AN ACT concerning insurance.

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

Section 3. The Illinois Insurance Code is amended by changing Sections 136, 143, and 408 as follows:

(215 ILCS 5/136) (from Ch. 73, par. 748)

Sec. 136. Annual statement.

(1) Every company authorized to do business in this State or accredited by this State shall submit to ~~file with~~ the Director by March 1st in each year ~~2 copies of~~ its financial statement for the year ending December 31st immediately preceding in such manner and in such form as ~~on forms~~ prescribed by the Director, which shall conform substantially to the form of statement adopted by the National Association of Insurance Commissioners. Unless the Director provides otherwise, the annual statement is to be prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the National Association of Insurance Commissioners. The Director shall have power to make such modifications and additions in this form as he may deem desirable or necessary to ascertain the condition and affairs of the company. The Director shall have authority to extend the time for filing any statement by any

company for reasons which he considers good and sufficient. In every statement the admitted assets shall be shown at the actual values as of the last day of the preceding year, in accordance with Section 126.7. The statement shall be verified by oaths of the president and secretary of the company or, in their absence, by 2 other principal officers. In addition, any company may be required by the Director, when he considers that action to be necessary and appropriate for the protection of policyholders, creditors, shareholders, or claimants, to file, within 60 days after mailing to the company a notice that such is required, a supplemental summary statement as of the last day of any calendar month occurring during the 100 days next preceding the mailing of such notice designated by him on forms prescribed and furnished by the Director. The Director may require supplemental summary statements to be certified by an independent actuary deemed competent by the Director or by an independent certified public accountant.

(2) The statement of an alien company shall embrace only its condition and transactions in the United States and shall be verified by the oaths of its resident manager or principal representative in the United States, except that in the case of any life company organized under the laws of Canada or any province thereof, the statement may be verified by the oaths of any of its principal officers designated for that purpose by its board of directors.

(3) For the information of the public generally the

Director shall cause an abstract of the information contained in the annual statement to be made available to the public as soon as practicable after filing with the Department, by printing those abstracts in pamphlet tabular form for free general distribution by the Department, or by such other publication in the city of Springfield or in the city of Chicago as may be reasonably necessary more fully to inform the public of the financial condition of companies transacting business in this State.

(4) Each domestic, foreign, and alien insurer authorized to do business in this State or accredited by this State shall participate in the National Association of Insurance Commissioners' Insurance Regulatory Information System, including the payment of all fees and charges of the system. Each company shall, on or before March 1 of each year, file with the National Association of Insurance Commissioners a copy of its annual financial statement along with any additional filings prescribed by the Director for the preceding year. The statement filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by this Code and shall include a signed jurat page and actuarial certification. Any amendments and addendums to the annual statement shall also be filed with the National Association of Insurance Commissioners. Each company shall also file with the National Association of Insurance Commissioners annual and quarterly financial statement

information in computer readable format as required by the Insurance Regulatory Information System. Failure of a company to file financial statement information in computer readable format shall subject the company to the provisions of Section 139.

(5) All financial analysis ratios and examination synopsis concerning insurance companies that are submitted to the Director by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the Director.

(6) Every property and casualty insurance company doing business in this State, unless otherwise exempted by the Director, shall annually submit the opinion of an appointed actuary entitled "Statement of Actuarial Opinion". This opinion shall be filed in accordance with the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions.

(a) Every property and casualty insurance company domiciled in this State that is required to submit a Statement of Actuarial Opinion shall annually submit an Actuarial Opinion Summary, written by the company's appointed actuary. This Actuarial Opinion Summary shall be filed in accordance with the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions and shall be considered as a document supporting the Actuarial Opinion

required in this subsection (6). Each foreign and alien property and casualty company authorized to do business in this State shall provide the Actuarial Opinion Summary upon request.

(b) An Actuarial Report and underlying workpapers as required by the appropriate National Association of Insurance Commissioners Property and Casualty Annual Statement Instructions shall be prepared to support each Actuarial Opinion. If the insurance company fails to provide a supporting Actuarial Report or workpapers at the request of the Director or the Director determines that the supporting Actuarial Report or workpapers provided by the insurance company is otherwise unacceptable to the Director, the Director may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting Actuarial Report or workpapers.

(c) The appointed actuary shall not be liable for damages to any person (other than the insurance company and the Director) for any act, error, omission, decision, or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the appointed actuary.

(d) The Statement of Actuarial Opinion shall be provided with the Annual Statement in accordance with the appropriate National Association of Insurance

Commissioners Property and Casualty Annual Statement Instructions and shall be treated as a public document. Documents, materials, or other information in the possession or control of the Director that are considered an Actuarial Report, workpapers, or Actuarial Opinion Summary provided in support of the opinion, and any other material provided by the company to the Director in connection with the Actuarial Report, workpapers or Actuarial Opinion Summary, must be given confidential treatment, are not subject to subpoena, and may not be made public by the Director or any other persons. This paragraph (d) shall not be construed to limit the Director's authority to release the documents to the Actuarial Board for Counseling and Discipline (ABCD), so long as the material is required for the purpose of professional disciplinary proceedings and that the ABCD establishes procedures satisfactory to the Director for preserving the confidentiality of the documents, nor shall this paragraph (d) be construed to limit the Director's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the Director's official duties. Neither the Director nor any person who received documents, materials, or other information while acting under the authority of the Director shall be permitted or required to testify in any private civil action concerning any confidential

documents, materials, or information subject to this subsection (6). Except where another provision of this Code expressly prohibits a disclosure of confidential information to the specific officials or organizations described in this subsection, the Director may:

(i) share documents, materials, or other information, including the confidential and privileged documents, materials or information subject to this paragraph (d) with the insurance department of any other state or country or with law enforcement officials of this or any other state or agency of the federal government at any time, as long as the agency or office receiving the document, material, or other information agrees in writing to hold it confidential and in a manner consistent with this Code;

(ii) receive documents, materials, or information, including otherwise confidential and privileged documents, materials, or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material, or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document,

material, or information; and

(iii) enter into agreements governing sharing and use of information consistent with paragraph (d).

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the Director under this Section or as a result of sharing as authorized in subparagraphs (i), (ii), and (iii) of paragraph (d) of subsection (6) of this Section. All 2008 Annual Statements, which are filed in 2009, and all subsequent Annual Statement filings shall be done in accordance with subsection (6) of this Section.

(Source: P.A. 96-145, eff. 8-7-09.)

(215 ILCS 5/143) (from Ch. 73, par. 755)

Sec. 143. Policy forms.

(1) Life, accident and health. No company transacting the kind or kinds of business enumerated in Classes 1 (a), 1 (b) and 2 (a) of Section 4 shall issue or deliver in this State a policy or certificate of insurance or evidence of coverage, attach an endorsement or rider thereto, incorporate by reference bylaws or other matter therein or use an application blank in this State until the form and content of such policy, certificate, evidence of coverage, endorsement, rider, bylaw or other matter incorporated by reference or application blank has been filed electronically with the Director, either through

the System for Electronic Rate and Form Filing (SERFF) or as otherwise prescribed by the Director, and approved by the Director. The Department shall mail a quarterly invoice to the company for the appropriate filing fees required under Section 408. Any such endorsement or rider that unilaterally reduces benefits and is to be attached to a policy subsequent to the date the policy is issued must be filed with, reviewed, and formally approved by the Director prior to the date it is attached to a policy issued or delivered in this State. It shall be the duty of the Director to withhold approval of any such policy, certificate, endorsement, rider, bylaw or other matter incorporated by reference or application blank filed with him if it contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, contrary to law or to the public policy of this State, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy. In all cases the Director shall approve or disapprove any such form within 60 days after submission unless the Director extends by not more than an additional 30 days the period within which he shall approve or disapprove any such form by giving written notice to the insurer of such extension before expiration of the initial 60 days period. The Director shall withdraw his approval of a policy, certificate, evidence of coverage, endorsement, rider, bylaw, or other matter

incorporated by reference or application blank if he subsequently determines that such policy, certificate, evidence of coverage, endorsement, rider, bylaw, other matter, or application blank is misrepresentative, unjust, unfair, inequitable, ambiguous, misleading, inconsistent, deceptive, contrary to law or public policy of this State, or contains exceptions or conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy or evidence of coverage.

If a previously approved policy, certificate, evidence of coverage, endorsement, rider, bylaw or other matter incorporated by reference or application blank is withdrawn for use, the Director shall serve upon the company an order of withdrawal of use, either personally or by mail, and if by mail, such service shall be completed if such notice be deposited in the post office, postage prepaid, addressed to the company's last known address specified in the records of the Department of Insurance. The order of withdrawal of use shall take effect 30 days from the date of mailing but shall be stayed if within the 30-day period a written request for hearing is filed with the Director. Such hearing shall be held at such time and place as designated in the order given by the Director. The hearing may be held either in the City of Springfield, the City of Chicago or in the county where the principal business address of the company is located. The action of the Director in disapproving or withdrawing such form

shall be subject to judicial review under the Administrative Review Law.

This subsection shall not apply to riders or endorsements issued or made at the request of the individual policyholder relating to the manner of distribution of benefits or to the reservation of rights and benefits under his life insurance policy.

(2) Casualty, fire, and marine. The Director shall require the filing of all policy forms issued or delivered by any company transacting the kind or kinds of business enumerated in Classes 2 (except Class 2 (a)) and 3 of Section 4 in an electronic format either through the System for Electronic Rate and Form Filing (SERFF) or as otherwise prescribed and approved by the Director. In addition, he may require the filing of any generally used riders, endorsements, certificates, application blanks, and other matter incorporated by reference in any such policy or contract of insurance. The Department shall mail a quarterly invoice to the company for the appropriate filing fees required under Section 408. Companies that are members of an organization, bureau, or association may have the same filed for them by the organization, bureau, or association. If the Director shall find from an examination of any such policy form, rider, endorsement, certificate, application blank, or other matter incorporated by reference in any such policy so filed that it (i) violates any provision of this Code, (ii) contains inconsistent, ambiguous, or misleading clauses, or

(iii) contains exceptions and conditions that will unreasonably or deceptively affect the risks that are purported to be assumed by the policy, he shall order the company or companies issuing these forms to discontinue their use. Nothing in this subsection shall require a company transacting the kind or kinds of business enumerated in Classes 2 (except Class 2 (a)) and 3 of Section 4 to obtain approval of these forms before they are issued nor in any way affect the legality of any policy that has been issued and found to be in conflict with this subsection, but such policies shall be subject to the provisions of Section 442.

(3) This Section shall not apply (i) to surety contracts or fidelity bonds, (ii) to policies issued to an industrial insured as defined in Section 121-2.08 except for workers' compensation policies, nor (iii) to riders or endorsements prepared to meet special, unusual, peculiar, or extraordinary conditions applying to an individual risk.

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

(215 ILCS 5/408) (from Ch. 73, par. 1020)

Sec. 408. Fees and charges.

(1) The Director shall charge, collect and give proper acquittances for the payment of the following fees and charges:

(a) For filing all documents submitted for the incorporation or organization or certification of a domestic company, except for a fraternal benefit society,

$2,000.

(b) For filing all documents submitted for the incorporation or organization of a fraternal benefit society, $500.

(c) For filing amendments to articles of incorporation and amendments to declaration of organization, except for a fraternal benefit society, a mutual benefit association, a burial society or a farm mutual, $200.

(d) For filing amendments to articles of incorporation of a fraternal benefit society, a mutual benefit association or a burial society, $100.

(e) For filing amendments to articles of incorporation of a farm mutual, $50.

(f) For filing bylaws or amendments thereto, $50.

(g) For filing agreement of merger or consolidation:

(i) for a domestic company, except for a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $2,000.

(ii) for a foreign or alien company, except for a fraternal benefit society, $600.

(iii) for a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $200.

(h) For filing agreements of reinsurance by a domestic company, $200.

(i) For filing all documents submitted by a foreign or

alien company to be admitted to transact business or accredited as a reinsurer in this State, except for a fraternal benefit society, $5,000.

(j) For filing all documents submitted by a foreign or alien fraternal benefit society to be admitted to transact business in this State, $500.

(k) For filing declaration of withdrawal of a foreign or alien company, $50.

(l) For filing annual statement by a domestic company, except a fraternal benefit society, a mutual benefit association, a burial society, or a farm mutual, $200.

(m) For filing annual statement by a domestic fraternal benefit society, $100.

(n) For filing annual statement by a farm mutual, a mutual benefit association, or a burial society, $50.

(o) For issuing a certificate of authority or renewal thereof except to a foreign fraternal benefit society, $400 ~~$200~~.

(p) For issuing a certificate of authority or renewal thereof to a foreign fraternal benefit society, $200 ~~$100~~.

(q) For issuing an amended certificate of authority, $50.

(r) For each certified copy of certificate of authority, $20.

(s) For each certificate of deposit, or valuation, or compliance or surety certificate, $20.

(t) For copies of papers or records per page, $1.

(u) For each certification to copies of papers or records, $10.

(v) For multiple copies of documents or certificates listed in subparagraphs (r), (s), and (u) of paragraph (1) of this Section, $10 for the first copy of a certificate of any type and $5 for each additional copy of the same certificate requested at the same time, unless, pursuant to paragraph (2) of this Section, the Director finds these additional fees excessive.

(w) For issuing a permit to sell shares or increase paid-up capital:

(i) in connection with a public stock offering, $300;

(ii) in any other case, $100.

(x) For issuing any other certificate required or permissible under the law, $50.

(y) For filing a plan of exchange of the stock of a domestic stock insurance company, a plan of demutualization of a domestic mutual company, or a plan of reorganization under Article XII, $2,000.

(z) For filing a statement of acquisition of a domestic company as defined in Section 131.4 of this Code, $2,000.

(aa) For filing an agreement to purchase the business of an organization authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act or of a

health maintenance organization or a limited health service organization, $2,000.

(bb) For filing a statement of acquisition of a foreign or alien insurance company as defined in Section 131.12a of this Code, $1,000.

(cc) For filing a registration statement as required in Sections 131.13 and 131.14, the notification as required by Sections 131.16, 131.20a, or 141.4, or an agreement or transaction required by Sections 124.2(2), 141, 141a, or 141.1, $200.

(dd) For filing an application for licensing of:

(i) a religious or charitable risk pooling trust or a workers' compensation pool, $1,000;

(ii) a workers' compensation service company, $500;

(iii) a self-insured automobile fleet, $200; or

(iv) a renewal of or amendment of any license issued pursuant to (i), (ii), or (iii) above, $100.

(ee) For filing articles of incorporation for a syndicate to engage in the business of insurance through the Illinois Insurance Exchange, $2,000.

(ff) For filing amended articles of incorporation for a syndicate engaged in the business of insurance through the Illinois Insurance Exchange, $100.

(gg) For filing articles of incorporation for a limited syndicate to join with other subscribers or limited

syndicates to do business through the Illinois Insurance Exchange, $1,000.

(hh) For filing amended articles of incorporation for a limited syndicate to do business through the Illinois Insurance Exchange, $100.

(ii) For a permit to solicit subscriptions to a syndicate or limited syndicate, $100.

(jj) For the filing of each form as required in Section 143 of this Code, $50 per form. The fee for advisory and rating organizations shall be $200 per form.

(i) For the purposes of the form filing fee, filings made on insert page basis will be considered one form at the time of its original submission. Changes made to a form subsequent to its approval shall be considered a new filing.

(ii) Only one fee shall be charged for a form, regardless of the number of other forms or policies with which it will be used.

(iii) (Blank).

(iv) The Director may by rule exempt forms from such fees.

(kk) For filing an application for licensing of a reinsurance intermediary, $500.

(ll) For filing an application for renewal of a license of a reinsurance intermediary, $200.

(2) When printed copies or numerous copies of the same

paper or records are furnished or certified, the Director may reduce such fees for copies if he finds them excessive. He may, when he considers it in the public interest, furnish without charge to state insurance departments and persons other than companies, copies or certified copies of reports of examinations and of other papers and records.

(3) The expenses incurred in any performance examination authorized by law shall be paid by the company or person being examined. The charge shall be reasonably related to the cost of the examination including but not limited to compensation of examiners, electronic data processing costs, supervision and preparation of an examination report and lodging and travel expenses. All lodging and travel expenses shall be in accord with the applicable travel regulations as published by the Department of Central Management Services and approved by the Governor's Travel Control Board, except that out-of-state lodging and travel expenses related to examinations authorized under Section 132 shall be in accordance with travel rates prescribed under paragraph 301-7.2 of the Federal Travel Regulations, 41 C.F.R. 301-7.2, for reimbursement of subsistence expenses incurred during official travel. All lodging and travel expenses may be reimbursed directly upon authorization of the Director. With the exception of the direct reimbursements authorized by the Director, all performance examination charges collected by the Department shall be paid to the Insurance Producers Administration Fund, however, the

electronic data processing costs incurred by the Department in the performance of any examination shall be billed directly to the company being examined for payment to the Statistical Services Revolving Fund.

(4) At the time of any service of process on the Director as attorney for such service, the Director shall charge and collect the sum of $20, which may be recovered as taxable costs by the party to the suit or action causing such service to be made if he prevails in such suit or action.

(5) (a) The costs incurred by the Department of Insurance in conducting any hearing authorized by law shall be assessed against the parties to the hearing in such proportion as the Director of Insurance may determine upon consideration of all relevant circumstances including: (1) the nature of the hearing; (2) whether the hearing was instigated by, or for the benefit of a particular party or parties; (3) whether there is a successful party on the merits of the proceeding; and (4) the relative levels of participation by the parties.

(b) For purposes of this subsection (5) costs incurred shall mean the hearing officer fees, court reporter fees, and travel expenses of Department of Insurance officers and employees; provided however, that costs incurred shall not include hearing officer fees or court reporter fees unless the Department has retained the services of independent contractors or outside experts to perform such functions.

(c) The Director shall make the assessment of costs

incurred as part of the final order or decision arising out of the proceeding; provided, however, that such order or decision shall include findings and conclusions in support of the assessment of costs. This subsection (5) shall not be construed as permitting the payment of travel expenses unless calculated in accordance with the applicable travel regulations of the Department of Central Management Services, as approved by the Governor's Travel Control Board. The Director as part of such order or decision shall require all assessments for hearing officer fees and court reporter fees, if any, to be paid directly to the hearing officer or court reporter by the party(s) assessed for such costs. The assessments for travel expenses of Department officers and employees shall be reimbursable to the Director of Insurance for deposit to the fund out of which those expenses had been paid.

(d) The provisions of this subsection (5) shall apply in the case of any hearing conducted by the Director of Insurance not otherwise specifically provided for by law.

(6) The Director shall charge and collect an annual financial regulation fee from every domestic company for examination and analysis of its financial condition and to fund the internal costs and expenses of the Interstate Insurance Receivership Commission as may be allocated to the State of Illinois and companies doing an insurance business in this State pursuant to Article X of the Interstate Insurance Receivership Compact. The fee shall be the greater fixed amount

based upon the combination of nationwide direct premium income and nationwide reinsurance assumed premium income or upon admitted assets calculated under this subsection as follows:

(a) Combination of nationwide direct premium income and nationwide reinsurance assumed premium.

(i) $150, if the premium is less than $500,000 and there is no reinsurance assumed premium;

(ii) $750, if the premium is $500,000 or more, but less than $5,000,000 and there is no reinsurance assumed premium; or if the premium is less than $5,000,000 and the reinsurance assumed premium is less than $10,000,000;

(iii) $3,750, if the premium is less than $5,000,000 and the reinsurance assumed premium is $10,000,000 or more;

(iv) $7,500, if the premium is $5,000,000 or more, but less than $10,000,000;

(v) $18,000, if the premium is $10,000,000 or more, but less than $25,000,000;

(vi) $22,500, if the premium is $25,000,000 or more, but less than $50,000,000;

(vii) $30,000, if the premium is $50,000,000 or more, but less than $100,000,000;

(viii) $37,500, if the premium is $100,000,000 or more.

(b) Admitted assets.

(i) $150, if admitted assets are less than $1,000,000;

(ii) $750, if admitted assets are $1,000,000 or more, but less than $5,000,000;

(iii) $3,750, if admitted assets are $5,000,000 or more, but less than $25,000,000;

(iv) $7,500, if admitted assets are $25,000,000 or more, but less than $50,000,000;

(v) $18,000, if admitted assets are $50,000,000 or more, but less than $100,000,000;

(vi) $22,500, if admitted assets are $100,000,000 or more, but less than $500,000,000;

(vii) $30,000, if admitted assets are $500,000,000 or more, but less than $1,000,000,000;

(viii) $37,500, if admitted assets are $1,000,000,000 or more.

(c) The sum of financial regulation fees charged to the domestic companies of the same affiliated group shall not exceed $250,000 in the aggregate in any single year and shall be billed by the Director to the member company designated by the group.

(7) The Director shall charge and collect an annual financial regulation fee from every foreign or alien company, except fraternal benefit societies, for the examination and analysis of its financial condition and to fund the internal costs and expenses of the Interstate Insurance Receivership

Commission as may be allocated to the State of Illinois and companies doing an insurance business in this State pursuant to Article X of the Interstate Insurance Receivership Compact. The fee shall be a fixed amount based upon Illinois direct premium income and nationwide reinsurance assumed premium income in accordance with the following schedule:

(a) $150, if the premium is less than $500,000 and there is no reinsurance assumed premium;

(b) $750, if the premium is $500,000 or more, but less than $5,000,000 and there is no reinsurance assumed premium; or if the premium is less than $5,000,000 and the reinsurance assumed premium is less than $10,000,000;

(c) $3,750, if the premium is less than $5,000,000 and the reinsurance assumed premium is $10,000,000 or more;

(d) $7,500, if the premium is $5,000,000 or more, but less than $10,000,000;

(e) $18,000, if the premium is $10,000,000 or more, but less than $25,000,000;

(f) $22,500, if the premium is $25,000,000 or more, but less than $50,000,000;

(g) $30,000, if the premium is $50,000,000 or more, but less than $100,000,000;

(h) $37,500, if the premium is $100,000,000 or more.

The sum of financial regulation fees under this subsection (7) charged to the foreign or alien companies within the same affiliated group shall not exceed $250,000 in the aggregate in

any single year and shall be billed by the Director to the member company designated by the group.

(8) Beginning January 1, 1992, the financial regulation fees imposed under subsections (6) and (7) of this Section shall be paid by each company or domestic affiliated group annually. After January 1, 1994, the fee shall be billed by Department invoice based upon the company's premium income or admitted assets as shown in its annual statement for the preceding calendar year. The invoice is due upon receipt and must be paid no later than June 30 of each calendar year. All financial regulation fees collected by the Department shall be paid to the Insurance Financial Regulation Fund. The Department may not collect financial examiner per diem charges from companies subject to subsections (6) and (7) of this Section undergoing financial examination after June 30, 1992.

(9) In addition to the financial regulation fee required by this Section, a company undergoing any financial examination authorized by law shall pay the following costs and expenses incurred by the Department: electronic data processing costs, the expenses authorized under Section 131.21 and subsection (d) of Section 132.4 of this Code, and lodging and travel expenses.

Electronic data processing costs incurred by the Department in the performance of any examination shall be billed directly to the company undergoing examination for payment to the Statistical Services Revolving Fund. Except for direct reimbursements authorized by the Director or direct

payments made under Section 131.21 or subsection (d) of Section 132.4 of this Code, all financial regulation fees and all financial examination charges collected by the Department shall be paid to the Insurance Financial Regulation Fund.

All lodging and travel expenses shall be in accordance with applicable travel regulations published by the Department of Central Management Services and approved by the Governor's Travel Control Board, except that out-of-state lodging and travel expenses related to examinations authorized under Sections 132.1 through 132.7 shall be in accordance with travel rates prescribed under paragraph 301-7.2 of the Federal Travel Regulations, 41 C.F.R. 301-7.2, for reimbursement of subsistence expenses incurred during official travel. All lodging and travel expenses may be reimbursed directly upon the authorization of the Director.

In the case of an organization or person not subject to the financial regulation fee, the expenses incurred in any financial examination authorized by law shall be paid by the organization or person being examined. The charge shall be reasonably related to the cost of the examination including, but not limited to, compensation of examiners and other costs described in this subsection.

(10) Any company, person, or entity failing to make any payment of $150 or more as required under this Section shall be subject to the penalty and interest provisions provided for in subsections (4) and (7) of Section 412.

(11) Unless otherwise specified, all of the fees collected under this Section shall be paid into the Insurance Financial Regulation Fund.

(12) For purposes of this Section:

(a) "Domestic company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of this State, and in addition includes a not-for-profit corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act, a health maintenance organization, and a limited health service organization.

(b) "Foreign company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of any state of the United States other than this State and in addition includes a health maintenance organization and a limited health service organization which is incorporated or organized under the laws of any state of the United States other than this State.

(c) "Alien company" means a company as defined in Section 2 of this Code which is incorporated or organized under the laws of any country other than the United States.

(d) "Fraternal benefit society" means a corporation, society, order, lodge or voluntary association as defined in Section 282.1 of this Code.

(e) "Mutual benefit association" means a company, association or corporation authorized by the Director to do

business in this State under the provisions of Article XVIII of this Code.

(f) "Burial society" means a person, firm, corporation, society or association of individuals authorized by the Director to do business in this State under the provisions of Article XIX of this Code.

(g) "Farm mutual" means a district, county and township mutual insurance company authorized by the Director to do business in this State under the provisions of the Farm Mutual Insurance Company Act of 1986.

(Source: P.A. 93-32, eff. 7-1-03; 93-1083, eff. 2-7-05.)

Section 5. The Dental Service Plan Act is amended by changing Section 25 as follows:

(215 ILCS 110/25) (from Ch. 32, par. 690.25)

Sec. 25. Application of Insurance Code provisions. Dental service plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 355.2, 367.2, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and subsection (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 91-549, eff. 8-14-99.)

Section 10. The Health Maintenance Organization Act is

amended by changing Section 5-3 as follows:

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

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

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

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

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to

substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

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

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

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

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

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

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be

acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

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

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

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

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

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

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

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

account the refund period and the immediately preceding 2 plan years.

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

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09;

95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-328, eff. 8-11-09; 96-639, eff. 1-1-10; 96-833, eff. 6-1-10; 96-1000, eff. 7-2-10.)

Section 15. The Limited Health Service Organization Act is amended by changing Section 4003 as follows:

(215 ILCS 130/4003) (from Ch. 73, par. 1504-3)

Sec. 4003. Illinois Insurance Code provisions. Limited health service organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.37, 355.2, 356v, 356z.10, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1 and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code. For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, limited health service organizations in the following categories are deemed to be domestic companies:

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

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

1/2 of the Illinois Insurance Code.

(Source: P.A. 95-520, eff. 8-28-07; 95-876, eff. 8-21-08.)

Section 20. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 136, 139, 140, 143, 143c, 149, 155.37, 354, 355.2, 356g, 356g.5, 356g.5-1, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.18, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-189, eff. 8-16-07; 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.

8-21-08; 95-958, eff. 6-1-09; 95-978, eff. 1-1-09; 95-1005, eff. 12-12-08; 95-1045, eff. 3-27-09; 95-1049, eff. 1-1-10; 96-328, eff. 8-11-09; 96-833, eff. 6-1-10; 96-1000, eff. 7-2-10.)

(215 ILCS 110/36 rep.)

(215 ILCS 110/37 rep.)

Section 25. The Dental Service Plan Act is amended by repealing Sections 36 and 37.

(215 ILCS 125/2-7 rep.)

Section 30. The Health Maintenance Organization Act is amended by repealing Section 2-7.

(215 ILCS 130/2007 rep.)

Section 35. The Limited Health Service Organization Act is amended by repealing Section 2007.

(215 ILCS 165/21 rep.)

(215 ILCS 165/22 rep.)

Section 40. The Voluntary Health Services Plans Act is amended by repealing Sections 21 and 22.