AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Insurance Code is amended by changing Sections 107a.12, 130.4, 370c.1, 500-30, 500-130, 1510, and 1565 as follows:

(215 ILCS 5/107a.12)

Sec. 107a.12. Annual statement.

(a) A pool authorized to do business in this State shall file with the Director by March 1st in each year 2 copies of its financial statement for the year ending December 31st immediately preceding on forms prescribed by the Director, which shall conform substantially to the form of statement adopted by the National Association of Insurance Commissioners. Unless the Director provides otherwise, the annual statement is to be prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners. The Director may promulgate rules for determining which portions of the annual statement instructions and Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners are germane for the purpose of ascertaining the condition and

affairs of a pool.

(b) The Director shall have authority to extend the time for filing any statement by any pool for reasons that he considers good and sufficient. The admitted assets shall be shown in the statement at the actual values as of the last day of the preceding year, in accordance with Section 126.7 of this Code. The statement shall be verified by oaths of a majority of the trustees or directors of the pool. In addition, when the Director considers it to be necessary and appropriate for the protection of policyholders, creditors, shareholders, or claimants, the Director may require the pool to file, within 60 days after mailing to the pool a notice that a supplemental summary statement is required, a supplemental summary statement, as of the last day of any calendar month occurring during the 100 days next preceding the mailing of the notice, designated by him or her on forms prescribed and furnished by the Director. The Director may require supplemental summary statements to be certified by an independent actuary deemed competent by the Director or by an independent certified public accountant.

(c) On or before June 1 of each year, a pool shall file with the Director an audited financial statement reporting the financial condition of the pool as of the end of the most recent calendar year and changes in the surplus funds for the year then ending. The annual audited financial report shall include the following:

(1) a report of an independent certified public accountant;

(2) a balance sheet reporting assets, as defined in this Article, liabilities, and surplus funds;

(3) a statement of gain and loss from operations;

(4) a statement of changes in financial position;

(5) a statement of changes in surplus funds; and

(6) the notes to financial statements.

(d) The Director shall require a pool to file an independent actuarial opinion as to the sufficiency of the loss and loss adjustment expense reserves. This opinion shall be due on March ~~June~~ 1 of each year.

(Source: P.A. 91-757, eff. 1-1-01.)

(215 ILCS 5/130.4)

Sec. 130.4. Disclosure requirement.

(a) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the Director a corporate governance annual disclosure that contains the information described in subsection (b) of Section 130.5. Notwithstanding any request from the Director made pursuant to subsection (c), if the insurer is a member of an insurance group, the insurer shall submit the report required by this Section to the Director of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures

outlined in the most recent Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(b) The corporate governance annual disclosure must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices ~~required by this Section~~ and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

(c) An insurer not required to submit a corporate governance annual disclosure under this Section shall do so upon the Director's request.

(d) For purposes of completing the corporate governance annual disclosure, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level, or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the corporate governance annual disclosure at the level at which the insurer's or insurance group's risk appetite is determined, the level at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of

those factors is coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the 3 criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

(e) The review of the corporate governance annual disclosure and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(f) Insurers providing information substantially similar to the information required by this Article in other documents provided to the Director, including proxy statements filed in conjunction with the requirements of Section 131.13 or other State or federal filings provided to the Department, are not required to duplicate that information in the corporate governance annual disclosure but are only required to cross-reference the document in which the information is included.

(Source: P.A. 101-600, eff. 12-6-19.)

(215 ILCS 5/370c.1)

Sec. 370c.1. Mental, emotional, nervous, or substance use disorder or condition parity.

(a) On and after the effective date of this amendatory Act of the 102nd General Assembly ~~this amendatory Act of the 99th General Assembly~~, every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions shall ensure prior to policy issuance that:

(1) the financial requirements applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant financial requirements applied to substantially all hospital and medical benefits covered by the policy and that there are no separate cost-sharing requirements that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits; and

(2) the treatment limitations applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant treatment limitations applied to substantially all hospital and medical benefits covered by the policy and that there are no separate treatment limitations that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits.

(b) The following provisions shall apply concerning aggregate lifetime limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed in this State on or after the effective date of this amendatory Act of the 99th General Assembly that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the following provisions shall apply:

(A) if the policy does not include an aggregate lifetime limit on substantially all hospital and medical benefits, then the policy may not impose any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an aggregate lifetime limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable lifetime limit"), then the policy shall either:

(i) apply the applicable lifetime limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition

benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable lifetime limit.

(2) In the case of a policy that is not described in paragraph (1) of subsection (b) of this Section and that includes no or different aggregate lifetime limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (b) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(c) The following provisions shall apply concerning annual limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed in this State on or after

the effective date of this amendatory Act of the 99th General Assembly that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the following provisions shall apply:

(A) if the policy does not include an annual limit on substantially all hospital and medical benefits, then the policy may not impose any annual limits on mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an annual limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable annual limit"), then the policy shall either:

(i) apply the applicable annual limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any annual limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable annual limit.

(2) In the case of a policy that is not described in paragraph (1) of subsection (c) of this Section and that includes no or different annual limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (c) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(d) With respect to mental, emotional, nervous, or substance use disorders or conditions, an insurer shall use policies and procedures for the election and placement of mental, emotional, nervous, or substance use disorder or condition treatment drugs on their formulary that are no less favorable to the insured as those policies and procedures the insurer uses for the selection and placement of drugs for medical or surgical conditions and shall follow the expedited coverage determination requirements for substance abuse treatment drugs set forth in Section 45.2 of the Managed Care Reform and Patient Rights Act.

(e) This Section shall be interpreted in a manner consistent with all applicable federal parity regulations including, but not limited to, the Paul Wellstone and Pete

Domenici Mental Health Parity and Addiction Equity Act of 2008, final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and final regulations applying the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care organizations, the Children's Health Insurance Program, and alternative benefit plans.

(f) The provisions of subsections (b) and (c) of this Section shall not be interpreted to allow the use of lifetime or annual limits otherwise prohibited by State or federal law.

(g) As used in this Section:

"Financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket maximums, but does not include an aggregate lifetime limit or an annual limit subject to subsections (b) and (c).

"Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

"Treatment limitation" includes limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on

the scope or duration of treatment. "Treatment limitation" includes both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of treatment. A permanent exclusion of all benefits for a particular condition or disorder shall not be considered a treatment limitation. "Nonquantitative treatment" means those limitations as described under federal regulations (26 CFR 54.9812-1). "Nonquantitative treatment limitations" include, but are not limited to, those limitations described under federal regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136.

(h) The Department of Insurance shall implement the following education initiatives:

(1) By January 1, 2016, the Department shall develop a plan for a Consumer Education Campaign on parity. The Consumer Education Campaign shall focus its efforts throughout the State and include trainings in the northern, southern, and central regions of the State, as defined by the Department, as well as each of the 5 managed care regions of the State as identified by the Department of Healthcare and Family Services. Under this Consumer Education Campaign, the Department shall: (1) by January 1, 2017, provide at least one live training in each region on parity for consumers and providers and one webinar

training to be posted on the Department website and (2) establish a consumer hotline to assist consumers in navigating the parity process by March 1, 2017. By January 1, 2018 the Department shall issue a report to the General Assembly on the success of the Consumer Education Campaign, which shall indicate whether additional training is necessary or would be recommended.

(2) The Department, in coordination with the Department of Human Services and the Department of Healthcare and Family Services, shall convene a working group of health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups for the purpose of discussing issues related to the treatment and coverage of mental, emotional, nervous, or substance use disorders or conditions and compliance with parity obligations under State and federal law. Compliance shall be measured, tracked, and shared during the meetings of the working group. The working group shall meet once before January 1, 2016 and shall meet semiannually thereafter. The Department shall issue an annual report to the General Assembly that includes a list of the health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups that participated in the working group meetings, details on the issues and topics covered, and any

legislative recommendations developed by the working group.

(3) Not later than August 1 of each year, the Department, in conjunction with the Department of Healthcare and Family Services, shall issue a joint report to the General Assembly and provide an educational presentation to the General Assembly. The report and presentation shall:

(A) Cover the methodology the Departments use to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and 42 U.S.C. 18031(j).

(B) Cover the methodology the Departments use to check for compliance with this Section and Sections 356z.23 and 370c of this Code.

(C) Identify market conduct examinations or, in the case of the Department of Healthcare and Family Services, audits conducted or completed during the preceding 12-month period regarding compliance with parity in mental, emotional, nervous, and substance use disorder or condition benefits under State and federal laws and summarize the results of such market

conduct examinations and audits. This shall include:

(i) the number of market conduct examinations and audits initiated and completed;

(ii) the benefit classifications examined by each market conduct examination and audit;

(iii) the subject matter of each market conduct examination and audit, including quantitative and nonquantitative treatment limitations; and

(iv) a summary of the basis for the final decision rendered in each market conduct examination and audit.

Individually identifiable information shall be excluded from the reports consistent with federal privacy protections.

(D) Detail any educational or corrective actions the Departments have taken to ensure compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), this Section, and Sections 356z.23 and 370c of this Code.

(E) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the Departments find appropriate, posting the report on the Departments' websites.

(i) The Parity Advancement Fund is created as a special fund in the State treasury. Moneys from fines and penalties collected from insurers for violations of this Section shall be deposited into the Fund. Moneys deposited into the Fund for appropriation by the General Assembly to the Department shall be used for the purpose of providing financial support of the Consumer Education Campaign, parity compliance advocacy, and other initiatives that support parity implementation and enforcement on behalf of consumers.

(j) The Department of Insurance and the Department of Healthcare and Family Services shall convene and provide technical support to a workgroup of 11 members that shall be comprised of 3 mental health parity experts recommended by an organization advocating on behalf of mental health parity appointed by the President of the Senate; 3 behavioral health providers recommended by an organization that represents behavioral health providers appointed by the Speaker of the House of Representatives; 2 representing Medicaid managed care organizations recommended by an organization that represents Medicaid managed care plans appointed by the Minority Leader of the House of Representatives; 2 representing commercial insurers recommended by an organization that represents insurers appointed by the Minority Leader of the Senate; and a representative of an organization that represents Medicaid managed care plans appointed by the Governor.

The workgroup shall provide recommendations to the General

Assembly on health plan data reporting requirements that separately break out data on mental, emotional, nervous, or substance use disorder or condition benefits and data on other medical benefits, including physical health and related health services no later than December 31, 2019. The recommendations to the General Assembly shall be filed with the Clerk of the House of Representatives and the Secretary of the Senate in electronic form only, in the manner that the Clerk and the Secretary shall direct. This workgroup shall take into account federal requirements and recommendations on mental health parity reporting for the Medicaid program. This workgroup shall also develop the format and provide any needed definitions for reporting requirements in subsection (k). The research and evaluation of the working group shall include, but not be limited to:

(1) claims denials due to benefit limits, if applicable;

(2) administrative denials for no prior authorization;

(3) denials due to not meeting medical necessity;

(4) denials that went to external review and whether they were upheld or overturned for medical necessity;

(5) out-of-network claims;

(6) emergency care claims;

(7) network directory providers in the outpatient benefits classification who filed no claims in the last 6 months, if applicable;

(8) the impact of existing and pertinent limitations and restrictions related to approved services, licensed providers, reimbursement levels, and reimbursement methodologies within the Division of Mental Health, the Division of Substance Use Prevention and Recovery programs, the Department of Healthcare and Family Services, and, to the extent possible, federal regulations and law; and

(9) when reporting and publishing should begin.

Representatives from the Department of Healthcare and Family Services, representatives from the Division of Mental Health, and representatives from the Division of Substance Use Prevention and Recovery shall provide technical advice to the workgroup.

(k) An insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions shall submit an annual report, the format and definitions for which will be developed by the workgroup in subsection (j), to the Department, or, with respect to medical assistance, the Department of Healthcare and Family Services starting on or before July 1, 2020 that contains the following information separately for inpatient in-network benefits, inpatient

out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits, and prescription drug benefits in the case of accident and health insurance or qualified health plans, or inpatient, outpatient, emergency care, and prescription drug benefits in the case of medical assistance:

(1) A summary of the plan's pharmacy management processes for mental, emotional, nervous, or substance use disorder or condition benefits compared to those for other medical benefits.

(2) A summary of the internal processes of review for experimental benefits and unproven technology for mental, emotional, nervous, or substance use disorder or condition benefits and those for other medical benefits.

(3) A summary of how the plan's policies and procedures for utilization management for mental, emotional, nervous, or substance use disorder or condition benefits compare to those for other medical benefits.

(4) A description of the process used to develop or select the medical necessity criteria for mental, emotional, nervous, or substance use disorder or condition benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(5) Identification of all nonquantitative treatment limitations that are applied to both mental, emotional,

nervous, or substance use disorder or condition benefits and medical and surgical benefits within each classification of benefits.

(6) The results of an analysis that demonstrates that for the medical necessity criteria described in subparagraph (A) and for each nonquantitative treatment limitation identified in subparagraph (B), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental, emotional, nervous, or substance use disorder or condition benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that a nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;

(B) identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative

treatment limitation;

(C) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(D) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) disclose the specific findings and conclusions reached by the insurer that the results of the analyses described in subparagraphs (C) and (D) indicate that the insurer is in compliance with this Section and the Mental Health Parity and Addiction

Equity Act of 2008 and its implementing regulations, which includes 42 CFR Parts 438, 440, and 457 and 45 CFR 146.136 and any other related federal regulations found in the Code of Federal Regulations.

(7) Any other information necessary to clarify data provided in accordance with this Section requested by the Director, including information that may be proprietary or have commercial value, under the requirements of Section 30 of the Viatical Settlements Act of 2009.

(l) An insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions on or after the effective date of this amendatory Act of the 100th General Assembly shall, in advance of the plan year, make available to the Department or, with respect to medical assistance, the Department of Healthcare and Family Services and to all plan participants and beneficiaries the information required in subparagraphs (C) through (E) of paragraph (6) of subsection (k). For plan participants and medical assistance beneficiaries, the information required in subparagraphs (C) through (E) of paragraph (6) of subsection (k) shall be made available on a publicly-available website whose web address is prominently displayed in plan and managed care organization

informational and marketing materials.

(m) In conjunction with its compliance examination program conducted in accordance with the Illinois State Auditing Act, the Auditor General shall undertake a review of compliance by the Department and the Department of Healthcare and Family Services with Section 370c and this Section. Any findings resulting from the review conducted under this Section shall be included in the applicable State agency's compliance examination report. Each compliance examination report shall be issued in accordance with Section 3-14 of the Illinois State Auditing Act. A copy of each report shall also be delivered to the head of the applicable State agency and posted on the Auditor General's website.

(Source: P.A. 99-480, eff. 9-9-15; 100-1024, eff. 1-1-19.)

(215 ILCS 5/500-30)

(Section scheduled to be repealed on January 1, 2027)

Sec. 500-30. Application for license.

(a) An individual applying for a resident insurance producer license must make application on a form specified by the Director and declare under penalty of refusal, suspension, or revocation of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief. Before approving the application, the Director must find that the individual:

(1) is at least 18 years of age;

(2) is sufficiently rehabilitated in cases in which the applicant has committed any act that is a ground for denial, suspension, or revocation set forth in Section 500-70, other than convictions set forth in paragraph (6) of subsection (a) of Section 500-70; with respect to applicants with convictions set forth in paragraph (6) of subsection (a) of Section 500-70, the Director shall determine in accordance with Section 500-76 that the conviction will not impair the ability of the applicant to engage in the position for which a license is sought;

(3) has completed, if required by the Director, a pre-licensing course of study before the insurance exam for the lines of authority for which the individual has applied (an individual who successfully completes the Fire and Casualty pre-licensing courses also meets the requirements for Personal Lines-Property and Casualty);

(4) has paid the fees set forth in Section 500-135; and

(5) has successfully passed the examinations for the lines of authority for which the person has applied.

(b) A pre-licensing course of study for each class of insurance for which an insurance producer license is requested must be established in accordance with rules prescribed by the Director and must consist of the following minimum hours:

Class of Insurance	Number of Hours

Life (Class 1(a))	20
Accident and Health (Class 1(b) or 2(a))	20
Fire (Class 3)	20
Casualty (Class 2)	20
Personal Lines-Property Casualty	20
Motor Vehicle (Class 2(b) or 3(e))	12.5

7.5 hours of each pre-licensing course must be completed in a classroom or webinar setting, except Motor Vehicle, which would require 5 hours in a classroom or webinar setting.

(c) A business entity acting as an insurance producer must obtain an insurance producer license. Application must be made using the Uniform Business Entity Application. Before approving the application, the Director must find that:

(1) the business entity has paid the fees set forth in Section 500-135; and

(2) the business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws and rules of this State.

(d) The Director may require any documents reasonably necessary to verify the information contained in an application.

(Source: P.A. 100-286, eff. 1-1-18.)

(215 ILCS 5/500-130)

(Section scheduled to be repealed on January 1, 2027)

Sec. 500-130. Bond required of insurance producers.

(a) An insurance producer who places insurance either directly or indirectly with an insurer with which the insurance producer does not have an agency contract ~~agent contact~~ must maintain in force while licensed a bond in favor of the people of the State of Illinois executed by an authorized surety company and payable to any party injured under the terms of the bond. The bond shall be continuous in form and in the amount of $2,500 or 5% of the premiums brokered in the previous calendar year, whichever is greater, but not to exceed $50,000 total aggregate liability. The bond shall be conditioned upon full accounting and due payment to the person or company entitled thereto, of funds coming into the insurance producer's possession as an incident to insurance transactions under the license or surplus line insurance transactions under the license as a surplus line producer.

(b) Authorized insurance producers of a business entity may meet the requirements of this Section with a bond in the name of the business entity, continuous in form, and in the amounts set forth in subsection (a) of this Section. Insurance producers may meet the requirements of this Section with a bond in the name of an association. An individual producer remains responsible for assuring that a producer bond is in effect and is for the correct amount. The association must have been in existence for 5 years, have common membership, and been formed for a purpose other than obtaining a bond.

(c) The surety may cancel the bond and be released from

further liability thereunder upon 30 days' written notice in advance to the principal. The cancellation does not affect any liability incurred or accrued under the bond before the termination of the 30-day period.

(d) The producer's license may be revoked if the producer acts without a bond that is required under this Section.

(e) If a party injured under the terms of the bond requests the producer to provide the name of the surety and the bond number, the producer must provide the information within 3 working days after receiving the request.

(f) An association may meet the requirements of this Section for all of its members with a bond in the name of the association that is continuous in form and in the amounts set forth in subsection (a) of this Section.

(Source: P.A. 92-386, eff. 1-1-02.)

(215 ILCS 5/1510)

Sec. 1510. Definitions. In this Article:

"Adjusting a claim for loss or damage covered by an insurance contract" means negotiating values, damages, or depreciation or applying the loss circumstances to insurance policy provisions.

"Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

"Department" means the Department of Insurance.

"Director" means the Director of Insurance.

"Fingerprints" means an impression of the lines on the finger taken for the purpose of identification. The impression may be electronic or in ink converted to electronic format.

"Home state" means the District of Columbia and any state or territory of the United States where the public adjuster's principal place of residence or principal place of business is located. If neither the state in which the public adjuster maintains the principal place of residence nor the state in which the public adjuster maintains the principal place of business has a substantially similar law governing public adjusters, the public adjuster may declare another state in which it becomes licensed and acts as a public adjuster to be the home state.

"Individual" means a natural person.

"Person" means an individual or a business entity.

"Public adjuster" means any person who, for compensation or any other thing of value on behalf of the insured:

(i) acts or aids, solely in relation to first party claims arising under insurance contracts that insure the real or personal property of the insured, on behalf of an insured in adjusting a claim for loss or damage covered by an insurance contract;

(ii) advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of

first party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or

(iii) directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy for the insured.

"Uniform individual application" means the current version of the National Association of Directors (NAIC) Uniform Individual Application for resident and nonresident individuals.

"Uniform business entity application" means the current version of the National Association of Insurance Commissioners (NAIC) Uniform Business Entity Application for resident and nonresident business entities.

"Webinar" means an online educational presentation during which a live and participating instructor and participating viewers, whose attendance is periodically verified throughout the presentation, actively engage in discussion and in the submission and answering of questions.

(Source: P.A. 96-1332, eff. 1-1-11.)

(215 ILCS 5/1565)

Sec. 1565. Continuing education.

(a) An individual who holds a public adjuster license and who is not exempt under subsection (b) of this Section shall satisfactorily complete a minimum of 24 hours of continuing education courses, including 3 hours of classroom or webinar ethics instruction, reported on a biennial basis in conjunction with the license renewal cycle.

The Director may not approve a course of study unless the course provides for classroom, seminar, or self-study instruction methods. A course given in a combination instruction method of classroom or seminar and self-study shall be deemed to be a self-study course unless the classroom or seminar certified hours meets or exceeds two-thirds of the total hours certified for the course. The self-study material used in the combination course must be directly related to and complement the classroom portion of the course in order to be considered for credit. An instruction method other than classroom or seminar shall be considered as self-study methodology. Self-study credit hours require the successful completion of an examination covering the self-study material. The examination may not be self-evaluated. However, if the self-study material is completed through the use of an approved computerized interactive format whereby the computer validates the successful completion of the self-study material, no additional examination is required. The self-study credit hours contained in a certified course shall

be considered classroom hours when at least two-thirds of the hours are given as classroom or seminar instruction.

The public adjuster must complete the course in advance of the renewal date to allow the education provider time to report the credit to the Department.

(b) This Section shall not apply to:

(1) licensees not licensed for one full year prior to the end of the applicable continuing education biennium; or

(2) licensees holding nonresident public adjuster licenses who have met the continuing education requirements of their home state and whose home state gives credit to residents of this State on the same basis.

(c) Only continuing education courses approved by the Director shall be used to satisfy the continuing education requirement of subsection (a) of this Section.

(Source: P.A. 96-1332, eff. 1-1-11.)

(215 ILCS 5/Art. XXXI.75 rep.)

Section 10. The Illinois Insurance Code is amended by repealing Article XXXI 3/4.

Section 99. Effective date. This Act takes effect upon becoming law, except that the changes to Section 107a.12 of the Illinois Insurance Code take effect January 1, 2022.