, a mental health professional, health professional, or significant relative. The required response time for a face-to-face visit is then extended until such a time as the police officer or ~~"~~appropriate escort~~other"~~ is available, not to exceed

three days beyond the required response time established for the priority.

3) The alleged victim~~client~~ does not wish or consent to a face-to-face visit within the time frame.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.241 Reporting a Suspicious Death
EMERGENCY

a) Where a report taker receives a report of a suspicious death, he or she shall promptly forward the report to the appropriate APS provider agency. The APS provider agency shall then immediately report the matter to both the appropriate law enforcement agency and the coroner or medical examiner.

b) Between 30 and 45 days after reporting a suspicious death, *the APS provider agency again shall contact the law enforcement agency and coroner or medical examiner to determine whether any further action was taken.*

1) *Upon request by* an APS *provider agency, a law enforcement agency and coroner or medical examiner shall supply a summary of its action in response to a reported death* of an alleged victim.

2) *A copy of the report shall be maintained and all subsequent follow-up with the law enforcement agency and coroner or medical examiner shall be documented in the case record* of the alleged victim. [320 ILCS 20/3(C-5)]

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.245 Access to Alleged Victims~~Eligible Adults~~

a) *The designated* APS *provider agencies shall have access to* alleged victims~~*eligible adults*~~ *who are*~~*have been*~~ *reported* ~~*or found*~~ *to be victims of abuse, neglect, or financial exploitation in order to assess the validity of the report, assess other needs of the* alleged victim~~*eligible adult*~~*, and provide services in accordance with the Act.* [320 ILCS 20/13(a)]

b) When the case worker is unable to access the alleged victim due to interference by another, the case worker shall seek the assistance of law enforcement. If the report is a "priority one", the adult protective services~~elder abuse~~ case worker shall immediately seek police assistance in accessing the alleged victim. If the report is a "priority two" or a "priority three", then the adult protective services~~elder abuse~~ case worker will make at least one additional attempt, and up to four additional attempts, to gain access to the residence prior to seeking police assistance.

c) *Where access to an eligible adult is denied, the Office of the Attorney General, the Department, or the APS provider agency may petition the court for an order to require appropriate access where:*

1) *a caregiver or third party has interfered with the assessment or service plan, or*

2) *the agency has reason to believe that the eligible adult is denying access because of coercion, extortion, or justifiable fear of future abuse, neglect, or financial exploitation.* [320 ILCS 20/13(b)]

d) If the initial face-to-face visit indicates that the alleged victim does not meet the eligibility~~age~~ criterion for the program, the APS~~elder abuse~~ provider agency will terminate the assessment, document this finding in the case record, and refer the person to other appropriate services or agencies.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.250 Minimum Assessment and Classification Standards
EMERGENCY

a) An APS~~A~~ *provider agency designated to receive reports of alleged or suspected abuse, neglect, or financial exploitation under the Act shall~~, upon receiving such a report,~~ conduct a face-to-face assessment with respect to such report. The assessment shall include, but not be limited to, a visit to the residence of the* alleged victim~~*eligible adult*~~ *who is the subject of the report and may include interviews or consultation with service agencies or individuals who may have knowledge of the* alleged victim's~~*eligible adult's*~~ *circumstances.* [320 ILCS

20/5(a)]

b) A decision on the merits of each report must be made according to the following:

1) Verified: When there is clear and convincing evidence resulting in a determination that the specific injury or harm was the result of abuse, neglect, or financial exploitation.

2) Some Indication: When there is a fair preponderance of evidence that suggests some indication of abuse, neglect, or financial exploitation has occurred~~exists~~.

3) No Indication: When there is a lack of credible evidence indicating that abuse, neglect, or financial exploitation has occurred~~exists~~.

4) Unable to Verify: This determination is used when the report does not meet the eligibility criteria of the program, the APS~~elder abuse~~ provider agency is unable to locate the alleged victim, the APS~~elder abuse~~ provider agency staff has been unable to gain access to the alleged victim, or the alleged victim refuses the assessment.

c) Each report must be either substantiated, unsubstantiated, or unable to substantiate, as follows:

1) Substantiated: When one or more of the alleged types of ANE was classified as either "verified" or "some indication".

2) Unsubstantiated: When all of the alleged types of ANE were determined to lack credible evidence that indicated abuse, neglect, or financial exploitation.

3) Unable to substantiate: When the APS provider agency lacked jurisdiction; was unable to locate the alleged victim; was unable to access the alleged victim; the alleged victim was ineligible; the alleged victim refused to cooperate; or the alleged victim was deceased.

d) If, after the assessment, the APS provider agency determines that the case is substantiated and the victim has consented to services, it shall develop a service care plan for the eligible adult.

e) The APS~~elder abuse~~ provider agency shall prepare~~establish~~ a confidential case record to document each report of abuse, neglect, or financial exploitation, to include the following information where available and when applicable to the case:

1) essential client information, such as name, address, age, and phone number;

2) descriptions of the reported, suspected or alleged abuse, neglect, or financial exploitation;

3) investigative reports;

4) injury location charts;

5) records of financial transactions;

6) summaries of conversations and communications with the eligible adult, the alleged or suspected abuser, and other sources of information;

7) information relating to the mental competency of the eligible adult;

8) information on the assessment of the eligible adult, including medical or psychiatric reports;

9) summaries of the substantiation decision;

10) summaries of services or interventions offered or arranged;~~ and~~

11) reports on the termination, resolution or closure of the case;

12) referrals to law enforcement, coroners or medical examiners;

13) notification to probate court of a substantiated finding of abuse, neglect or financial exploitation by a guardian; and

14) suspicious death reports and any follow up documentation.

f) An APS provider agency shall prepare a final investigative report, upon the completion or closure of an investigation, in all cases of reported abuse, neglect, financial exploitation of an eligible adult, whether or not there is a substantiated finding.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.255 Abuse, Neglect and Financial Exploitation~~ANE~~ Case Work, Follow-Up, Referrals~~Referral to Law Enforcement~~ and Case Closure
EMERGENCY

a) Case Work
APS provider~~Provider~~ agencies shall assist, to the extent possible, eligible adults who need agency services to allow them to continue to function independently. [320 ILCS 20/3(c)]

1) If, after the assessment, the APS provider agency determines that the case is substantiated, it shall develop a case~~service care~~ plan for the eligible adult, where he or she~~the adult~~ consents to services.

A) *In developing a case plan, the APS provider agency may consult with any other appropriate* professional and/or *provider of services*, such as, advocacy, care coordination, counseling, education, emergency aid, financial, housing, law enforcement, legal, long term care, managed care, medical, nutrition, personal assistance, relocation, respite, social supports through charitable and community assistance, disability agencies, private means, or public benefit programs to meet identified needs for the purpose of stabilizing the abusive situation and reducing the risk of further harm, and such professionals and/or providers shall be immune from civil or criminal liability on account of such acts. [320 ILCS 20/5(a)]

B) *The case plan shall include alternatives suggested or recommended services which are appropriate to the needs of the eligible adult and which involve the least restriction of the eligible adult's activities commensurate with his or her needs.* [320 ILCS 20/5(a)]

i) The case worker shall use his or her professional judgment in advocating in the best interest, safety, and welfare of the eligible adult.

ii) The eligible adult's interests to live in the most independent setting with the least restrictive alternatives for legal, medical, and social services come before those of any other family community members.

iii) The case worker shall involve the eligible adult, and his or her family for support, if possible, in the development of the intervention, and explain, in a direct manner, the situation, the range of available options for services, and the consequences of failing to cooperate or refusing to accept services, so the eligible adult can exercise his or her maximum decision-making ability.

iv) The APS provider agencies shall establish working relationships with disability agencies for purposes of mutual training, referral and service response.

2) *Only those services to which consent is given in accordance with Section 9 of* the *Act shall be provided, contingent upon the availability of such services.* [320 ILCS 20/5(a)]

b) Follow-up

All services provided to an eligible adult shall be reviewed by the APS provider agency on at least a quarterly basis for up to one year to determine whether the service care plan should be continued or modified except that, upon review, the Department may grant a waiver to extend the service care plan for up to 1~~one~~ additional year. [320 ILCS 20/7]

c) Referral

An APS~~A~~ provider agency shall refer evidence of crimes against an eligible adult to the appropriate law enforcement agency according to Department policies. A referral to law enforcement may be made at intake or any time during the case. ~~Where a provider agency has reason to believe the death of an eligible adult may be the result of abuse or neglect, the agency shall immediately report the matter~~

~~*to the coroner or medical examiner and shall cooperate fully with any subsequent investigation.*~~ [320 ILCS 20/5(b)]

d) The "evidence of crimes" referred to in subsection (c) includes:

1) death that may have been the result of abuse or neglect;

2) brain damage;

3) loss or substantial impairment of a bodily function or organ;

4) bone fracture;

5) extensive burns;

6) substantial disfigurement;

7) sexual assault or aggravated sexual assault;

8) serious bodily injury as the result of a pattern of repetitive actions;

9) extensive swelling or bruising, depending on such factors as the eligible adult's physical condition, circumstances under which the injury occurred, and the number and location of bruises;

10) serious symptoms resulting from the use of medications or chemical restraints, or the withholding of life sustaining medications (e.g., insulin);

11) evidence of severe neglect, such as unreasonable decubiti;

12) other activity that would place the eligible adult in imminent danger of death or serious bodily injury; or

13) any felonious criminal activity directed at the eligible adult that the case worker directly observes.

e) *Where an APS provider agency has reason to believe that the death of an eligible adult that occurs during the course of assessment, case work, or follow-up may be the result of abuse or neglect, the agency shall promptly report the matter to both*

the appropriate law enforcement agency and coroner or medical examiner and make subsequent contact with them in accordance with the timeframes set forth in Section 270.241(b). [320 ILCS 20/3(c-5)]

f) Upon request by an APS provider agency, law enforcement agencies, coroners and medical examiners shall supply a summary of its action in response to a reported death of an eligible adult. The APS provider agency shall maintain a copy of the report and all follow-up with law enforcement, coroners and medical examiners shall be documents in the case record of the eligible adult.

g) In all cases in which there is a substantiated finding of abuse, neglect, or financial exploitation by a guardian, the APS provider agency shall, within 30 days after the finding, notify the probate court with jurisdiction over the guardianship.

h) Case Closure
An APS~~elder abuse~~ provider agency shall close a case when:

1) the alleged victim refuses services;

2) the alleged victim is deceased, unless the death was the apparent result of the ANE, subject to cooperation under subsection (c);

3) the alleged victim has entered a long term care facility and resided there for 60 days; provided the Department may waive the 60 day limitation in cases where theAPS provider agency submits evidence that such a waiver is necessary to protect the safety and well being of the client;

4) the alleged victim has moved out of the area; provided, if the alleged victim remains at risk and the APS~~elder abuse~~ provider agency is aware of the new location, the APS provider agency shall refer the case to the APS~~elder abuse~~ provider agency in the location of the new residence for case work and follow-up services;

5) the victim is no longer at risk of ANE;

6) the victim has received "uninterrupted" follow-up services for 12 months, which shall be considered an "administrative closure"; ~~or~~

7) the report is not substantiated; or

8) the alleged victim is determined to be ineligible for services.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.260 Authority to Consent ~~to Services~~ and Court Petitions
EMERGENCY

a) The APS provider agency shall conduct an initial interview to determine:

1) the level of risk to an alleged victim,

2) the need for early intervention services in order to assure safety and welfare or otherwise reduce risk to the alleged victim, and

3) his or her decisional capacity to consent to an assessment and/or services.

b) If it reasonably appears to the APS provider agency that the alleged victim has decisional capacity at the initial interview, then the APS provider agency will conduct an assessment of the reported incident of suspected abuse, neglect, financial exploitation, or self-neglect in accordance with Section 270.250, put Early Intervention Services in place as needed under Section 270.265, and provide other services as appropriate in completing case work, follow-up, referral to law enforcement and case closure under Section 270.255.

1) *If* the alledged victim*~~an eligible adult~~ consents to services being provided according to the case~~service care~~ plan, such services shall be arranged to meet the adult's needs, based upon the availability of resources to provide such services.*

2) *If an adult withdraws his or her consent for an assessment of the reported incident or withdraws his or her consent for services and~~or~~ refuses to accept such services, the services shall not be provided.* [320 ILCS 20/9(a)]

c) An alleged victim *"lacks the capacity to consent" if qualified staff of an agency designated under* the *Act reasonably determine, that he or she appears either unable to receive and evaluate information related to the assessment or services*

or unable to communicate in any manner decisions related to the assessment of the reported incident or services. [320 ILCS 20/9(d-5)]

d) If it reasonably appears to the APS provider agency that the alleged victim lacks decisional capacity at the initial interview, and there is no immediate risk of harm, then the APS provider agency will continue to intervene in order to determine if the alleged victim has a guardian or agent under an advance directive with authority to act on his or her behalf for consenting to an assessment and/or services.

1) Upon consent by the guardian or agent under an advance directive, services will be provided according to the case plan and shall be arranged to meet the alleged victim's needs, based upon the availability of resources to provide such services.

2) If the alleged victim either does not have a guardian or agent, or the guardian or agent lacks authority to act, the APS provider agency shall either contact:

A) an immediate family member, other relative, close personal friend of the alleged victim, or other person identified by the alleged victim as being involved with his or her care, to petition the court for that individual's appointment as a guardian in accordance with *Article XIa of the Probate Act of 1975* [755 ILCS 5/Art. XIa] *for the purposes of consenting to an assessment of the reported incident and services, together with an order for an evaluation of the alleged victim's decisional capacity and his or her physical, psychological, and medical condition.* [320 ILCS 20/9(b)]; or

B) *the Illinois Guardianship and Advocacy Commission, the Office of State Guardian, or any other appropriate agency, of the potential need for appointment of a temporary guardian as provided in Article XIa of the Probate Act of 1975 for the purposes of consenting to an assessment of the reported incident and services, together with an order for an evaluation of the* alleged victim's *decisional capacity and his or her physical, psychological, and medical condition.* [320 ILCS 20/9(b)]

3~~b~~) ~~*If it reasonably appears to the Department or other agency designated*~~

~~*under the Act that a person is an eligible adult and lacks the capacity to consent to necessary services, including an assessment, the Department or other agency may seek the appointment of a guardian as provided in Article XIa of the Probate Act of 1975* [755 ILCS 5/Art. XIa] *for the purpose of consenting to such services.* [320 ILCS 20/9(b)]~~ If the APS ~~Department or elder abuse~~ provider agency seeks the appointment of a guardian pursuant to Article XIa of the Probate Act of 1975, the APS~~Department or elder abuse~~ provider agency shall notify the nearest relatives of the disabled person not less than 14 days prior to the scheduled hearing, as provided by Sections 11a-8 and 11a-10(f) of the Probate Act of 1975. [320 ILCS 20/9(b)]

4~~c~~) ~~*A guardian of the person of an eligible adult may consent to services being provided according to the service care plan.*~~ *If a guardian or agent is the suspected abuser and he or she withdraws ~~his or her~~ consent for the assessment of the reported incident, or refuses to allow services to be provided to the* alleged victim~~*eligible adult*~~*, the APS provider~~Department, an~~ agency~~ designated under the Act~~, or the Office of the Attorney General may request a court order seeking appropriate remedies, and may in addition request removal of the guardian and appointment of a successor guardian or request removal of the agent and appointment of a guardian*. [320 ILCS 20/9(c)]

e~~d~~) If it reasonably appears to the APS provider agency that the alleged victim lacks decisional capacity at the initial interview, and there is an immediate risk of harm or some other~~*If an* emergency exists~~, ~~*and the Department or other agency designated under the Act reasonably believes that a person is an eligible adult and lacks the capacity to consent to necessary services,*~~ *then the APS provider~~Department or other~~ agency may*:

1) take appropriate action necessary to ameliorate the risk by consulting with any other appropriate professional and/or provider of services, through charitable and community assistance, disability agencies, private means, or public benefit programs to meet identified needs, stabilize the abusive situation and reduce the risk of further harm, such as:

A) seeking assistance of law enforcement to gain access to the alleged victim;

B) obtaining emergency medical care;

C) petitioning for Orders of Protection, Restraining Orders, or orders freezing assets;

D) purchasing early intervention services under Section 270.265; and

E) applying for appointment of a representative payee; and/or

2) *request an ex parte order from the circuit court of the county in which the petitioner or respondent resides or in which the alleged abuse, neglect, ~~or~~ financial exploitation, or self-neglect occurred, authorizing an assessment of a report of alleged or suspected abuse, neglect, ~~or~~ financial exploitation or self-neglect or the provision of necessary services, or both, including relief available under the Illinois Domestic Violence Act of 1986* [750 ILCS 60]. [320 ILCS 20/9(d)]

f~~e~~) *Within 15 days after the entry of the ex parte emergency order, the order shall expire, or, if the need for assessment of the reported incident or services continues, the APS provider agency shall petition for the appointment of a guardian as provided in Article XIa of the Probate Act of 1975 for the purpose of consenting to such assessment or services or to protect the* alleged victim~~*eligible adult*~~ *from further harm.* [320 ILCS 20/9(e)]

g~~f~~) *If the APS~~elder abuse~~ provider agency has substantiated financial exploitation against an* alleged victim~~*eligible adult*~~*, and has documented a reasonable belief that the* alleged victim~~*eligible adult*~~ *will be irreparably harmed as a result of the financial exploitation, the Office of the Attorney General~~, the Department,~~ or the APS provider agency may petition for an order freezing the assets of the* alleged victim~~*eligible adult*~~*. The petition shall be filed in the county or counties in which the assets are located.* [320 ILCS 20/13(d)]

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.265 Early~~Emergency~~ Intervention Services EMERGENCY

a) ~~The Department shall establish a fund for elder abuse clients to be called the~~

~~Emergency Intervention Services fund. Eligibility criteria to receive Emergency Intervention Services funds are as follows:~~

~~1) that there be an imminent threat to the health, welfare and/or safety of the client if the service is not available; and~~

~~2) community services/resources for which the client is eligible cannot be mobilized in a timely manner or are insufficient to protect the client's health, welfare and/or safety; and~~

~~3) client resources are insufficient or unavailable to purchase needed services falling under the Emergency Intervention Services categories.~~

~~b)~~ Services that may be purchased by the APS~~elder abuse~~ provider agency for eligible adults include emergency aid, respite care, legal assistance, housing and relocation services, or other services designed to protect the health, welfare and/or safety of the eligible adult.

b~~e~~) The Department shall establish a maximum amount available to a victim in~~within~~ each year he or she receives services. The Department shall also establish procedures whereby the regional administrative agency and the Department may allow for additional expenditures of such funds as are necessary to obtain emergency or essential services to protect the client.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.270 Multi-disciplinary Teams
EMERGENCY

a) Every APS~~elder abuse~~ provider agency ~~(EAPA)~~ that has more than 7,200 potential eligible adults~~persons 60 years of age and older~~ in their designated service area shall develop and maintain a multi-disciplinary team (M-Team).

b) The M-Team shall act in an advisory role to the APS~~elder abuse~~ provider agency for the purpose of providing professional knowledge and expertise in the handling of complex ~~elder~~ abuse cases.

c) Each M-Team shall consist of one volunteer representative each from the

following professions: banking or finance; disability care; health care; law; law enforcement; mental health care; and clergy. The APS provider agency~~EAPA~~ may choose to add representatives from the fields of substance abuse, domestic violence, sexual assault, or other related fields.

d) The M-Team shall meet a minimum of eight times a year.

e) Each M-Team member shall sign a confidentiality agreement not to release any ~~elder abuse~~ client information.

f) The APS provider agency~~EAPA~~ shall have written procedures for recruiting M-Team members; for preparing and conducting M-Team meetings; and for financial management of M-Teams.

g) The Department shall provide funding to APS provider agencies~~EAPAs~~ to support the cost of staff time, mailings, meeting space and other costs related to M-Team meetings. M-Team members shall not be reimbursed for their services.

h) Law enforcement agencies, coroners, and medical examiners shall supply records to M-Teams as may be requested in particular cases.

(Source: Amended by emergency rulemaking at 37 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.275 Confidentiality and Disclosure
EMERGENCY

a) The Adult Protective Services~~Elder Abuse and Neglect~~ Act provides that the identity of any person making a report of alleged or suspected ~~elder~~ abuse, neglect, or financial exploitation may be disclosed only with that person's written consent or by court order.

b) *All records concerning reports of ~~elder~~ abuse, neglect, ~~or~~ financial exploitation or self-neglect and all records generated as a result of such reports, including, but not limited to, referrals and intervention services, shall be confidential and shall not be disclosed or subject to subpoena except as specifically authorized by the Act or other applicable law and only after a case is closed [320 ILCS 20/8].*

c) These confidential records are exempt from inspection and copying under the Freedom of Information Act [5 ILCS 140/7.5(y)].

d) *Access to such records, but not access to the identity of the person or persons making a report of alleged abuse, neglect, ~~or~~ financial exploitation, or self-neglect as contained in such records, shall be allowed to the following persons and for the following persons:*

1) *Department staff, APS provider agency staff, other aging network staff, and regional administrative agency staff in the furtherance of their responsibilities under the Act;*

2) *A law enforcement agency investigating a known or suspected case of ~~elder~~ abuse, neglect, ~~or~~ financial exploitation or self-neglect. Where an APS~~a~~ provider agency has reason to believe that the death of an eligible adult may be the result of abuse or neglect, including any reports made after death, the agency shall immediately provide the appropriate law enforcement agency with all records pertaining to the eligible adult;*

3) *A physician who has before him or her or who is involved in the treatment of an eligible adult whom he or she reasonably suspects may be abused, neglected, ~~or~~ financially exploited or self-neglected or who has been referred to the Adult Protective Services~~Elder Abuse and Neglect~~ Program;*

4) *An eligible adult reported to be abused, neglected, ~~or~~ financially exploited, or self-neglected or to such adult's legal~~authorized~~ guardian or agent* when access to such records is relevant to representing the interests of the eligible adult, and a complete authorization for release of records is submitted, *unless the guardian or agent is the* substantiated *abuser or is the alleged abuser* in an open case*;*

5) *An executor or administrator of the estate of an eligible adult who is deceased* when relevant to administration of the estate and a complete authorization for release of records is submitted*;*

6) *A court or a guardian ad litem, upon its or his or her* written *finding that access to such records may be necessary for the determination of an issue before the~~such~~ court. However, such access shall be limited to an in*

camera inspection of the records, unless the court determines, following the in camera inspection, *that disclosure of the information contained therein is necessary for the resolution of an issue then pending before it;*

7) *In cases regarding self-neglect, a guardian ad litem;*

8~~7~~) *A grand jury, upon its determination that access to such records is necessary for conduct of its official business;*

9~~8~~) *Any person authorized by the Director, in writing, for audit,* program monitoring *or bona fide research purposes;*

10~~9~~) *A coroner or medical examiner who has reason to believe that an eligible adult has died as the result of abuse, neglect, or financial exploitation. The APS provider agency shall immediately provide the coroner or medical examiner with all records pertaining to the eligible adult;*

11~~10~~) *A coroner or medical examiner having proper jurisdiction, pursuant to a written agreement between an APS~~a~~ provider agency and the coroner or medical examiner, under which the APS provider agency may furnish to the office of the coroner or medical examiner a list of all eligible adults who may be at imminent risk of death as a result of abuse, neglect, ~~or~~ financial exploitation or self-neglect; ~~and~~*

12~~11~~) *Department of* Financial and *Professional Regulation staff and members of the Illinois Medical Disciplinary Board or the Social Work Examining and Disciplinary Board in the course of investigating alleged violations of the Clinical Social Work and Social Work Practice Act* [225 ILCS 20] *by APS provider agency staff or other licensing bodies at the discretion of the Director of the Department on Aging*. ~~[320 ILCS 20/8]~~

13) *Department of Healthcare and Family Services staff when that Department is funding services to the eligible adult, including being given access to the identity of the eligible adult;*

14) *Department of Human Services staff when that Department is funding services to the eligible adult or is providing reimbursement for services provided by the abuser or alleged abuser, including being given access to the identity of the eligible adult;*

15) *The Illinois Guardianship and Advocacy Commission and the agency designated by the Governor under Section 1 of the Protection and Advocacy for Developmentally Disabled Persons Act* [405 ILCS 40] *shall have access, through the Department, to records, including the findings, pertaining to a completed or closed investigation of a report of suspected abuse, neglect, financial exploitation, or self-neglect of an eligible adult.* [320 ILCS 20/8]

e) An authorization for release of records by the Department or the APS provider agencies must be legally sufficient and include:

1) supporting documentation of the agency or guardianship evidencing current authority to act on behalf of the eligible adult or his or her estate; and

2) a sworn statement as to the purpose of the request and its relevance to representing the interests of the eligible adult or his or her estate.

f) The release of records may be refused if evident to not in the best interest of the eligible adult.

g~~e~~) All records must be maintained as confidential and stored in a designated and secure area within the APS~~elder abuse~~ provider agency offices.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31,2013, for a maximum of 150 days)

SUBPART D: ADULT PROTECTIVE SERVICES~~ELDER ABUSE~~ VOLUNTEER CORPS

Section 270.280 Definitions
EMERGENCY

Activity Plan: The document that describes and records the recruitment, selection, screening, training, appointment, assignment, supervision, and evaluation of the individual volunteer.

Agreement: The document signed by an authorized representative of the APS~~elder abuse~~ provider agency and the volunteer in which the APS~~elder abuse~~

provider agency appoints the volunteer as an agent and representative of the Adult Protective Services~~Elder Abuse and Neglect~~ Program and the volunteer accepts that appointment and the concomitant responsibilities. This agreement shall constitute the volunteer contract required by the State Employee Indemnification Act [5 ILCS 350].

Companion-type services: Activities intended to assist the eligible adults served by the APS~~elder abuse~~ provider agency, which may include, but are not limited to, visitations, assistance in transportation, and other personal assistance that does not involve medical, nursing or professional services.

APS~~Elder abuse~~ provider agency: An organization designated by the Department pursuant to Section 3 of the Act to provide services to eligible adults pursuant to that Act.

Public awareness: Activities designed to educate and inform the public, which may include, but are not limited to, giving public presentations and speeches; participation in public informational fairs; representing the APS~~elder abuse~~ provider agency with community, social service or senior advocacy groups; the creation or production of television or radio public service announcements; and the writing, editing or distribution of newspaper articles, magazine articles, press releases or information sheets.

Regional Administrative Agency: A public or private entity that has been designated by the Department pursuant to Section 3 of the Act.

Volunteer: An individual who has been appointed by the APS~~elder abuse~~ provider agency to provide "public awareness services" to that agency or "companion-type services" to eligible adults in accordance with the APS~~elder abuse~~ provider agency's Volunteer Plan and the individual volunteer's Activity Plan.

Volunteer Plan: The document created by the APS~~elder abuse~~ provider agency and approved by the Department that describes the procedure for the recruitment, selection, screening, training, appointment, assignment, supervision, and evaluation of volunteers.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.285 Selection and Screening
EMERGENCY

a) Each APS~~elder abuse~~ provider agency utilizing volunteers under this Subpart shall create a Volunteer Plan, approved by the Department, to recruit, select, screen, train, appoint, assign, supervise and evaluate volunteers.

b) The recruitment, selection, and screening of volunteer applicants shall be the responsibility of the APS~~elder abuse~~ provider agency. Each volunteer applicant shall submit the required personal, professional and background information (see subsection (c)) on a form prescribed by the Department.

c) The APS~~elder abuse~~ provider agency shall conduct a screening of each volunteer applicant. This screening process may include, but is not limited to, personal interviews; reference checks; fingerprint checks; credit checks; medical and mental health checks; background checks; driving record checks; and reviews of professional disciplinary actions, criminal prosecutions, and police records.

d) The purpose of the screening process is solely to determine the suitability of the volunteer applicant to serve as an appointed volunteer. The APS~~elder abuse~~ provider agency shall not seek any personal information on a volunteer applicant beyond that which is necessary to complete the screening process. The screening process of the volunteer applicant shall be the same regardless of expected assignment of the individual volunteer.

e) Each volunteer applicant shall be required to sign an authorization for the release of the information the APS~~elder abuse~~ provider agency has determined to be necessary to complete the screening process. All such information gathered in the course of the background checks and reviews of volunteer candidates shall be held in the strictest confidence permitted by law.

f) Upon the completion of the screening process, the APS~~elder abuse~~ provider agency shall notify the volunteer applicant whether he or she will be designated as a volunteer. The APS~~elder abuse~~ provider agency shall also inform those volunteer applicants who are not so selected of the basis for the decision. The decision of the APS~~elder abuse~~ provider agency is final.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.290 Training
EMERGENCY

a) The training of volunteers is the responsibility of the APS~~elder abuse~~ provider agency, and shall be done according to the Volunteer Plan. Prior to being assigned any responsibilities, the volunteer must have satisfactorily completed an initial course of training of not less than six hours.

b) The initial volunteer training shall include materials on program procedures, APS~~elder abuse~~ provider agency organization, types of ~~elder~~ abuse and neglect, confidentiality, safety procedures, the dynamics of client interaction, and additional subjects as each APS~~elder abuse~~ provider agency deems necessary.

c) Each volunteer shall take the advanced training deemed appropriate and necessary by the APS~~elder abuse~~ provider agency to undertake the activities to which the volunteer will be assigned.

d) The initial volunteer training shall be repeated for classes of new volunteers as needed.

e) As a part of the Volunteer Plan, the APS~~elder abuse~~ provider agency shall maintain copies of past and current training agendas.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.295 Volunteer Agreement and Volunteer Responsibilities
EMERGENCY

Each volunteer, upon being appointed, and prior to entering into his or her assigned activities, shall sign a volunteer agreement with the APS~~elder abuse~~ provider agency. The agreement shall have been approved by the Department, and shall include the name and contact information for the volunteer, the number of hours per week or month that the volunteer anticipates serving, a statement of the general activities to which the volunteer will be assigned, and the following stipulations by the volunteer:

a) the volunteer agrees to maintain confidentiality as required by the Act, the standards of the Adult Protective Services~~Elder Abuse and Neglect~~ Program, and the policies of the APS~~elder abuse~~ provider agency, during and after the period of volunteer service;

b) the volunteer acknowledges and accepts the responsibilities of being a mandated reporter for abuse of older adults, persons with disabilities, and children;

c) the volunteer agrees to inform the APS~~elder abuse~~ provider agency, in writing, of the existence of any apparent conflict of interest, including a preexisting personal or professional relationship with any client of the program to whom the volunteer might be assigned;

d) the volunteer agrees to maintain the appropriate driver's license and statutorily required insurance coverage if the volunteer is to be acting as a driver for eligible adults; and

e) the volunteer agrees to abide by all statutory law, administrative rules, Departmental policies, and APS~~elder abuse~~ provider agency policies that apply to and govern the APS~~elder abuse~~ provider agency.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

Section 270.300 Activities and Supervision
EMERGENCY

a) The APS~~elder abuse~~ provider agency shall assign volunteers and provide supervision of each volunteer according to the Volunteer Plan. Each volunteer shall have an individualized Activity Plan, which shall include a job description of the specific assignment of the volunteer.

b) A copy of the Activity Plan for each volunteer shall be maintained in the records of the APS~~elder abuse~~ provider agency.

c) Each individualized Activity Plan shall include a record of all the training, assignments, activities, supervision, and evaluations of the volunteer.

d) The Volunteer Plan shall be available for inspection and copying by law enforcement agencies, the Regional Administrative Agency, and the Department on Aging.

e) The individual Activity Plans shall be available for inspection and copying by law enforcement agencies in the course of conducting a criminal investigation, and by the Department and appropriate Regional Administrative Agency (with redactions of identifying client information as necessary to maintain confidentiality) for monitoring and supervisory purposes.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2357, effective December 31, 2013, for a maximum of 150 days)

DEPARTMENT OF HUMAN SERVICES

NOTICE OF EMERGENCY RULES

1) Heading of the Part: Mental Health Reporting for Firearm Owner's Identification Card

2) Code Citation: 59 Ill. Adm. Code 150

3)

Section Numbers:	Emergency Action:
150.10	New Section
150.20	New Section
150.30	New Section
150.40	New Section
150.100	New Section
150.110	New Section
150.120	New Section
150.200	New Section
150.210	New Section
150.220	New Section
150.230	New Section
150.400	New Section
150.500	New Section
150.600	New Section

4) Statutory Authority: Implementing and authorized by the Firearm Concealed Carry Act [430 ILCS 66/95] and Section 6-103.2 and 6-103.3 of the Mental Health and Developmental Disabilities Code [405 ILCS 5/6-103.2 and 6-103.3]

5) Effective Date of Rule: December 31, 2013

6) If these emergency rules are to expire before the end of the 150-day period, please specify the date on which they are to expire: These emergency rules will expire at the end of the 150-day period, or upon adoption of permanent rules, whichever comes first.

7) Date filed with the Index Department: December 31, 2013

8) A copy of the emergency rules, 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: This emergency rulemaking implements the changes made by PA 98-63 to mental health reporting for the Firearm Owner's Identification (FOID) Card and indirectly for the implementation of concealed carry. The purpose of the rule is to provide clarity to those reporting institutions and clinicians to ensure that the persons

who have been admitted to a mental health facility, adjudicated to be a disabled person, involuntarily admitted, determined to be a clear and present danger, or developmentally disabled are reported to DHS so that the Illinois State Police can make the determination as to whether the person should be issued or possess a FOID Card (and ultimately possess a firearm or ammunition). Failure of clinicians or reporting institutions to report people who should be prohibited from having or receiving a FOID Card due to mental health concerns could result in such persons possessing or obtaining firearms which could pose a threat to community safety.

10) A Complete Description of the Subject and Issues Involved: Pursuant to provisions of PA 98-63, this rulemaking is being proposed to establish the procedures by which the Department of Human Services (DHS) will collect information which the Illinois State Police (ISP) will be able to use to determine eligibility or continued eligibility for a Firearm Owner's Identification Card.

Besides creating the Concealed Carry Act, PA 98-63 made significant changes to the Firearm Owner's Identification Card Act (FOID ACT) and other acts related to reporting of persons with mental illness relative to possessing a firearm. On December 6, 2013, PA 98-600 was signed into law and it made some modifications to the earlier Act (PA 98-63). The changes in statute require that additional data elements to be collected and reported by hospitals, nursing homes and other in-patient mental health facilities. As a result of this rulemaking, clinicians and out-patient mental health facilities will also have to report specific events to DHS. This rulemaking clarifies the mental health reporting parameters for providers in order to make it easier for them to comply with the law.

11) Are there any other proposed rulemakings pending on this Part? No

12) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a State mandate.

13) Information and questions regarding these emergency rules shall be directed to:

Tracie Drew, Bureau Chief
Bureau of Administrative Rules and Procedures
Department of Human Services
100 South Grand Avenue East
Harris Bldg., 3rd Floor
Springfield IL 62762

DEPARTMENT OF HUMAN SERVICES

NOTICE OF EMERGENCY RULES

217/785-9772

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

DEPARTMENT OF HUMAN SERVICES

NOTICE OF EMERGENCY RULES

TITLE 59: MENTAL HEALTH
CHAPTER I: DEPARTMENT OF HUMAN SERVICES

PART 150: MENTAL HEALTH REPORTING FOR FIREARM OWNER'S IDENTIFICATION CARD

SUBPART A: GENERAL PROVISIONS

Section
150.10 Purpose
EMERGENCY
150.20 Incorporation by Reference
EMERGENCY
150.30 Definitions
EMERGENCY
150.40 Immunity
EMERGENCY

SUBPART B: MENTAL HEALTH FACILITY REPORTING

Section
150.100 Reporting
EMERGENCY
150.110 Recordkeeping
EMERGENCY
150.120 Error Correcting
EMERGENCY

SUBPART C: CLINICIAN REPORTING

Section
150.200 Reporting of Developmental Disabilities
EMERGENCY
150.210 Reporting of Clear and Present Danger
EMERGENCY
150.220 Recordkeeping
EMERGENCY
150.230 Error Correcting
EMERGENCY

DEPARTMENT OF HUMAN SERVICES

NOTICE OF EMERGENCY RULES

SUBPART D: DATABASE USE

Section
150.400 Database Use
EMERGENCY

SUBPART E: APPEALS

Section
150.500 Appeals
EMERGENCY

SUBPART F: MEMORANDUM OF UNDERSTANDING

Section
150.600 Memorandum of Understanding
EMERGENCY

AUTHORITY: Implementing and authorized by the Firearm Concealed Carry Act [430 ILCS 66/95] and Sections 6-103.2 and 6-103.3 of the Mental Health and Developmental Disabilities Code [405 ILCS 5/6-103.2 and 6-103.3].

SOURCE: Adopted by emergency rulemaking at 38 Ill. Reg. 2413, effective December 31, 2013, for a maximum of 150 days.

SUBPART A: GENERAL PROVISIONS

Section 150.10 Purpose
EMERGENCY

a) The requirements set forth in this Part establish the criteria for reporting by various providers under Sections 6-103.2 and 6-103.3 of the Mental Health and Developmental Disabilities Code [405 ILCS 5] and Section 12(b) of the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110].

b) The requirements set forth in this Part establish the procedures by which the Department of Human Services (DHS) shall collect information which the Illinois State Police (ISP) will be able to use to determine eligibility or continued

eligibility for a Firearm Owner's Identification Card under Section 8 of the Firearm Owner's Identification Card Act (FOID Act) [430 ILCS 65].

Section 150.20 Incorporation by Reference
EMERGENCY

Any rules or standards of an agency of the United States or of a nationally-recognized organization or association that are incorporated by reference in this Part are incorporated as of the date specified and do not include any later amendments or editions.

Section 150.30 Definitions
EMERGENCY

For the purposes of this Part, the following terms are defined:

"Adjudicated a mentally disabled person" – The person is the subject of a determination by a court, board, commission or other lawful authority that the person, as a result of marked subnormal intelligence, mental illness, mental impairment, incompetency, condition, or disease:

presents a clear and present danger to himself, herself, or to others;

lacks the mental capacity to manage his or her own affairs or is adjudicated a disabled person as defined in Section 11a-2 of the Probate Act of 1975 [755 ILCS 5];

is not guilty in a criminal case by reason of insanity, mental disease or defect as provided in Section 5-2-4 of the Unified Code of Corrections [730 ILCS 5];

is guilty but mentally ill, as provided in Section 5-2-6 of the Unified Code of Corrections [730 ILCS 5];

is incompetent to stand trial in a criminal case as provided in Article 104 of the Code of Criminal Procedure [725 ILCS 5];

is not guilty by reason of lack of mental responsibility pursuant to Articles 50a and 72b of the Uniform Code of Military Justice (10 USC 850a, 876b);

is a sexually violent person under Section 5(f) of the Sexually Violent Persons Commitment Act [725 ILCS 207];

has been found to be a sexually dangerous person under the Sexually Dangerous Persons Act [725 ILCS 205];

is unfit to stand trial under the Juvenile Court Act of 1987 [705 ILCS 405];

is not guilty by reason of insanity under the Juvenile Court Act of 1987 [705 ILCS 405];

is subject to involuntary admission as an inpatient as defined in Section 1-119 of the Mental Health and Development Disabilities Code [405 ILCS 5];

is subject to involuntary admissions as an outpatient as defined in Section 1-119.1 of the Mental Health and Developmental Disabilities Code [405 ILCS 5];

is subject to judicial admission as set forth in Section 4-500 of the Mental Health and Developmental Disabilities Code [405 ILCS 5]; or

is subject to the provisions of the Interstate Agreements on Sexually Dangerous Persons Act [45 ILCS 20] (see Section 1.1 of the FOID Act).

"Clear and present danger" – a person who:

communicates a serious threat of physical violence against a reasonably identifiable victim or poses a clear and imminent risk of serious physical injury to himself, herself, or another person as determined by a clinician; or

demonstrates threatening physical or verbal behavior, such as violent, suicidal, or assaultive threats, actions, or other behavior, as determined by a clinician, school administrator, or law enforcement official (see Section 1.1 of the FOID Act).

"Clinical psychologist" – a person licensed by the Illinois Department of Financial and Professional Regulation under the Clinical Psychologist Licensing Act [225 ILCS 15] (see 405 ILCS 5/1-103).

"Clinical social worker" – a person who:

has a master's or doctoral degree in social work from an accredited graduate school of social work; and

has at least 3 years of supervised postmaster's clinical social work practice which shall include the provision of mental health services for the evaluation, treatment and prevention of mental and emotional disorders (see 405 ILCS 5/1-122.1).

"Clinician"– a physician, psychiatrist, clinical psychologist or qualified examiner.

"Confidentiality Act" – the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110].

"Developmentally disabled" – a person with a disability which is attributable to any other condition which results in impairment similar to that caused by an intellectual disability and which requires services similar to those required by intellectually disabled persons. The disability must originate before the age of 18 years, be expected to continue indefinitely, and constitute a substantial handicap (see Section 1.1 of the FOID Act). This can include an intellectual disability, autism, cerebral palsy and epilepsy.

"DHS" – the Illinois Department of Human Services.

"DPH" – the Illinois Department of Public Health.

"FOID Act" – means the Firearm Owner's Identification Card Act [430 ILCS 65].

"Intellectual disability" – significantly subaverage general intellectual functioning which exists concurrently with impairment in adaptive behavior and which originates before the age of 18 years.

"Involuntarily admitted" – has the meaning as prescribed in Sections 1-119 and 1-119.1 of the Mental Health and Developmental Disabilities (MHDD) Code (see Section 1.1 of the FOID Act).

"MHDD Code" – the Mental Health and Developmental Disabilities Code [405 ILCS 5].

"Mental health facility" – any licensed private hospital or hospital affiliate, institution, or facility, or part thereof, and any facility, or part thereof, operated by the State or a political subdivision thereof which provides treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, mental health centers, colleges, universities, long-term care facilities, and nursing homes, or parts thereof, which provides treatment of persons with mental illness whether or not the primary purpose is to provide treatment of persons with mental illness (see Section 1.1 of the FOID Act). For purposes of this Part, an inpatient mental health facility includes:

State-operated mental health facility as described in Section 4 of the Mental Health and Developmental Disabilities Administrative Act [20 ILCS 1705];

Psychiatric hospital as authorized by DPH;

The specific units of a general hospital providing psychiatric services as authorized by the DPH; and

Residential settings. Residential settings include:

Nursing homes or long-term care facilities which are considered Institutes for Mental Disease as that term is described in section 1905(i) of Title XIX of the Social Security Act (42 USC 1396d(i));

The specific units of a nursing home or long-term care facility authorized by the DPH to provide psychiatric or behavioral healthcare;

The specific units of a nursing home or long-term care facility held out by the facility as providing psychiatric or behavioral health care;

Specialized Mental Health Rehabilitation Facilities as described in the Specialized Mental Health Rehabilitation Act of 2013 [210 ILCS 49]; and

A supervised transitional residential program funded by the DHS Division of Mental Health (DHS-DMH) where that level of service has been determined to be medically necessary as that term is defined by 59 Ill. Adm. Code 132.

For the purposes of this Part, an outpatient mental health facility includes:

A community mental health agency;

A general hospital that does not provide inpatient psychiatric care;

A general hospital emergency department;

The portions of a psychiatric hospital (or general hospital with psychiatric services) that do not provide inpatient psychiatric services;

A nursing home or long-term care facility that does not provide inpatient psychiatric care;

A health counseling center or health clinic operated by a college or university;

A clinic.

It is possible for a facility to qualify as both an inpatient and outpatient mental health facility.

"National Instant Criminal Background Check System" or "NICS" – the system which a federal firearm licensee must, with limited exceptions, contact for information on whether receipt of a firearm by a person who is not licensed under 18 USC 923 would violate Federal or state law (28 CFR 25.2).

"Patient" –

a person who voluntarily receives mental health treatment as an inpatient or resident of any public or private mental health facility, unless the treatment was solely for an alcohol abuse disorder and no other secondary substance abuse disorder or mental illness; or

a person who voluntarily receives mental health treatment as an outpatient or is provided services by a public or private mental health facility, and who poses a clear and present danger to himself, herself, or to others (see Section 1.1 of the FOID Act).

For the purposes of this Part, a person is considered to voluntarily receive mental health services on an inpatient basis if the person is admitted:

On a voluntary basis as that term is used in Article IV of Chapter III of the MHDD Code;

On an informal basis as that term is used in Section 3-300 of the MHDD Code;

As a juvenile under the provisions of Article V of Chapter III of the MHDD Code;

On a petition or a petition and one or more certificates as described in Article VI, VII or VII-A of Chapter III of the MHDD Code; or

On a court order for detention and examination under the provisions of Section 3-607 of the MHDD Code.

"Physician" – *any person licensed by the State of Illinois to practice medicine in all its branches and includes any person holding a temporary license, as provided* in the Medical Practice Act of 1987 [225 ILCS 60]. *Physician includes a psychiatrist as defined* in this Section [405 ILCS 5/1-120].

"Psychiatrist" – *a physician as defined* in this Section *who has successfully completed* a residency program in psychiatry *accredited by either the Accreditation Council for Graduate Medical Education* (www.acgme.org) *or the American Osteopathic Association* (www.osteopathic.org) [405 ILCS 5/1-121].

"Qualified examiner" – a person who is:

A clinical social worker as defined in this Part;

A registered nurse with a master's degree in psychiatric nursing who has 3 years of clinical training and experience in the evaluation and treatment of mental illness which has been acquired subsequent to any training and experience which constituted a part of the degree program;

A licensed clinical professional counselor with a master's or doctoral degree in counseling or psychology or a similar master's or doctorate program from a regionally accredited institution who has at least 3 years of supervised post-master's clinical professional counseling experience that includes the provision of mental health services for the evaluation, treatment, and prevention of mental and emotional disorders; or

A licensed marriage and family therapist with a master's or doctoral degree in marriage and family therapy from a regionally accredited educational institution or a similar master's program or from a program accredited by either the Commission on Accreditation for Marriage and Family Therapy Education (http://www.aamft.org/imis15/content/coamfte/About_COAMFTE.aspx) or the Council for Accreditation of Counseling & Related Educational Programs (www.cacrep.org), who has at least 3 years of supervised post-master's experience as a marriage and family therapist that includes the provisions of mental health services for the evaluation, treatment, and prevention of mental and emotional disorders.

A social worker who is a qualified examiner shall be a licensed clinical social worker under the Clinical Social Work and Social Work Practice Act [225 ILCS 20] (see 405 ILCS 5/1-122).

Section 150.40 Immunity
EMERGENCY

a) Any person, institution, or agency, under this Part participating in good faith in the reporting or disclosure of records and communications otherwise in accordance with this provision or with rules, regulations or guidelines issued by DHS shall have immunity from any liability, civil, criminal or otherwise, that might result by reason of the action. For the purpose of any proceeding, civil or

criminal, arising out of a report or disclosure in accordance with this provision, the good faith of any person, institution, or agency so reporting or disclosing shall be presumed. The full extent of the immunity shall apply to any person, institution or agency that fails to make a report or disclosure in the good faith belief that the report or disclosure would violate federal regulations governing the confidentiality of alcohol and drug abuse patient records under 42 USC 290dd-3 and 290ee-3 (see Confidentiality Act, Section 12(b)).

b) The clinician making the determination that the person poses a clear and present danger or making the determination that the person has a developmental disability and his or her employer may not be held criminally, civilly, or professionally liable for making or not making the notification required under this Section, except for willful or wanton misconduct (see Sections 6-103.2 and 6-103.1 of the MHDD Code and Section 8.1 of the FOID Act).

SUBPART B: MENTAL HEALTH FACILITY REPORTING

Section 150.100 Reporting
EMERGENCY

a) Inpatient mental health facilities are required to report to DHS all persons who are prohibited from obtaining a FOID Card under Section 8(e), (f), (g), (r), (s) and/or (t) of the FOID Act.

1) Those provisions cover the following situations:

A) a person who has been a patient of a mental health facility within the past 5 years (see Section 8(e) of the FOID Act);

B) a person who had been a patient in a mental health facility more than 5 years ago who has not received the certification required under Section 8(u) of the FOID Act (see Section 8(e) of the FOID Act);

C) a person who is a clear and present danger to himself or herself, any other person or persons or the community (see Section 8(f) of the FOID Act);

D) a person who is intellectually disabled (see Section 8(g) of the FOID Act);

E) a person who has been adjudicated as a mentally disabled person (see Section 8(r) of the FOID Act);

F) a person who has been found to be developmentally disabled (see Section 8(s) of the FOID Act); or

G) a person involuntarily admitted into a mental health facility (see Section 8(t) of the FOID Act).

2) It should be noted that outpatient mental health facilities that provide only outpatient services must report events that would quality under Section 8(f), (g), (r), (s) and/or (t) of the FOID Act.

b) Mental health facilities are required to report within7 days after a person is admitted as an inpatient or as a resident and within 7 days after a person is discharged from inpatient or residential care.

1) The following are several examples relating to inpatient settings which clarify when an inpatient setting is required to report to DHS:

A) The person is admitted to the hospital and to the psychiatric or behavioral health unit of the hospital for evaluation and treatment of a mental illness. The person would be reported as an admission.

B) The person is admitted to the hospital and to the psychiatric or behavioral health unit of the hospital for evaluation and treatment of a mental illness and an alcohol or substance abuse issue. The person would be reported as an admission.

C) The person with mental illness is admitted to the hospital and to a non-psychiatric or behavioral health unit (e.g. intensive care unit, rehabilitation unit, etc.) of the hospital for evaluation and treatment of an injury or illness. The hospital transfers the person to the psychiatric or behavioral health unit. The person would be reported as an admission.

D) The person with mental illness comes to the emergency department of a hospital for the mental illness and is transferred to another hospital for admission to their psychiatric or behavioral unit. The person would not be reported by the sending hospital but is required to be reported by the receiving hospital as an admission.

2) The following are several examples relating to inpatient settings which clarify when an inpatient setting is not required to report to DHS:

A) The person is admitted to the hospital and to the behavioral health unit of the hospital for evaluation and treatment of only an alcohol or substance abuse issue. The person would not be reported as an admission.

B) The person is admitted to the hospital and to the psychiatric or behavioral health unit of the hospital for evaluation and treatment of a mental illness. Upon evaluation, the person is determined to only have an alcohol or substance abuse issue. The person would not be reported as an admission.

C) The person with mental illness is admitted to the hospital and to a non-psychiatric, non-behavioral health unit (e.g. intensive care unit, rehabilitation unit, etc.) for evaluation and treatment of an injury or illness. The hospital provides maintenance medication for the mental illness, but the person is not admitted to the psychiatric or behavioral health unit. The person would not be reported as an admission.

D) The person with mental illness comes to the emergency department of a hospital for an injury or illness, is treated and released. The person would not be reported as an admission.

E) The person with mental illness comes to the emergency department of a hospital for an injury or illness, is admitted to the hospital (non-psychiatric unit) for the injury or illness. The person would not be reported as an admission.

F) The person with mental illness comes to the emergency department of a hospital for an injury or illness, is moved to an observation

area for 48 hours. The person is treated and released. The person would not be reported as an admission.

G) The person with mental illness comes to the emergency department of a hospital for mental illness, is given a prescription for medication and a referral, but not admitted to the hospital. The person would not be reported as an admission.

3) The following are several examples relating to residential settings which clarify when a residential setting is required to report to DHS:

A) The person with mental illness is admitted to a nursing home and is placed on a specialized behavioral health unit. The person would be reported as an admission.

B) The person with mental illness is provided outpatient treatment while living in a supervised transitional residential program. The supervised transitional residential program would report the person as an admission. The outpatient program would not report the person.

C) The person with mental illness resides in a Specialized Mental Health Rehabilitation Facility. The facility would report the person as an admission.

4) The following are several examples relating to residential settings which clarify when a residential setting is not required to report to DHS:

A) The person with mental illness is admitted for outpatient treatment at a community mental health agency or a clinic setting while living in his or her own home or apartment. The person would not be reported.

B) The person with mental illness is admitted to a nursing home for rehabilitation and/or physical therapy and is not placed in a specialized behavioral health unit. The person would not be reported as an admission.

5) An adjudication as a mentally disabled person or an involuntary admission is required to be reported within 7 days of the event or knowledge of that event. This may occur during the course of a patient's admission, resulting in a report of the admission, a report of the adjudication as a mentally disabled person and finally a report upon discharge. It is possible that for a single admission there could be several reporting events.

6) When a person is determined to be a clear and present danger, he/she must be reported within 24 hours. If a person is determined to be a clear and present danger during his/her admission to a mental health facility, both a report of an admission and a report of a clear and present danger must be made.

7) When a person has been determined to be developmentally disabled, that event is required to be reported within 24 hours. This may occur during the course of a patient's admission, resulting in a report of the admission, a report of the determination that a person is developmentally disabled, and finally a report upon discharge.

8) To assist in meeting the reporting timeframes, DHS shall establish a web-based reporting platform. DHS shall update its records and information and shall notify ISP. Information disclosed under this Section shall remain privileged and confidential, and shall not be re-disclosed, except as required under Section 3.1(e) of the FOID Act, nor used for any other purpose. The method of providing this information shall guarantee that the information is not released beyond that which is necessary for the purpose of this Section.

9) The identity of the mental health facility reporting under this Section shall not be disclosed to the person who is the subject of the report.

Section 150.110 Recordkeeping
EMERGENCY

Persons who are reported by mental health facilities shall remain in the database unless removed under Section 150.120 or Section 150.500.

Section 150.120 Error Correcting
EMERGENCY

The mental health facility reporting the information shall be responsible for assuring the accuracy of the information they provide to the database and shall correct any of their errors.

SUBPART C: CLINICIAN REPORTING

Section 150.200 Reporting of Developmental Disabilities
EMERGENCY

a) Irrespective of whether the clinician is employed by the State or privately, such clinician shall notify DHS within 24 hours of making the determination that the person has a developmental disability.

b) DHS shall establish a web-based reporting platform. DHS shall update its records and information and shall notify ISP. Information disclosed under this Section shall remain privileged and confidential, and shall not be re-disclosed, except as required under Section 3.1(e) of the FOID Act, nor used for any other purpose. The method of providing this information shall guarantee that the information is not released beyond that which is necessary for the purpose of this Section.

c) The identity of the clinician reporting under this Section shall not be disclosed to the person who is the subject of the report.

Section 150.210 Reporting of Clear and Present Danger
EMERGENCY

a) Irrespective of whether the clinician is employed by the State or privately, such clinician shall notify DHS within 24 hours of making the determination that the person poses a clear and present danger as that term is defined in Section 1.1 of the FOID Act.

b) DHS shall establish a web-based reporting platform. DHS shall update its records and information and shall notify ISP. Information disclosed under this Section shall remain privileged and confidential and shall not be re-disclosed, except as required under Section 3.1(e) of the FOID Act, nor used for any other purpose. The method of providing this information shall guarantee that the information is not released beyond that which is necessary for the purpose of this Section.

c) The identity of the clinician reporting under this Section shall not be disclosed to the person who is the subject of the report.

Section 150.220 Recordkeeping
EMERGENCY

Persons who are reported by a clinician shall permanently remain in the database unless removed under Section 150.230 or Section 150.500.

Section 150.230 Error Correcting
EMERGENCY

The clinician shall be responsible for assuring the accuracy of the information he or she provides to the database and shall correct any of his or her errors.

SUBPART D: DATABASE USE

Section 150.400 Database Use
EMERGENCY

a) The information maintained in the database shall be used to assist ISP in determining eligibility for a Firearm Owner's Identification Card under the FOID Act. The process used shall be to cross-reference entries in the DHS FOID database file against entries in the database file of FOID card applicants and current cardholders supplied by ISP. Only those entries that are common to both database files shall be forwarded to ISP for further action.

b) As provided in Section 3.1(e)(2) of the FOID Act and in the Memorandum of Understanding developed pursuant to Section 150.600, certain information may be provided to the National Instant Criminal Background Check System Index, Denied Persons Files (28 CFR 25).

c) The DHS database is prohibited from additional uses not associated with the FOID Act.

SUBPART E: APPEALS

Section 150.500 Appeals
EMERGENCY

a) Appeals may be made by utilizing the provisions of 20 Ill. Adm. Code 1230.

b) An individual whose adjudication as a mentally disabled person has been overturned by the court system may submit a copy of such court order. Upon verification and consultation with ISP, the adjudication that has been overturned by the court order may be removed from the database.

SUBPART F: MEMORANDUM OF UNDERSTANDING

Section 150.600 Memorandum of Understanding
EMERGENCY

Pursuant to Section 3.1(e)(2) of the FOID Act, ISP and DHS shall, in accordance with State and federal law regarding confidentiality, enter into a memorandum of understanding with the Federal Bureau of Investigation for the purpose of implementing the National Instant Criminal Background Check System in the State. ISP shall report the name, date of birth, and physical description of any person prohibited from possessing a firearm pursuant to the FOID Act or 18 USC 922(g) and (n) to the National Instant Criminal Background Check System Index, Denied Persons Files (28 CFR 25).

ILLINOIS STATE TOLL HIGHWAY AUTHORITY

NOTICE OF EMERGENCY AMENDMENTS

1) Heading of the Part: State Toll Highway Rules

2) Code Citation: 92 Ill. Adm. Code 2520

3)

Section Numbers:	Emergency Action:
2520.410	Amend
2520.420	Amend

4) Statutory Authority: 605 ILCS 10/10, 625 ILCS 5/11-601, 625 ILCS 5/11-603

5) Effective Date of Emergency Rulemaking: January 7, 2014

6) If this emergency rulemaking expires before the end of the 150-day period, please specify the date on which it is to expire: These emergency amendments will expire upon the Tollway's adoption of the proposed replacement rulemaking.

7) Date Filed with the Index Department: January 2, 2014

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: In August 2013, the Governor approved legislation permitting an increase in speed limits to 70 mph on interstate highways outside of urban districts. The Illinois Department of Transportation (IDOT) and other transportation entities intend to increase speed limits shortly after the new law takes effect on January 1, 2014.

The Illinois State Toll Highway Authority (Tollway), unlike IDOT and other transportation bodies, must comply with time consuming administrative approval requirements before it may change its speed limits. Required procedures include a public notice/comment period and other requirements associated with the approval and publication of the new speed limits in its administrative rules. See 605 ILCS 5/11-603.

Given the recent enactment of law and the time necessary to submit and approve administrative rule changes in the traditional manner, the speed limit change will not complete the regulatory review, notice and approval process under the Illinois Administrative Procedure Act until a date sometime after January 2014. This is an issue because interstates and highways, operated by IDOT and other transportation agencies, connect and intersect with Illinois tollways. Without the enactment of this emergency

rulemaking, there likely will be inconsistent speed limits until the Tollway's proposed rulemaking is finalized near the spring of 2014.

Concurrent implementation of the 70 mile speed limit makes sense and supports these emergency amendments for the following reasons: 1) The agencies' concurrent speed limit implementation will provide for more consistent speed limits and minimize speed limit differences between like interstates and highways under different jurisdictions; 2) recent media concerning the increased speed limit will likely heighten motorist awareness of the new law and their expectation that the increased limits will be soon implemented; 3) concurrent implementation will likely reduce motorist confusion; and finally 4) the Tollway believes that the concurrent implementation of the new speed limits will allow for more consistent speed limit compliance by the motoring public and lead to fewer enforcement issues. Public interest and public safety support the enactment of these emergency amendments.

10) A Complete Description of the Subjects and Issues Involved: All of the procedural requirements necessary for Tollway speed limit approval have been, or are in the process of being, completed. This emergency rulemaking will bridge the gap and allow for the prompt implementation of the new speed limits while allowing for statutorily mandated publication, public comment and approval procedures.

11) Are there any proposed rulemaking pending on this Part? There is also an identical permanent rulemaking that has been published on this matter. See 37 Ill. Reg. 20630, December 27, 2013.

12) Statement of Statewide Policy Objective: This emergency rulemaking does not create or expand any State mandate.

13) Information and questions regarding this emergency rulemaking shall be directed to:

David Goldberg
General Counsel
Illinois Toll Highway Authority
2700 Ogden Avenue
Downers Grove, IL 60515

630/241-6800
TDD/TTY: 630/241-6898

ILLINOIS STATE TOLL HIGHWAY AUTHORITY

NOTICE OF EMERGENCY AMENDMENTS

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

ILLINOIS STATE TOLL HIGHWAY AUTHORITY

NOTICE OF EMERGENCY AMENDMENTS

TITLE 92: TRANSPORTATION
CHAPTER IV: ILLINOIS STATE TOLL HIGHWAY AUTHORITY

PART 2520
STATE TOLL HIGHWAY RULES

SUBPART A: AUTHORITY AND DEFINITIONS

Section
2520.100 Authority
2520.110 Authority Rulemaking
2520.120 Related Statutes
2520.130 Definitions

SUBPART B: GENERAL TRAFFIC RULES AND REGULATIONS

Section
2520.200 Illinois Vehicle Code
2520.203 Use of Tollway Prohibited or Restricted
2520.206 Vehicles Excepted from Provisions of Section 2520.203
2520.209 Transportation of Hazardous Materials
2520.212 Special Usage Toll
2520.215 Loading or Unloading of Vehicles
2520.218 Full Stop at All Toll Plazas
2520.221 Entering and Leaving the Tollway
2520.224 "U" Turns, Etc.
2520.227 Backing Up of Vehicles
2520.230 Parking, Standing or Stopping
2520.233 Relocating of Vehicles
2520.236 Pushing or Towing of Vehicles
2520.239 Stopping or Halting Vehicles by the Authority
2520.242 Destruction of Authority Property
2520.245 Picnics
2520.248 Aircraft
2520.251 Sale of Goods and Services
2520.254 Solicitation of Rides
2520.257 Loitering or Interfering with Traffic
2520.260 Approaching/Departing a Toll Plaza
2520.263 Compliance with Orders or Directions of State Troopers, Etc.

ILLINOIS STATE TOLL HIGHWAY AUTHORITY

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2520.266 Duty Upon Striking Fixtures, Structures or Other Property on Tollway
2520.269 Payment of Tolls
2520.272 I-Pass Registration
2520.275 Prohibited and Restricted Lanes
2520.278 Traffic Control Devices
2520.281 Penalty for Violation

SUBPART C: TRESPASS

Section
2520.300 Authority
2520.310 Restriction of Vehicles Using the Tollway
2520.320 Restriction on Nature of Use of Tollway
2520.340 Persons and Vehicles Excepted from the Requirements of Subpart C
2520.350 Penalties

SUBPART D: SPEED RESTRICTIONS

Section
2520.410 Maximum Speed Limits for Passenger Cars
EMERGENCY
2520.420 Maximum Speed Limits for Trucks, Buses, Passenger Cars Towing Trailers, House Trailers and Campers
EMERGENCY
2520.430 Maximum Speed Limits for Designated I-Pass Lanes, Service Areas, Parking Areas, Access Roads and Ramps, and Barrier Toll Plaza Approaches
2520.440 Road Hazards and Construction Zones
2520.450 Special Road Conditions
2520.460 Minimum Speed Limits

SUBPART E: FINES AND PENALTIES

Section
2520.510 Violations
2520.520 Littering – Penalty
2520.530 Spurious or Counterfeit Tickets, Coupons or Tokens – Penalty
2520.540 Toll Collection Devices – Penalty for Breaking
2520.550 I-PASS Customer − Penalties

ILLINOIS STATE TOLL HIGHWAY AUTHORITY

NOTICE OF EMERGENCY AMENDMENTS

SUBPART F: TOLL VIOLATIONS – ADMINISTRATIVE ADJUDICATION SYSTEM

Section
2520.700 Authority
2520.705 Notice of Violation to Respondent
2520.710 Effective Date of Notices
2520.715 Establishment of the Toll-Free Telephone Number
2520.720 Timely Request for Hearing
2520.725 Hearing Officers – Appointment, Disqualification, Powers and Duties
2520.730 Discovery
2520.735 Continuance
2520.740 Hearings Format
2520.745 Failure to Respond to Notice of Violation − Default
2520.750 Penalties
2520.755 Liability of Lessor
2520.760 Liability of Registered Owner
2520.765 Enforcement of Final Order
2520.770 Judicial Review

SUBPART G: EMPLOYMENT

2520.800 Tollway Employees

2520.APPENDIX A Rules and Regulations for Overweight and Overdimension Vehicles and Loads

AUTHORITY: Implementing and authorized by the Toll Highway Act [605 ILCS 10].

SOURCE: Filed January 3, 1973; effective February 1, 1973; codified at 8 Ill. Reg. 19884; Part repealed, new Part adopted at 17 Ill. Reg. 8539, effective May 27, 1993; amended at 20 Ill. Reg. 10200, effective July 12, 1996; emergency amendment at 24 Ill. Reg. 2737, effective February 4, 2000, for a maximum of 150 days; emergency expired July 2, 2000; emergency amendment at 24 Ill. Reg. 4234, effective February 29, 2000, for a maximum of 150 days; emergency expired July 27, 2000; amended at 24 Ill. Reg. 16078, effective October 11, 2000; emergency amendment at 26 Ill. Reg. 16325, effective October 31, 2002, for a maximum of 150 days ; amended at 27 Ill. Reg. 6325, effective April 1, 2003; emergency amendment at 27 Ill. Reg. 18238, effective November 6, 2003, for a maximum of 150 days; emergency expired April 5, 2004; emergency amendment at 28 Ill. Reg. 1780, effective January 14, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 6911, effective April 23, 2004; emergency amendment at 28 Ill. Reg.

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7688, effective May 24, 2004, for a maximum of 150 days; emergency expired October 20, 2004; amended at 28 Ill. Reg. 14530, effective October 25, 2004; old Part repealed at 30 Ill. Reg. 11261 and new Part adopted at 30 Ill. Reg. 11264, effective June 9, 2006; amended at 35 Ill. Reg. 535, effective December 27, 2010; emergency rulemaking at 38 Ill. Reg. 2433, effective January 7, 2014, for a maximum of 150 days.

SUBPART D: SPEED RESTRICTIONS

Section 2520.410 Maximum Speed Limits for Passenger Cars
EMERGENCY

The following shall be the maximum speed limits for passenger cars (includes motorcycles) on the Tollway, except as provided by Sections 2520.430 and 2520.440:

a) Tri-State Tollway (I-94 portion north ~~North~~ of Stearns School~~Lake Cook~~ Rd.):

55 miles per hour south of M.P.7.0~~3.0~~

65 miles per hour north of M.P.7.0~~3.0~~

Tri-State Tollway (I-294 portion in its entirety):

55 miles per hour, M.P.0.0 to M.P.52

b) Northwest Tollway (I-90):

55 miles per hour east of M.P.27.2 (west of Randall Road)

65 miles per hour west of M.P.27.2 (west of Randall Road) to M.P.17.4 (west of the I-39 Interchange)

70 miles per hour west of M.P.17.4

c) Ronald Reagan Memorial Highway (I-88):

55 miles per hour between the Eisenhower Expressway I-290 M.P.140.4 and M.P.115.0 (east of Orchard Rd. M.P.114.4)

65 miles per hour west of M.P.115.0 (east of Orchard Road M.P.114.4) to

ILLINOIS STATE TOLL HIGHWAY AUTHORITY

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M.P.109 (west of Rte. 47)

70 miles per hour west of M.P.109 (west of Rte. 47)

d) North-South Tollway (I-355):

55 miles per hour north of I-55 (M.P.12)

65 miles per hour south of I-55 (M.P.12)

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2433, effective January 7, 2014, for a maximum of 150 days)

Section 2520.420 Maximum Speed Limits for Trucks, Buses, Passenger Cars Towing Trailers, House Trailers and Campers
EMERGENCY

The maximum speed for trucks, buses, and passenger cars towing trailers, house trailers and campers is generally 55 miles per hour, but 70~~65~~ miles per hour west of Kane County (M.P.101) on I-88 and west of McHenry County (M.P.47.7) on I-90, except as provided by Sections 2520.430 and 2520.440.

(Source: Amended by emergency rulemaking at 38 Ill. Reg. 2433, effective January 7, 2014, for a maximum of 150 days)

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 December 31, 2013 through January 7, 2014. The Department of Public Health rulemaking is scheduled for review at the Committee's January 14, 2014 meeting. The Secretary of State rulemaking will be considered at the February 18, 2014 meeting. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rulemaking should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield IL 62706.

Second Notice Expires	Agency and Rule	Start Of First Notice	JCAR Meeting
2/13/14	Department of Public Health, Control of Communicable Diseases Code (77 Ill. Adm. Code 690)	4/12/13 37 Ill. Reg. 4479	1/14/14
2/20/14	Secretary of State, Illinois Safety Responsibility Law (92 Ill. Adm. Code 1070)	11/8/13 37 Ill. Reg. 17344	2/18/14

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

1. Statute requiring agency to publish information concerning Private Letter Rulings and General Information Letters in the Illinois Register:

Name of Act: Illinois Department of Revenue Sunshine Act
Citation: 20 ILCS 2515/1

2. Summary of information:

Index of Department of Revenue Sales and Miscellaneous Tax Private Letter Rulings and General Information Letters issued for the Third Quarter of 2013. Private letter rulings are issued by the Department in response to specific taxpayer inquiries concerning the application of a tax statute or rule to a particular fact situation. Private letter rulings are binding on the Department only as to the taxpayer who is the subject of the request for ruling. (See 2 Ill. Adm. Code 1200.110) General information letters are issued by the Department in response to written inquiries from taxpayers, taxpayer representatives, business, trade, industrial associations or similar groups. General information letters contain general discussions of tax principles or applications. General information letters are designed to provide general background information on topics of interest to taxpayers. General information letters do not constitute statements of agency policy that apply, interpret, or prescribe tax laws administered by the Department. *General information letters may not be relied upon by taxpayers in taking positions with reference to tax issues and create no rights for taxpayers under the Taxpayers' Bill of Rights Act.* (See 2 Ill. Adm. Code 1200.120)

The letters are listed numerically, are identified as either a General Information Letter or a Private Letter Ruling and are summarized with a brief synopsis under the following subjects:

Central of Registration
Certificates of Resale
Cigarette Tax
Claims for Credit
Community Water Supply
Computer Software
Construction Contractors
Enterprise Zones
Exempt Organizations
Food, Drugs & Medical Appliances
Governmental Bodies
Gross Receipts
Hotel Operators' Occupation Tax
Interstate Commerce
Leasing
Liquor Tax
Local Taxes
Medical Appliances

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

Miscellaneous
Motor Fuel Tax
Municipalities
Nexus
Occasional Sale
Returns
Rolling Stock Exemption
Sale for Resale
Sale of Service
Service Occupation Tax
Telecommunications Excise Tax
Use Tax Food
Tobacco Products Act

Copies of the ruling letters themselves are available for inspection and may be purchased for a minimum of $1.00 per opinion plus 50¢ per page for each page over one. Copies of the ruling letters may be downloaded free of charge from the Department's World Wide Web site at www.tax.illinois.gov/.

The annual index of Sales and Excise Tax letter rulings (all four quarters) is available for $3.00.

3. Name and address of person to contact concerning this information:

Lisa Marcure
Illinois Department of Revenue
Legal Services Office
101 West Jefferson Street
Springfield, Illinois 62794

Telephone: 217/782-2844

CERTIFICATE OF REGISTRATION

ST 13-0052-GIL 09/11/2013 Section 2a of the Retailers' Occupation Tax requires that a corporate applicant must submit the name, title and social security number of each corporate officer in order to obtain registration for sales taxes. See 35 ILCS 120/2a.

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

CERTIFICATES OF RESALE

ST-13-0060-GIL 10/22/2013 This letter discusses requirements for certificates of resale. *See* 86 Ill. Adm. Code 130.1405

ST-13-0062-GIL 10/22/2013 This letter discusses the standard drop-shipment scenario and certificates of resale. *See* 86 Ill. Adm. Code 130.225 and 86 Ill. Adm. Code 130.1405.

CIGARETTE TAX

ST 13-0020-GIL 04/30/2013 Retailers must obtain cigarettes for sale at retail from licensed distributors. 35 ILCS 130/4d.

CLAIMS FOR CREDIT

ST 13-0029-GIL 06/10/2013 If a taxpayer pays an amount of tax under the Retailers' Occupation Tax that is not due, either as a result of a mistake of fact or an error of law, the taxpayer may file a claim for credit with the Department. No credit shall be given the taxpayer unless the taxpayer shows that he or she has borne the burden of the tax or has unconditionally repaid the amount of the tax to the purchaser from whom it was collected. See 86 Ill. Adm. Code 130.1501.

COMMUNITY WATER SUPPLY

ST-13-0059-GIL 10/18/2013 This letter concerns the community water supply exemption. See 35 ILCS 105/3-5(34) and 35 ILCS 120/2-5(39).

COMPUTER SOFTWARE

DEPARTMENT OF REVENUE

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

ST 13-0015-GIL	03/31/2013	If transactions for the licensing of computer software meet all of the criteria provided in subsection (a)(1) of Section 130.1935, neither the transfer of the software nor the subsequent software updates will be subject to Retailers' Occupation Tax. See 86 Ill. Adm. Code 130.1935.
ST 13-0023-GIL	04/30/2013	If all the criteria listed in subsection (a)(1)(A)-(E) of Section 130.1935 are met, then neither a transaction involving the licensing of computer software nor the subsequent software updates will be considered a taxable retail sale subject to Retailers' Occupation and Use Tax. See 86 Ill. Adm. Code 130.1935.
ST 13-0027-GIL	05/28/2013	This letter concerns computer software maintenance agreements. See 86 Ill. Adm. Code 130.1935.
ST 13-0032-GIL	06/19/2013	A license of canned software is subject to Retailers' Occupation Tax liability if all of the criteria set out in 86 Ill. Adm. Code 130.1935(a)(1) are not met.
ST 13-0049-GIL	09/11/2013	This letter concerns the taxation of computer software transactions. See 86 Ill. Adm. Code 130.1935.
ST 13-0051-GIL	09/13/2013	This letter concerns the taxation of computer software. See 86 Ill. Adm. Code 130.1935.
ST 13-0054-GIL	09/19/2013	This letter discusses the taxability of computer software licenses and maintenance fees and the filing of quarterly returns. See 86 Ill. Adm. Code 130.502. See also 86 Ill. Adm. Code 130.1935 and 86 Ill. Adm. Code 140.301.
ST 13-0075-GIL	11/26/2013	This letter discusses the taxability of computer software licenses. See 86 Ill. Adm. Code 130.1935
ST 13-0076-GIL	11/26/2013	If transactions for the licensing of computer software meet all of the criteria provided in subsection (a)(1) of Section 130.1935,

DEPARTMENT OF REVENUE

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

neither the transfer of the software nor the subsequent software updates will be subject to Retailers' Occupation Tax. See 86 Ill. Adm. Code 130.1935

CONSTRUCTION CONTRACTORS

ST 13-0002-PLR	07/31/2013	When a construction contractor permanently affixes tangible personal property to real property, the contractor is deemed the end user of that tangible personal property. As the end user, the contractor incurs Use Tax on the cost price of that tangible personal property. See 86 Ill. Adm. Code 130.2075.
ST 13-0010-GIL	02/19/2013	Construction contractors who physically incorporate tangible personal property into real estate owned by exempt organizations or governmental entities that hold tax exempt "E" numbers can purchase such property tax free by providing their suppliers with the certification described in 86 Ill. Adm. Code 130.2075(d). See 86 Ill. Adm. Code Section 130.2075.
ST 13-0012-GIL	03/26/2013	Construction contractors who physically incorporate tangible personal property into real estate owned by exempt organizations or governmental entities that hold tax exempt "E" numbers can purchase such property tax free by providing their suppliers with the certification described in 86 Ill. Adm. Code 130.2075(d). See 86 Ill. Adm. Code Section 130.2075.
ST 13-0022-GIL	04/30/2013	When a construction contractor permanently affixes tangible personal property to real property, the contractor is deemed the end user of that tangible personal property. As the end user, the contractor incurs Use Tax on the cost price of that tangible personal property. See 86 Ill. Adm. Code 130.2075.
ST 13-0068-GIL	11/27/13	Construction contractors who physically incorporate tangible personal property into real estate owned by exempt organizations or governmental entities that hold tax exempt "E" numbers can purchase such property tax free by providing their suppliers with

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

the certification described in 86 Ill. Adm. Code 130.2075(d). See 86 Ill. Adm. Code Section 130.2075.

CONTRACTORS

ST 13-0066-GIL 10/07/2013 Construction contractors are deemed end users of tangible personal property purchased for incorporation into real property, and they incur Use Tax liability based upon their cost price of the tangible personal property. *See* 86 Ill. Adm. Code 130.1940 and 86 Ill. Adm. Code 130.2075

ENTERPRISE ZONES

ST 13-0007-GIL 02/05/2013 This letter describes the documentation required to document the Enterprise Zone building materials exemption. 35 ILCS 120/5k and 86 Ill. Adm. Code 130.1951(e).

EXEMPT ORGANIZATIONS

ST 13-0047-GIL 09/10/2013 The State of Illinois or any local governments in Illinois, or any agency or instrumentality of any such government body, incurs Retailers' Occupation Tax liability when it engages in the selling of tangible personal property at retail to the public other than in the performance of a governmental function. See 86 Ill. Adm. Code 130.2055.

FOOD

ST 13-0040-GIL 08/23/2013 This letter discusses the State tax rate applicable to sales of food, soft drinks and candy. See 86 Ill. Adm. Code 130.310.

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ST-13-0061-GIL 10/22/2013 This letter discusses the applicable sales tax rates for food. See 86 Ill. Adm. Code 130.310.

FOOD, DRUGS & MEDICAL APPLIANCES

ST 13-0014-GIL 03/29/2013 This letter discusses the State tax rates applicable to sales of food, drugs and medical appliances. See 86 Ill. Adm. Code 130.310 and 130.311.

GOVERNMENTAL BODIES

ST 13-0001-PLR 07/31/2013 Generally, a government contractor who purchases items to fulfill his obligations under a contract with a governmental unit purchases those items for use. See, U.S. v. New Mexico, 455 U.S. 720, 102 S. Ct. 1373 (1982). However, if the contract with the governmental unit explicitly requires the contractor to sell those items to the governmental unit, the purchase of those items by the contractor can be structured as purchases for the purpose of resale to the governmental unit. See 86 Ill. Adm. Code 130.2076.

GROSS RECEIPTS

ST 13-0037-GIL 08/02/2013 This letter discusses sales of prescription drugs by servicemen. See 86 Ill. Adm. Code Part 140.101.

HOTEL OPERATORS' TAX

ST 13-0028-GIL 05/28/2013 This letter discusses the Hotel Operators' Tax Act. See 86 Ill. Adm. Code 480.101 (b)(3).

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

ST 13-0043-GIL 08/23/2013 Redemption of a hotel chain's "rewards points" for stay at one of its hotels is not subject to Hotel Operators' Tax liability. See 35 ILCS 145/1 *et seq*.

ST 13-0077-GIL 11/26/2013 Gross receipts received from representatives of Taipei Economic and Cultural Representative Office in the United States possessing cards issued by American Institute of Taiwan that state the holder of the card is exempt from state and local sales taxes, restaurant and similar taxes are exempt from the Hotel Operators' Occupation Tax. 35 ILCS 145/3.

INTERSTATE COMMERCE

ST 13-0070-GIL 11/26/2013 This letter discusses sales in interstate and foreign commerce that originate in Illinois. *See* 86 Ill. Adm. Code 130.605.

LEASING

ST 13-0008-GIL 02/05/2013 Information regarding the tax liabilities in lease situations may be found at 86 Ill. Adm. Code 130.220 and 86 Ill. Adm. Code 130.2010.

ST 13-0026-GIL 05/28/2013 Information regarding the tax liabilities in lease situations may be found at 86 Ill. Adm. Code 130.220 and 86 Ill. Adm. Code 130.2010.

ST 13-0031-GIL 06/12/2013 Information regarding sales tax liabilities in lease situations may be found at 86 Ill. Adm. Code 130.220 and 86 Ill. Adm. Code 130.2010.

LIQUOR TAX

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

ST 13-0025-GIL 05/28/2013 Under the Liquor Control Act of 1934, out-of-state wineries who are going to sell wine directly to Illinois residents must complete an Application For State Of Illinois Winery Shipper's License ("Direct Shipping Permit").

LOCAL TAXES

ST 13-0005-GIL 01/25/2013 If a sale is made in a jurisdiction that imposes a local retailers' occupation tax, that local jurisdiction's tax will be incurred on that sale. See 86 Ill. Adm. Code 270.115(b).

MEDICAL APPLIANCES

ST 13-0038-GIL 08/08/2013 This letter discusses the State tax rates applicable to sales of medical appliances. See 86 Ill. Adm. Code 130.311.

MISCELLANEOUS

ST 13-0009-GIL 02/05/2013 This letter discusses "prepaid telephone calling arrangements". See 35 ILCS 120/2-7.

ST 13-0016-GIL 03/31/2013 This letter discusses "prepaid telephone calling arrangements" and the Prepaid Wireless 9-1-1 Surcharge Act. See 35 ILCS 120/2-7 and 50 ILCS 753.

ST 13-0036-GIL 07/31/2013 This letter responds to an annual survey. See 86 Ill. Adm. Code, Parts 120, 130, 140, and 160.

ST 13-0046-GIL 09/10/2013 This letter responds to a survey on series LLCs. See 86 Ill. Adm. Code Parts 130 and 150.

ST 13-0053-GIL 09/11/2013 This letter discusses "prepaid telephone calling arrangements" and prepaid calling plans. See 35 ILCS 120/2-7.

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

ST-13-0057-GIL	10/16/2013	The Department will not approve the accuracy of private legal publications.
ST 13-0072-GIL	11/13/2013	The exemption for materials, parts, equipment, components, and furnishings incorporated into or upon an aircraft as part of the modification, refurbishment, completion, replacement, repair, or maintenance of the aircraft applies only to the sale of qualifying tangible personal property to persons who modify, refurbish, complete, repair, replace, or maintain aircraft and who (i) hold an Air Agency Certificate and are empowered to operate an approved repair station by the Federal Aviation Administration, (ii) have a Class IV Rating, and (iii) conduct operations in accordance with Part 145 of the Federal Aviation Regulations. See 86 Ill. Adm. Code 130.120(aaa).

MOTOR FUEL TAX

ST 13-0013-GIL	03/29/2013	This letter describes documentation requirements under the Motor Fuel Tax Law. See 86 Ill. Adm. Code 500.335, 500.340 and 500.345.
ST 13-0045-GIL	08/23/2013	Motor Fuel Tax is imposed "on the privilege of operating motor vehicles upon the public highways, including toll roads, and recreational-type watercraft upon the waters of this State." 86 Ill. Adm. Code 500.200(a). This letter discusses taxes applicable to a specific type of dual-fuel vehicle.

MUNICIPALITIES

ST 13-0055-GIL	09/19/2013	This letter discusses collections of Retailer's Occupation Tax in business districts created by municipalities. See 65 ILCS 5/11.

NEXUS

DEPARTMENT OF REVENUE

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

ST 13-0006-GIL 01/30/2013 This letter responds to questionnaire regarding nexus. See Quill Corp. v. North Dakota, 112 S.Ct. 1904 (1992).

ST 13-0069-GIL 11/26/2013 This letter discusses nexus. See *Quill Corp. v. North Dakota*, 112 S.Ct. 1904 (1992).

OCCASIONAL SALE

ST 13-0033-GIL 07/30/2013 When persons sell tangible personal property which they are not otherwise engaged in the business of selling, such transactions may be occasional sales not subject to ROT. See 86 Ill. Adm. Code 130.110.

RETURNS

ST 13-0030-GIL 06/11/2013 A manufacturer or wholesaler whose products are sold by numerous distributors in Illinois may assume the responsibility of collecting and remitting Retailers' Occupation Tax on behalf of all sales made by those distributors under the provisions of 86 Ill. Adm. Code 130.550. See 86 Ill. Adm. Code 130.550.

ST 13-0067-GIL 11/27/13 This letter discusses the rules regarding when a retailer must file a monthly return. *See* 86 Ill. Adm. Code 130.501.

ROLLING STOCK EXEMPTION

ST 13-0002-GIL 01/18/2013 This letter discusses diesel exhaust fluid (DEF) and the rolling stock exemption. See 86 Ill. Adm. Code Section 130.340.

ST 13-0044-GIL 08/23/2013 This letter concerns the rolling stock exemption. See 86 Ill. Adm. Code Section 130.340.

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

ST-13-0064-GIL 10/22/2013 This letter concerns the rolling stock exemption. See 86 Ill. Adm. Code Section 130.340.

SALE FOR RESALE

ST 13-0001-GIL 01/09/2013 This letter concerns sales for resale. See 86 Ill. Adm. Code 130.1401.

ST 13-0018-GIL 04/23/2013 This letter addresses sales for resale. See 86 Ill. Adm. Code 130.1405.

ST 13-0042-GIL 08/23/2013 This letter describes the standard drop-shipment scenario and certificates of resale. *See* 86 Ill. Adm. Code 130.225. (This is a GIL.)See 86 Ill. Adm. Code.

ST-13-0056-GIL 10/08/2013 This letter addresses the resale of "Motor Fuel". See 86 Ill. Adm. Code 130.1405.

SALE OF SERVICE

ST 13-0004-GIL 01/25/2013 This letter clarifies and replaces the Department's previous response regarding the inquiry about the "Tire Disposal Fees" provided in our General Information Letter dated April 13, 2006, ST-06-0036.

ST 13-0019-GIL 04/26/2013 This letter rescinds, in part, ST-13-0004, regarding the taxation of the Tire User Fee.

ST 13-0034-GIL 07/31/2013 Under the Service Occupation Tax Act, servicemen are taxed on tangible personal property transferred as an incident to sales of service. See 86 Ill. Adm. Code 140.101.

ST 13-0050-GIL 09/11/2013 This letter addresses sales for resale. See 86 Ill. Adm. Code 130.1405.

DEPARTMENT OF REVENUE

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

SERVICE OCCUPATION TAX

ST 13-0003-GIL	01/18/2013	This letter concerns the taxation of tangible personal property transferred incident to sales of service. See 86 Ill. Adm. Code 140.01.
ST 13-0021-GIL	04/30/2013	The Service Occupation Tax is a tax imposed upon servicemen engaged in the business of making sales of service in this State, based on the tangible personal property transferred incident to sales of service. See 86 Ill. Adm. Code Part 140.
ST 13-0024-GIL	05/28/2013	If no tangible personal property is transferred to the customer, then no Illinois Retailers' Occupation Tax or Service Occupation Tax would apply. See 86 Ill. Adm. Code Parts 130 and 140.
ST 13-0035-GIL	07/31/2013	The Service Occupation Tax is a tax imposed upon servicemen engaged in the business of making sales of service in this State, based on the tangible personal property transferred incident to sales of service. See 86 Ill. Adm. Code Part 140.
ST 13-0039-GIL	08/23/2013	Rhe Service Occupation Tax is a tax imposed upon servicemen engaged in the business of making sales of service in this State, based on the tangible personal property transferred incident to sales of service. See 86 Ill. Adm. Code Part 140.
ST-13-0058-GIL	10/18/2013	If no tangible personal property is transferred to the customer, then no Illinois Retailers' Occupation Tax or Service Occupation Tax would apply. See 86 Ill. Adm. Code Parts 130 and 140.
ST-13-0065-GIL	10/22/2013	If no tangible personal property is transferred to the customer, then no Illinois Retailers' Occupation Tax or Service Occupation Tax would apply. See 86 Ill. Adm. Code Parts 130 and 140.

DEPARTMENT OF REVENUE

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

ST 13-0071-GIL 11/13/2013 Prior to Public Act 98-583, water service utilities generally acted as de minimis unregistered servicemen with respect to chemicals used in providing water service. As such, they would pay Use Tax to their suppliers for the chemicals. Public Act 98-583 provides that water that is delivered to customers through pipes, pipelines, or mains is not subject to tax under the Use Tax Act, the Service Use Tax Act, the Service Occupation Tax Act, or the Retailers' Occupation Tax Act. Therefore, chemicals transferred as a component part of the water are not subject to these taxes. See 86 Ill. Adm. Code 140.108 and Public Act 98-583.

TELECOMMUNICATIONS EXCISE TAX

ST 13-0011-GIL 03/12/2013 This letter concerns the very limited exemptions from Telecommunications Excise Tax. See 35 ILCS 630/2.

ST 13-0041-GIL 08/23/2013 Telecommunications Excise Tax is imposed upon the act or privilege of originating or receiving intrastate or interstate telecommunications in Illinois at the rate of 7% of the gross charges for such telecommunications purchased at retail from retailers. See 35 ILCS 630/1 *et seq.*

ST 13-0048-GIL 09/11/2013 The Telecommunications Excise Tax is imposed upon the act or privilege of originating or receiving intrastate or interstate telecommunications in Illinois at the rate of 7% of the gross charges for such telecommunications purchased at retail from retailers. See 35 ILCS 630/1 *et seq.*

ST 13-0073-GIL 11/26/2013 Generally, one-time account set-up fees are necessary for, and are directly related to, the retailer's provision of telecommunications to customers and are included in the gross charges subject to Telecommunications Excise Tax. See 86 Ill. Adm. Code 495.100(a).

ST 13-0074-GIL 11/26/2013 The Telecommunications Excise Tax is imposed upon the act or privilege of originating or receiving intrastate or interstate

DEPARTMENT OF REVENUE

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2013 ANNUAL SALES & MISCELLANEOUS TAX SUNSHINE INDEX

telecommunications in Illinois at the rate of 7% of the gross charges for such telecommunications purchased at retail from retailers. See 35 ILCS 630/1 *et seq.*

TOBACCO PRODUCTS TAX ACT

ST 13-0017-GIL	03/31/2013	This letter discusses the taxation of moist snuff. See 35 ILCS 143/10-10.

USE TAX

ST-13-0063-GIL	10/22/2013	This letter discusses the obligations of registered out-of-state sellers to collect Use Tax. *See* 86 Ill. Adm. Code 150.801.

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NOTICE OF PUBLIC INFORMATION

2013 FOURTH QUARTER SALES & MISCELLANEOUS TAX SUNSHINE INDEX

1. Statute requiring agency to publish information concerning Private Letter Rulings and General Information Letters in the Illinois Register:

Name of Act: Illinois Department of Revenue Sunshine Act
Citation: 20 ILCS 2515/1

2. Summary of information:

Index of Department of Revenue Sales and Miscellaneous Tax Private Letter Rulings and General Information Letters issued for the Third Quarter of 2013. Private letter rulings are issued by the Department in response to specific taxpayer inquiries concerning the application of a tax statute or rule to a particular fact situation. Private letter rulings are binding on the Department only as to the taxpayer who is the subject of the request for ruling. (See 2 Ill. Adm. Code 1200.110) General information letters are issued by the Department in response to written inquiries from taxpayers, taxpayer representatives, business, trade, industrial associations or similar groups. General information letters contain general discussions of tax principles or applications. General information letters are designed to provide general background information on topics of interest to taxpayers. General information letters do not constitute statements of agency policy that apply, interpret, or prescribe tax laws administered by the Department. *General information letters may not be relied upon by taxpayers in taking positions with reference to tax issues and create no rights for taxpayers under the Taxpayers' Bill of Rights Act.* (See 2 Ill. Adm. Code 1200.120)

The letters are listed numerically, are identified as either a General Information Letter or a Private Letter Ruling and are summarized with a brief synopsis under the following subjects:

Certificates of Resale
Community Water Supply
Computer Software
Construction Contractors
Food
Hotel Operators' Occupation Tax
Interstate Commerce
Miscellaneous
Nexus
Returns
Rolling Stock Exemption
Sale for Resale
Telecommunications Excise Tax
Use Tax

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2013 FOURTH QUARTER SALES & MISCELLANEOUS TAX SUNSHINE INDEX

Copies of the ruling letters themselves are available for inspection and may be purchased for a minimum of $1.00 per opinion plus 50¢ per page for each page over one. Copies of the ruling letters may be downloaded free of charge from the Department's World Wide Web site at www.tax.illinois.gov/.

The annual index of Sales and Excise Tax letter rulings (all four quarters) is available for $3.00.

3. Name and address of person to contact concerning this information:

Lisa Marcure
Illinois Department of Revenue
Legal Services Office
101 West Jefferson Street
Springfield, Illinois 62794

Telephone: 217782-2844

DEPARTMENT OF REVENUE

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2013 FOURTH QUARTER SALES & MISCELLANEOUS TAX SUNSHINE INDEX

CERTIFICATES OF RESALE

ST 13-0060-GIL	10/22/2013	This letter discusses requirements for certificates of resale. *See* 86 Ill. Adm. Code 130.1405
ST 13-0062-GIL	10/22/2013	This letter discusses the standard drop-shipment scenario and certificates of resale. *See* 86 Ill. Adm. Code 130.225 and 86 Ill. Adm. Code 130.1405.

COMMUNITY WATER SUPPLY

ST 13-0059-GIL	10/18/2013	This letter concerns the community water supply exemption. See 35 ILCS 105/3-5(34) and 35 ILCS 120/2-5(39).

COMPUTER SOFTWARE

ST 13-0075-GIL	11/26/2013	This letter discusses the taxability of computer software licenses. See 86 Ill. Adm. Code 130.1935
ST 13-0076-GIL	11/26/2013	If transactions for the licensing of computer software meet all of the criteria provided in subsection (a)(1) of Section 130.1935, neither the transfer of the software nor the subsequent software updates will be subject to Retailers' Occupation Tax. See 86 Ill. Adm. Code 130.1935

CONTRACTORS

ST 13-0066-GIL	10/07/2013	Construction contractors are deemed end users of tangible personal property purchased for incorporation into real property, and they incur Use Tax liability based upon their cost price of the tangible personal property. *See* 86 Ill. Adm. Code 130.1940 and 86 Ill. Adm. Code 130.2075

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2013 FOURTH QUARTER SALES & MISCELLANEOUS TAX SUNSHINE INDEX

CONSTRUCTION CONTRACTORS

ST 13-0068-GIL	11/27/2013	Construction contractors who physically incorporate tangible personal property into real estate owned by exempt organizations or governmental entities that hold tax exempt "E" numbers can purchase such property tax free by providing their suppliers with the certification described in 86 Ill. Adm. Code 130.2075(d). See 86 Ill. Adm. Code Section 130.2075.

FOOD

ST 13-0061-GIL	10/22/2013	This letter discusses the applicable sales tax rates for food. See 86 Ill. Adm. Code 130.310.

HOTEL OPERATORS' OCCUPATION TAX

ST 13-0077-GIL	11/26/2013	Gross receipts received from representatives of Taipei Economic and Cultural Representative Office in the United States possessing cards issued by American Institute of Taiwan that state the holder of the card is exempt from state and local sales taxes, restaurant and similar taxes are exempt from the Hotel Operators' Occupation Tax. 35 ILCS 145/3.

INTERSTATE COMMERCE

ST 13-0070-GIL	11/26/2013	This letter discusses sales in interstate and foreign commerce that originate in Illinois. *See* 86 Ill. Adm. Code 130.605.

MISCELLANEOUS

DEPARTMENT OF REVENUE

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2013 FOURTH QUARTER SALES & MISCELLANEOUS TAX SUNSHINE INDEX

ST 13-0057-GIL 10/16/2013 The Department will not approve the accuracy of private legal publications.

ST 13-0072-GIL 11/13/2013 The exemption for materials, parts, equipment, components, and furnishings incorporated into or upon an aircraft as part of the modification, refurbishment, completion, replacement, repair, or maintenance of the aircraft applies only to the sale of qualifying tangible personal property to persons who modify, refurbish, complete, repair, replace, or maintain aircraft and who (i) hold an Air Agency Certificate and are empowered to operate an approved repair station by the Federal Aviation Administration, (ii) have a Class IV Rating, and (iii) conduct operations in accordance with Part 145 of the Federal Aviation Regulations. See 86 Ill. Adm. Code 130.120(aaa).

NEXUS

ST 13-0069-GIL 11/26/2013 This letter discusses nexus. See *Quill Corp. v. North Dakota*, 112 S.Ct. 1904 (1992).

RETURNS

ST 13-0067-GIL 11/27/2013 This letter discusses the rules regarding when a retailer must file a monthly return. *See* 86 Ill. Adm. Code 130.501.

ROLLING STOCK EXEMPTION

ST 13-0064-GIL 10/22/2013 This letter concerns the rolling stock exemption. See 86 Ill. Adm. Code Section 130.340.

SALE FOR RESALE

ST 13-0056-GIL 10/08/2013 This letter addresses the resale of "Motor Fuel". See 86 Ill. Adm. Code 130.1405.

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

2013 FOURTH QUARTER SALES & MISCELLANEOUS TAX SUNSHINE INDEX

SERVICE OCCUPATION TAX

ST 13-0058-GIL 10/18/2013 If no tangible personal property is transferred to the customer, then no Illinois Retailers' Occupation Tax or Service Occupation Tax would apply. See 86 Ill. Adm. Code Parts 130 and 140.

ST 13-0065-GIL 10/22/2013 If no tangible personal property is transferred to the customer, then no Illinois Retailers' Occupation Tax or Service Occupation Tax would apply. See 86 Ill. Adm. Code Parts 130 and 140.

ST 13-0071-GIL 11/13/2013 Prior to Public Act 98-583, water service utilities generally acted as de minimis unregistered servicemen with respect to chemicals used in providing water service. As such, they would pay Use Tax to their suppliers for the chemicals. Public Act 98-583 provides that water that is delivered to customers through pipes, pipelines, or mains is not subject to tax under the Use Tax Act, the Service Use Tax Act, the Service Occupation Tax Act, or the Retailers' Occupation Tax Act. Therefore, chemicals transferred as a component part of the water are not subject to these taxes. See 86 Ill. Adm. Code 140.108 and Public Act 98-583.

TELECOMMUNICATIONS EXCISE TAX

ST 13-0073-GIL 11/26/2013 Generally, one-time account set-up fees are necessary for, and are directly related to, the retailer's provision of telecommunications to customers and are included in the gross charges subject to Telecommunications Excise Tax. See 86 Ill. Adm. Code 495.100(a).

ST 13-0074-GIL 11/26/2013 The Telecommunications Excise Tax is imposed upon the act or privilege of originating or receiving intrastate or interstate telecommunications in Illinois at the rate of 7% of the gross charges for such telecommunications purchased at retail from retailers. See 35 ILCS 630/1 *et seq.*

DEPARTMENT OF REVENUE

NOTICE OF PUBLIC INFORMATION

2013 FOURTH QUARTER SALES & MISCELLANEOUS TAX SUNSHINE INDEX

USE TAX

ST 13-0063-GIL	10/22/2013	This letter discusses the obligations of registered out-of-state sellers to collect Use Tax. *See* 86 Ill. Adm. Code 150.801.

ENVIRONMENTAL PROTECTION AGENCY

NOTICE OF PUBLIC INFORMATION

The Illinois Environmental Protection Agency (Illinois EPA) Bureau of Air is accepting public comment on a variance granted by the Illinois Pollution Control Board (Board) to Illinois Power Holdings, LLC (IPH) and AmerenEnergy Medina Valley Cogen, LLC (Medina Valley) for the purpose of submitting such variance to the United States Environmental Protection Agency (USEPA) as a revision to the Illinois State Implementation Plan (SIP) under the Clean Air Act (CAA), 42 USC § 7401 *et seq*. In order for a variance to be considered for approval as a revision to the SIP, the State must submit it in accordance with the requirements of 40 Code of Federal Regulations (CFR) § 51.104.

On July 22, 2013, IPH and Medina Valley, along with Ameren Energy Resources, LLC (AER), filed a Petition for Variance with the Board. *Illinois Power Holdings, LLC and AmerenEnergy Medina Valley Cogen, LLC, and Ameren Energy Resources, LLC v. Illinois Environmental Protection Agency*, PCB 14-10. IPH and Medina Valley requested a variance for the electrical generating units in AER's Multi-Pollutant Standards (MPS) Group from both the 2015 and 2017 sulfur dioxide (SO_2) emission rate provisions of the Illinois MPS, 35 Ill. Adm. Code 225.233, specifically the SO_2 emission standards set forth in Section 225.233(e)(3)(C)(iii) and (iv). This variance replaces the variance from the MPS for the same plants that AER currently holds. *Ameren Energy Resources v. Illinois Environmental Protection Agency*, PCB 12-126.

IPH, an indirect subsidiary of Dynegy, Inc., has acquired ownership of the Ameren operating merchant generating stations, namely the Coffeen Energy Center located in Montgomery County, the Duck Creek Energy Center located in Fulton County, the E.D. Edwards Energy Center located in Peoria County, the Joppa Energy Center located in Massac County, and the Newton Energy Center located in Jasper County, under a transaction agreement between Ameren and IPH. Medina Valley has acquired the shuttered generating stations, the Meredosia Energy Center in Morgan County and the Hutsonville Energy Center in Crawford County. On November 21, 2013, the Board granted the variance to IPH and Medina Valley from the applicable requirements of 35 Ill. Adm. Code 225.233(e)(3)(C)(iii) for a period beginning December 31, 2015, until December 31, 2019, and 35 Ill. Adm. Code 255.233(e)(3)(C)(iv) for a period beginning January 1, 2017, until December 31, 2019, subject to certain conditions.

The MPS is a multi-pollutant comprehensive approach to reduce emissions of nitrogen oxides, SO_2, and mercury. Section 225.233(e) is an approved rule of the Illinois SIP. On July 6, 2012, the USEPA approved the Illinois plan submitted to address the visibility protection requirements of Section 169A of the CAA, 42 U.S.C. § 7491, and the Regional Haze Rule, as codified in 40 CFR § 51.308. *See*, 77 Federal Register 39943 (July 6, 2012). The Illinois plan includes Section 225.233(e). Accordingly, since the petition for variance sought relief from provisions of the MPS and such relief was granted by the Board, the variance must be submitted to the USEPA for

approval as a SIP revision addressing the visibility requirements under the CAA and the Regional Haze Rule.

The Illinois EPA will accept written comments from the public. The written comments must be postmarked by February 18, 2014, unless a public hearing is requested. Requests for public hearing must be mailed in sufficient time to arrive at Illinois EPA no later than February 18, 2014. Comments and requests for hearing should be mailed to:

Dean Studer, Hearing Officer
Illinois EPA
1021 North Grand Avenue East
P.O. Box 19276
Springfield, Illinois 62794-9276
Telephone: 217/558-8280 or TDD: 217/782-9143

If a timely request for a public hearing is physically received by February 18, 2014, a public hearing will be scheduled through a separate notice and held to receive comments regarding the proposed SIP revision. If a public hearing is conducted, the written public comment period will be extended as provided for in the separate notice.

If no request for a public hearing is received by the Illinois EPA by U.S. Mail, carrier mail, or hand delivered by February 18, 2014, no hearing will be scheduled. Verification of a public hearing will be posted by February 28, 2014, on the Illinois EPA's website at http://www.epa.state.il.us/public-notices/. Interested persons may also contact Dean Studer, the Illinois EPA's Hearing Officer, at the phone number listed above to inquire as to the status of a public hearing.

Copies of the proposed SIP revision may be viewed by the public during regular business hours (Monday through Friday 8:30 a.m. until 4:30 p.m, except for State holidays) at the following Illinois EPA offices: 1021 North Grand Avenue East, Springfield, Illinois; 9511 W. Harrison St., Des Plaines, Illinois; and 2009 Mall Street, Collinsville, Illinois. No walk-in requests for copies of this material will be accommodated, unless advance notice is provided. Requests and public inquiries should be directed to Dean Studer, the Illinois EPA's Hearing Officer, at the address and phone number listed above.

If a hearing request is received, the hearing will be held in accordance with the provisions of the Illinois EPA's "Procedures for Informational and Quasi-Legislative Public Hearings," set forth at 35 Ill. Adm. Code 164. This notice is intended to satisfy the requirements of Section 110(l) of the CAA (42 USC § 7410(l) (public notice for SIP revisions)).

EXECUTIVE ORDER

2013-7
EXTENSION OF THE NORTHEASTERN ILLINOIS PUBLIC TRANSIT TASK FORCE

WHEREAS, on August 15, 2013, Executive Order Number 13-06 established the Northeastern Illinois Public Transit Task Force; and

WHEREAS, the purpose of the Task Force is to study, examine and evaluate the Northeastern Illinois Transit Agencies to determine how the operations of these agencies can be reorganized, streamlined or restructured to, among other things, ensure greater efficiency, accountability, coordination and transparency; and

WHEREAS, the Task Force has conducted numerous public meetings, public hearings and received comments and testimony from the Northeastern Illinois Transit Agencies and their leadership, governmental bodies, nationally-recognized transit experts and everyday commuters; and

WHEREAS, the Task Force on December 11, 2013 requested an extension to allow additional time to present recommendations to improve the transit agencies of Northeastern Illinois; and

WHEREAS, as Governor of the State of Illinois I am committed to improving the operations of the Northeastern Illinois Transit Agencies, repairing the damage done to the public trust and modernizing the transit system for the people who depend upon these systems to get them to work, school, home and other destinations; and

WHEREAS, we must take advantage of this opportunity to transform the Northeastern Illinois transit system and provide the Task Force with additional time to make recommendations to the Governor and General Assembly;

THEREFORE, I, Pat Quinn, Governor of Illinois, pursuant to the authority vested in me by Article V of the Illinois State Constitution of 1970, hereby order as follows:

I. TASK FORCE FINAL REPORT

The Task Force shall submit a final report no later than March 31, 2014 to the Governor and General Assembly, providing specific recommendations to improve the efficiency, accountability, coordination and transparency of the Transit Agencies.

II. TASK FORCE TERMINATION DATE

The Task Force shall terminate on March 31, 2014, upon completion of a final report providing comprehensive recommendations to the Governor and the General Assembly.

III. EFFECT ON EXECUTIVE ORDER 13-06

Executive Order 13-06 Sections II.d. and III.b. are hereby nullified. All other provisions of Executive Order 13-06 shall remain in full force and effect as amended.

IV. EFFECTIVE DATE

This Order shall take effect immediately upon its execution.

Issued by Governor: December 31, 2013
Filed with Secretary of State: December 31, 2013

PROCLAMATIONS

2014-1
GUBERNATORIAL DISASTER PROCLAMATION

Heavy snowfall and frigid temperatures have impacted Illinois since January 1, 2014. Many locations in the State have received 18 inches or more of snow this weekend. An ensuing arctic air blast has brought dangerously cold temperatures and high winds. Due to the snow, heavy gusting winds, and continued subzero temperatures, a widespread public safety threat exists as safe travel throughout Illinois is gravely compromised. Many Illinois highways and interstates have dozens of stranded motorists who are in need of immediate assistance.

In the interest of aiding the people of Illinois and the local governments responsible for ensuring public health and safety, and pursuant to the provisions of Section 7 of the Illinois Emergency Management Agency Act, 20 ILCS 3305/7, I hereby proclaim that a disaster exists within the State of Illinois as a result of this severe winter weather. I hereby invoke my authority to activate the Illinois National Guard to provide aid.

Issued by the Governor January 6, 2014.
Filed by the Secretary of State January 7, 2014

ILLINOIS ADMINISTRATIVE CODE
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