AN ACT concerning insurance.

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 187, 209, 531.03, 531.04, 531.05, 531.06, 531.07, 531.08, 531.09, 531.10, 531.11, 531.12, 531.14, 531.18, 537.2, and 545 and by adding Section 206.1 as follows:

(215 ILCS 5/187) (from Ch. 73, par. 799)

Sec. 187. Scope of Article.

(1) This Article shall apply to every corporation, association, society, order, firm, company, partnership, individual, and aggregation of individuals to which any Article of this Code is applicable, or which is subject to examination, visitation or supervision by the Director under any provision of this Code or under any law of this State, or which is engaging in or proposing or attempting to engage in or is representing that it is doing an insurance or surety business, or is undertaking or proposing or attempting to undertake to provide or arrange for health care services as a health care plan as defined in subsection (7) of Section 1-2 of the Health Maintenance Organization Act, including the exchanging of reciprocal or inter-insurance contracts between individuals, partnerships and corporations in this State, or which is in the

process of organization for the purpose of doing or attempting or intending to do such business, anything as to any such corporation, association, society, order, firm, company, partnership, individual or aggregation of individuals provided in this Code or elsewhere in the laws of this State to the contrary notwithstanding.

(2) The word "company" as used in this Article includes all of the corporations, associations, societies, orders, firms, companies, partnerships, and individuals specified in subsections (1), (4), and (5) of this Section and agents, managing general agents, brokers, premium finance companies, insurance holding companies, and all other non-risk bearing entities or persons engaged in any aspect of the business of insurance on behalf of an insurer against which a receivership proceeding has been or is being filed under this Article, including, but not limited to, entities or persons that provide management, administrative, accounting, data processing, marketing, underwriting, claims handling, or any other similar services to that insurer, whether or not those entities are licensed to engage in the business of insurance in Illinois, if the entity or person is an affiliate of that insurer.

(3) The word "court" shall mean the court before which the conservation, rehabilitation, or liquidation proceeding of the company is pending, or the judge presiding in such proceedings.

(4) The word "affiliate" as used in this Article means a person that directly, or indirectly through one or more

intermediaries, controls, is controlled by, or is under common control with, the person specified.

(5) The word "person" as used in this Article means an individual, an aggregation of individuals, a partnership, or a corporation.

(6) The word "assets" as used in this Article includes all deposits and funds of a special or trust nature.

(7) The words "receivership proceedings" mean any conservation, rehabilitation, liquidation, or ancillary receivership.

(8) "Netting agreement", as used in this Article, means (a) a contract or agreement (including terms and conditions incorporated by reference therein), including a master agreement (which master agreement, together with all schedules, confirmations, definitions, and addenda thereto and transactions under any thereof, shall be treated as one netting agreement), that documents one or more transactions between the parties to the agreement for or involving one or more qualified financial contracts and that provides for the netting, liquidation, setoff, termination, acceleration, or close out under or in connection with one or more qualified financial contracts or present or future payment or delivery obligations or payment or delivery entitlements thereunder (including liquidation or close-out values relating to such obligations or entitlements) among the parties to the netting agreement; (b) any master agreement or bridge agreement for one or more master

agreements described in paragraph (a) of this subsection (8); or (c) any security agreement or arrangement or other credit enhancement or guarantee or reimbursement obligation related to any contract or agreement described in paragraph (a) or (b) of this subsection (8); provided that any contract or agreement described in paragraphs (a) or (b) of this subsection (8) relating to agreements or transactions that are not qualified financial contracts shall be deemed to be a netting agreement only with respect to those agreements or transactions that are qualified financial contracts.

(9) "Qualified financial contract" means any commodity contract, forward contract, repurchase agreement, securities contract, swap agreement, or any similar agreement that the Director determines by regulation, resolution, or order to be a qualified financial contract for the purposes of this Act.

(a) "Commodity contract" means:

(1) a contract for the purchase or sale of a commodity for future delivery on, or subject to the rules of, a board of trade or contract market under the federal Commodity Exchange Act or a board of trade outside the United States;

(2) an agreement that is subject to regulation under Section 19 of the federal Commodity Exchange Act and that is commonly known to the commodities trade as a margin account, margin contract, leverage account, or leverage contract;

(3) an agreement or transaction that is subject to regulation under Section 4c(b) of the federal Commodity Exchange Act and that is commonly known to the commodities trade as a commodity option;

(4) any combination of the agreements or transactions referred to in this paragraph (a); or

(5) any option to enter into an agreement or transaction referred to in this paragraph (a).

(b) "Forward contract", "repurchase agreement", "securities contract", and "swap agreement" shall have the meanings set forth in the Federal Deposit Insurance Act, 12 U.S.C. § 1821(e)(8)(D), as amended from time to time.

(Source: P.A. 92-140, eff. 7-24-01.)

(215 ILCS 5/206.1 new)

Sec. 206.1. Qualified financial contracts.

(a) Notwithstanding any other provision of this Article, including any other provision of this Article permitting the modification of contracts, or other law of a state, no person shall be stayed or prohibited from exercising:

(1) a contractual right to cause the termination, liquidation, acceleration, or close out of obligations under or in connection with any netting agreement or qualified financial contract with an insurer because of:

(A) the insolvency, financial condition, or default of the insurer at any time, provided that the

right is enforceable under an applicable law other than this Code; or

(B) the commencement of a formal delinquency proceeding under this Code;

(2) any right under a pledge, security, collateral, reimbursement or guarantee agreement or arrangement, any other similar security agreement or arrangement, or other credit enhancement relating to one or more netting agreements or qualified financial contracts;

(3) subject to any provision of Section 206 of this Article, any right to set off or net out any termination value, payment amount, or other transfer obligation arising under or in connection with one or more qualified financial contracts where the counterparty or its guarantor is organized under the laws of the United States or a state or a foreign jurisdiction approved by the Securities Valuation Office of the National Association of Insurance Commissioners as eligible for netting; or

(4) if a counterparty to a master netting agreement or a qualified financial contract with an insurer subject to a proceeding under this Article terminates, liquidates, closes out or accelerates the agreement or contract, then damages shall be measured as of the date or dates of termination, liquidation, close out, or acceleration; the amount of a claim for damages shall be actual direct compensatory damages calculated in accordance with

subsection (f) of this Section.

(b) Upon termination of a netting agreement or qualified financial contract, the net or settlement amount, if any, owed by a nondefaulting party to an insurer against which an application or petition has been filed under this Code shall be transferred to or on the order of the receiver for the insurer, even if the insurer is the defaulting party, notwithstanding any walkaway clause in the netting agreement or qualified financial contract.

For the purposes of this subsection (b), the term "walkaway clause" means a provision in a netting agreement or a qualified financial contract that, after calculation of a value of a party's position or an amount due to or from one of the parties in accordance with its terms upon termination, liquidation, or acceleration of the netting agreement or qualified financial contract, either does not create a payment obligation of a party or extinguishes a payment obligation of a party in whole or in part solely because of the party's status as a nondefaulting party. Any limited 2-way payment or first method provision in a netting agreement or qualified financial contract with an insurer that has defaulted shall be deemed to be a full 2-way payment or second method provision as against the defaulting insurer. Any such property or amount shall, except to the extent that it is subject to one or more secondary liens or encumbrances or rights of netting or setoff, be a general asset of the insurer.

(c) In making any transfer of a netting agreement or qualified financial contract of an insurer subject to a proceeding under this Code, the receiver shall either:

(1) transfer to one party (other than an insurer subject to a proceeding under this Article) all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding, including:

(A) all rights and obligations of each party under each netting agreement and qualified financial contract; and

(B) all property, including any guarantees or other credit enhancement, securing any claims of each party under each netting agreement and qualified financial contract; or

(2) transfer none of the netting agreements, qualified financial contracts, rights, obligations, or property referred to in paragraph (1) of this subsection (c) (with respect to the counterparty and any affiliate of the counterparty).

(d) If a receiver for an insurer makes a transfer of one or more netting agreements or qualified financial contracts, then the receiver shall use its best efforts to notify any person who is party to the netting agreements or qualified financial contracts of the transfer by 12:00 noon (the receiver's local time) on the business day following the transfer. For the

purposes of this subsection (d), "business day" means a day other than a Saturday, Sunday, or any day on which either the New York Stock Exchange or the Federal Reserve Bank of New York is closed.

(e) Notwithstanding any other provision of this Article, a receiver may not avoid a transfer of money or other property arising under or in connection with a netting agreement or qualified financial contract (or any pledge, security, collateral, or guarantee agreement or any other similar security arrangement or credit support document relating to a netting agreement or qualified financial contract) that is made before the commencement of a formal delinquency proceeding under this Article.

(f) The following provisions shall apply concerning disaffirmance and repudiation:

(1) In exercising the rights of disaffirmance or repudiation of a receiver with respect to any netting agreement or qualified financial contract to which an insurer is a party, the receiver for the insurer shall either:

(A) disaffirm or repudiate all netting agreements and qualified financial contracts between a counterparty or any affiliate of the counterparty and the insurer that is the subject of the proceeding; or

(B) disaffirm or repudiate none of the netting agreements and qualified financial contracts referred

to in subparagraph (A) (with respect to the person or any affiliate of the person).

(2) Notwithstanding any other provision of this Article, any claim of a counterparty against the estate arising from the receiver's disaffirmance or repudiation of a netting agreement or qualified financial contract that has not been previously affirmed in the liquidation or immediately preceding a conservation or rehabilitation case shall be determined and shall be allowed or disallowed as if the claim had arisen before the date of the filing of the petition for liquidation or, if a conservation or rehabilitation proceeding is converted to a liquidation proceeding, as if the claim had arisen before the date of the filing of the petition for conservation or rehabilitation. The amount of the claim shall be the actual direct compensatory damages determined as of the date of the disaffirmance or repudiation of the netting agreement or qualified financial contract. The term "actual direct compensatory damages" does not include punitive or exemplary damages, damages for lost profit or lost opportunity, or damages for pain and suffering, but does include normal and reasonable costs of cover or other reasonable measures of damages utilized in the derivatives, securities, or other market for the contract and agreement claims.

(q) The term "contractual right", as used in this Section,

includes any right set forth in a rule or bylaw of a derivatives clearing organization, as defined in the Commodity Exchange Act; a multilateral clearing organization, as defined in the Federal Deposit Insurance Corporation Improvement Act of 1991; a national securities exchange; a national securities association; a securities clearing agency; a contract market designated under the Commodity Exchange Act; a derivatives transaction execution facility registered under the Commodity Exchange Act; or a board of trade, as defined in the Commodity Exchange Act or in a resolution of the governing board thereof and any right, whether or not evidenced in writing, arising under statutory or common law or under law merchant or by reason of normal business practice.

(h) The provisions of this Section shall not apply to persons who are affiliates of the insurer that is the subject of the proceeding.

(i) All rights of counterparties under this Article shall apply to netting agreements and qualified financial contracts entered into on behalf of the general account or separate accounts if the assets of each separate account are available only to counterparties to netting agreements and qualified financial contracts entered into on behalf of that separate account.

(215 ILCS 5/209) (from Ch. 73, par. 821)

Sec. 209. Proof and allowance of claims.

(1) The following provisions shall apply concerning proof and allowance of claims:

(a) Proof of claim shall consist of a statement signed by the claimant or on behalf of the claimant that includes all of the following that are applicable:

(i) the particulars of the claim including the consideration given for it;

(ii) the identity and amount of the security on the claim;

(iii) the payments made on the debt, if any;

(iv) that the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim;

(v) any right of priority of payment or other specific right asserted by the claimant;

(vi) the name and address of the claimant and the attorney, if any, who represents the claimant; and

(vii) the claimant's social security or federal employer identification number.

(b) The Director may require that a prescribed form be used and may require that other information and documents be included.

(c) At any time the Director may require the claimant to present information or evidence supplementary to that required under paragraph (a) and may take testimony under oath, require production of affidavits or depositions, or

otherwise obtain additional information or evidence.

(2) ~~(1) A proof of claim shall consist of a written statement signed under oath setting forth the claim, the consideration for it, whether the claim is secured and, if so, how, what payments have been made on the claim, if any, and that the sum claimed is justly owing from the company.~~ Whenever a claim is based upon a document, the document, unless lost or destroyed, shall be filed with the proof of claim. If the document is lost or destroyed, a statement of that fact and of the circumstances of the loss or destruction shall be included in the proof of claim. A claim may be allowed even if contingent or unliquidated as of the date fixed by the court pursuant to subsection (a) of Section 194 if it is filed in accordance with this subsection. Except as otherwise provided in subsection (7), a proof of claim required under this Section must identify a known loss or occurrence.

~~(2) At any time, the Director may require the claimant to present information or evidence supplementary to that required under subsection (1) and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.~~

(3) Upon the liquidation, rehabilitation, or conservation of any company which has issued policies insuring the lives of persons, the Director shall, within a reasonable time, after the last day set for the filing of claims, make a list of the persons who have not filed proofs of claim with him and whose

rights have not been reinsured, to whom it appears from the books of the company, there are owing amounts on such policies and he shall set opposite the name of each person such amount so owing to such person. The Director shall incur no personal liability by reason of any mistake in such list. Each person whose name shall appear upon said list shall be deemed to have duly filed prior to the last day set for filing of claims a proof of claim for the amount set opposite his name on said list.

(4)(a) When a Liquidation, Rehabilitation, or Conservation Order has been entered in a proceeding against an insurer under this Code, any insured under an insurance policy shall have the right to file a contingent claim. The Court at the time of the entry of the Order of Liquidation, Rehabilitation or Conservation shall fix the final date for the liquidation of insureds' contingent claims, but in no event shall said date be more than 3 years after the last day fixed for the filing of claims, provided, such date may be extended by the Court on petition of the Director should the Director determine that such extension will not delay distribution of assets under Section 210. Such a contingent claim shall be allowed if such claim is liquidated and the insured claimant presents evidence of payment of such claim to the Director on or before the last day fixed by the Court.

(b) When an insured has been unable to liquidate its claim under paragraph (a) of this subsection (4), the insured may

have its claim allowed by estimation if (i) it may be reasonably inferred from the proof presented upon the claim that a claim exists under the policy; (ii) the insured has furnished suitable proof, unless the court for good cause shown shall otherwise direct, that no further valid claims against the insurer arising out of the cause of action other than those already presented can be made, and (iii) the total liability of the insurer to all claimants arising out of the same act shall be no greater than its total liability would be were it not in liquidation, rehabilitation, or conservation.

(5) The obligation of the insurer, if any, to defend or continue the defense of any claim or suit under a liability insurance policy shall terminate on the entry of the Order of Liquidation, Rehabilitation or Conservation, except during the appeal of an Order of Liquidation as provided by Section 190.1 or, unless upon the petition of the Director, the court directs otherwise. Insureds may include in contingent claims reasonable attorneys fees for services rendered subsequent to the date of Liquidation, Rehabilitation or Conservation in defense of claims or suits covered by the insured's policy provided such attorneys fees have actually been paid by the assured and evidence of payment presented in the manner required for insured's contingent claims.

(6) When a liquidation, rehabilitation, or conservation order has been entered in a proceeding against an insurer under this Code, any person who has a cause of action against an

insured of the insurer under an insurance policy issued by the insurer shall have the right to file a claim in the proceeding, regardless of the fact that the claim may be contingent, and the claim may be allowed by estimation (a) if it may be reasonably, inferred from proof presented upon the claim that the claimant would be able to obtain a judgment upon the cause of action against the insured; and (b) if the person has furnished suitable proof, unless the court for good cause shown shall otherwise direct, that no further valid claims against the insurer arising out of the cause of action other than those already presented can be made, and (c) the total liability of the insurer to all claimants arising out of the same act shall be no greater than its total liability would be were it not in liquidation, rehabilitation, or conservation.

(7) Contingent or unliquidated general creditors' and ceding insurers' claims that are not made absolute and liquidated by the last day fixed by the court pursuant to subsection (4) may be determined and allowed by estimation. Any such estimate shall be based upon an actuarial evaluation made with reasonable actuarial certainty or upon another accepted method of valuing claims with reasonable certainty and, with respect to ceding insurers' claims, may include an estimate of incurred but not reported losses.

(7.5) (a) The estimation and allowance of the loss development on a known loss or occurrence shall trigger a reinsurer's obligation to pay pursuant to its reinsurance

contract with the insolvent company, provided that the allowance is made in accordance with paragraph (b) of subsection (4) or subsection (6). The Director shall have the authority to exercise all available remedies on behalf of the insolvent company to marshal these reinsurance recoverables.

(b) That portion of any estimated and allowed contingent claim that is attributable to claims incurred but not reported to the insolvent company's reinsured shall not be billable to the insolvent company's reinsurers, except to the extent that (A) such claims develop into known losses or occurrences and become billable under paragraph (a) of this subsection or (B) the reinsurance contract specifically provides for the payment of such losses or reserves.

(c) Notwithstanding any other provision of this Code, the liquidator may negotiate a voluntary commutation and release of all obligations arising from reinsurance contracts or other agreements.

(8) No judgment against such an insured or an insurer taken after the date of the entry of the liquidation, rehabilitation, or conservation order shall be considered in the proceedings as evidence of liability, or of the amount of damages, and no judgment against an insured or an insurer taken by default, or by collusion prior to the entry of the liquidation order shall be considered as conclusive evidence in the proceeding either of the liability of such insured to such person upon such cause of action or of the amount of damages to which such person is

therein entitled.

(9) The value of securities held by secured creditors shall be determined by converting the same into money according to the terms of the agreement pursuant to which such securities were delivered to such creditors, or by such creditors and the Director by agreement, or by the court, and the amount of such value shall be credited upon the claims of such secured creditors and their claims allowed only for the balance.

(10) Claims of creditors or policyholders who have received preferences voidable under Section 204 or to whom conveyances or transfers, assignments or incumbrances have been made or given which are void under Section 204, shall not be allowed unless such creditors or policyholders shall surrender such preferences, conveyances, transfers, assignments or incumbrances.

(11)(a) When the Director denies a claim or allows a claim for less than the amount requested by the claimant, written notice of the determination and of the right to object shall be given promptly to the claimant or the claimant's representative by first class mail at the address shown on the proof of claim. Within 60 days from the mailing of the notice, the claimant may file his written objections with the Director. If no such filing is made on a timely basis, the claimant may not further object to the determination.

(b) Whenever objections are filed with the Director and he does not alter his determination as a result of the objection

and the claimant continues to object, the Director shall petition the court for a hearing as soon as practicable and give notice of the hearing by first class mail to the claimant or his representative and to any other persons known by the Director to be directly affected, not less than 10 days before the date of the hearing.

(12) The Director shall review all claims duly filed in the liquidation, rehabilitation, or conservation proceeding, unless otherwise directed by the court, and shall make such further investigation as he considers necessary. The Director may compound, compromise, or in any other manner negotiate the amount for which claims will be recommended to the court. Unresolved disputes shall be determined under subsection (11).

(13)(a) The Director shall present to the court reports of claims reviewed under subsection (12) with his recommendations as to each claim.

(b) The court may approve or disapprove any recommendations contained in the reports of claims filed by the Director, except that the Director's agreements with claimants shall be accepted as final by the court on claims settled for $10,000 or less.

(14) The changes made in this Section by this amendatory Act of 1993 apply to all liquidation, rehabilitation, or conservation proceedings that are pending on the effective date of this amendatory Act of 1993 and to all future liquidation, rehabilitation, or conservation proceedings, except that the

changes made to the provisions of this Section by this amendatory Act of 1993 shall not apply to any company ordered into liquidation on or before January 1, 1982.

(15) The changes made in this Section by this amendatory Act of the 93rd General Assembly do not apply to any company ordered into liquidation on or before January 1, 2004.

(Source: P.A. 93-1083, eff. 2-7-05.)

(215 ILCS 5/531.03) (from Ch. 73, par. 1065.80-3)

Sec. 531.03. Coverage and limitations.

(1) This Article shall provide coverage for the policies and contracts specified in paragraph (2) of this Section:

(a) to persons who, regardless of where they reside (except for non-resident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees of the persons covered under subparagraph (1)(b), and

(b) <u>to persons who are owners of or certificate holders under the policies or contracts (other than unallocated annuity contracts and structured settlement annuities) and in each case who:</u>

<u>(i) are residents; or</u>

<u>(ii) are not residents, but only under all of the following conditions:</u>

<u>(A) the insurer that issued the policies or contracts is domiciled in this State;</u>

(B) the states in which the persons reside have associations similar to the Association created by this Article;

(C) the persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in that state at the time specified in that state's guaranty association law.

(c) For unallocated annuity contracts specified in subsection (2), paragraphs (a) and (b) of this subsection (1) shall not apply and this Article shall (except as provided in paragraphs (e) and (f) of this subsection) provide coverage to:

(i) persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this State; and

(ii) persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(d) For structured settlement annuities specified in subsection (2), paragraphs (a) and (b) of this subsection (1) shall not apply and this Article shall (except as provided in paragraphs (e) and (f) of this subsection) provide coverage to a person who is a payee under a

structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(i) is a resident, regardless of where the contract owner resides; or

(ii) is not a resident, but only under both of the following conditions:

(A) with regard to residency:

(I) the contract owner of the structured settlement annuity is a resident; or

(II) the contract owner of the structured settlement annuity is not a resident but the insurer that issued the structured settlement annuity is domiciled in this State and the state in which the contract owner resides has an association similar to the Association created by this Article; and

(B) neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(e) This Article shall not provide coverage to:

(i) a person who is a payee or beneficiary of a contract owner resident of this State if the payee or beneficiary is afforded any coverage by the association of another state; or

(ii) a person covered under paragraph (c) of this

subsection (1), if any coverage is provided by the association of another state to that person.

(f) This Article is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this Article is provided coverage under the laws of any other state, then the person shall not be provided coverage under this Article. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this Article shall be construed in conjunction with other state laws to result in coverage by only one association. ~~to persons who are owners of or certificate holders under such policies or contracts; or, in the case of unallocated annuity contracts, to the persons who are the contract holders, and who~~

~~(i) are residents of this State, or~~

~~(ii) are not residents, but only under all of the following conditions:~~

~~(A) the insurers which issued such policies or contracts are domiciled in this State;~~

~~(B) such insurers never held a license or certificate of authority in the states in which such persons reside;~~

~~(C) such states have associations similar to the association created by this Act; and~~

~~(D) such persons are not eligible for coverage by such associations.~~

(2)(a) This Article shall provide coverage to the persons specified in paragraph (l) of this Section for direct, (i) nongroup life, health, annuity and supplemental policies, or contracts, (ii) for certificates under direct group policies or contracts, (iii) for unallocated annuity contracts and (iv) for contracts to furnish health care services and subscription certificates for medical or health care services issued by persons licensed to transact insurance business in this State under the Illinois Insurance Code. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts and any immediate or deferred annuity contracts.

(b) This Article shall not provide coverage for:

(i) that portion <u>of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner</u> ~~or part of such policies or contracts under which the risk is borne by the policyholder; provided however, that nothing in this subparagraph (i) shall make this Article inapplicable to~~

~~assessment life and accident and health insurance policies or contracts~~; ~~or~~

(ii) any such policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued; ~~or~~

(iii) any portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor is determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value: ~~any portion of a policy or contract to the extent such portion represents an accrued value that the rate of interest on which it is accrued~~

(A) averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier, exceeds the rate of interest determined by subtracting 2 percentage points from Moody's Corporate Bond Yield Average averaged for that same 4-year period or for such lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier ~~averaged over the period of four years prior to the date on which the Association becomes obligated with~~

~~respect to such policy or contract, exceeds a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four year period or for such lesser period if the policy or contract was issued less than four years before the Association became obligated~~; and

(B) on and after the date on which the member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's Corporate Bond Yield Average as most recently available ~~on and after the date on which the Association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available~~; ~~or~~

(iv) any unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan ~~any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation~~; ~~or~~

(v) any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery; ~~or~~

(vi) an obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(A) a claim based on marketing materials;

(B) a claim based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(C) a misrepresentation of or regarding policy benefits;

(D) an extra-contractual claim; or

(E) a claim for penalties or consequential or incidental damages; ~~any burial society organized under Article XIX of this Act, any fraternal benefit society organized under Article XVII of this Act, any mutual benefit association organized under Article XVIII of this Act, and any foreign fraternal benefit society licensed under Article VI of this Act; or~~

~~(vii) any health maintenance organization established pursuant to the Health Maintenance Organization Act including any health maintenance organization business of~~

~~a member insurer; or~~

~~(viii) any health services plan corporation established pursuant to the Voluntary Health Services Plans Act; or~~

~~(ix) (blank); or~~

~~(x) any dental service plan corporation established pursuant to the Dental Service Plan Act; or~~

(vii) ~~(xi)~~ any stop-loss insurance, as defined in clause (b) of Class 1 or clause (a) of Class 2 of Section 4, and further defined in subsection (d) of Section 352; ~~or~~

(viii) any policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto;

(ix) any portion of a policy or contract to the extent that the assessments required by Section 531.09 of this Code with respect to the policy or contract are preempted or otherwise not permitted by federal or State law;

(x) any portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association,

or other person under:

(A) a multiple employer welfare arrangement as defined in 29 U.S.C. Section 1144;

(B) a minimum premium group insurance plan;

(C) a stop-loss group insurance plan; or

(D) an administrative services only contract;

(xi) any portion of a policy or contract to the extent that it provides for:

(A) dividends or experience rating credits;

(B) voting rights; or

(C) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(xii) any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this State;

(xiii) any contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(xiv) any portion of a policy or contract to the extent that it provides for interest or other changes in value to

be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this Code, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this Section, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; or

(xv) ~~(xii)~~ that portion or part of a variable life insurance or variable annuity contract not guaranteed by an insurer.

(3) The benefits for which the Association may become liable shall in no event exceed the lesser of:

(a) the contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer, or

(b)(i) with respect to any one life, regardless of the number of policies or contracts:

(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(B) in health insurance benefits:

(I) $100,000 for coverages not defined as disability insurance or basic hospital, medical, and surgical insurance or major medical insurance or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(II) $300,000 for disability insurance and $300,000 for long-term care insurance as defined in Section 351A-1 of this Code; and

(III) $500,000 for basic hospital medical and surgical insurance or major medical insurance ~~$300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values~~;

(C) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) with respect to each individual participating in a governmental retirement benefit plan established under Sections 401, 403(b), or 457 of the U.S. Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $250,000 in present value annuity benefits,

including net cash surrender and net cash withdrawal values;

(iii) with respect to each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if deceased, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any; or

(iv) with respect to either (1) one contract owner provided coverage under subparagraph (ii) of paragraph (c) of subsection (1) of this Section or (2) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subparagraph (ii) of paragraph (b) of this subsection, $5,000,000 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this Article and are owned by a trust or other entity for the benefit of 2 or more plan sponsors, coverage shall be afforded by the Association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this State. In no event shall the Association be obligated to cover more than $5,000,000 in benefits with respect to all these unallocated contracts.

In no event shall the Association be obligated to cover

more than (1) an aggregate of $300,000 in benefits with respect to any one life under subparagraphs (i), (ii), and (iii) of this paragraph (b) except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under item (B) of subparagraph (i) of this paragraph (b), in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual or (2) with respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

The limitations set forth in this subsection are limitations on the benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the Association's obligations under this Article may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

~~$100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;~~

~~(ii) with respect to each individual participating in a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, $100,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values; provided, however, that in no event shall the Association be liable to expend more than $300,000 in the aggregate with respect to any one individual under subparagraph (1) and this subparagraph;~~

~~(iii) with respect to any one contract holder covered by any unallocated annuity contract not included in subparagraph (3)(b)(ii) of this Section above, $5,000,000 in benefits, irrespective of the number of such contracts held by that contract holder.~~

(4) In performing its obligations to provide coverage under Section 531.08 of this Code, the Association shall not be required to guarantee, assume, reinsure, or perform or cause to be guaranteed, assumed, reinsured, or performed the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

(Source: P.A. 90-177, eff. 7-23-97; 91-357, eff. 7-29-99.)

(215 ILCS 5/531.04) (from Ch. 73, par. 1065.80-4)

Sec. 531.04. Construction.~~)~~ This Article shall be ~~is to be liberally~~ construed to effect the purpose under Section 531.02 ~~which constitutes an aid and guide to interpretation~~.

(Source: P.A. 81-899.)

(215 ILCS 5/531.05) (from Ch. 73, par. 1065.80-5)

Sec. 531.05. Definitions. As used in this Act:

~~(1)~~ "Account" means either of the 3 accounts created under Section 531.06.

~~(2)~~ "Association" means the Illinois Life and Health Insurance Guaranty Association created under Section 531.06.

"Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the Board of Directors has been passed whereby an assessment shall be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

"Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

"Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the Association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the Association to member insurers.

~~(3)~~ "Director" means the Director of Insurance of this State.

~~(4)~~ "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 531.03.

~~(5)~~ "Covered person" means any person who is entitled to the protection of the Association as described in Section 531.02.

~~(6)~~ "Covered policy" means any policy or contract within the scope of this Article under Section 531.03.

"Extra-contractual claims" shall include claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.

"Impaired insurer" means (A) a member insurer which, after the effective date of this amendatory Act of the 96th General Assembly, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction or (B) a member insurer deemed by the Director after the effective date of this amendatory Act of the 96th General Assembly to be potentially unable to fulfill its contractual obligations and not an insolvent insurer. ~~(7) "Impaired insurer" means a member insurer deemed by the Director after the effective date of this Article to be potentially unable to fulfill its contractual obligations and not an insolvent insurer.~~

"Insolvent insurer" means a member insurer that, after the effective date of this amendatory Act of the 96th General Assembly, is placed under a final order of liquidation by a court of competent jurisdiction with a finding of insolvency. ~~(8) "Insolvent insurer" means (a) a member insurer either at the time the policy was issued or when the insured event occurred, or any company which has acquired such direct policy obligations through purchase, merger, consolidation, reinsurance or otherwise, whether or not such acquiring company held a certificate of authority to transact insurance in this State at the time such policy was issued or when the insured event occurred; and (b) becomes insolvent and is placed under a final order of liquidation, rehabilitation or conservation by a court of competent jurisdiction.~~

"Member insurer" means an insurer licensed or holding a certificate of authority to transact in this State any kind of insurance for which coverage is provided under Section 531.03 of this Code and includes an insurer whose license or certificate of authority in this State may have been suspended, revoked, not renewed, or voluntarily withdrawn or whose certificate of authority may have been suspended pursuant to Section 119 of this Code, but does not include:

(1) a hospital or medical service organization, whether profit or nonprofit;

(2) a health maintenance organization;

(3) any burial society organized under Article XIX of

this Code, any fraternal benefit society organized under Article XVII of this Code, any mutual benefit association organized under Article XVIII of this Code, and any foreign fraternal benefit society licensed under Article VI of this Code or a fraternal benefit society;

(4) a mandatory State pooling plan;

(5) a mutual assessment company or other person that operates on an assessment basis;

(6) an insurance exchange;

(7) an organization that is permitted to issue charitable gift annuities pursuant to Section 121-2.10 of this Code;

(8) any health services plan corporation established pursuant to the Voluntary Health Services Plans Act;

(9) any dental service plan corporation established pursuant to the Dental Service Plan Act; or

(10) an entity similar to any of the above. ~~(9) "Member insurer" means any person licensed or who holds a certificate of authority to transact in this State any kind of insurance business to which this Article applies under Section 531.03. For purposes of this Article "member insurer" includes any person whose certificate of authority may have been suspended pursuant to Section 119.~~

~~(10)~~ "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

"Owner" of a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner, and policy owner do not include persons with a mere beneficial interest in a policy or contract.

"Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

"Plan sponsor" means:

(1) the employer in the case of a benefit plan established or maintained by a single employer;

(2) the employee organization in the case of a benefit plan established or maintained by an employee organization; or

(3) in a case of a benefit plan established or maintained by 2 or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

"Premiums" mean amounts or considerations, by whatever name called, received on covered policies or contracts less

returned premiums, considerations, and deposits and less dividends and experience credits.

"Premiums" does not include:

(A) amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 531.03 of this Code except that assessable premium shall not be reduced on account of the provisions of subparagraph (iii) of paragraph (b) of subsection (a) of Section 531.03 of this Code relating to interest limitations and the provisions of paragraph (b) of subsection (3) of Section 531.03 relating to limitations with respect to one individual, one participant, and one contract owner;

(B) premiums in excess of $5,000,000 on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code; or

(C) with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner. ~~(11) "Premiums" means direct gross insurance~~

~~premiums or subscriptions and annuity considerations received on covered policies or contracts, less return premiums and considerations thereon and dividends paid or credited to policyholders on such direct business. "Premiums" do not include premiums and considerations on contracts between insurers and reinsurers. "Premiums" do not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under paragraph (2) of Section 531.03 except that assessable premium shall not be reduced on account of subparagraph (2)(b)(iii) of Section 531.03 relating to interest limitations and subparagraph (3)(b) of Section 531.03 relating to limitations with respect to any one individual, any one participant and any one contractholder; provided that "premiums" shall not include any premiums in excess of five million dollars on any unallocated annuity contract not issued under a governmental retirement plan established under Sections 401, 403(b) or 457 of the United States Internal Revenue Code.~~

~~(12) "Person" means any individual, corporation, partnership, association or voluntary organization.~~

"Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a

whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

(A) the state in which the primary executive and administrative headquarters of the entity is located;

(B) the state in which the principal office of the chief executive officer of the entity is located;

(C) the state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(D) the state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(E) the state from which the management of the overall operations of the entity is directed; and

(F) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However, in the case of a plan sponsor, if more than 50% of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

The principal place of business of a plan sponsor of a

benefit plan described in this Section shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

"Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the insurer.

"Resident" means a person to whom a contractual obligation is owed and who resides in this State on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries or (ii) residents of United States possessions, territories, or protectorates that do not have an association similar to the Association created by this Article, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts. ~~(13) "Resident" means any person who resides in this State at the time the insurer is~~

~~determined to be impaired or insolvent and to whom contractual obligations are owed. A person may be a resident of only one state which, in the case of a person other than a natural person, shall be its principal place of business.~~

"Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

"State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

"Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or a life, health, or annuity contract. ~~(14) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.~~

~~(15)~~ "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

(Source: P.A. 86-753.)

(215 ILCS 5/531.06) (from Ch. 73, par. 1065.80-6)

Sec. 531.06. Creation of the Association. There is created a non-profit legal entity to be known as the Illinois Life and

Health Insurance Guaranty Association. All member insurers are and must remain members of the Association as a condition of their authority to transact insurance in this State. The Association must perform its functions under the plan of operation established and approved under Section 531.10 and must exercise its powers through a board of directors established under Section 531.07. For purposes of administration and assessment, the Association must maintain 2 accounts:

(1) The life insurance and annuity account, which includes the following subaccounts:

(a) Life Insurance Account;

(b) Annuity account, which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Section 401, 403(b), or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities ~~Annuity account~~; and

(c) Unallocated annuity account, which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b), or 457 of the United States Internal Revenue Code ~~Unallocated Annuity Account which shall include contracts qualified under Section 403(b) of the United States Internal Revenue Code~~.

(2) The health insurance account.

The Association shall be supervised by the Director and is subject to the applicable provisions of the Illinois Insurance Code. Meetings or records of the Association may be opened to the public upon majority vote of the board of directors of the Association.

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 5/531.07) (from Ch. 73, par. 1065.80-7)

Sec. 531.07. Board of Directors.) The board of directors of the Association consists of not less than 7 ~~5~~ nor more than 11 ~~9~~ members serving terms as established in the plan of operation. The insurers ~~members~~ of the board are to be selected by member insurers subject to the approval of the Director. In addition, 2 persons who must be public representatives may be appointed by the Director to the board of directors. A public representative may not be an officer, director, or employee of an insurance company or any person engaged in the business of insurance. Vacancies on the board must be filled for the remaining period of the term in the manner described in the plan of operation. ~~To select the initial board of directors, and initially organize the Association, the Director must give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer is entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational~~

~~meeting, the Director may appoint the initial members.~~

In approving selections or in appointing members to the board, the Director must consider, whether all member insurers are fairly represented.

Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors but members of the board may not otherwise be compensated by the Association for their services.

(Source: P.A. 81-899.)

(215 ILCS 5/531.08) (from Ch. 73, par. 1065.80-8)

Sec. 531.08. Powers and duties of the Association.

(a) In addition to the powers and duties enumerated in other Sections of this Article:

(1) If a member insurer is an impaired insurer, then the Association may, in its discretion and subject to any conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer and that are approved by the Director:

(A) guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; or

(B) provide such money, pledges, loans, notes, guarantees, or other means as are proper to effectuate paragraph (A) and assure payment of the contractual obligations of the impaired insurer pending action

under paragraph (A).

(2) If a member insurer is an insolvent insurer, then the Association shall, in its discretion, either:

(A) guaranty, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the policies or contracts of the insolvent insurer or assure payment of the contractual obligations of the insolvent insurer and provide money, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the Association's duties; or

(B) provide benefits and coverages in accordance with the following provisions:

(i) with respect to life and health insurance policies and annuities, ensure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

(a) with respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the Association becomes obligated with respect to the policies and contracts;

(b) with respect to nongroup policies, contracts, and annuities not later than the earlier of the next renewal date (if any) under the policies or contracts or one year, but in no event less than 30 days, from the date on which the Association becomes obligated with respect to the policies or contracts;

(ii) make diligent efforts to provide all known insureds or annuitants (for nongroup policies and contracts), or group policy owners with respect to group policies and contracts, 30 days notice of the termination (pursuant to subparagraph (i) of this paragraph (B)) of the benefits provided;

(iii) with respect to nongroup life and health insurance policies and annuities covered by the Association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of paragraph (3), if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to

individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class.

~~(1) If a domestic insurer is an impaired insurer, the Association may, subject to any conditions imposed by the Association other than those which impair the contractual obligations of the impaired insurer, and approved by the impaired insurer and the Director:~~

~~(a) Guarantee or reinsure, or cause to be guaranteed, assumed or reinsured, any or all of the covered policies of covered persons of the impaired insurer;~~

~~(b) Provide such monies, pledges, notes, guarantees, or other means as are proper to effectuate paragraph (a), and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a);~~

~~(c) Loan money to the impaired insurer;~~

~~(2) If a domestic, foreign, or alien insurer is an insolvent insurer, the Association shall, subject to the approval of the Director;~~

~~(a)(i) Guarantee, assume or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies~~

~~of covered persons of the insolvent insurer;~~

~~(ii) Assure payment of the contractual obligations of the insolvent insurer to covered persons;~~

~~(iii) Provide such monies, pledges, notes, guaranties, or other means as are reasonably necessary to discharge such duties; or~~

~~(b) with respect to only life and health insurance policies, provide benefits and coverages in accordance with Section 531.08(3).~~

~~(c) Provided however that this subsection (2) shall not apply when the Director has determined that the foreign or alien insurers domiciliary jurisdiction or state of entry provides, by statute, protection substantially similar to that provided by this Article for residents of this State and such protection will be provided in a timely manner.~~

~~(3) When proceeding under subparagraph (2)(b) of this Section the Association shall, with respect to only life and health insurance policies:~~

~~(a) assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies of the insolvent insurer, for claims incurred:~~

~~(i) with respect to group policies, not later than the earlier of the next renewal date under~~

~~such policies or contracts or sixty days, but in no event less than thirty days, after the date on which the Association becomes obligated with respect to such policies;~~

~~(ii) with respect to non group policies, not later than the earlier of the next renewal date (if any) under such policies or one year, but in no event less than thirty days, from the date on which the Association becomes obligated with respect to such policies;~~

~~(b) make diligent efforts to provide all known insureds or group policyholders with respect to group policies thirty days notice of the termination of the benefits provided; and~~

~~(c) with respect to non-group policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (3)(d) of this Section, if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue a non-group policy in force until a specified age or for a specified time, during which the insurer has no right unilaterally to make changes in any

~~provision of the policy or had a right only to make changes in premium by class.~~

(b) ~~(d)(i)~~ In providing the substitute coverage required under subparagraph (iii) of paragraph (B) of item (2) of subsection (a) ~~(3)(c)~~ of this Section, the Association may offer either to reissue the terminated coverage or to issue an alternative policy.

~~(ii)~~ Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

~~(iii)~~ The Association may reinsure any alternative or reissued policy.

~~(e)(i)~~ Alternative policies adopted by the Association shall be subject to the approval of the Director. The Association may adopt alternative policies of various types for future insurance without regard to any particular impairment or insolvency.

~~(ii)~~ Alternative policies shall contain at least the minimum statutory provisions required in this State and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the

original policy was last underwritten.

~~(iii)~~ Any alternative policy issued by the Association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the Association.

(c) ~~(f)~~ If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the Association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the Director or by a court of competent jurisdiction.

(d) ~~(g)~~ The Association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policyholder, the insured, or the Association.

(e) ~~(4)~~ When proceeding under ~~subparagraph (2)(b) of~~ this Section with respect to any policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with subparagraph (2)(b)(iii)(B) of Section 531.03.

(f) ~~(5)~~ Nonpayment of premiums thirty-one days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the Association's obligations under such policy or coverage under this Act with respect to such

policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this Act.

(g) ~~(6)~~ Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association, and the Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

(h) In carrying out its duties under paragraph (2) of subsection (a) of this Section, the Association may:

(1) subject to approval by a court in this State, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement if the Association finds that the amounts which can be assessed under this Article are less than the amounts needed to assure full and prompt performance of the Association's duties under this Article or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest; or

(2) subject to approval by a court in this State, impose temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts in addition to any contractual provisions for deferral of cash

or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the Association may defer the payment of cash values, policy loans, or other rights by the Association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the Association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

~~(7) (a) In carrying out its duties under subsection (2), permanent policy liens, or contract liens, may be imposed in connection with any guarantee, assumption or reinsurance agreement, if the court:~~

~~(i) Finds that the amounts which can be assessed under this Act are less than the amounts needed to assure full and prompt performance of the insolvent insurer's contractual obligations, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens, to be in the public interest; and~~

~~(ii) Approves the specific policy liens or~~

~~contract liens to be used.~~

~~(b) Before being obligated under subsection (2) the Association may request that there be imposed temporary moratoriums or liens on payments of cash values and policy loans in addition to any contractual provisions for deferral of cash or policy loan values, and such temporary moratoriums and liens may be imposed if they are approved by the court.~~

(i) ~~(8)~~ There shall be no liability on the part of and no cause of action shall arise against the Association or against any transferee from the Association in connection with the transfer by reinsurance or otherwise of all or any part of an impaired or insolvent insurer's business by reason of any action taken or any failure to take any action by the impaired or insolvent insurer at any time.

(j) ~~(9)~~ If the Association fails to act within a reasonable period of time as provided in subsection (2) of this Section with respect to an insolvent insurer, the Director shall have the powers and duties of the Association under this Act with regard to such insolvent insurers.

(k) ~~(10)~~ The Association or its designated representatives may render assistance and advice to the Director, upon his request, concerning rehabilitation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(l) The Association shall have standing to appear or

intervene before a court or agency in this State with jurisdiction over an impaired or insolvent insurer concerning which the Association is or may become obligated under this Article or with jurisdiction over any person or property against which the Association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The Association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the Association is or may become obligated or with jurisdiction over any person or property against whom the Association may have rights through subrogation or otherwise. ~~(11) The Association has standing to appear before any court concerning all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring or guaranteeing the covered policies of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations.~~

(m)(1) A person receiving benefits under this Article shall be deemed to have assigned the rights under and any causes of action against any person for losses arising under, resulting

from, or otherwise relating to the covered policy or contract to the Association to the extent of the benefits received because of this Article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The Association may require an assignment to it of such rights and cause of action by any payee, policy, or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Article upon the person. ~~(12) (a) Any person receiving benefits under this Article is deemed to have assigned the rights under the covered policy to the Association to the extent of the benefits received because of this Article whether the benefits are payments of contractual obligations or continuation of coverage. The Association may require an assignment to it of such rights by any payee, policy or contract owner, beneficiary, insured, certificate holder or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this Article upon such person. The Association is subrogated to these rights against the assets of any insolvent insurer.~~

(2) ~~(b)~~ The subrogation rights of the Association under this subsection have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this Article.

(3) In addition to paragraphs (1) and (2), the Association

shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, or payee of a policy or contract with respect to the policy or contracts, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity to the extent of benefits received pursuant to this Article, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130.

(4) If the preceding provisions of this subsection (l) are invalid or ineffective with respect to any person or claim for any reason, then the amount payable by the Association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies, or portion thereof, covered by the Association.

(5) If the Association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the Association has rights as described in the preceding paragraphs of this subsection (10), then the person shall pay to the Association the portion of the recovery attributable to the policies, or portion thereof, covered by the Association.

(n) ~~(13)~~ The Association may:

(1) ~~(a)~~ Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Article;

(2) ~~(b)~~ Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under Section 531.09. The Association shall not be liable for punitive or exemplary damages;

(3) ~~(c)~~ Borrow money to effect the purposes of this Article. Any notes or other evidence of indebtedness of the Association not in default are legal investments for domestic insurers and may be carried as admitted assets.

(4) ~~(d)~~ Employ or retain such persons as are necessary to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under this Article.

(5) ~~(e)~~ Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the Association.

(6) ~~(f)~~ Take such legal action as may be necessary to avoid payment of improper claims.

(7) ~~(g)~~ Exercise, for the purposes of this Article and to the extent approved by the Director, the powers of a domestic life or health insurer, but in no case may the Association issue insurance policies or annuity contracts other than those issued to perform the contractual

obligations of the impaired or insolvent insurer.

(8) ~~(h)~~ Exercise all the rights of the Director under Section 193(4) of this Code with respect to covered policies after the association becomes obligated by statute.

(9) Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under this Article with respect to the person, and the person shall promptly comply with the request.

(10) Take other necessary or appropriate action to discharge its duties and obligations under this Article or to exercise its powers under this Article.

(o) ~~(14)~~ With respect to covered policies for which the Association becomes obligated after an entry of an order of liquidation or rehabilitation, the Association may elect to succeed to the rights of the insolvent insurer arising after the date of the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the Association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

(p) A deposit in this State, held pursuant to law or

required by the Director for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this State or in a reciprocal state, pursuant to Article XIII 1/2 of this Code, shall be promptly paid to the Association. The Association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all policy owners' claims in this State related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the Association less the amount retained pursuant to this subsection (13). Any amount so paid to the Association and retained by it shall be treated as a distribution of estate assets pursuant to applicable State receivership law dealing with early access disbursements.

(q) The Board of Directors of the Association shall have discretion and may exercise reasonable business judgment to determine the means by which the Association is to provide the benefits of this Article in an economical and efficient manner.

(r) Where the Association has arranged or offered to provide the benefits of this Article to a covered person under a plan or arrangement that fulfills the Association's obligations under this Article, the person shall not be

entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

(s) Venue in a suit against the Association arising under the Article shall be in Cook County. The Association shall not be required to give any appeal bond in an appeal that relates to a cause of action arising under this Article.

(t) The Association may join an organization of one or more other State associations of similar purposes to further the purposes and administer the powers and duties of the Association.

(u) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under subsections (1) or (2), the Association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(1) in lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate, or (ii) payment of dividends with minimum guarantees, or (iii) a different method for calculating interest or changes in value;

(2) there is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(3) the alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

(Source: P.A. 93-326, eff. 1-1-04.)

(215 ILCS 5/531.09) (from Ch. 73, par. 1065.80-9)

Sec. 531.09. Assessments.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such times and for such amounts as the board finds necessary. Assessments shall be due not less than 30 days after written notice to the member insurers and shall accrue interest from the due date at such adjusted rate as is established under Section 6621 of Chapter 26 of the United States Code and such interest shall be compounded daily.

(2) There shall be 2 classes of assessments, as follows:

(a) Class A assessments shall be made for the purpose of meeting administrative costs and other general expenses and examinations conducted under the authority of the Director under subsection (5) of Section 531.12.

(b) Class B assessments shall be made to the extent

necessary to carry out the powers and duties of the Association under Section 531.08 with regard to an impaired or insolvent domestic insurer or insolvent foreign or alien insurers.

(3)(a) The amount of any Class A assessment shall be determined at the discretion of the board of directors and such assessments shall be authorized and called on a non-pro rata basis. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts and subaccounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(b) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this State by each assessed member insurer on policies or contracts covered by each account or subaccount for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this State for such calendar years by all assessed member insurers.

(c) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this Article. Classification of assessments under subsection

(2) and computations of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(4) The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this Section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the Association.

(5) (a) Subject to the provisions of subparagraph (ii) of this paragraph, the total of all assessments authorized by the Association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in one calendar year exceed 2% of that member insurer's average annual premiums received in this State on the policies and contracts covered by the subaccount or account during the 3 calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

If 2 or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent

in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subparagraph (a) of this paragraph shall be equal and limited to the higher of the 3-year average annual premiums for the applicable subaccount or account as calculated pursuant to this Section.

If the maximum assessment, together with the other assets of the Association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this Article.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(c) If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to paragraph (b) of subsection (3), the board shall assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in paragraph (a) of this subsection.

~~(4) The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability~~

~~of the member insurer to fulfill its contractual obligations. The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder may not in any one calendar year exceed 2% and for the health account may not in any one calendar year exceed 2% of such insurer's average premiums received in this State on the policies and contracts covered by the account or subaccount during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If a one percent assessment for any subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to subsection 3(b), the board shall access all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in this subsection.~~

~~(5) In the event an assessment against a member insurer is abated, or deferred, in whole or in part, because of the limitations set forth in subsection (4) of this Section the amount by which such assessment is abated or deferred, may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this Section. If the maximum assessment, together with the other assets of the Association in either account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds may be assessed as soon thereafter as~~

~~permitted by this Article. The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.~~

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the Association with regard to that account, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses ~~if refunds are impractical~~.

(7) An assessment is deemed to occur on the date upon which the board votes such assessment. The board may defer calling the payment of the assessment or may call for payment in one or more installments.

(8) It is proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this Article, to consider the amount reasonably necessary to meet its assessment obligations under this Article.

(9) The Association must issue to each insurer paying a Class B assessment under this Article a certificate of

contribution, in a form acceptable to the Director, for the amount of the assessment so paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Director may approve, provided the insurer shall in any event at its option have the right to show a certificate of contribution as an admitted asset at percentages of the original face amount for calendar years as follows:

100% for the calendar year after the year of issuance;

80% for the second calendar year after the year of issuance;

60% for the third calendar year after the year of issuance;

40% for the fourth calendar year after the year of issuance;

20% for the fifth calendar year after the year of issuance.

(10) The Association may request information of member insurers in order to aid in the exercise of its power under this Section and member insurers shall promptly comply with a request.

(Source: P.A. 95-86, eff. 9-25-07 (changed from 1-1-08 by P.A. 95-632).)

(215 ILCS 5/531.10) (from Ch. 73, par. 1065.80-10)

Sec. 531.10. Plan of Operation.) (1) (a) The Association

must submit to the Director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The plan of operation and any amendments thereto become effective upon approval in writing by the Director.

(b) If the Association fails to submit a suitable plan of operation within 180 days following the effective date of this Article or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Director may, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Article. Such rules are in force until modified by the Director or superseded by a plan submitted by the Association and approved by the Director.

(2) All member insurers must comply with the plan of operation.

(3) The plan of operation must, in addition to requirements enumerated elsewhere in this Article:

(a) Establish procedures for handling the assets of the Association;

(b) Establish the amount and method of reimbursing members of the board of directors under Section 531.07;

(c) Establish regular places and times for meetings of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the Association, its agents, and

the board of directors;

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the Director;

(f) Establish any additional procedures for assessments under Section 531.09; and

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

(4) The plan of operation shall establish a procedure for protest by any member insurer of assessments made by the Association pursuant to Section 531.09. Such procedures shall require that:

(a) a member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the Association. The payment shall be available to meet Association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest; ~~Any member insurer that wishes to protest all or any part of an assessment for any year shall first pay the full amount of the assessment as set forth in the notice provided by the Association. Such payments shall be accompanied by a statement in writing that the payment is~~

~~made under protest, setting forth a brief statement of the ground for the protest. The Association shall hold such payments in a separate interest bearing account.~~

(b) within ~~Within~~ 30 days following the payment of an assessment under protest by any protesting member insurer, the Association must notify the member insurer in writing of its determination with respect to the protest unless the Association notifies the member that additional time is required to resolve the issues raised by the protest;~~.~~

(c) in ~~In~~ the event the Association determines that the protesting member insurer is entitled to a refund, such refund shall be made within 30 days following the date upon which the Association makes its determination; ~~.~~

(d) the ~~The~~ decision of the Association with respect to a protest may be appealed to the Director pursuant to Section 531.11(3);~~.~~

(e) in ~~In~~ the alternative to rendering a decision with respect to any protest based on a question regarding the assessment base, the Association may refer such protests to the Director for final decision, with or without a recommendation from the Association; and~~.~~

(f) interest ~~Interest~~ on any refund due a protesting member insurer shall be paid at the rate actually earned by the Association ~~on the separate account~~.

(5) The plan of operation may provide that any or all powers and duties of the Association, except those under

paragraph (c) of subsection (10) of Section 531.08 and Section 531.09 are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in 2 or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the Board of Directors and the Director, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.

(Source: P.A. 84-1035.)

(215 ILCS 5/531.11) (from Ch. 73, par. 1065.80-11)

Sec. 531.11. Duties and powers of the Director. In addition to the duties and powers enumerated elsewhere in this Article:

(1) The Director must do all of the following:

(a) Upon request of the board of directors, provide the Association with a statement of the premiums in the appropriate accounts for each member insurer.

(b) Notify ~~notify~~ the board of directors of the existence of an impaired or insolvent insurer not later than 3 days after a determination of impairment or insolvency is made or when the Director receives notice of

impairment or insolvency.

(c) Give ~~give~~ notice to an impaired insurer as required by Sections 34 or 60. Notice to the impaired insurer shall constitute notice to its shareholders, if any.

(d) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the Director shall be appointed conservator.

(2) The Director may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this State of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the Director may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture may not exceed 5% of the unpaid assessment per month, but no forfeiture may be less than $100 per month.

(3) Any action of the board of directors or the Association may be appealed to the Director by any member insurer or any other person adversely affected by such action if such appeal is taken within 30 days of the action being appealed. Any final action or order of the Director is subject to judicial review in a court of competent jurisdiction.

(4) The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the

effect of this Article.

(Source: P.A. 89-97, eff. 7-7-95.)

(215 ILCS 5/531.12) (from Ch. 73, par. 1065.80-12)

Sec. 531.12. Prevention of Insolvencies. To aid in the detection and prevention of insurer insolvencies or impairments:

(1) It shall be the duty of the Director:

(a) To notify the Commissioners of all other states, territories of the United States, and the District of Columbia when he takes any of the following actions against a member insurer:

(i) revocation of license;

(ii) suspension of license;

(iii) makes any formal order except for an order issued pursuant to Article XII 1/2 of this Code that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the State, reinsure all or any part of its business, or increase capital, surplus or any other account for the security of policyholders or creditors.

Such notice shall be transmitted to all commissioners within 30 days following the action taken or the date on which the action occurs.

(b) To report to the board of directors when he has taken any of the actions set forth in subparagraph (a) of this paragraph or has received a report from any other commissioner

indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(c) To report to the board of directors when the Director has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(d) To furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners. The board may use the information contained therein in carrying out its duties and responsibilities under this Section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the Director or other lawful authority.

(2) The Director may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member companies and companies seeking admission to transact insurance business in this State.

(3) The board of directors may, upon majority vote, make reports and recommendations to the Director upon any matter germane to the liquidation, rehabilitation or conservation of

any member insurer. Such reports and recommendations shall not be considered public documents.

(4) The board of directors may, upon majority vote, make recommendations to the Director for the detection and prevention of insurer insolvencies.

(5) The board of directors shall, at the conclusion of any insurer insolvency in which the Association was obligated to pay covered claims prepare a report to the Director containing such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations.
(Source: P.A. 86-753.)

(215 ILCS 5/531.14) (from Ch. 73, par. 1065.80-14)

Sec. 531.14. Miscellaneous Provisions.~~)~~

(1) Nothing in this Article may be construed to reduce the liability for unpaid assessments of the insured of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records must be kept of all negotiations and meetings in which the Association or its representatives are involved to discuss the activities of the Association in carrying out its powers and duties under Section 531.08. Records of such

negotiations or meetings may be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this paragraph (2) limits the duty of the Association to render a report of its activities under Section 531.15.

(3) For the purpose of carrying out its obligations under this Article, the Association is deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee (under paragraph (8) of Section 531.08). All assets of the impaired or insolvent insurer attributable to covered policies must be used to continue all covered policies and pay all contractual obligations of the impaired insurer as required by this Article. "Assets attributable to covered policies", as used in this paragraph (3), is that proportion of the assets which the reserves that should have been established for such policies bear to the reserve that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) (a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders and

policyowners of the impaired or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such impaired or insolvent insurer. In such a determination, consideration must be given to the welfare of the policyholders of the continuing or successor insurer.

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until and unless the total amount of valid claims of the Association for funds expended in carrying out its powers and duties under Section 531.08, with respect to such insurer have been fully recovered by the Association.

(5) (a) If an order for liquidation or rehabilitation of an insurer domiciled in this State has been entered, the receiver appointed under such order has a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the 5 years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (b) to (d).

(b) No such dividend is recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(c) Any person who as an affiliate that controlled the

insurer at the time the distributions were paid is liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared, is liable up to the amount of distributions he would have received if they had been paid immediately. If 2 persons are liable with respect to the same distributions, they are jointly and severally liable.

(d) The maximum amount recoverable under subsection (5) of this Section is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(e) If any person liable under paragraph (c) of subsection (5) of this Section is insolvent, all its affiliates that controlled it at the time the dividend was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(6) As a creditor of the impaired or insolvent insurer as established in subsection (3) of this Section and consistent with subsection (2) of Section 205 of this Code, the Association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this Article. If the liquidator has not, within 120 days after a final determination of insolvency of an insurer by the receivership court, made an application to the court for the

approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the Association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(Source: P.A. 81-899.)

(215 ILCS 5/531.18) (from Ch. 73, par. 1065.80-18)

Sec. 531.18. Stay of Proceedings - Reopening Default Judgments.) All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed 180 ~~60~~ days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict, or finding based on default the Association may apply to have such judgment set aside by the same court that made such judgment and must be permitted to defend against such suit on the merits.

(Source: P.A. 82-210.)

(215 ILCS 5/537.2) (from Ch. 73, par. 1065.87-2)

Sec. 537.2. Obligation of Fund. The Fund shall be obligated to the extent of the covered claims existing prior to the entry of an Order of Liquidation against an insolvent company and arising within 30 days after the entry of such Order, or before

the policy expiration date if less than 30 days after the entry of such Order, or before the insured replaces the policy or on request effects cancellation, if he does so within 30 days after the entry of such Order. If the entry of an Order of Liquidation occurs on or after October 1, 1975 and before October 1, 1977, such obligations shall not: (i) exceed $100,000, or (ii) include any obligation to refund the first $100 of any unearned premium claim; and if the entry of an Order of Liquidation occurs on or after October 1, 1977 and before January 1, 1988, such obligations shall not: (i) exceed $150,000, except that this limitation shall not apply to any workers compensation claims, or (ii) include any obligation to refund the first $100 of any unearned premium claim; and if the entry of an Order of Liquidation occurs on or after January 1, 1988 and before January 1, 2011, such obligations shall not: (i) exceed $300,000, except that this limitation shall not apply to any workers compensation claims, or (ii) include any obligation to refund the first $100 of any unearned premium claim or to refund any unearned premium over $10,000 under any one policy. If the entry of an Order of Liquidation occurs on or after January 1, 2011, then such obligations shall not: (i) exceed $500,000, except that this limitation shall not apply to any workers compensation claims or (ii) include any obligation to refund the first $100 of any unearned premium claim or refund any unearned premium over $10,000 under any one policy. In no event shall the Fund be obligated to a policyholder or

claimant in an amount in excess of the face amount of the policy from which the claim arises.

In no event shall the Fund be liable for any interest on any judgment entered against the insured or the insolvent company, or for any other interest claim against the insured or the insolvent company, regardless of whether the insolvent company would have been obligated to pay such interest under the terms of its policy. The Fund shall be liable for interest at the statutory rate on money judgments entered against the Fund until the judgment is satisfied.

Any obligation of the Fund to defend an insured shall cease upon the Fund's payment or tender of an amount equal to the lesser of the Fund's covered claim obligation limit or the applicable policy limit.

(Source: P.A. 92-77, eff. 7-12-01.)

(215 ILCS 5/545) (from Ch. 73, par. 1065.95)

Sec. 545. Effect of paid claims.

(a) Every insured or claimant seeking the protection of this Article shall cooperate with the Fund to the same extent as such person would have been required to cooperate with the insolvent company. The Fund shall have all the rights, duties and obligations under the policy to the extent of the covered claim payment, provided the Fund shall have no cause of action against the insured of the insolvent company for any sums it has paid out except such causes of action as the insolvent

company would have had if such sums had been paid by the insolvent company and except as provided in paragraph (d) of this Section.

(b) The Fund and any similar organization in another state shall be recognized as claimants in the liquidation of an insolvent company for any amounts paid by them on covered claims obligations as determined under this Article or similar laws in other states and shall receive dividends at the priority set forth in paragraph (d) of subsection (1) of Section 205 of this Code; provided that if, at the time that the Liquidator issues a cut-off notice to the Fund in anticipation of closing the estate, a reserve has been established by the Fund, or any similar organization in another state, for the amount of their future administrative expenses and loss development associated with unpaid reported pending claims, these reserves will be deemed to have been paid as of the date of the notice and payment shall be made accordingly. The liquidator of an insolvent company shall be bound by determinations of covered claim eligibility under the Act and by settlements of claims made by the Fund or a similar organization in another state on the receipt of certification of such payments, to the extent those determinations or settlements satisfy obligations of the Fund, but the receiver shall not be bound in any way by those determinations or settlements to the extent that there remains a claim in the estate for amounts in excess of the payments by the Fund. In

submitting their claim for covered claim payments the Fund and any similar organization in another state shall not be subject to the requirements of Sections 208 and 209 of this Code and shall not be affected by the failure of the person receiving a covered claim payment to file a proof of claim.

(c) The expenses of the Fund and of any similar organization in any other state, other than expenses incurred in the performance of duties under Section 547 or similar duties under the statute governing a similar organization in another state, shall be accorded the same priority as the liquidator's expenses. The liquidator shall make prompt reimbursement to the Fund and any similar organization for such expense payments.

(d) The Fund has the right to recover from the following persons the amount of any covered claims and allocated claims expenses which the Fund paid or incurred on behalf of such person in satisfaction, in whole or in part, of liability obligations of such person to any other person:

(i) any insured whose net worth on December 31 of the year next preceding the date the company becomes an insolvent company exceeds $25,000,000; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its affiliates as calculated on a consolidated basis.

(ii) any insured who is an affiliate of the insolvent company.

(Source: P.A. 89-206, eff. 7-21-95; 90-499, eff. 8-19-97.)

Section 10. The Health Maintenance Organization Act is amended by changing Sections 6-4, 6-5, 6-8, 6-9, 6-10, and 6-18 as follows:

(215 ILCS 125/6-4) (from Ch. 111 1/2, par. 1418.4)

Sec. 6-4. Construction. This Article shall be ~~is to be liberally~~ construed ~~to be for the benefit of the member organizations' enrollees and~~ to effect the purpose under Section 6-2 ~~which constitutes an aid and guide to interpretation~~.

(Source: P.A. 85-20.)

(215 ILCS 125/6-5) (from Ch. 111 1/2, par. 1418.5)

Sec. 6-5. Definitions. As used in this Act:

(1) "Association" means the Illinois Health Maintenance Organization Guaranty Association created under Section 6-6.

(2) "Director" means the Director of Insurance of this State.

(3) "Contractual obligation" means any obligation of the member organization under covered health care plan certificates.

(4) "Covered person" means any enrollee who is entitled to the protection of the Association as described in Section 6-2.

(5) "Covered health care plan certificate" means any health

care plan certificate, contract or other evidence of coverage within the scope of this Article under Section 6-3.

(6) "Fund" means the fund created under Section 6-6.

(7) "Impaired organization" means a member organization deemed by the Director after the effective date of this Article to be potentially unable to fulfill its contractual obligations and not an insolvent organization.

(8) "Insolvent organization" means a member organization which becomes insolvent and is placed under a final order of liquidation or rehabilitation by a court of competent jurisdiction.

(9) "Member organization" means any person licensed or who holds a certificate of authority to transact in this State any kind of business to which this Article applies under Section 6-3. For purposes of this Article "member organization" includes any person whose certificate of authority may have been suspended pursuant to Section 5-5 of this Act.

(10) "Premiums" means direct gross premiums or subscriptions received on covered health care plan certificates. <u>"Premiums" does not include amounts or considerations received for policies, contracts, or certificates or for the portions of policies, contracts, or certificates for which coverage is not provided.</u>

(11) "Person" means any individual, corporation, partnership, association or voluntary organization.

(12) "Resident" means any person who resides in this State

at the time the organization is issued a Notice of Impairment by the Director or at the time a complaint for liquidation or rehabilitation is filed and to whom contractual obligations are owed. A person may be a resident of only one state which, in the case of a person other than a natural person, shall be its principal place of business.

(Source: P.A. 88-297.)

(215 ILCS 125/6-8) (from Ch. 111 1/2, par. 1418.8)

Sec. 6-8. Powers and duties of the Association. In addition to the powers and duties enumerated in other Sections of this Article, the Association shall have the powers set forth in this Section.

(1) If a domestic organization is an impaired organization, the Association may, subject to any conditions imposed by the Association other than those which impair the contractual obligations of the impaired organization, and approved by the impaired organization and the Director:

(a) guarantee<u>, assume,</u> or reinsure, or cause to be guaranteed, assumed or reinsured, any or all of the covered health care plan certificates of covered persons of the impaired organization;

(b) provide such monies, pledges, notes, guarantees, or other means as are proper to effectuate paragraph (a), and assure payment of the contractual obligations of the impaired organization pending action under paragraph (a);

and

(c) loan money to the impaired organization.

(2) If a domestic, foreign, or alien organization is an insolvent organization, the Association shall, subject to the approval of the Director:

(a) guarantee, assume, indemnify or reinsure or cause to be guaranteed, assumed, indemnified or reinsured the covered health care plan benefits of covered persons of the insolvent organization; however, in the event that the Director of Healthcare and Family Services (formerly Director of the Department of Public Aid) assigns individuals that are recipients of public aid from an insolvent organization to another organization, the Director of Healthcare and Family Services shall, before fixing the rates to be paid by the Department of Healthcare and Family Services to the transferee organization on account of such individuals, consult with the Director of the Department of Insurance as to the reasonableness of such rates in light of the health care needs of such individuals and the costs of providing health care services to such individuals;

(b) assure payment of the contractual obligations of the insolvent organization to covered persons;

(c) make payments to providers of health care, or indemnity payments to covered persons, so as to assure the continued payment of benefits substantially similar to

those provided for under covered health care plan certificate issued by the insolvent organization to covered persons; and

(d) provide such monies, pledges, notes, guaranties, or other means as are reasonably necessary to discharge such duties.

This subsection (2) shall not apply when the Director has determined that the foreign or alien organization's domiciliary jurisdiction or state of entry provides, by statute, protection substantially similar to that provided by this Article for residents of this State and such protection will be provided in a timely manner.

(3) There shall be no liability on the part of and no cause of action shall arise against the Association or against any transferee from the Association in connection with the transfer by reinsurance or otherwise of all or any part of an impaired or insolvent organization's business by reason of any action taken or any failure to take any action by the impaired or insolvent organization at any time.

(4) If the Association fails to act within a reasonable period of time as provided in subsection (2) of this Section with respect to an insolvent organization, the Director shall have the powers and duties of the Association under this Article with regard to such insolvent organization.

(5) The Association or its designated representatives may render assistance and advice to the Director, upon his request,

concerning rehabilitation, payment of claims, continuations of coverage, or the performance of other contractual obligations of any impaired or insolvent organization.

(6) The Association has standing to appear before any court concerning all matters germane to the powers and duties of the Association, including, but not limited to, proposals for reinsuring or guaranteeing the covered health care plan certificates of the impaired or insolvent organization and the determination of the covered health care plan certificates and contractual obligations.

(7) (a) Any person receiving benefits under this Article is deemed to have assigned the rights under the covered health care plan certificates to the Association to the extent of the benefits received because of this Article whether the benefits are payments of contractual obligations or continuation of coverage. The Association may require an assignment to it of such rights by any payee, enrollee or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this Article upon such person. The Association is subrogated to these rights against the assets of any insolvent organization and against any other party who may be liable to such payee, enrollee or beneficiary.

(b) The subrogation rights of the Association under this subsection have the same priority against the assets of the insolvent organization as that possessed by the person entitled to receive benefits under this Article.

(8) (a) The contractual obligations of the insolvent organization for which the Association becomes or may become liable are as great as but no greater than the contractual obligations of the insolvent organization would have been in the absence of an insolvency unless such obligations are reduced as permitted by subsection (3), but the aggregate liability of the Association shall not exceed $300,000 with respect to any one natural person.

(b) Furthermore, the Association shall not be required to pay, and shall have no liability to, any provider of health care services to an enrollee:

(i) if such provider, or his or its affiliates or members of his immediate family, at any time within the one year prior to the date of the issuance of the first order, by a court of competent jurisdiction, of conservation, rehabilitation or liquidation pertaining to the health maintenance organization:

(A) was a securityholder of such organization (but excluding any securityholder holding an equity interest of 5% or less);

(B) exercised control over the organization by means such as serving as an officer or director, through a management agreement or as a principal member of a not-for-profit organization;

(C) had a representative serving by virtue or his or her official position as a representative of such

provider on the board of any entity which exercised control over the organization;

(D) received provider payments made by such organization pursuant to a contract which was not a product of arms-length bargaining; or

(E) received distributions other than for physician services from a not-for-profit organization on account of such provider's status as a member of such organization.

For purposes of this subparagraph (i), the terms "affiliate," "person," "control" and "securityholder" shall have the meanings ascribed to such terms in Section 131.1 of the Illinois Insurance Code; or

(ii) if and to the extent such a provider has agreed by contract not to seek payment from the enrollee for services provided to such enrollee or if, and to the extent, as a matter of law such provider may not seek payment from the enrollee for services provided to such enrollee.

(iii) related to any policy, contract, or certificate providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto; or

(iv) for any portion of a policy, contract, or certificate to the extent that the assessments required by

this Article with respect to the policy or contract are preempted or otherwise not permitted by federal or State law; or

(v) for any obligation that does not arise under the express written terms of the policy or contract issued by the organization to the contract owner or policy owner, including without limitation:

(A) claims based on marketing materials;

(B) claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(C) misrepresentations of or regarding policy benefits;

(D) extra-contractual claims; or

(E) claims for penalties or consequential or incidental damages.

(c) In no event shall the Association be required to pay any provider participating in the insolvent organization any amount for in-plan services rendered by such provider prior to the insolvency of the organization in excess of (1) the amount provided by a capitation contract between a physician provider and the insolvent organization for such services; or (2) the amounts provided by contract between a hospital provider and the Department of Healthcare and Family Services (formerly Department of Public Aid) for similar services to recipients of

public aid; or (3) in the event neither (1) nor (2) above is applicable, then the amounts paid under the Medicare area prevailing rate for the area where the services were provided, or if no such rate exists with respect to such services, then 80% of the usual and customary rates established by the Health Insurance Association of America. The payments required to be made by the Association under this Section shall constitute full and complete payment for such provider services to the enrollee.

(d) The Association shall not be required to pay more than an aggregate of $300,000 for any organization which is declared to be insolvent prior to July 1, 1987, and such funds shall be distributed first to enrollees who are not public aid recipients pursuant to a plan recommended by the Association and approved by the Director and the court having jurisdiction over the liquidation.

(9) The Association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Article.

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under Section 6-9. The Association shall not be liable for punitive or exemplary damages.

(c) Borrow money to effect the purposes of this Article. Any notes or other evidence of indebtedness of the

Association not in default are legal investments for domestic organizations and may be carried as admitted assets.

(d) Employ or retain such persons as are necessary to handle the financial transactions of the Association, and to perform such other functions as become necessary or proper under this Article.

(e) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the Association.

(f) Take such legal action as may be necessary to avoid payment of improper claims.

(g) Exercise, for the purposes of this Article and to the extent approved by the Director, the powers of a domestic organization, but in no case may the Association issue evidence of coverage other than that issued to perform the contractual obligations of the impaired or insolvent organization.

(h) Exercise all the rights of the Director under Section 193(4) of the Illinois Insurance Code with respect to covered health care plan certificates after the association becomes obligated by statute.

(i) Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under this Article with respect to the person and the person shall promptly comply

with the request.

(j) Take other necessary or appropriate action to discharge its duties and obligations under this Article or to exercise its powers under this Article.

(10) The obligations of the Association under this Article shall not relieve any reinsurer, insurer or other person of its obligations to the insolvent organization (or its conservator, rehabilitator, liquidator or similar official) or its enrollees, including without limitation any reinsurer, insurer or other person liable to the insolvent insurer (or its conservator, rehabilitator, liquidator or similar official) or its enrollees under any contract of reinsurance, any contract providing stop loss coverage or similar coverage or any health care contract. With respect to covered health care plan certificates for which the Association becomes obligated after an entry of an order of liquidation or rehabilitation, the Association may elect to succeed to the rights of the insolvent organization arising after the date of the order of liquidation or rehabilitation under any contract of reinsurance, any contract providing stop loss coverage or similar coverages or any health care service contract to which the insolvent organization was a party, on the terms set forth under such contract, to the extent that such contract provides coverage for health care services provided after the date of the order of liquidation or rehabilitation. As a condition to making this election, the Association must pay premiums for coverage

relating to periods after the date of the order of liquidation or rehabilitation.

(11) The Association shall be entitled to collect premiums due under or with respect to covered health care certificates for a period from the date on which the domestic, foreign, or alien organization became an insolvent organization until the Association no longer has obligations under subsection (2) of this Section with respect to such certificates. The Association's obligations under subsection (2) of this Section with respect to any covered health care plan certificates shall terminate in the event that all such premiums due under or with respect to such covered health care plan certificates are not paid to the Association (i) within 30 days of the Association's demand therefor, or (ii) in the event that such certificates provide for a longer grace period for payment of premiums after notice of non-payment or demand therefor, within the lesser of (A) the period provided for in such certificates or (B) 60 days.

(12) The Board of Directors of the Association shall have discretion and may exercise reasonable business judgment to determine the means by which the Association is to provide the benefits of this Article in an economical and efficient manner.

(13) Where the Association has arranged or offered to provide the benefits of this Article to a covered person under a plan or arrangement that fulfills the Association's obligations under this Article, the person shall not be

entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

(14) Venue in a suit against the Association arising under the Article shall be in Cook County. The Association shall not be required to give any appeal bond in an appeal that relates to a cause of action arising under this Article.

(Source: P.A. 95-331, eff. 8-21-07.)

(215 ILCS 125/6-9) (from Ch. 111 1/2, par. 1418.9)

Sec. 6-9. Assessments. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member organizations, at such times and for such amounts as the board finds necessary. Assessments shall be due not less than 30 days after written notice to the member organizations and shall accrue interest from the due date at such adjusted rate as is established under Section 531.09 of the Illinois Insurance Code and such interest shall be compounded daily.

(2) There shall be 2 classes of assessments, as follows:

(a) Class A assessments shall be made for the purpose of meeting administrative costs and other general expenses and examinations conducted under the authority of the Director under subsection (5) of Section 6-12.

(b) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under Section 6-8 with regard to an impaired or insolvent

domestic organization or insolvent foreign or alien organizations.

(3) (a) The amount of any Class A assessment shall be determined by the Board and may be made on a non-pro rata basis.

(b) Class B assessments against member organizations shall be in the proportion that the premiums received on health maintenance organization business in this State by each assessed member organization on covered health care plan certificates for the calendar year preceding the assessment bears to such premiums received on health maintenance organization business in this State for the calendar year preceding the assessment by all assessed member organizations.

(c) Assessments to meet the requirements of the Association with respect to an impaired or insolvent organization shall not be made until necessary to implement the purposes of this Article. Classification of assessments under subsection (2) and computations of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(4) (a) The Association may abate or defer, in whole or in part, the assessment of a member organization if, in the opinion of the board, payment of the assessment would endanger the ability of the member organization to fulfill its contractual obligations.

(b) The total of all assessments upon a member organization

may not in any one calendar year exceed 2% of such organization's premiums in this State during the calendar year preceding the assessment on the covered health care plan certificates.

(5) In the event an assessment against a member organization is abated, or deferred, in whole or in part, because of the limitations set forth in subsection (4) of this Section, the amount by which such assessment is abated or deferred, may be assessed against the other member organizations in a manner consistent with the basis for assessments set forth in this Section. If the maximum assessment, together with the other assets of the Association, does not provide in any one year an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds may be assessed as soon thereafter as permitted by this Article.

(6) The board may, by an equitable method as established in the plan of operation, refund to member organizations, in proportion to the contribution of each organization, the amount by which the assets of the fund exceed the amount the board finds is necessary to carry out during the coming year the obligations of the Association, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in the fund to provide moneys for the continuing expenses of the Association and for future losses ~~if refunds are impractical~~.

(7) An assessment is deemed to occur on the date upon which the board votes such assessment. The board may defer calling the payment of the assessment or may call for payment in one or more installments.

(8) It is proper for any member organization, in determining its rates to consider the amount reasonably necessary to meet its assessment obligations under this Article.

(9) The Association must issue to each organization paying a Class B assessment under this Article a certificate of contribution, in a form prescribed by the Director, for the amount of the assessment so paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the organization in its financial statement as an admitted asset in such form and for such amount, if any, and period of time as the Director may approve, provided the organization shall in any event at its option have the right to show a certificate of contribution as an asset at percentages of the original face amount for calendar years as follows:

100% for the calendar year after the year of issuance;

80% for the second calendar year after the year of issuance;

60% for the third calendar year after the year of issuance;

40% for the fourth calendar year after the year of issuance;

20% for the fifth calendar year after the year of issuance.

(10) The Association may request information of member organizations in order to aid in the exercise of its power under this Section and member organizations shall promptly comply with a request.

(Source: P.A. 85-20.)

(215 ILCS 125/6-10) (from Ch. 111 1/2, par. 1418.10)

Sec. 6-10. Plan of Operation. (1) (a) The Association must submit to the Director a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The plan of operation and any amendments thereto become effective upon approval in writing by the Director.

(b) If the Association fails to submit a suitable plan of operation within 90 days following the effective date of this Article or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Director may, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Article. Such rules are in force until modified by the Director or superseded by a plan submitted by the Association and approved by the Director.

(2) All member organizations must comply with the plan of operation.

(3) The plan of operation must, in addition to requirements

enumerated elsewhere in this Article:

(a) Establish procedures for handling the assets of the Association;

(b) Establish the amount and method of reimbursing members of the board of directors under Section 6-7;

(c) Establish regular places and times for meetings of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the board of directors;

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the Director;

(f) Establish any additional procedures for assessments under Section 6-9; and

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

(4) The plan of operation shall establish a procedure for protest by any member organization of assessments made by the Association pursuant to Section 6-9. Such procedures shall require that:

(a) A member organization that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the Association. The payment shall be available to meet Association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement

in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest. ~~Any member organization that wishes to protest all or any part of an assessment for any year shall first pay the full amount of the assessment as set forth in the notice provided by the Association. Such payments shall be accompanied by a statement in writing that the payment is made under protest, setting forth a brief statement of the ground for the protest. The Association shall hold such payments in a separate interest bearing account.~~

(b) Within 30 days following the payment of an assessment under protest by any protesting member organization, the Association must notify the member organization in writing of its determination with respect to the protest unless the Association notifies the member that additional time is required to resolve the issues raised by the protest.

(c) In the event the Association determines that the protesting member organization is entitled to a refund, such refund shall be made within 30 days following the date upon which the Association makes its determination.

(d) The decision of the Association with respect to a protest may be appealed to the Director pursuant to subsection (3) of Section 6-11.

(e) In the alternative to rendering a decision with respect to any protest based on a question regarding the assessment base, the Association may refer such protests to the Director

for final decision, with or without a recommendation from the Association.

(f) Interest on any refund due a protesting member organization shall be paid at the rate actually earned by the Association ~~on the separate account~~.

(5) The plan of operation may provide that any or all powers and duties of the Association, except those under paragraph (c) of subsection (10) of Section 6-8 and Section 6-9 are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in 2 or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the Board of Directors and the Director, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Article.

(Source: P.A. 85-20.)

(215 ILCS 125/6-18) (from Ch. 111 1/2, par. 1418.18)

Sec. 6-18. Stay of Proceedings - Reopening Default Judgments. All proceedings in which the insolvent organization is a party in any court in this State shall be stayed 180 ~~60~~

days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict, or finding based on default the Association may apply to have such judgment set aside by the same court that made such judgment and must be permitted to defend against such suit on the merits.

(Source: P.A. 85-20.)

Section 99. Effective date. This Act takes effect upon becoming law.

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Statutes amended in order of appearance

215 ILCS 125/6-17 from Ch. 111 1/2, par. 1418.17

215 ILCS 125/6-18 from Ch. 111 1/2, par. 1418.18