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37TH LEGISLATIVE DAY

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12:10 O'CLOCK P.M.

NO. 37
[April 30, 2003]

SENATE
Daily Journal Index
37th Legislative Day

The Senate met pursuant to adjournment.
Honorable Emil Jones Jr., President of the Senate, presiding.
Prayer by Pastor John Price, Springfield Church of Christ, Springfield, Illinois.
Senator Link led the Senate in the Pledge of Allegiance.

Senator Woolard moved that reading and approval of the Journals of Wednesday, April 16, 2003 and Tuesday, April 29, 2003 be postponed pending arrival of the printed Journals.
The motion prevailed.

LEGISLATIVE MEASURES FILED

The following Committee amendments to the House Bills listed below have been filed with the Secretary, and referred to the Committee on Rules:

Senate Committee Amendment No. 1 to House Bill 560
Senate Committee Amendment No. 1 to House Bill 954
Senate Committee Amendment No. 1 to House Bill 2553
Senate Committee Amendment No. 3 to House Bill 2809
Senate Committee Amendment No. 1 to House Bill 3528

The following Floor amendments to the House Bill listed below have been filed with the Secretary, and referred to the Committee on Rules:

Senate Floor Amendment No. 2 to House Bill 3183

REPORTS FROM STANDING COMMITTEES

Senator Shadid, Chairperson of the Committee on Transportation to which was referred **House Bills numbered 136, 298, 499, 1186, 1189, 1273, 1389, 1491, 1574, 2273, 2492, 2840, 3063, 3106, 3540, 3543 and 3692** reported the same back with the recommendation that the bills do pass.
Under the rules, the bills were ordered to a second reading.

Senator Shadid, Chairperson of the Committee on Transportation to which was referred **House Bills numbered 44, 463 and 3061** reported the same back with amendments having been adopted thereto, with the recommendation that the bills, as amended, do pass.
Under the rules, the bills were ordered to a second reading.

Senator Trotter, Chairperson of the Committee on Appropriations I to which was referred **House Bills numbered 2663, 2664, 2669, 2672, 2673, 2678, 2680, 2681, 2686, 2696, 2698, 2700, 2705, 2708, 2716, 2718, 2719, 2721, 2726, 2730, 2739, 2743, 2747, 2751, 2756, 2761 and 2762** reported the same back with the recommendation that the bills do pass.
Under the rules, the bills were ordered to a second reading.

Senator Haine, Chairperson of the Committee on Local Government to which was referred **House Bills numbered 30, 116, 120, 138, 263, 273, 300, 462, 528, 1246, 1267, 1385, 1434, 1447, 1751, 2299, 2477, 2549, 2618, 2634, 3079, 3231, 3402, 3411, 3530 and 3679** reported the same back with the recommendation that the bills do pass.
Under the rules, the bills were ordered to a second reading.

Senator Haine, Chairperson of the Committee on Local Government to which was referred **House Bills numbered 1195, 1251, 1514, 2301 and 2317** reported the same back with amendments having been adopted thereto, with the recommendation that the bills, as amended, do pass.
Under the rules, the bills were ordered to a second reading.

Senator Clayborne, Chairperson of the Committee on Environment & Energy to which was referred **House Bills numbered 548, 1165, 1279, 2200, 2265, 2489, 2839 and 3553** reported the same back with the recommendation that the bills do pass.

Under the rules, the bills were ordered to a second reading.

Senator Clayborne, Chairperson of the Committee on Environment & Energy to which was referred **House Bills numbered 176, 3321, 3407 and 3507** reported the same back with amendments having been adopted thereto, with the recommendation that the bills, as amended, do pass.

Under the rules, the bills were ordered to a second reading.

Senator Walsh, Chairperson of the Committee on Agriculture & Conservation to which was referred **House Bills numbered 231, 264, 1121, 1458, 2889, 2890, 2918, 2949 and 2950** reported the same back with the recommendation that the bills do pass.

Under the rules, the bills were ordered to a second reading.

Senator Walsh, Chairperson of the Committee on Agriculture & Conservation to which was referred **House Bill No. 1096** reported the same back with amendments having been adopted thereto, with the recommendation that the bill, as amended, do pass.

Under the rules, the bill was ordered to a second reading.

INTRODUCTION OF BILLS

SENATE BILL NO. 2086. Introduced by Senator Burzynski, a bill for AN ACT in relation to public aid.

The bill was taken up, read by title a first time, ordered printed and referred to the Committee on Rules.

READING BILLS FROM THE HOUSE OF REPRESENTATIVES A SECOND TIME

On motion of Senator Silverstein, **House Bill No. 56** was taken up and read by title a second time.

Floor Amendment No. 1 was held in the Committee on Rules.

There being no further amendments the bill was ordered to a third reading.

On motion of Senator Righter, **House Bill No. 194** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Trotter, **House Bill No. 205** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Walsh, **House Bill No. 269** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Martinez, **House Bill No. 275** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Martinez, **House Bill No. 293** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Radogno, **House Bill No. 338** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Halvorson, **House Bill No. 385** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Welch, **House Bill No. 430** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Education, adopted and ordered printed:

AMENDMENT NO. 1

AMENDMENT NO. 1. Amend House Bill 430 by replacing everything after the enacting clause with

the following:

"Section 5. The School Code is amended by changing Section 18-8.05 as follows:

(105 ILCS 5/18-8.05)

Sec. 18-8.05. Basis for apportionment of general State financial aid and supplemental general State aid to the common schools for the 1998-1999 and subsequent school years.

(A) General Provisions.

(1) The provisions of this Section apply to the 1998-1999 and subsequent school years. The system of general State financial aid provided for in this Section is designed to assure that, through a combination of State financial aid and required local resources, the financial support provided each pupil in Average Daily Attendance equals or exceeds a prescribed per pupil Foundation Level. This formula approach imputes a level of per pupil Available Local Resources and provides for the basis to calculate a per pupil level of general State financial aid that, when added to Available Local Resources, equals or exceeds the Foundation Level. The amount of per pupil general State financial aid for school districts, in general, varies in inverse relation to Available Local Resources. Per pupil amounts are based upon each school district's Average Daily Attendance as that term is defined in this Section.

(2) In addition to general State financial aid, school districts with specified levels or concentrations of pupils from low income households are eligible to receive supplemental general State financial aid grants as provided pursuant to subsection (H). The supplemental State aid grants provided for school districts under subsection (H) shall be appropriated for distribution to school districts as part of the same line item in which the general State financial aid of school districts is appropriated under this Section.

(3) To receive financial assistance under this Section, school districts are required to file claims with the State Board of Education, subject to the following requirements:

(a) Any school district which fails for any given school year to maintain school as required by law, or to maintain a recognized school is not eligible to file for such school year any claim upon the Common School Fund. In case of nonrecognition of one or more attendance centers in a school district otherwise operating recognized schools, the claim of the district shall be reduced in the proportion which the Average Daily Attendance in the attendance center or centers bear to the Average Daily Attendance in the school district. A "recognized school" means any public school which meets the standards as established for recognition by the State Board of Education. A school district or attendance center not having recognition status at the end of a school term is entitled to receive State aid payments due upon a legal claim which was filed while it was recognized.

(b) School district claims filed under this Section are subject to Sections 18-9, 18-10, and 18-12, except as otherwise provided in this Section.

(c) If a school district operates a full year school under Section 10-19.1, the general State aid to the school district shall be determined by the State Board of Education in accordance with this Section as near as may be applicable.

(d) (Blank).

(4) Except as provided in subsections (H) and (L), the board of any district receiving any of the grants provided for in this Section may apply those funds to any fund so received for which that board is authorized to make expenditures by law.

School districts are not required to exert a minimum Operating Tax Rate in order to qualify for assistance under this Section.

(5) As used in this Section the following terms, when capitalized, shall have the meaning ascribed herein:

(a) "Average Daily Attendance": A count of pupil attendance in school, averaged as provided for in subsection (C) and utilized in deriving per pupil financial support levels.

(b) "Available Local Resources": A computation of local financial support, calculated on the basis of Average Daily Attendance and derived as provided pursuant to subsection (D).

(c) "Corporate Personal Property Replacement Taxes": Funds paid to local school districts pursuant to "An Act in relation to the abolition of ad valorem personal property tax and the replacement of revenues lost thereby, and amending and repealing certain Acts and parts of Acts in connection therewith", certified August 14, 1979, as amended (Public Act 81-1st S.S.-1).

(d) "Foundation Level": A prescribed level of per pupil financial support as provided for in subsection (B).

(e) "Operating Tax Rate": All school district property taxes extended for all purposes, except Bond and Interest, Summer School, Rent, Capital Improvement, and Vocational Education Building purposes.

(B) Foundation Level.

(1) The Foundation Level is a figure established by the State representing the minimum level of per

pupil financial support that should be available to provide for the basic education of each pupil in Average Daily Attendance. As set forth in this Section, each school district is assumed to exert a sufficient local taxing effort such that, in combination with the aggregate of general State financial aid provided the district, an aggregate of State and local resources are available to meet the basic education needs of pupils in the district.

(2) For the 1998-1999 school year, the Foundation Level of support is $4,225. For the 1999-2000 school year, the Foundation Level of support is $4,325. For the 2000-2001 school year, the Foundation Level of support is $4,425.

(3) For the 2001-2002 school year and each school year thereafter, the Foundation Level of support is $4,560 or such greater amount as may be established by law by the General Assembly.

(C) Average Daily Attendance.

(1) For purposes of calculating general State aid pursuant to subsection (E), an Average Daily Attendance figure shall be utilized. The Average Daily Attendance figure for formula calculation purposes shall be the monthly average of the actual number of pupils in attendance of each school district, as further averaged for the best 3 months of pupil attendance for each school district. In compiling the figures for the number of pupils in attendance, school districts and the State Board of Education shall, for purposes of general State aid funding, conform attendance figures to the requirements of subsection (F).

(2) The Average Daily Attendance figures utilized in subsection (E) shall be the requisite attendance data for the school year immediately preceding the school year for which general State aid is being calculated or the average of the attendance data for the 3 preceding school years, whichever is greater. The Average Daily Attendance figures utilized in subsection (H) shall be the requisite attendance data for the school year immediately preceding the school year for which general State aid is being calculated.

(D) Available Local Resources.

(1) For purposes of calculating general State aid pursuant to subsection (E), a representation of Available Local Resources per pupil, as that term is defined and determined in this subsection, shall be utilized. Available Local Resources per pupil shall include a calculated dollar amount representing local school district revenues from local property taxes and from Corporate Personal Property Replacement Taxes, expressed on the basis of pupils in Average Daily Attendance.

(2) In determining a school district's revenue from local property taxes, the State Board of Education shall utilize the equalized assessed valuation of all taxable property of each school district as of September 30 of the previous year. The equalized assessed valuation utilized shall be obtained and determined as provided in subsection (G).

(3) For school districts maintaining grades kindergarten through 12, local property tax revenues per pupil shall be calculated as the product of the applicable equalized assessed valuation for the district multiplied by 3.00%, and divided by the district's Average Daily Attendance figure. For school districts maintaining grades kindergarten through 8, local property tax revenues per pupil shall be calculated as the product of the applicable equalized assessed valuation for the district multiplied by 2.30%, and divided by the district's Average Daily Attendance figure. For school districts maintaining grades 9 through 12, local property tax revenues per pupil shall be the applicable equalized assessed valuation of the district multiplied by 1.05%, and divided by the district's Average Daily Attendance figure.

(4) The Corporate Personal Property Replacement Taxes paid to each school district during the calendar year 2 years before the calendar year in which a school year begins, divided by the Average Daily Attendance figure for that district, shall be added to the local property tax revenues per pupil as derived by the application of the immediately preceding paragraph (3). The sum of these per pupil figures for each school district shall constitute Available Local Resources as that term is utilized in subsection (E) in the calculation of general State aid.

(E) Computation of General State Aid.

(1) For each school year, the amount of general State aid allotted to a school district shall be computed by the State Board of Education as provided in this subsection.

(2) For any school district for which Available Local Resources per pupil is less than the product of 0.93 times the Foundation Level, general State aid for that district shall be calculated as an amount equal to the Foundation Level minus Available Local Resources, multiplied by the Average Daily Attendance of the school district.

(3) For any school district for which Available Local Resources per pupil is equal to or greater than the product of 0.93 times the Foundation Level and less than the product of 1.75 times the Foundation Level, the general State aid per pupil shall be a decimal proportion of the Foundation Level derived using a linear algorithm. Under this linear algorithm, the calculated general State aid per pupil shall

decline in direct linear fashion from 0.07 times the Foundation Level for a school district with Available Local Resources equal to the product of 0.93 times the Foundation Level, to 0.05 times the Foundation Level for a school district with Available Local Resources equal to the product of 1.75 times the Foundation Level. The allocation of general State aid for school districts subject to this paragraph 3 shall be the calculated general State aid per pupil figure multiplied by the Average Daily Attendance of the school district.

(4) For any school district for which Available Local Resources per pupil equals or exceeds the product of 1.75 times the Foundation Level, the general State aid for the school district shall be calculated as the product of $218 multiplied by the Average Daily Attendance of the school district.

(5) The amount of general State aid allocated to a school district for the 1999-2000 school year meeting the requirements set forth in paragraph (4) of subsection (G) shall be increased by an amount equal to the general State aid that would have been received by the district for the 1998-1999 school year by utilizing the Extension Limitation Equalized Assessed Valuation as calculated in paragraph (4) of subsection (G) less the general State aid allotted for the 1998-1999 school year. This amount shall be deemed a one time increase, and shall not affect any future general State aid allocations.

(F) Compilation of Average Daily Attendance.

(1) Each school district shall, by July 1 of each year, submit to the State Board of Education, on forms prescribed by the State Board of Education, attendance figures for the school year that began in the preceding calendar year. The attendance information so transmitted shall identify the average daily attendance figures for each month of the school year. Beginning with the general State aid claim form for the 2002-2003 school year, districts shall calculate Average Daily Attendance as provided in subdivisions (a), (b), and (c) of this paragraph (1).

(a) In districts that do not hold year-round classes, days of attendance in August shall be added to the month of September and any days of attendance in June shall be added to the month of May.

(b) In districts in which all buildings hold year-round classes, days of attendance in July and August shall be added to the month of September and any days of attendance in June shall be added to the month of May.

(c) In districts in which some buildings, but not all, hold year-round classes, for the non-year-round buildings, days of attendance in August shall be added to the month of September and any days of attendance in June shall be added to the month of May. The average daily attendance for the year-round buildings shall be computed as provided in subdivision (b) of this paragraph (1). To calculate the Average Daily Attendance for the district, the average daily attendance for the year-round buildings shall be multiplied by the days in session for the non-year-round buildings for each month and added to the monthly attendance of the non-year-round buildings.

Except as otherwise provided in this Section, days of attendance by pupils shall be counted only for sessions of not less than 5 clock hours of school work per day under direct supervision of: (i) teachers, or (ii) non-teaching personnel or volunteer personnel when engaging in non-teaching duties and supervising in those instances specified in subsection (a) of Section 10-22.34 and paragraph 10 of Section 34-18, with pupils of legal school age and in kindergarten and grades 1 through 12.

Days of attendance by tuition pupils shall be accredited only to the districts that pay the tuition to a recognized school.

(2) Days of attendance by pupils of less than 5 clock hours of school shall be subject to the following provisions in the compilation of Average Daily Attendance.

(a) Pupils regularly enrolled in a public school for only a part of the school day may be counted on the basis of 1/6 day for every class hour of instruction of 40 minutes or more attended pursuant to such enrollment, unless a pupil is enrolled in a block-schedule format of 80 minutes or more of instruction, in which case the pupil may be counted on the basis of the proportion of minutes of school work completed each day to the minimum number of minutes that school work is required to be held that day.

(b) Days of attendance may be less than 5 clock hours on the opening and closing of the school term, and upon the first day of pupil attendance, if preceded by a day or days utilized as an institute or teachers' workshop.

(c) A session of 4 or more clock hours may be counted as a day of attendance upon certification by the regional superintendent, and approved by the State Superintendent of Education to the extent that the district has been forced to use daily multiple sessions.

(d) A session of 3 or more clock hours may be counted as a day of attendance (1) when the remainder of the school day or at least 2 hours in the evening of that day is utilized for an in-service training program for teachers, up to a maximum of 5 days per school year of which a maximum of 4 days of such 5 days may be used for parent-teacher conferences, provided a district conducts an in-

service training program for teachers which has been approved by the State Superintendent of Education; or, in lieu of 4 such days, 2 full days may be used, in which event each such day may be counted as a day of attendance; and (2) when days in addition to those provided in item (1) are scheduled by a school pursuant to its school improvement plan adopted under Article 34 or its revised or amended school improvement plan adopted under Article 2, provided that (i) such sessions of 3 or more clock hours are scheduled to occur at regular intervals, (ii) the remainder of the school days in which such sessions occur are utilized for in-service training programs or other staff development activities for teachers, and (iii) a sufficient number of minutes of school work under the direct supervision of teachers are added to the school days between such regularly scheduled sessions to accumulate not less than the number of minutes by which such sessions of 3 or more clock hours fall short of 5 clock hours. Any full days used for the purposes of this paragraph shall not be considered for computing average daily attendance. Days scheduled for in-service training programs, staff development activities, or parent-teacher conferences may be scheduled separately for different grade levels and different attendance centers of the district.

(e) A session of not less than one clock hour of teaching hospitalized or homebound pupils on-site or by telephone to the classroom may be counted as 1/2 day of attendance, however these pupils must receive 4 or more clock hours of instruction to be counted for a full day of attendance.

(f) A session of at least 4 clock hours may be counted as a day of attendance for first grade pupils, and pupils in full day kindergartens, and a session of 2 or more hours may be counted as 1/2 day of attendance by pupils in kindergartens which provide only 1/2 day of attendance.

(g) For children with disabilities who are below the age of 6 years and who cannot attend 2 or more clock hours because of their disability or immaturity, a session of not less than one clock hour may be counted as 1/2 day of attendance; however for such children whose educational needs so require a session of 4 or more clock hours may be counted as a full day of attendance.

(h) A recognized kindergarten which provides for only 1/2 day of attendance by each pupil shall not have more than 1/2 day of attendance counted in any one day. However, kindergartens may count 2 1/2 days of attendance in any 5 consecutive school days. When a pupil attends such a kindergarten for 2 half days on any one school day, the pupil shall have the following day as a day absent from school, unless the school district obtains permission in writing from the State Superintendent of Education. Attendance at kindergartens which provide for a full day of attendance by each pupil shall be counted the same as attendance by first grade pupils. Only the first year of attendance in one kindergarten shall be counted, except in case of children who entered the kindergarten in their fifth year whose educational development requires a second year of kindergarten as determined under the rules and regulations of the State Board of Education.

(G) Equalized Assessed Valuation Data.

(1) For purposes of the calculation of Available Local Resources required pursuant to subsection (D), the State Board of Education shall secure from the Department of Revenue the value as equalized or assessed by the Department of Revenue of all taxable property of every school district, together with (i) the applicable tax rate used in extending taxes for the funds of the district as of September 30 of the previous year and (ii) the limiting rate for all school districts subject to property tax extension limitations as imposed under the Property Tax Extension Limitation Law.

This equalized assessed valuation, as adjusted further by the requirements of this subsection, shall be utilized in the calculation of Available Local Resources.

(2) The equalized assessed valuation in paragraph (1) shall be adjusted, as applicable, in the following manner:

(a) For the purposes of calculating State aid under this Section, with respect to any part of a school district within a redevelopment project area in respect to which a municipality has adopted tax increment allocation financing pursuant to the Tax Increment Allocation Redevelopment Act, Sections 11-74.4-1 through 11-74.4-11 of the Illinois Municipal Code or the Industrial Jobs Recovery Law, Sections 11-74.6-1 through 11-74.6-50 of the Illinois Municipal Code, no part of the current equalized assessed valuation of real property located in any such project area which is attributable to an increase above the total initial equalized assessed valuation of such property shall be used as part of the equalized assessed valuation of the district, until such time as all redevelopment project costs have been paid, as provided in Section 11-74.4-8 of the Tax Increment Allocation Redevelopment Act or in Section 11-74.6-35 of the Industrial Jobs Recovery Law. For the purpose of the equalized assessed valuation of the district, the total initial equalized assessed valuation or the current equalized assessed valuation, whichever is lower, shall be used until such time as all redevelopment project costs have been paid.

(b) The real property equalized assessed valuation for a school district shall be adjusted by

subtracting from the real property value as equalized or assessed by the Department of Revenue for the district an amount computed by dividing the amount of any abatement of taxes under Section 18-170 of the Property Tax Code by 3.00% for a district maintaining grades kindergarten through 12, by 2.30% for a district maintaining grades kindergarten through 8, or by 1.05% for a district maintaining grades 9 through 12 and adjusted by an amount computed by dividing the amount of any abatement of taxes under subsection (a) of Section 18-165 of the Property Tax Code by the same percentage rates for district type as specified in this subparagraph (b).

(3) For the 1999-2000 school year and each school year thereafter, if a school district meets all of the criteria of this subsection (G)(3), the school district's Available Local Resources shall be calculated under subsection (D) using the district's Extension Limitation Equalized Assessed Valuation as calculated under this subsection (G)(3).

For purposes of this subsection (G)(3) the following terms shall have the following meanings:

"Budget Year": The school year for which general State aid is calculated and awarded under subsection (E).

"Base Tax Year": The property tax levy year used to calculate the Budget Year allocation of general State aid.

"Preceding Tax Year": The property tax levy year immediately preceding the Base Tax Year.

"Base Tax Year's Tax Extension": The product of the equalized assessed valuation utilized by the County Clerk in the Base Tax Year multiplied by the limiting rate as calculated by the County Clerk and defined in the Property Tax Extension Limitation Law.

"Preceding Tax Year's Tax Extension": The product of the equalized assessed valuation utilized by the County Clerk in the Preceding Tax Year multiplied by the Operating Tax Rate as defined in subsection (A).

"Extension Limitation Ratio": A numerical ratio, certified by the County Clerk, in which the numerator is the Base Tax Year's Tax Extension and the denominator is the Preceding Tax Year's Tax Extension.

"Operating Tax Rate": The operating tax rate as defined in subsection (A).

If a school district is subject to property tax extension limitations as imposed under the Property Tax Extension Limitation Law, the State Board of Education shall calculate the Extension Limitation Equalized Assessed Valuation of that district. For the 1999-2000 school year, the Extension Limitation Equalized Assessed Valuation of a school district as calculated by the State Board of Education shall be equal to the product of the district's 1996 Equalized Assessed Valuation and the district's Extension Limitation Ratio. For the 2000-2001 school year and each school year thereafter, the Extension Limitation Equalized Assessed Valuation of a school district as calculated by the State Board of Education shall be equal to the product of the Equalized Assessed Valuation last used in the calculation of general State aid and the district's Extension Limitation Ratio. If the Extension Limitation Equalized Assessed Valuation of a school district as calculated under this subsection (G)(3) is less than the district's equalized assessed valuation as calculated pursuant to subsections (G)(1) and (G)(2), then for purposes of calculating the district's general State aid for the Budget Year pursuant to subsection (E), that Extension Limitation Equalized Assessed Valuation shall be utilized to calculate the district's Available Local Resources under subsection (D).

(4) For the purposes of calculating general State aid for the 1999-2000 school year only, if a school district experienced a triennial reassessment on the equalized assessed valuation used in calculating its general State financial aid apportionment for the 1998-1999 school year, the State Board of Education shall calculate the Extension Limitation Equalized Assessed Valuation that would have been used to calculate the district's 1998-1999 general State aid. This amount shall equal the product of the equalized assessed valuation used to calculate general State aid for the 1997-1998 school year and the district's Extension Limitation Ratio. If the Extension Limitation Equalized Assessed Valuation of the school district as calculated under this paragraph (4) is less than the district's equalized assessed valuation utilized in calculating the district's 1998-1999 general State aid allocation, then for purposes of calculating the district's general State aid pursuant to paragraph (5) of subsection (E), that Extension Limitation Equalized Assessed Valuation shall be utilized to calculate the district's Available Local Resources.

(5) For school districts having a majority of their equalized assessed valuation in any county except Cook, DuPage, Kane, Lake, McHenry, or Will, if the amount of general State aid allocated to the school district for the 1999-2000 school year under the provisions of subsection (E), (H), and (J) of this Section is less than the amount of general State aid allocated to the district for the 1998-1999 school year under these subsections, then the general State aid of the district for the 1999-2000 school year only shall be increased by the difference between these amounts. The total payments made under this paragraph (5)

shall not exceed $14,000,000. Claims shall be prorated if they exceed $14,000,000.

(H) Supplemental General State Aid.

(1) In addition to the general State aid a school district is allotted pursuant to subsection (E), qualifying school districts shall receive a grant, paid in conjunction with a district's payments of general State aid, for supplemental general State aid based upon the concentration level of children from low-income households within the school district. Supplemental State aid grants provided for school districts under this subsection shall be appropriated for distribution to school districts as part of the same line item in which the general State financial aid of school districts is appropriated under this Section.

(1.5) This paragraph (1.5) applies only to those school years preceding the 2003-2004 school year. For purposes of this subsection (H), the term "Low-Income Concentration Level" shall be the low-income eligible pupil count from the most recently available federal census divided by the Average Daily Attendance of the school district. If, however, (i) the percentage decrease from the 2 most recent federal censuses in the low-income eligible pupil count of a high school district with fewer than 400 students exceeds by 75% or more the percentage change in the total low-income eligible pupil count of contiguous elementary school districts, whose boundaries are coterminous with the high school district, or (ii) a high school district within 2 counties and serving 5 elementary school districts, whose boundaries are coterminous with the high school district, has a percentage decrease from the 2 most recent federal censuses in the low-income eligible pupil count and there is a percentage increase in the total low-income eligible pupil count of a majority of the elementary school districts in excess of 50% from the 2 most recent federal censuses, then the high school district's low-income eligible pupil count from the earlier federal census shall be the number used as the low-income eligible pupil count for the high school district, for purposes of this subsection (H). The changes made to this paragraph (1) by Public Act 92-28 shall apply to supplemental general State aid grants for school years preceding the 2003-2004 school year that are paid in fiscal year 1999 or ~~and in each fiscal year~~ thereafter and to any State aid payments made in fiscal year 1994 through fiscal year 1998 pursuant to subsection 1(n) of Section 18-8 of this Code (which was repealed on July 1, 1998), and any high school district that is affected by Public Act 92-28 is entitled to a recomputation of its supplemental general State aid grant or State aid paid in any of those fiscal years. This recomputation shall not be affected by any other funding.

(1.10) This paragraph (1.10) applies to the 2003-2004 school year and each school year thereafter. For purposes of this subsection (4), the term "Low-Income Concentration Level" shall be the low-income eligible pupil count (as determined by the Department of Human Services based on the number of pupils who are eligible for at least one of the following low income programs: Medicaid, KidCare, TANF, and Food Stamps) divided by the Average Daily Attendance of the school district.

(2) Supplemental general State aid pursuant to this subsection (H) shall be provided as follows for the 1998-1999, 1999-2000, and 2000-2001 school years only:

(a) For any school district with a Low Income Concentration Level of at least 20% and less than 35%, the grant for any school year shall be $800 multiplied by the low income eligible pupil count.

(b) For any school district with a Low Income Concentration Level of at least 35% and less than 50%, the grant for the 1998-1999 school year shall be $1,100 multiplied by the low income eligible pupil count.

(c) For any school district with a Low Income Concentration Level of at least 50% and less than 60%, the grant for the 1998-99 school year shall be $1,500 multiplied by the low income eligible pupil count.

(d) For any school district with a Low Income Concentration Level of 60% or more, the grant for the 1998-99 school year shall be $1,900 multiplied by the low income eligible pupil count.

(e) For the 1999-2000 school year, the per pupil amount specified in subparagraphs (b), (c), and (d) immediately above shall be increased to $1,243, $1,600, and $2,000, respectively.

(f) For the 2000-2001 school year, the per pupil amounts specified in subparagraphs (b), (c), and (d) immediately above shall be $1,273, $1,640, and $2,050, respectively.

(2.5) Supplemental general State aid pursuant to this subsection (H) shall be provided as follows for the 2002-2003 school year ~~and each school year thereafter~~:

(a) For any school district with a Low Income Concentration Level of less than 10%, the grant for each school year shall be $355 multiplied by the low income eligible pupil count.

(b) For any school district with a Low Income Concentration Level of at least 10% and less than 20%, the grant for each school year shall be $675 multiplied by the low income eligible pupil count.

(c) For any school district with a Low Income Concentration Level of at least 20% and less than 35%, the grant for each school year shall be $1,330 multiplied by the low income eligible pupil count.

(d) For any school district with a Low Income Concentration Level of at least 35% and less than 50%, the grant for each school year shall be $1,362 multiplied by the low income eligible pupil count.

(e) For any school district with a Low Income Concentration Level of at least 50% and less than 60%, the grant for each school year shall be $1,680 multiplied by the low income eligible pupil count.

(f) For any school district with a Low Income Concentration Level of 60% or more, the grant for each school year shall be $2,080 multiplied by the low income eligible pupil count.

(2.10) Except as otherwise provided, supplemental general State aid pursuant to this subsection (H) shall be provided as follows for the 2003-2004 school year and each school year thereafter:

(a) For any school district with a Low Income Concentration Level of 15% or less, the grant for each school year shall be $355 multiplied by the low income eligible pupil count.

(b) For any school district with a Low Income Concentration Level greater than 15%, the grant for each school year shall be $294.25 added to the product of $2,700 and the square of the Low Income Concentration Level, all multiplied by the low income eligible pupil count.

For the 2003-2004 school year only, the grant shall be no less than the grant for the 2002-2003 school year. For the 2004-2005 school year only, the grant shall be no less than the grant for the 2002-2003 school year multiplied by 0.66. For the 2005-2006 school year only, the grant shall be no less than the grant for the 2002-2003 school year multiplied by 0.33.

For the 2003-2004 school year only, the grant shall be no greater than 1.25 multiplied by the amount of the grant received during the 2002-2003 school year. For the 2004-2005 school year only, the grant shall be no greater than 1.50 multiplied by the grant received during the 2002-2003 school year. For the 2005-2006 school year only, the grant shall be no greater than 1.75 multiplied by the grant received during the 2002-2003 school year.

(3) School districts with an Average Daily Attendance of more than 1,000 and less than 50,000 that qualify for supplemental general State aid pursuant to this subsection shall submit a plan to the State Board of Education prior to October 30 of each year for the use of the funds resulting from this grant of supplemental general State aid for the improvement of instruction in which priority is given to meeting the education needs of disadvantaged children. Such plan shall be submitted in accordance with rules and regulations promulgated by the State Board of Education.

(4) School districts with an Average Daily Attendance of 50,000 or more that qualify for supplemental general State aid pursuant to this subsection shall be required to distribute from funds available pursuant to this Section, no less than $261,000,000 in accordance with the following requirements:

(a) The required amounts shall be distributed to the attendance centers within the district in proportion to the number of pupils enrolled at each attendance center who are eligible to receive free or reduced-price lunches or breakfasts under the federal Child Nutrition Act of 1966 and under the National School Lunch Act during the immediately preceding school year.

(b) The distribution of these portions of supplemental and general State aid among attendance centers according to these requirements shall not be compensated for or contravened by adjustments of the total of other funds appropriated to any attendance centers, and the Board of Education shall utilize funding from one or several sources in order to fully implement this provision annually prior to the opening of school.

(c) Each attendance center shall be provided by the school district a distribution of noncategorical funds and other categorical funds to which an attendance center is entitled under law in order that the general State aid and supplemental general State aid provided by application of this subsection supplements rather than supplants the noncategorical funds and other categorical funds provided by the school district to the attendance centers.

(d) Any funds made available under this subsection that by reason of the provisions of this subsection are not required to be allocated and provided to attendance centers may be used and appropriated by the board of the district for any lawful school purpose.

(e) Funds received by an attendance center pursuant to this subsection shall be used by the attendance center at the discretion of the principal and local school council for programs to improve educational opportunities at qualifying schools through the following programs and services: early childhood education, reduced class size or improved adult to student classroom ratio, enrichment programs, remedial assistance, attendance improvement, and other educationally beneficial expenditures which supplement the regular and basic programs as determined by the State Board of Education. Funds provided shall not be expended for any political or lobbying purposes as defined by board rule.

(f) Each district subject to the provisions of this subdivision (H)(4) shall submit an acceptable plan to meet the educational needs of disadvantaged children, in compliance with the requirements of this paragraph, to the State Board of Education prior to July 15 of each year. This plan shall be consistent with the decisions of local school councils concerning the school expenditure plans

developed in accordance with part 4 of Section 34-2.3. The State Board shall approve or reject the plan within 60 days after its submission. If the plan is rejected, the district shall give written notice of intent to modify the plan within 15 days of the notification of rejection and then submit a modified plan within 30 days after the date of the written notice of intent to modify. Districts may amend approved plans pursuant to rules promulgated by the State Board of Education.

Upon notification by the State Board of Education that the district has not submitted a plan prior to July 15 or a modified plan within the time period specified herein, the State aid funds affected by that plan or modified plan shall be withheld by the State Board of Education until a plan or modified plan is submitted.

If the district fails to distribute State aid to attendance centers in accordance with an approved plan, the plan for the following year shall allocate funds, in addition to the funds otherwise required by this subsection, to those attendance centers which were underfunded during the previous year in amounts equal to such underfunding.

For purposes of determining compliance with this subsection in relation to the requirements of attendance center funding, each district subject to the provisions of this subsection shall submit as a separate document by December 1 of each year a report of expenditure data for the prior year in addition to any modification of its current plan. If it is determined that there has been a failure to comply with the expenditure provisions of this subsection regarding contravention or supplanting, the State Superintendent of Education shall, within 60 days of receipt of the report, notify the district and any affected local school council. The district shall within 45 days of receipt of that notification inform the State Superintendent of Education of the remedial or corrective action to be taken, whether by amendment of the current plan, if feasible, or by adjustment in the plan for the following year. Failure to provide the expenditure report or the notification of remedial or corrective action in a timely manner shall result in a withholding of the affected funds.

The State Board of Education shall promulgate rules and regulations to implement the provisions of this subsection. No funds shall be released under this subdivision (H)(4) to any district that has not submitted a plan that has been approved by the State Board of Education.

(I) General State Aid for Newly Configured School Districts.

(1) For a new school district formed by combining property included totally within 2 or more previously existing school districts, for its first year of existence the general State aid and supplemental general State aid calculated under this Section shall be computed for the new district and for the previously existing districts for which property is totally included within the new district. If the computation on the basis of the previously existing districts is greater, a supplementary payment equal to the difference shall be made for the first 4 years of existence of the new district.

(2) For a school district which annexes all of the territory of one or more entire other school districts, for the first year during which the change of boundaries attributable to such annexation becomes effective for all purposes as determined under Section 7-9 or 7A-8, the general State aid and supplemental general State aid calculated under this Section shall be computed for the annexing district as constituted after the annexation and for the annexing and each annexed district as constituted prior to the annexation; and if the computation on the basis of the annexing and annexed districts as constituted prior to the annexation is greater, a supplementary payment equal to the difference shall be made for the first 4 years of existence of the annexing school district as constituted upon such annexation.

(3) For 2 or more school districts which annex all of the territory of one or more entire other school districts, and for 2 or more community unit districts which result upon the division (pursuant to petition under Section 11A-2) of one or more other unit school districts into 2 or more parts and which together include all of the parts into which such other unit school district or districts are so divided, for the first year during which the change of boundaries attributable to such annexation or division becomes effective for all purposes as determined under Section 7-9 or 11A-10, as the case may be, the general State aid and supplemental general State aid calculated under this Section shall be computed for each annexing or resulting district as constituted after the annexation or division and for each annexing and annexed district, or for each resulting and divided district, as constituted prior to the annexation or division; and if the aggregate of the general State aid and supplemental general State aid as so computed for the annexing or resulting districts as constituted after the annexation or division is less than the aggregate of the general State aid and supplemental general State aid as so computed for the annexing and annexed districts, or for the resulting and divided districts, as constituted prior to the annexation or division, then a supplementary payment equal to the difference shall be made and allocated between or among the annexing or resulting districts, as constituted upon such annexation or division, for the first 4 years of their existence. The total difference payment shall be allocated between or among the annexing or resulting districts in the same ratio as the pupil enrollment from that portion of the annexed or divided

district or districts which is annexed to or included in each such annexing or resulting district bears to the total pupil enrollment from the entire annexed or divided district or districts, as such pupil enrollment is determined for the school year last ending prior to the date when the change of boundaries attributable to the annexation or division becomes effective for all purposes. The amount of the total difference payment and the amount thereof to be allocated to the annexing or resulting districts shall be computed by the State Board of Education on the basis of pupil enrollment and other data which shall be certified to the State Board of Education, on forms which it shall provide for that purpose, by the regional superintendent of schools for each educational service region in which the annexing and annexed districts, or resulting and divided districts are located.

(3.5) Claims for financial assistance under this subsection (I) shall not be recomputed except as expressly provided under this Section.

(4) Any supplementary payment made under this subsection (I) shall be treated as separate from all other payments made pursuant to this Section.

(J) Supplementary Grants in Aid.

(1) Notwithstanding any other provisions of this Section, the amount of the aggregate general State aid in combination with supplemental general State aid under this Section for which each school district is eligible shall be no less than the amount of the aggregate general State aid entitlement that was received by the district under Section 18-8 (exclusive of amounts received under subsections 5(p) and 5(p-5) of that Section) for the 1997-98 school year, pursuant to the provisions of that Section as it was then in effect. If a school district qualifies to receive a supplementary payment made under this subsection (J), the amount of the aggregate general State aid in combination with supplemental general State aid under this Section which that district is eligible to receive for each school year shall be no less than the amount of the aggregate general State aid entitlement that was received by the district under Section 18-8 (exclusive of amounts received under subsections 5(p) and 5(p-5) of that Section) for the 1997-1998 school year, pursuant to the provisions of that Section as it was then in effect.

(2) If, as provided in paragraph (1) of this subsection (J), a school district is to receive aggregate general State aid in combination with supplemental general State aid under this Section for the 1998-99 school year and any subsequent school year that in any such school year is less than the amount of the aggregate general State aid entitlement that the district received for the 1997-98 school year, the school district shall also receive, from a separate appropriation made for purposes of this subsection (J), a supplementary payment that is equal to the amount of the difference in the aggregate State aid figures as described in paragraph (1).

(3) (Blank).

(K) Grants to Laboratory and Alternative Schools.

In calculating the amount to be paid to the governing board of a public university that operates a laboratory school under this Section or to any alternative school that is operated by a regional superintendent of schools, the State Board of Education shall require by rule such reporting requirements as it deems necessary.

As used in this Section, "laboratory school" means a public school which is created and operated by a public university and approved by the State Board of Education. The governing board of a public university which receives funds from the State Board under this subsection (K) may not increase the number of students enrolled in its laboratory school from a single district, if that district is already sending 50 or more students, except under a mutual agreement between the school board of a student's district of residence and the university which operates the laboratory school. A laboratory school may not have more than 1,000 students, excluding students with disabilities in a special education program.

As used in this Section, "alternative school" means a public school which is created and operated by a Regional Superintendent of Schools and approved by the State Board of Education. Such alternative schools may offer courses of instruction for which credit is given in regular school programs, courses to prepare students for the high school equivalency testing program or vocational and occupational training. A regional superintendent of schools may contract with a school district or a public community college district to operate an alternative school. An alternative school serving more than one educational service region may be established by the regional superintendents of schools of the affected educational service regions. An alternative school serving more than one educational service region may be operated under such terms as the regional superintendents of schools of those educational service regions may agree.

Each laboratory and alternative school shall file, on forms provided by the State Superintendent of Education, an annual State aid claim which states the Average Daily Attendance of the school's students by month. The best 3 months' Average Daily Attendance shall be computed for each school. The general State aid entitlement shall be computed by multiplying the applicable Average Daily Attendance by the Foundation Level as determined under this Section.

(L) Payments, Additional Grants in Aid and Other Requirements.

(1) For a school district operating under the financial supervision of an Authority created under Article 34A, the general State aid otherwise payable to that district under this Section, but not the supplemental general State aid, shall be reduced by an amount equal to the budget for the operations of the Authority as certified by the Authority to the State Board of Education, and an amount equal to such reduction shall be paid to the Authority created for such district for its operating expenses in the manner provided in Section 18-11. The remainder of general State school aid for any such district shall be paid in accordance with Article 34A when that Article provides for a disposition other than that provided by this Article.

(2) (Blank).

(3) Summer school. Summer school payments shall be made as provided in Section 18-4.3.

(M) Education Funding Advisory Board.

The Education Funding Advisory Board, hereinafter in this subsection (M) referred to as the "Board", is hereby created. The Board shall consist of 5 members who are appointed by the Governor, by and with the advice and consent of the Senate. The members appointed shall include representatives of education, business, and the general public. One of the members so appointed shall be designated by the Governor at the time the appointment is made as the chairperson of the Board. The initial members of the Board may be appointed any time after the effective date of this amendatory Act of 1997. The regular term of each member of the Board shall be for 4 years from the third Monday of January of the year in which the term of the member's appointment is to commence, except that of the 5 initial members appointed to serve on the Board, the member who is appointed as the chairperson shall serve for a term that commences on the date of his or her appointment and expires on the third Monday of January, 2002, and the remaining 4 members, by lots drawn at the first meeting of the Board that is held after all 5 members are appointed, shall determine 2 of their number to serve for terms that commence on the date of their respective appointments and expire on the third Monday of January, 2001, and 2 of their number to serve for terms that commence on the date of their respective appointments and expire on the third Monday of January, 2000. All members appointed to serve on the Board shall serve until their respective successors are appointed and confirmed. Vacancies shall be filled in the same manner as original appointments. If a vacancy in membership occurs at a time when the Senate is not in session, the Governor shall make a temporary appointment until the next meeting of the Senate, when he or she shall appoint, by and with the advice and consent of the Senate, a person to fill that membership for the unexpired term. If the Senate is not in session when the initial appointments are made, those appointments shall be made as in the case of vacancies.

The Education Funding Advisory Board shall be deemed established, and the initial members appointed by the Governor to serve as members of the Board shall take office, on the date that the Governor makes his or her appointment of the fifth initial member of the Board, whether those initial members are then serving pursuant to appointment and confirmation or pursuant to temporary appointments that are made by the Governor as in the case of vacancies.

The State Board of Education shall provide such staff assistance to the Education Funding Advisory Board as is reasonably required for the proper performance by the Board of its responsibilities.

For school years after the 2000-2001 school year, the Education Funding Advisory Board, in consultation with the State Board of Education, shall make recommendations as provided in this subsection (M) to the General Assembly for the foundation level under subdivision (B)(3) of this Section and for the supplemental general State aid grant level under subsection (H) of this Section for districts with high concentrations of children from poverty. The recommended foundation level shall be determined based on a methodology which incorporates the basic education expenditures of low-spending schools exhibiting high academic performance. The Education Funding Advisory Board shall make such recommendations to the General Assembly on January 1 of odd numbered years, beginning January 1, 2001.

(N) (Blank).

(O) References.

(1) References in other laws to the various subdivisions of Section 18-8 as that Section existed before its repeal and replacement by this Section 18-8.05 shall be deemed to refer to the corresponding provisions of this Section 18-8.05, to the extent that those references remain applicable.

(2) References in other laws to State Chapter 1 funds shall be deemed to refer to the supplemental general State aid provided under subsection (H) of this Section. (Source: P.A. 91-24, eff. 7-1-99; 91-93, eff. 7-9-99; 91-96, eff. 7-9-99; 91-111, eff. 7-14-99; 91-357, eff. 7-29-99; 91-533, eff. 8-13-99; 92-7, eff. 6-29-01; 92-16, eff. 6-28-01; 92-28, eff. 7-1-01; 92-29, eff. 7-1-01; 92-269, eff. 8-7-01; 92-604, eff. 7-1-02; 92-636, eff. 7-11-02; 92-651, eff. 7-11-02; revised 7-26-02.)

Section 99. Effective date. This Act takes effect on July 1, 2003.".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Walsh, **House Bill No. 526** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Walsh, **House Bill No. 527** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Local Government, adopted and ordered printed:

AMENDMENT NO. 1

AMENDMENT NO. 1. Amend House Bill 527 on page 1, line 19, immediately after "board", by inserting ", with the approval of the county treasurer,".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Clayborne, **House Bill No. 531** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Maloney, **House Bill No. 1118** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Silverstein, **House Bill No. 1157** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Clayborne, **House Bill No. 1192** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Halvorson, **House Bill No. 1274** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Maloney, **House Bill No. 1280** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Collins, **House Bill No. 1387** was taken up, read by title a second time and ordered to a third reading.

On motion of Garrett, **House Bill No. 1425** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Welch, **House Bill No. 1486** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Jacobs, **House Bill No. 1490** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Hunter, **House Bill No. 1530** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Health & Human Services, adopted and ordered printed:

AMENDMENT NO. 1

AMENDMENT NO. 1. Amend House Bill 1530 as follows:
on page 2, line 9, by inserting "liquid" after "containing"; and
on page 2, line 10, by inserting "liquid" after "wherein the"; and
on page 3, line 22, by inserting "or a fluorescent light bulb" after "battery".

There being no further amendments, the bill, as amended, was ordered to a third reading.

On motion of Senator Clayborne, **House Bill No. 1536** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Martinez, **House Bill No. 1630** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Jacobs, **House Bill No. 1640** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator J. Sullivan, **House Bill No. 2105** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Sandoval, **House Bill No. 2434** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Sandoval, **House Bill No. 2441** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Demuzio, **House Bill No. 2805** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Garrett, **House Bill No. 2855** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Woolard, **House Bill No. 2887** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Petka, **House Bill No. 2910** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Walsh, **House Bill No. 3036** was taken up and read by title a second time.
Floor amendment No. 1 was held in the Committee on Rules.
There being no further amendments the bill was ordered to a third reading.

On motion of Senator Welch, **House Bill No. 3053** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Jacobs, **House Bill No. 3506** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Clayborne, **House Bill No. 3508** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Sandoval, **House Bill No. 3522** was taken up, read by title a second time and ordered to a third reading.

On motion of Senator Jacobs, **House Bill No. 3661** having been printed, was taken up and read by title a second time.

The following amendment was offered in the Committee on Insurance & Pensions, adopted and ordered printed:

AMENDMENT NO. 1

AMENDMENT NO. 1. Amend House Bill 3661 by replacing everything after the enacting clause with the following:

"Section 3. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.2 as follows:

(5 ILCS 375/6.2) (from Ch. 127, par. 526.2)

Sec. 6.2. When the Director, with the advice and consent of the Commission, determines that it would be in the best interests of the State and its employees, the program of health benefits under this Act may be administered with the State as a self-insurer in whole or in part. The State assumes the risks of the program. The State may provide the administrative services in connection with the self-insurance health plan or purchase administrative services from an administrative service organization. A plan of self-insurance may combine forms of re-insurance or stop-loss insurance which limits the amount of State liability.

The program of health benefits shall provide a continuation and conversion privilege for persons whose State employment is terminated and a continuation privilege for members' spouses and dependent children who are covered under the provisions of the program, consistent with the requirements of federal law and Sections 367.2, ~~and~~ 367e, and 367e.1 of the Illinois Insurance Code. (Source: P.A. 85-848.)

Section 5. The Illinois Insurance Code is amended by changing Sections 245.25, 367.2, and 367e, by resectioning Section 367e as Sections 367e and 367e.1, and by adding Section 367.2-5 as follows:

(215 ILCS 5/245.25) (from Ch. 73, par. 857.25)

Sec. 245.25. Except for subparagraphs (1) (a), (1) (f), (1) (g) and (3) of Section 226 of the Illinois Insurance Code, in the case of a variable annuity contract and subparagraphs (1) (b), (1) (f), (1) (g), (1) (h), (1) (i), and (1) (k) of Section 224, subparagraph (1) (c) of Section 225, and subparagraph (h) of Section 231 in the case of a variable life insurance policy, except for Sections 357.4, 357.5, ~~and~~ 367e, and 367e.1 in the case of a variable health insurance policy, and except as otherwise provided in this Article, all pertinent provisions of the Illinois Insurance Code which are appropriate to those contracts apply to separate accounts and contracts relating thereto. Any individual variable life insurance contract, delivered or issued for delivery in this State, must contain grace, reinstatement and non-forfeiture provisions appropriate to such a contract. Any individual variable annuity contract, delivered or issued for delivery in this State, must contain grace and reinstatement provisions appropriate to such a contract. Any group variable life insurance contract, delivered or issued for delivery in this State, must contain a grace provision appropriate to such a contract. A group variable health insurance contract delivered or issued for delivery in this State must contain a continuation of group coverage provision appropriate to the contract. The reserve liability for variable contracts must be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees. (Source: P.A. 90-381, eff. 8-14-97.)

(215 ILCS 5/367.2) (from Ch. 73, par. 979.2)

Sec. 367.2. Spousal continuation privilege; group contracts. A. No policy of group accident or health insurance, nor any certificate thereunder shall be delivered or issued for delivery in this State after December 1, 1985, unless the policy provides for a continuation of the existing insurance benefits for an employee's spouse and dependent children who are insured under the provisions of that group policy or certificate thereunder, notwithstanding that the marriage is dissolved by judgment or terminated by the death of the employee ~~spouse~~ or, after the effective date of this amendatory Act of the 93rd General Assembly ~~1991~~, notwithstanding the retirement of the employee ~~spouse~~ provided that the employee's spouse is at least 55 years of age, in each case without any other eligibility requirements. The provisions of this amendatory Act of the 93rd General Assembly ~~1991~~ apply to every group policy of accident or health insurance and every certificate issued thereunder delivered or issued for delivery after the effective date of this amendatory Act of the 93rd General Assembly ~~1991~~.

B. Within 30 days of the entry of judgment or the death or retirement of the employee ~~spouse~~, the spouse of an employee insured under the policy who seeks a continuation of coverage thereunder shall give the employer or ~~and~~ the insurer written notice of the dissolution of the marriage or the death or retirement of the employee ~~spouse~~. The employer, within 15 days of receipt of the notice shall give written notice of the dissolution of the employee's marriage or the death or retirement of the employee and that former spouse's or retired employee's spouse's residence~~,~~ to the insurance company issuing the policy.~~, of the dissolution of the employee's marriage or the death or retirement of the employee spouse and the former or retired employee's spouse's residence.~~

The employer shall immediately send a copy of the notice to the former spouse of the employee or the spouse of the retired employee at the retired employee's spouse's residence or at the former spouse's residence. For purposes of this Act, the term "former spouse" includes "widow" or "widower".

C. Within 30 days after the date of receipt of a notice from the employer, retired employee's spouse or former spouse or of the initiation of a new group policy, the insurance company, by certified mail, return receipt requested, shall notify the retired employee's spouse or former spouse at his or her residence that the policy may be continued for ~~as to~~ that retired employee's spouse or former spouse and

covered dependents, and the notice shall include:

(i) a form for election to continue the insurance coverage;

(ii) the amount of periodic premiums to be charged for continuation coverage and the method and place of payment; and

(iii) instructions for returning the election form ~~by certified mail, return receipt requested,~~ within 30 days after the date it is received from ~~of the mailing receipt of the instruction by~~ the insurance company.

Failure of the retired employee's spouse or former spouse to exercise the election to continue insurance coverage by notifying the insurance company in writing ~~by certified mail, return receipt requested,~~ within such 30 day period shall terminate the continuation of benefits and the right to continuation.

If the insurance company fails to notify the retired employee's spouse or former spouse as provided for in subsection C hereof, all premiums shall be waived from the date the notice was required until notice is sent, and the benefits shall continue under the terms and provisions of the policy, from the date the notice was required until the notice is sent, notwithstanding any other provision hereof, except where the benefits in existence at the time the company's notice was to be sent pursuant to subsection C are terminated as to all employees.

D. With respect to a former spouse who has not attained the age of 55 at the time continuation coverage begins ~~hereunder~~, the monthly premium for continuation shall be computed as follows:

(i) an amount, if any, that would be charged an employee if the former spouse were a current employee of the employer, plus;

(ii) an amount, if any, that the employer would contribute toward the premium if the former spouse were a current employee.

Failure to pay the initial monthly premium within 30 days after the date of receipt of notice required in subsection C of this Section terminates the continuation benefits and the right to continuation benefits.

The continuation coverage for ~~right granted hereunder to~~ former spouses who have not attained the age of 55 at the time coverage begins ~~hereunder~~ shall terminate upon the earliest to happen of the following:

(i) The failure to pay premiums when due, including any grace period allowed by the policy; or

(ii) When coverage would terminate under the terms of the existing policy if the employee and former spouse were still married to each other; however, the existing coverage shall not be modified or terminated during the first 120 consecutive days subsequent to the employee spouse's death or to the entry of the judgment dissolving the marriage existing between the employee and the former spouse unless the master policy in existence at the time is modified or terminated as to all employees; or

(iii) the date on which the former spouse first becomes, after the date of election, an insured employee under any other group health plan; or

(iv) the date on which the former spouse remarries; or

(v) the expiration of 2 years from the date continuation coverage began ~~hereunder~~.

Upon the termination of continuation coverage ~~hereunder~~, the former spouse shall be entitled to convert the coverage to an individual policy.

The continuation rights granted to former spouses who have not attained age 55 shall also include eligible dependents insured prior to the dissolution of marriage or the death of the employee.

E. With respect to a retired employee's spouse or former spouse who has attained the age of 55 at the time continuation coverage begins ~~hereunder~~, the monthly premium for the continuation shall be computed as follows:

(i) an amount, if any, that would be charged an employee if the retired employee's spouse or former spouse were a current employee of the employer, plus;

(ii) an amount, if any, that the employer would contribute toward the premium if the retired employee's spouse or former spouse were a current employee.

Beginning 2 years after coverage begins under this paragraph, the monthly premium shall be computed as follows:

(i) an amount, if any, that would be charged an employee if the retired employee's spouse or former spouse were a current employee of the employer, plus;

(ii) an amount, if any, that the employer would contribute toward the premium if the retired employee's spouse or former spouse were a current employee.

(iii) an additional amount, not to exceed 20% of (i) and (ii) above, for costs of administration.

Failure to pay the initial monthly premium within 30 days after the date of receipt of the notice required in subsection C of this Section terminates the continuation benefits and the right to continuation

benefits.

The continuation coverage for ~~right granted to~~ retired employees' spouses and former spouses who have attained the age of 55 at the time coverage begins ~~hereunder~~ shall terminate upon the earliest to happen of the following:

(i) The failure to pay premiums when due, including any grace period allowed by the policy; or

(ii) When coverage would terminate, except due to the retirement of an employee, under the terms of the existing policy if the employee and former spouse were still married to each other; however, the existing coverage shall not be modified or terminated during the first 120 consecutive days subsequent to the employee spouse's death or retirement to the entry of the judgment dissolving the marriage existing between the employee and the former spouse unless the master policy in existence at the time is modified or terminated as to all employees; or

(iii) the date on which the retired employee's spouse or former spouse first becomes, after the date of election, an insured employee under any other group health plan; or

(iv) the date on which the former spouse remarries; or

(v) the date that person reaches the qualifying age or otherwise establishes eligibility under the Medicare Program pursuant to Title XVIII of the federal Social Security Act.

Upon the termination of continuation coverage ~~hereunder~~, the former spouse shall be entitled to convert the coverage to an individual policy.

The continuation rights granted to former spouses who have attained age 55 shall also include eligible dependents insured prior to the dissolution of marriage, the death of the employee, or the retirement of the employee.

F. The renewal, amendment, or extension of any group policy affected by this Section shall be deemed to be delivery or issuance for delivery of a new policy or contract of insurance in this State.

G. If (i) the policy is canceled ~~cancelled~~, and (ii) another insurance company contracts to provide group health and accident insurance to the employer, and (iii) continuation coverage is in effect for the retired employee's spouse or former spouse at the time of cancellation and (iv) the employee is or would have been included under the new group policy, then the new insurer must also offer continuation coverage to the retired employee's spouse and to an employee's former spouse under the same terms and conditions as contained in this Section.

H. This Section shall not limit the right of the retired employee's spouse or any former spouse to exercise the privilege to convert to an individual policy as contained in this Code.

I. No person who obtains coverage under this Section shall be required to pay a rate greater than that applicable to any employee or member covered under that group except as provided in clause (iii) of the second paragraph of subsection E. (Source: P.A. 87-615.)

(215 ILCS 5/367.2-5 new)

Sec. 367.2-5. Dependent child continuation privilege; group contracts.

(a) No policy of group accident or health insurance, nor any certificate thereunder shall be amended, renewed, delivered, or issued for delivery in this State after July 1, 2004, unless the policy provides for a continuation of the existing insurance benefits for an employee's dependent child who is insured under the provisions of that group policy or certificate in the event of the death of the employee and the child is not eligible for coverage as a dependent under the provisions of Section 367.2 or the dependent child has attained the limiting age under the policy.

(b) In the event of the death of the employee, if continuation coverage is desired, the dependent child or a responsible adult acting on behalf of the dependent child shall give the employer or the insurer written notice of the death of employee within 30 days of the date the coverage terminates. The employer, within 15 days of receipt of the notice, shall give written notice to the insurance company issuing the policy of the death of the employee and the dependent child's residence. The employer shall immediately send a copy of the notice to the dependent child or responsible adult at the dependent child's residence.

(c) In the event of the dependent child attaining the limiting age under the policy, if continuation coverage is desired, the dependent child shall give the employer or the insurer written notice of the attainment of the limiting age within 30 days of the date the coverage terminates. The employer, within 15 days of receipt of the notice, shall give written notice to the insurance company issuing the policy of the attainment of the limiting age by the dependent child and of the dependent child's residence.

(d) Within 30 days after the date of receipt of a notice from the employer, dependent child, or responsible adult acting on behalf of the dependent child, or of the initiation of a new group policy, the insurance company, by certified mail, return receipt requested, shall notify the dependent child or responsible adult at the dependent child's residence that the policy may be continued for the dependent child. The notice shall include:

(1) a form for election to continue the insurance coverage;

(2) the amount of periodic premiums to be charged for continuation coverage and the method and place of payment; and

(3) instructions for returning the election form within 30 days after the date it is received from the insurance company.

Failure of the dependent child or the responsible adult acting on behalf of the dependent child to exercise the election to continue insurance coverage by notifying the insurance company in writing within such 30 day period shall terminate the continuation of benefits and the right to continuation.

If the insurance company fails to notify the dependent child or responsible adult acting on behalf of the dependent child as provided for in this subsection (d), all premiums shall be waived from the date the notice was required until notice was sent, and the benefits shall continue under the terms and provisions of the policy, from the date the notice was required until the notice was sent, notwithstanding any other provision hereof, except where the benefits in existence at the time the company's notice was to be sent pursuant to this subsection (d) are terminated as to all employees.

(e) The monthly premium for continuation shall be computed as follows:

(1) an amount, if any, that would be charged an employee if the dependent child were a current employee of the employer, plus;

(2) an amount, if any, that the employer would contribute toward the premium if the dependent child were a current employee.

Failure to pay the initial monthly premium within 30 days after the date of receipt of notice required in subsection (d) of this Section terminates the continuation benefits and the right to continuation benefits.

Continuation coverage provided under this Act shall terminate upon the earliest to happen of the following:

(1) the failure to pay premiums when due, including any grace period allowed by the policy;

(2) when coverage would terminate under the terms of the existing policy if the dependent child was still an eligible dependent of the employee;

(3) the date on which the dependent child first becomes, after the date of election, an insured employee under any other group health plan; or

(4) the expiration of 2 years from the date continuation coverage began.

Upon the termination of continuation coverage, the dependent child shall be entitled to convert the coverage to an individual policy.

(f) The renewal, amendment, or extension of any group policy affected by this Section shall be deemed to be delivery or issuance for delivery of a new policy or contract of insurance in this State.

(g) If (1) the policy is cancelled, and (2) another insurance company contracts to provide group health and accident insurance to the employer, and (3) continuation coverage is in effect for the dependent child at the time of cancellation, and (4) the employee is or would have been included under the new group policy, then the new insurer must also offer continuation coverage to the dependent child under the same terms and conditions as contained in this Section.

(h) This Section shall not limit the right of any dependent child to exercise the privilege to convert to an individual policy as contained in this Code.

(i) No person who obtains coverage under this Section shall be required to pay a rate greater than that applicable to any employee or member covered under that group.

(215 ILCS 5/367e) (from Ch. 73, par. 979e)

Sec. 367e. Continuation of Group Hospital, Surgical and Major Medical Coverage After Termination of Employment or Membership.

A group policy delivered, issued for delivery, renewed or amended in this state which insures employees or members for hospital, surgical or major medical insurance on an expense incurred or service basis, other than for specific diseases or for accidental injuries only, shall provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment or membership or because of a reduction in hours below the minimum required by the group plan shall be entitled to continue their hospital, surgical and major medical insurance under that group policy, for themselves and their eligible dependents, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

1. Continuation shall only be available to an employee or member who has been continuously insured under the group policy (and for similar benefits under any group policy which it replaced) during the entire 3 months period ending with such termination or reduction in hours below the minimum required by the group plan.

2. Continuation shall not be available for any person who is covered by Medicare, except for those

individuals who have been covered under a group Medicare supplement policy. Neither shall continuation be available for any person who is covered by any other insured or uninsured plan which provides hospital, surgical or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination or reduction in hours below the minimum required by the group plan or who exercises his conversion privilege under the group policy.

3. Continuation need not include dental, vision care, prescription drug benefits, disability income, specified disease, or similar supplementary benefits which are provided under the group policy in addition to its hospital, surgical or major medical benefits.

4. Upon termination or reduction in hours below the minimum required by the group plan written notice of continuation shall be presented to the employee or member by the employer or mailed by the employer to the last known address of the employee. An employee or member who wishes continuation of coverage must request such continuation in writing within the ten-day period following the later of: (i) the date of such termination or reduction in hours below the minimum required by the group plan, or (ii) the date the employee is given written notice of the right of continuation by either the employer or the group policyholder. In no event, however, may the employee or member elect continuation more than 60 days after the date of such termination or reduction in hours below the minimum required by the group plan. Written notice of continuation presented to the employee or member by the policyholder, or mailed by the policyholder to the last known address of the employee, shall constitute the giving of notice for the purpose of this provision.

5. An employee or member electing continuation must pay to the group policyholder or his employer, on a monthly basis in advance, the total amount of premium required by the insurer, including that portion of the premium contributed by the policyholder or employer, if any, but not more than the group rate for the insurance being continued with appropriate reduction in premium for any supplementary benefits which have been discontinued under paragraph (3) of this Section. The premium rate required by the insurer shall be the applicable premium required on the due date of each payment.

6. Continuation of insurance under the group policy for any person shall terminate when he becomes eligible for Medicare or is covered by any other insured or uninsured plan which provides hospital, surgical or medical coverage for individuals in a group and under which the person was not covered immediately prior to such termination or reduction in hours below the minimum required by the group plan as provided in condition 2 above or, if earlier, at the first to occur of the following:

(a) The date 9 months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership or reduction in hours below the minimum required by the group plan.

(b) If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made.

(c) The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this (c) applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following shall apply:

(i) The employee or member shall have the right to become covered under that other group policy, for the balance of the period that he would have remained covered under the prior group policy in accordance with condition 6 had a termination described in this (c) not occurred.

(ii) The prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

7. A notification of the continuation privilege shall be included in each certificate of coverage.

8. Continuation shall not be available for any employee who was discharged because of the commission of a felony in connection with his work, or because of theft in connection with his work, for which the employer was in no way responsible; provided the employee admitted his commission of the felony or theft or such act has resulted in a conviction or order of supervision by a court of competent jurisdiction.

The requirements of this amendatory Act of 1983 shall apply to any group policy as defined in this Section, delivered or issued for delivery on or after 180 days following the effective date of this amendatory Act of 1983.

The requirements of this amendatory Act of 1985 shall apply to any group policy as defined in this Section, delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this amendatory Act of 1985. (Source: P.A. 85-210; 86-1475.)

(215 ILCS 5/367e.1 new)

Sec. 367e.1. Group Accident and Health Insurance Conversion Privilege. (A) A group policy which provides hospital, medical, or major medical expense insurance, or any combination of these

coverages, on an expense-incurred basis, but not including a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that an employee or member (i) whose insurance under the group policy has been terminated for any reason other than discontinuance of the group policy in its entirety where there is a succeeding carrier, or failure of the employee or member to pay any required contribution; and (ii) who has been continuously insured under the group policy (and under any group policy providing similar benefits which it replaces) for at least three months immediately prior to termination, shall be entitled to have issued to him by the insurer a policy of health insurance (hereafter referred to as the converted policy), subject to the following conditions:

(1) Written application for the converted policy shall be made and the first premium paid to the insurer not later than the latter of (i) thirty-one days after such termination or (ii) 15 days after the employee or member has been given written notice of the existence of the conversion privilege, but in no event later than 60 days after such termination.

Written notice presented to the employee or member by the policyholder, or mailed by the policyholder to the last known address of the employee or member, shall constitute the giving of notice for the purpose of this provision.

(2) The converted policy shall be issued without evidence of insurability.

(3) The initial premium for the converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under the converted policy and to the type and amount of the insurance provided. Conditions pertaining to health shall not be an acceptable basis of classification for the purposes of this subsection. The frequency of premium payment shall be the frequency customarily required by the insurer for the policy form and plan selected, provided that the insurer shall not require premium payments less frequently than quarterly without the consent of the insured.

(4) The effective date of the converted policy shall be the day following the termination of insurance under the group policy.

(5) The converted policy shall cover the employee or member and his dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(6) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if (i) such person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or (ii) such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or (iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any statute, and the benefits provided or available under the sources referred to in (i), (ii), (iii) above for such person together with the converted policy would result in overinsurance according to the insurer's standards.

(7) In the event that coverage would be continued under the group policy on an employee following his retirement prior to the time he is or could be covered by Medicare, he may elect, in lieu of such continuation of such group insurance, to have the same conversion rights as would apply had his insurance terminated at retirement by reason of termination of employment or membership.

(8) Subject to the conditions set forth above, the conversion privilege shall also be available (i) to the surviving spouse, if any, at the death of the employee or member, with respect to the spouse and such children whose coverage under the group policy terminates by reason of such death, otherwise to each surviving child whose coverage under the group policy terminates by reason of such death, or, if the group policy provides for continuation of dependents' coverage following the employee's or member's death, at the end of such continuation; (ii) to the spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and such children whose coverage under the group policy terminates at the same time; or (iii) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(9) A notification of the conversion privilege shall be included in each certificate.

(10) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted policy.

(B) A converted policy issued upon the exercise of the conversion privilege required by subsection (A) of this Section shall conform to the following minimum standards:

(1) If the group policy provided hospital, surgical, or medical expense insurance, or a combination thereof, the converted policy shall provide benefits on an expense-incurred basis equal to the lesser of (i) the hospital room and board, miscellaneous hospital, surgical and medical benefits provided under the group policy; and (ii) the corresponding benefits described below:

(a) Hospital room and board benefits in an amount per day elected by the group policyholder, but in no event less than 60% of the then average semi-private hospital room and board charge in the State, such benefits to be payable for a maximum of not less than 70 days for any period of hospital confinement, as defined in the converted policy.

(b) Miscellaneous hospital benefits for any one period of hospital confinement in an amount up to twenty times the hospital room and board daily benefit provided under the converted policy.

(c) Surgical benefits according to a surgical schedule providing a benefit amount elected by the group policy holder, but in no event less than 60% of the then average surgical charge in the State and with a maximum amount appropriate thereto. The maximum surgical benefit shall be applicable to all surgical operations of an individual resulting from or contributed to by the same and all related causes occurring in one period of disability. Two or more surgical procedures performed in the course of a single operation through the same incision, or in the same natural body orifice, may be treated as one surgical procedure with the payment determined by the scheduled benefit for the most expensive procedure performed. The surgical schedule shall be consistent with the schedule of operations customarily offered by the insurer under group or individual health insurance policies.

(d) Non-surgical medical attendance benefits for in-hospital services in an amount elected by the group policyholder, but in no event less than 60% of the then average in-hospital physician's visit charge in the State, such benefits may be limited to one visit per day of hospitalization and a maximum number of visits numbering not less than seventy for any period of hospital confinement as defined in the converted policy.

(2) If the group policy provided major medical insurance, the insurer may offer the insurance described in (1) above only, major medical insurance only, or a combination of the insurance described in (1) above and major medical insurance. If the insurer elects to provide major medical insurance, the converted policy shall provide:

(a) A maximum benefit at least equal to (i) or (ii) below:

(i) A maximum payment of twenty-five thousand dollars for all covered medical expenses incurred during the covered person's lifetime with an annual restoration of the lesser of, while coverage is in force, one thousand dollars and the amount counted against the maximum benefit which was not previously restored; or

(ii) A maximum payment of twenty-five thousand dollars for each unrelated injury or illness.

(b) Payment of benefits for covered medical expenses, in excess of the deductible, at a rate not less than 80% except as otherwise permitted below.

(c) A deductible for each benefit period which, at the option of the insurer, shall be (i) the greater of $500 and the benefits deductible; (ii) the sum of the benefits deductible and $100; or (iii) the corresponding deductible in the group policy. The term "benefit period," as used herein, means, when the maximum payment is determined by (a) (i) above, either a calendar year or a period of twelve consecutive months; and, when the maximum payment is determined by (a) (ii) above, a period of twenty-four consecutive months. The term "benefits deductible," as used herein, means the value of any benefits provided on an expense-incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract of medical practice or other prepayment plan, or any other plans or program whether on an insured or uninsured basis, or of any similar benefits which are provided or made available pursuant to or in accordance with the requirements of any statute and, if, pursuant to the provisions of this subsection, the converted policy provides both the coverage described in (1) above and major medical insurance, the value of the coverage described in (1) above. The insurer may require that the deductible be satisfied during a period of not less than three months. If the maximum payment is determined by (a) (i) above, and if no benefits become payable during the preceding benefit period due to the cash deductible not being satisfied; credit shall be given, in the succeeding benefit period, to any expense applied toward the cash deductible of the preceding benefit period and incurred during the last three months of such preceding benefit period, subject to any requirement that the deductible be satisfied during a

specified period of time.

(d) The term "covered medical expenses," as used above, may be limited (i) in the case of hospital room and board benefits, maximum surgical schedule, and non-surgical medical attendance benefits to amounts not less than the amounts provided in (1) (a), (1) (c) and (1) (d) above; and (ii) in the case of mental and nervous condition treatments while the patient is not a hospital in-patient, to co-insurance of 50%, a maximum benefit of $500 per calendar year or twelve consecutive month periods subject to the inclusion by the insurer of reasonable limits on the number of visits and the maximum permissible expense per visit.

(3) The converted policy may contain any exclusion, reduction, or limitation contained in the group policy and any exclusion, reduction, or limitation customarily used in individual accident and health policies delivered or issued for delivery in this state. It is not required that the converted policy contain all of the covered medical expenses or the same level of benefits as provided in the group policy.

(4) The insurer may, at its option, also offer alternative plans for group accident and health conversion.

(5) The converted policy may only exclude a pre-existing condition excluded by the group policy. Any hospital, surgical, medical or major medical benefits payable under the converted policy may be reduced by the amount of any such benefits payable under the group policy after the termination of the individual's insurance thereunder and, during the first policy year of such converted policy, the benefits payable under the converted policy may be so reduced so that they are not in excess of the benefits that would have been payable had the individual's insurance under the group policy remained in force and effect.

(6) The converted policy may provide for the termination of coverage thereunder of any person when he is or could be covered by Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded).

(7) The converted policy may provide that the insurer may request information from the converted policyholder, in advance of any premium due date of the converted policy, to determine whether any person covered thereunder (i) is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or (ii) is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or (iii) has similar benefits provided for or available to such person, pursuant to or in accordance with the requirements of any statute. The converted policy may also provide that the insurer need not renew the converted policy or the coverage of any person insured thereunder if either the benefits provided or available under the sources referred to in (i), (ii), (iii) above for such person, together with the converted policy, would result in overinsurance according to the insurer's standards, or if the converted policyholder refuses to provide the requested information.

(8) The converted policy shall not contain any provision allowing the insurer to non-renew due to a change in the health of an insured.

(9) The converted policy may contain any provisions permitted herein and may also include any other provisions not expressly prohibited by law. Any provisions required or permitted herein may be made a part of the converted policy by means of an endorsement or rider.

(10) In the conversion of group health insurance in accordance with the provisions of subsection (A) above, the insurer may, at its option, accomplish the conversion by issuing one or more converted policies.

(11) With respect to any person who was covered by the group policy, the period specified in the Time Limit on Certain Defenses provisions of the converted policy shall commence with the date the person's insurance became effective under the group policy.

(12) If the insurer elects to provide group insurance coverage in lieu of a converted policy, the benefit levels required for a converted policy must be applicable to such group insurance coverage.

(C) The requirements of this Section shall apply to any group policy of accident and health insurance delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this Section. (Source: P.A. 85-210; 86-1475.)

Section 7. The Comprehensive Health Insurance Plan Act is amended by changing Section 2 as follows:

(215 ILCS 105/2) (from Ch. 73, par. 1302)

Sec. 2. Definitions. As used in this Act, unless the context otherwise requires:

"Plan administrator" means the insurer or third party administrator designated under Section 5 of this

Act.

"Benefits plan" means the coverage to be offered by the Plan to eligible persons and federally eligible individuals pursuant to this Act.

"Board" means the Illinois Comprehensive Health Insurance Board.

"Church plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Continuation coverage" means continuation of coverage under a group health plan or other health insurance coverage for former employees or dependents of former employees that would otherwise have terminated under the terms of that coverage pursuant to any continuation provisions under federal or State law, including the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, Sections 367.2, ~~and~~ 367e, and 367e.1 of the Illinois Insurance Code, or any other similar requirement in another State.

"Covered person" means a person who is and continues to remain eligible for Plan coverage and is covered under one of the benefit plans offered by the Plan.

"Creditable coverage" means, with respect to a federally eligible individual, coverage of the individual under any of the following:

(A) A group health plan.

(B) Health insurance coverage (including group health insurance coverage).

(C) Medicare.

(D) Medical assistance.

(E) Chapter 55 of title 10, United States Code.

(F) A medical care program of the Indian Health Service or of a tribal organization.

(G) A state health benefits risk pool.

(H) A health plan offered under Chapter 89 of title 5, United States Code.

(I) A public health plan (as defined in regulations consistent with Section 104 of the Health Care Portability and Accountability Act of 1996 that may be promulgated by the Secretary of the U.S. Department of Health and Human Services).

(J) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(K) Any other qualifying coverage required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or regulations under that Act.

"Creditable coverage" does not include coverage consisting solely of coverage of excepted benefits, as defined in Section 2791(c) of title XXVII of the Public Health Service Act (42 U.S.C. 300 gg-91), nor does it include any period of coverage under any of items (A) through (K) that occurred before a break of more than 90 days during all of which the individual was not covered under any of items (A) through (K) above. Any period that an individual is in a waiting period for any coverage under a group health plan (or for group health insurance coverage) or is in an affiliation period under the terms of health insurance coverage offered by a health maintenance organization shall not be taken into account in determining if there has been a break of more than 90 days in any creditable coverage.

"Department" means the Illinois Department of Insurance.

"Dependent" means an Illinois resident: who is a spouse; or who is claimed as a dependent by the principal insured for purposes of filing a federal income tax return and resides in the principal insured's household, and is a resident unmarried child under the age of 19 years; or who is an unmarried child who also is a full-time student under the age of 23 years and who is financially dependent upon the principal insured; or who is a child of any age and who is disabled and financially dependent upon the principal insured.

"Direct Illinois premiums" means, for Illinois business, an insurer's direct premium income for the kinds of business described in clause (b) of Class 1 or clause (a) of Class 2 of Section 4 of the Illinois Insurance Code, and direct premium income of a health maintenance organization or a voluntary health services plan, except it shall not include credit health insurance as defined in Article IX 1/2 of the Illinois Insurance Code.

"Director" means the Director of the Illinois Department of Insurance.

"Eligible person" means a resident of this State who qualifies for Plan coverage under Section 7 of this Act.

"Employee" means a resident of this State who is employed by an employer or has entered into the employment of or works under contract or service of an employer including the officers, managers and employees of subsidiary or affiliated corporations and the individual proprietors, partners and employees of affiliated individuals and firms when the business of the subsidiary or affiliated corporations, firms or individuals is controlled by a common employer through stock ownership, contract, or otherwise.

"Employer" means any individual, partnership, association, corporation, business trust, or any person

or group of persons acting directly or indirectly in the interest of an employer in relation to an employee, for which one or more persons is gainfully employed.

"Family" coverage means the coverage provided by the Plan for the covered person and his or her eligible dependents who also are covered persons.

"Federally eligible individual" means an individual resident of this State:

(1)(A) for whom, as of the date on which the individual seeks Plan coverage under Section 15 of this Act, the aggregate of the periods of creditable coverage is 18 or more months, and (B) whose most recent prior creditable coverage was under group health insurance coverage offered by a health insurance issuer, a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with any such plans) or any other type of creditable coverage that may be required by the federal Health Insurance Portability and Accountability Act of 1996, as it may be amended, or the regulations under that Act;

(2) who is not eligible for coverage under (A) a group health plan, (B) part A or part B of Medicare due to age, or (C) medical assistance, and does not have other health insurance coverage;

(3) with respect to whom the most recent coverage within the coverage period described in paragraph (1)(A) of this definition was not terminated based upon a factor relating to nonpayment of premiums or fraud;

(4) if the individual had been offered the option of continuation coverage under a COBRA continuation provision or under a similar State program, who elected such coverage; and

(5) who, if the individual elected such continuation coverage, has exhausted such continuation coverage under such provision or program.

"Group health insurance coverage" means, in connection with a group health plan, health insurance coverage offered in connection with that plan.

"Group health plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Governmental plan" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital and medical expense-incurred policy, certificate, or contract provided by an insurer, non-profit health care service plan contract, health maintenance organization or other subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. Health insurance coverage shall not include short term, accident only, disability income, hospital confinement or fixed indemnity, dental only, vision only, limited benefit, or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"Health insurance issuer" means an insurance company, insurance service, or insurance organization (including a health maintenance organization and a voluntary health services plan) that is authorized to transact health insurance business in this State. Such term does not include a group health plan.

"Health Maintenance Organization" means an organization as defined in the Health Maintenance Organization Act.

"Hospice" means a program as defined in and licensed under the Hospice Program Licensing Act.

"Hospital" means a duly licensed institution as defined in the Hospital Licensing Act, an institution that meets all comparable conditions and requirements in effect in the state in which it is located, or the University of Illinois Hospital as defined in the University of Illinois Hospital Act.

"Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance.

"Insured" means any individual resident of this State who is eligible to receive benefits from any insurer (including health insurance coverage offered in connection with a group health plan) or health insurance issuer as defined in this Section.

"Insurer" means any insurance company authorized to transact health insurance business in this State and any corporation that provides medical services and is organized under the Voluntary Health Services Plans Act or the Health Maintenance Organization Act.

"Medical assistance" means the State medical assistance or medical assistance no grant (MANG) programs provided under Title XIX of the Social Security Act and Articles V (Medical Assistance) and VI (General Assistance) of the Illinois Public Aid Code (or any successor program) or under any similar program of health care benefits in a state other than Illinois.

"Medically necessary" means that a service, drug, or supply is necessary and appropriate for the diagnosis or treatment of an illness or injury in accord with generally accepted standards of medical practice at the time the service, drug, or supply is provided. When specifically applied to a confinement it further means that the diagnosis or treatment of the covered person's medical symptoms or condition cannot be safely provided to that person as an outpatient. A service, drug, or supply shall not be medically necessary if it: (i) is investigational, experimental, or for research purposes; or (ii) is provided solely for the convenience of the patient, the patient's family, physician, hospital, or any other provider; or (iii) exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or (iv) could have been omitted without adversely affecting the covered person's condition or the quality of medical care; or (v) involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration.

"Medical care" means the ordinary and usual professional services rendered by a physician or other specified provider during a professional visit for treatment of an illness or injury.

"Medicare" means coverage under both Part A and Part B of Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395, et seq.

"Minimum premium plan" means an arrangement whereby a specified amount of health care claims is self-funded, but the insurance company assumes the risk that claims will exceed that amount.

"Participating transplant center" means a hospital designated by the Board as a preferred or exclusive provider of services for one or more specified human organ or tissue transplants for which the hospital has signed an agreement with the Board to accept a transplant payment allowance for all expenses related to the transplant during a transplant benefit period.

"Physician" means a person licensed to practice medicine pursuant to the Medical Practice Act of 1987.

"Plan" means the Comprehensive Health Insurance Plan established by this Act.

"Plan of operation" means the plan of operation of the Plan, including articles, bylaws and operating rules, adopted by the board pursuant to this Act.

"Provider" means any hospital, skilled nursing facility, hospice, home health agency, physician, registered pharmacist acting within the scope of that registration, or any other person or entity licensed in Illinois to furnish medical care.

"Qualified high risk pool" has the same meaning given that term in the federal Health Insurance Portability and Accountability Act of 1996.

"Resident" means a person who is and continues to be legally domiciled and physically residing on a permanent and full-time basis in a place of permanent habitation in this State that remains that person's principal residence and from which that person is absent only for temporary or transitory purpose.

"Skilled nursing facility" means a facility or that portion of a facility that is licensed by the Illinois Department of Public Health under the Nursing Home Care Act or a comparable licensing authority in another state to provide skilled nursing care.

"Stop-loss coverage" means an arrangement whereby an insurer insures against the risk that any one claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount.

"Third party administrator" means an administrator as defined in Section 511.101 of the Illinois Insurance Code who is licensed under Article XXXI 1/4 of that Code. (Source: P.A. 91-357, eff. 7-29-99; 91-735, eff. 6-2-00; 92-153, eff. 7-25-01.)

Section 10. The Health Maintenance Organization Act is amended by changing Sections 4-9.2 and 5-3 as follows:

(215 ILCS 125/4-9.2) (from Ch. 111 1/2, par. 1409.2-2)

Sec. 4-9.2. Continuation of group HMO coverage after termination of employee or membership. A group contract delivered, issued for delivery, renewed, or amended in this State that covers employees or members for health care services shall provide that employees or members whose coverage under the group contract would otherwise terminate because of termination of employment or membership <u>or because of a reduction in hours below the minimum required by the group contract</u> shall be entitled to continue their coverage under that group contract, for themselves and their eligible dependents, subject to all of the group contract's terms and conditions applicable to those forms of coverage and to the following conditions:

(1) Continuation shall only be available to an employee or member who has been continuously covered under the group contract (and for similar benefits under any group contract that it replaced) during the entire 3 month period ending with the termination of employment or membership <u>or reduction in hours below the minimum required by the group contract</u>.

(2) Continuation shall not be available for any enrollee who is covered by Medicare, except for

those individuals who have been covered under a group Medicare supplement policy. Continuation shall not be available for any enrollee who is covered by any other insured or uninsured plan that provides hospital, surgical, or medical coverage for individuals in a group and under which the enrollee was not covered immediately before termination or reduction in hours below the minimum required by the group contract or who exercises his or her conversion privilege under the group policy.

(3) Continuation need not include dental, vision care, prescription drug, or similar supplementary benefits that are provided under the group contract in addition to its basic health care services.

(4) Upon termination or reduction in hours below the minimum required by the group contract, written notice of continuation shall be presented to the employee or member by the employer or mailed by the employer to the last known address of the employee. An employee or member who wishes continuation of coverage must request continuation in writing within the 10 day period following the later of (i) the date of termination or reduction in hours below the minimum required by the group contract or (ii) the date the employee is given written notice of the right of continuation by either the employer or the group policyholder. In no event, however, shall the employee or member elect continuation more than 60 days after the date of termination or reduction in hours below the minimum required by the group contract. Written notice of continuation presented to the employee or member by the policyholder, or mailed by the policyholder to the last known address of the employee, shall constitute the giving of notice for the purpose of this paragraph.

(5) An employee or member electing continuation must pay to the group policyholder or his employer, on a monthly basis in advance, the total amount of premium required by the HMO, including that portion of the premium contributed by the policyholder or employer, if any, but not more than the group rate for the coverage being continued with appropriate reduction in premium for any supplementary benefits that have been discontinued under paragraph (3) of this Section. The premium rate required by the HMO shall be the applicable premium required on the due date of each payment.

(6) Continuation of coverage under the group contract for any person shall terminate when the person becomes eligible for Medicare or is covered by any other insured or uninsured plan that provides hospital, surgical, or medical coverage for individuals in a group and under which the person was not covered immediately before termination or reduction in hours below the minimum required by the group contract as provided in paragraph (2) of this Section or, if earlier, at the first to occur of the following:

(a) The expiration of 9 months after the employee's or member's coverage because of termination of employment or membership or reduction in hours below the minimum required by the group contract.

(b) If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made.

(c) The date on which the group contract is terminated or, in the case of an employee, the date his or her employer terminates participation under the group contract. If, however, this paragraph applies and the coverage ceasing by reason of termination is replaced by similar coverage under another group contract, then (i) the employee or member shall have the right to become covered under the replacement group contract for the balance of the period that he or she would have remained covered under the prior group contract in accordance with paragraph (6) had a termination described in this item (c) not occurred and (ii) the prior group contract shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

(7) A notification of the continuation privilege shall be included in each evidence of coverage.

(8) Continuation shall not be available for any employee who was discharged because of the commission of a felony in connection with his or her work, or because of theft in connection with his or her work, for which the employer was in no way responsible if the employee (i) admitted to committing the felony or theft or (ii) was convicted or placed under supervision by a court of competent jurisdiction.

The requirements of this amendatory Act of 1992 shall apply to any group contract, as defined in this Section, delivered or issued for delivery on or after 180 days following the effective date of this amendatory Act of 1992.

(Source: P.A. 87-1090.)

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions. (a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152,

153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 367.2, 367.2-5, 367i, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance

Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section. (Source: P.A. 91-357, eff. 7-29-99; 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00; 92-764, eff. 1-1-03.)

Section 15. The Voluntary Health Services Plans Act is amended by changing Section 15.5 as follows:

(215 ILCS 165/15.5) (from Ch. 32, par. 609.5)

Sec. 15.5. Conversion Privilege-Group Type Contracts. (1) Every service plan contract of a health service plan corporation which provides that the continued coverage of a beneficiary is contingent upon the continued employment or membership of the subscriber with a particular employer, union, or association shall further provide for the right of said person to make application for an individual service plan contract under the circumstances and in accordance with the requirements set forth in Sections ~~Section~~ 367e and 367e.1 of the "Illinois Insurance Code". The application of Sections ~~Section~~ 367e and 367e.1 of the Code shall not be construed in such a manner as to require a health service plan corporation to furnish a service or kind of benefit not customarily provided by such corporation and which is inconsistent with the provision of this Act.

(2) The requirements of this Section shall apply to all such contracts delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this Section. (Source: P.A. 82-498.)".

AMENDMENT NO. 2

AMENDMENT NO. 2. Amend House Bill 3661, AS AMENDED, in the introductory clause of Section 5, by changing "367.2, and 367e" to "367.2, 367e, and 404.1"; and

in Section 5, at the end, by inserting the following:

"(215 ILCS 5/404.1) (from Ch. 73, par. 1016.1)

Sec. 404.1. Safekeeping of deposits. The Director may maintain with a corporation qualified to administer trusts in this State under the Corporate Fiduciary Act ~~"An Act to provide for and regulate the administration of trusts by trust companies", approved June 15, 1887, as amended,~~ for the securities deposited with the Director, a limited agency, custodial, or depository account, or other type of account for the safekeeping of those securities, and for collecting the income from those securities and providing supportive accounting services relating to such safekeeping and collection. Such a corporation, in safekeeping such securities, shall have all the powers, rights, duties and responsibilities that it has for holding securities in its fiduciary accounts under the Securities in Fiduciary Accounts Act ~~"An Act concerning the powers of corporations authorized to accept and execute trusts, to register and hold securities of fiduciary accounts in bulk and to deposit same with a clearing corporation", approved September 1, 1972, as amended~~. The Director shall arrange with any depository institution that has been authorized to accept and execute trusts to provide for collateralization of any cash accounts resulting from the failure of any depositing company to give instruction regarding the investment of any such cash amounts as provided for by Section 6 of the Public Funds Investment Act. (Source: P.A. 83-746.)".

AMENDMENT NO. 3

AMENDMENT NO. 3. Amend House Bill 3661, AS AMENDED, in the introductory clause of Section 5, by replacing "245.25" with "143.17a, 245.25"; and

in Section 5, immediately below the introductory clause, by inserting the following:

"(215 ILCS 5/143.17a) (from Ch. 73, par. 755.17a)

Sec. 143.17a. Notice of intention not to renew. a. No company shall fail to renew any policy of insurance, to which Section 143.11 applies, except for those defined in subsections (a), (b), (c), and (h) of Section 143.13, unless it shall send by mail to the named insured at least 60 days advance notice of its intention not to renew. The company shall maintain proof of mailing of such notice on one of the

following forms: a recognized U.S. Post Office form or a form acceptable to the U.S. Post Office or other commercial mail delivery service. An exact and unaltered copy of such notice shall also be sent to the insured's broker, if known, or the agent of record and to the mortgagee or lien holder at the last mailing address known by the company. However, where cancellation is for nonpayment of premium, the notice of cancellation must be mailed at least 10 days before the effective date of the cancellation.

b. This Section does not apply if the company has manifested its willingness to renew directly to the named insured. Provided, however, that no company may increase the renewal premium on any policy of insurance to which Section 143.11 applies, except for those defined in subsections (a), (b), (c), and (h) of Section 143.13, by 30% or more, nor impose changes in deductibles or coverage that materially alter the policy, unless the company shall have mailed or delivered to the named insured written notice of such increase or change in deductible or coverage at least 60 days prior to the renewal or anniversary date. The increase in premium shall be the renewal premium based on the known exposure as of the date of the quotation compared to the premium as of the last day of coverage for the current year's policy, annualized. The premium on the renewal policy may be subsequently amended to reflect any change in exposure or reinsurance costs not considered in the quotation. An exact and unaltered copy of such notice shall also be sent to the insured's broker, if known, or the agent of record. If the company intends to increase the premium on a policy by 30% or more and the renewal date is less than 60 but more than 30 days away, then the company must extend the current policy under the same terms, conditions, and premium to allow 60 days notice of renewal and provide the actual renewal premium quotation and any change in coverage or deductible on the policy. Proof of mailing or proof of receipt may be proven by a sworn affidavit by the insurer as to the usual and customary business practices of mailing notice pursuant to this Section or may be proven consistent with Illinois Supreme Court Rule 236. ~~The company shall maintain proof of mailing or proof of receipt whichever is required.~~

c. Should a company fail to comply with the notice requirements of this Section, the policy shall terminate only as provided in this subsection. In the event of a nonrenewal, if a notice of nonrenewal is not provided at least ~~31 days, but less than~~ 60 days prior to expiration of the policy, the policy shall be extended for an additional year ~~a period of 60 days or until the effective date of any similar insurance procured by the insured, whichever is less,~~ on the same terms and conditions as the policy sought to be terminated. In the event notice is provided less than 31 days prior to the expiration of the policy, the policy shall be extended for a period of one year or until the effective date of any similar insurance procured by the insured, whichever is less, on the same terms and conditions as the policy sought to be terminated unless the insurer has manifested its willingness to renew at a premium which represents an increase not exceeding 30%. ~~The premium for coverage shall be prorated in accordance with the amount of the last year's premium, and the company shall be entitled to this premium for the extension of coverage and such extension may be contingent upon the payment of such premium.~~

d. Renewal of a policy does not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

e. In all notices of intention not to renew any policy of insurance, as defined in Section 143.11 the company shall provide a specific explanation of the reasons for nonrenewal. (Source: P.A. 89-669, eff. 1-1-97.)

"; and

at the end of the bill, by inserting the following:

"Section 99. Effective date. The changes made to Sec. 143.17a of the Illinois Insurance Code in Section 5 of this Act take effect upon becoming law.".

Floor Amendment No. 4 was tabled in the Committee on Insurance and Pensions.

There being no further amendments, the bill, as amended, was ordered to a third reading.

REPORT FROM RULES COMMITTEE

Senator Demuzio, Chairperson of the Committee on Rules, during its April 30, 2003 meeting, reported the following Legislative Measures have been assigned to the indicated Standing Committees of the Senate:

Executive: **Senate Committee Amendment No. 1 to House Bill 318; Senate Committee Amendment No. 1 to House Bill 560; Senate Committee Amendment No. 1 to House Bill 685; Senate Committee Amendment No. 1 to House Bill 714; Senate Committee Amendment No. 1 to House Bill 741; Senate Committee Amendment No. 1 to House Bill 914; Senate Committee**

Amendment No. 1 to House Bill 954; Senate Committee Amendment No. 1 to House Bill 1044; Senate Committee Amendment No. 1 to House Bill 1459.

Licensed Activities:**Senate Committee Amendments numbered 1 and 2 to House Bill 2370; Senate Committee Amendment No. 1 to House Bill 2553; Senate Committee Amendment No. 3 to House Bill 2809; Senate Committee Amendment No. 1 to House Bill 3047**.

MESSAGE FROM THE HOUSE

A message from the House by
Mr. Rossi, Clerk:

Mr. President -- I am directed to inform the Senate that the House of Representatives has concurred with the Senate in the passage of a bill of the following title, to-wit:

SENATE BILL NO. 41

A bill for AN ACT in relation to estates.

Passed the House, April 30, 2003.

ANTHONY D. ROSSI, Clerk of the House

Senator Halvorson requested a democrat caucus immediately upon adjournment.

Senator Burzynski requested a republican caucus immediately upon adjournment.

At the hour of 12:45 o'clock p.m., the Chair announced that the Senate stand adjourned until Thursday, May 1, 2003, at 12:30 o'clock p.m.