AN ACT in relation to insurance.

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

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

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

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

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

(Source: P.A. 85-848.)

Section 5. The Illinois Insurance Code is amended by changing Sections 143.17a, 245.25, 367.2, 367e, and 404.1, by resectioning Section 367e as Sections 367e and 367e.1, and by adding Section 367.2-5 as follows:

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

Sec. 143.17a. Notice of intention not to renew.

a. No company shall fail to renew any policy of insurance, to which Section 143.11 applies, except for those defined in subsections (a), (b), (c), and (h) of Section 143.13, unless it shall send by mail to the named insured at least 60 days advance notice of its intention not to renew. The company shall maintain proof of mailing of such notice on one of the following forms: a recognized U.S. Post Office form or a form acceptable to the U.S. Post Office or other commercial mail delivery service. An exact and unaltered copy of such notice shall also be sent to the insured's broker, if known, or the agent of record and to the mortgagee or lien holder at the last mailing address known by the company. However, where cancellation is for nonpayment of premium, the notice of cancellation must be mailed at least 10 days before the effective date of the cancellation.

b. This Section does not apply if the company has manifested its willingness to renew directly to the named insured. Provided, however, that no company may increase the renewal premium on any policy of insurance to which Section 143.11 applies, except for those defined in subsections (a), (b), (c), and (h) of Section 143.13, by 30% or more, nor impose changes in deductibles or coverage that materially alter the policy, unless the company shall have mailed or delivered to the named insured written notice of such increase or change in deductible or coverage at least 60 days prior to the renewal or anniversary date. The increase in premium shall be the renewal premium based on the known exposure as of the date of the quotation compared to the premium as of the last day of coverage for the current year's policy, annualized. The premium on the renewal policy may be subsequently amended to reflect any change in exposure <u>or reinsurance costs</u> not considered in the quotation. An exact

and unaltered copy of such notice shall also be sent to the insured's broker, if known, or the agent of record. If an insurer fails to provide the notice required by this subsection, then the company must extend the current policy under the same terms, conditions, and premium to allow 60 days notice of renewal and provide the actual renewal premium quotation and any change in coverage or deductible on the policy. Proof of mailing or proof of receipt may be proven by a sworn affidavit by the insurer as to the usual and customary business practices of mailing notice pursuant to this Section or may be proven consistent with Illinois Supreme Court Rule 236. ~~The company shall maintain proof of mailing or proof of receipt whichever is required.~~

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

~~this premium for the extension of coverage and such extension may be contingent upon the payment of such premium.~~

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

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

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

Sec. 245.25. Except for subparagraphs (1) (a), (1) (f), (1) (g) and (3) of Section 226 of the Illinois Insurance Code, in the case of a variable annuity contract and subparagraphs (1) (b), (1) (f), (1) (g), (1) (h), (1) (i), and (1) (k) of Section 224, subparagraph (1) (c) of Section 225, and subparagraph (h) of Section 231 in the case of a variable life insurance policy, except for Sections 357.4, 357.5, ~~and~~ 367e<u>, and 367e.1</u> in the case of a variable health insurance policy, and except as otherwise provided in this Article, all pertinent provisions of the Illinois Insurance Code which are appropriate to those contracts apply to separate accounts and contracts relating thereto. Any individual variable life insurance contract, delivered or issued for delivery in this State, must contain grace, reinstatement and non-forfeiture provisions appropriate to such a contract. Any individual variable annuity contract, delivered or issued for delivery in this State, must contain grace and reinstatement provisions appropriate to such a contract. Any group variable life insurance contract, delivered or issued for delivery in this State, must contain a grace provision appropriate to such a contract. A group variable health insurance contract delivered or issued for delivery in this State must contain a continuation of group

coverage provision appropriate to the contract. The reserve liability for variable contracts must be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

(Source: P.A. 90-381, eff. 8-14-97.)

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

Sec. 367.2. Spousal continuation privilege; group contracts.

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

B. Within 30 days of the entry of judgment or the death or retirement of the employee ~~spouse~~, the spouse of an employee insured under the policy who seeks a continuation of coverage thereunder shall give the employer or ~~and~~ the insurer written notice of the dissolution of the marriage or the death or retirement of the employee ~~spouse~~. The

employer, within 15 days of receipt of the notice shall give written notice of the dissolution of the employee's marriage or the death or retirement of the employee and that former spouse's or retired employee's spouse's residence, to the insurance company issuing the policy. ~~,-of-the-dissolution--of the--employee's--marriage--or--the-death-or-retirement-of-the employee-spouse-and-the-former-or-retired-employee's-spouse's residence.~~

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

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

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

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

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

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

terminate the continuation of benefits and the right to continuation.

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

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

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

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

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

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

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

(ii) When coverage would terminate under the terms of the existing policy if the employee and former spouse

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

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

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

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

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

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

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

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

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

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

(i) an amount, if any, that would be charged an

employee if the retired employee's spouse or former spouse were a current employee of the employer, plus;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Source: P.A. 87-615.)

(215 ILCS 5/367.2-5 new)

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

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

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

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

of the dependent child's residence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) If (1) the policy is cancelled, and (2) another insurance company contracts to provide group health and accident insurance to the employer, and (3) continuation

coverage is in effect for the dependent child at the time of cancellation, and (4) the employee is or would have been included under the new group policy, then the new insurer must also offer continuation coverage to the dependent child under the same terms and conditions as contained in this Section.

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

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

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

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

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

1. Continuation shall only be available to an employee or member who has been continuously insured under the group policy (and for similar benefits under any group policy which

it replaced) during the entire 3 months period ending with such termination or reduction in hours below the minimum required by the group plan.

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

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

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

policyholder to the last known address of the employee, shall constitute the giving of notice for the purpose of this provision.

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

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

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

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

(c) The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this (c) applies and the coverage ceasing by

reason of such termination is replaced by similar coverage under another group policy, the following shall apply:

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

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

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

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

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

The requirements of this amendatory Act of 1985 shall apply to any group policy as defined in this Section, delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this amendatory Act of 1985.

(Source: P.A. 85-210; 86-1475.)

(215 ILCS 5/367e.1 new)

Sec. 367e.1. Group Accident and Health Insurance Conversion Privilege.

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

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

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

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

(3) The initial premium for the converted policy shall be determined in accordance with the insurer's

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

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

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

(6) The insurer shall not be required to issue a converted policy covering any person if such person is or could be covered by Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded). Furthermore, the insurer shall not be required to issue a converted policy covering any person if (i) such person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or (ii) such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or

uninsured basis; or (iii) similar benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any statute, and the benefits provided or available under the sources referred to in (i), (ii), (iii) above for such person together with the converted policy would result in overinsurance according to the insurer's standards.

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

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

otherwise provided above with respect to such termination.

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

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

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

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

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

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

(c) Surgical benefits according to a surgical schedule providing a benefit amount elected by the group policy holder, but in no event less than 60% of the then average surgical charge in the State and with a maximum amount appropriate thereto. The maximum surgical benefit shall be applicable to all

surgical operations of an individual resulting from or contributed to by the same and all related causes occurring in one period of disability. Two or more surgical procedures performed in the course of a single operation through the same incision, or in the same natural body orifice, may be treated as one surgical procedure with the payment determined by the scheduled benefit for the most expensive procedure performed. The surgical schedule shall be consistent with the schedule of operations customarily offered by the insurer under group or individual health insurance policies.

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

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

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

(i) A maximum payment of twenty-five thousand dollars for all covered medical expenses incurred during the covered person's lifetime with an annual restoration of the

lesser of, while coverage is in force, one thousand dollars and the amount counted against the maximum benefit which was not previously restored; or

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

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

(c) A deductible for each benefit period which, at the option of the insurer, shall be (i) the greater of $500 and the benefits deductible; (ii) the sum of the benefits deductible and $100; or (iii) the corresponding deductible in the group policy. The term "benefit period," as used herein, means, when the maximum payment is determined by (a) (i) above, either a calendar year or a period of twelve consecutive months; and, when the maximum payment is determined by (a) (ii) above, a period of twenty-four consecutive months. The term "benefits deductible," as used herein, means the value of any benefits provided on an expense-incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical, or medical insurance policy or hospital or medical service subscriber contract of medical practice or other prepayment plan, or any other plans or program whether on an insured or uninsured basis, or of any similar benefits which are provided or made available pursuant to or in accordance with the requirements of any statute and, if, pursuant to the provisions of this subsection, the converted policy provides both the coverage described in (1) above

and major medical insurance, the value of the coverage described in (1) above. The insurer may require that the deductible be satisfied during a period of not less than three months. If the maximum payment is determined by (a) (i) above, and if no benefits become payable during the preceding benefit period due to the cash deductible not being satisfied; credit shall be given, in the succeeding benefit period, to any expense applied toward the cash deductible of the preceding benefit period and incurred during the last three months of such preceding benefit period, subject to any requirement that the deductible be satisfied during a specified period of time.

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

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

medical expenses or the same level of benefits as provided in the group policy.

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

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

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

(7) The converted policy may provide that the insurer may request information from the converted policyholder, in advance of any premium due date of the converted policy, to determine whether any person covered thereunder (i) is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or (ii) is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for

individuals in a group, whether on an insured or uninsured basis; or (iii) has similar benefits provided for or available to such person, pursuant to or in accordance with the requirements of any statute. The converted policy may also provide that the insurer need not renew the converted policy or the coverage of any person insured thereunder if either the benefits provided or available under the sources referred to in (i), (ii), (iii) above for such person, together with the converted policy, would result in overinsurance according to the insurer's standards, or if the converted policyholder refuses to provide the requested information.

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

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

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

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

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

(C) The requirements of this Section shall apply to any group policy of accident and health insurance delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this Section.

(Source: P.A. 85-210; 86-1475.)

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

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

(Source: P.A. 83-746.)

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

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

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

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

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

"Board" means the Illinois Comprehensive Health Insurance Board.

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

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

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

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

(A) A group health plan.

(B) Health insurance coverage (including group

health insurance coverage).

(C) Medicare.

(D) Medical assistance.

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

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

(G) A state health benefits risk pool.

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

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

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

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

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

"Department" means the Illinois Department of Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) who, if the individual elected such continuation coverage, has exhausted such continuation

coverage under such provision or program.

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

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

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

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

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

a group health plan.

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

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

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

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

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

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

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

"Medically necessary" means that a service, drug, or supply is necessary and appropriate for the diagnosis or

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

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

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

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

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

all expenses related to the transplant during a transplant benefit period.

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

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

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

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

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

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

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

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

"Third party administrator" means an administrator as defined in Section 511.101 of the Illinois Insurance Code who

is licensed under Article XXXI 1/4 of that Code.

(Source: P.A. 91-357, eff. 7-29-99; 91-735, eff. 6-2-00; 92-153, eff. 7-25-01.)

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

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

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

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

(2) Continuation shall not be available for any enrollee who is covered by Medicare, except for those individuals who have been covered under a group Medicare supplement policy. Continuation shall not be available for any enrollee who is covered by any other insured or uninsured plan that provides hospital, surgical, or

medical coverage for individuals in a group and under which the enrollee was not covered immediately before termination or reduction in hours below the minimum required by the group contract or who exercises his or her conversion privilege under the group policy.

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

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

(5) An employee or member electing continuation must pay to the group policyholder or his employer, on a monthly basis in advance, the total amount of premium required by the HMO, including that portion of the premium contributed by the policyholder or employer, if

any, but not more than the group rate for the coverage being continued with appropriate reduction in premium for any supplementary benefits that have been discontinued under paragraph (3) of this Section. The premium rate required by the HMO shall be the applicable premium required on the due date of each payment.

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

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

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

(c) The date on which the group contract is terminated or, in the case of an employee, the date his or her employer terminates participation under the group contract. If, however, this paragraph applies and the coverage ceasing by reason of termination is replaced by similar coverage under another group contract, then (i) the employee or member shall have the right to become covered under the replacement group contract for the balance of the period that he or she would have remained

covered under the prior group contract in accordance with paragraph (6) had a termination described in this item (c) not occurred and (ii) the prior group contract shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

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

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

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

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

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

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, <u>367.2, 367.2-5,</u> 367i, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

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

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

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

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

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

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

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

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

(A) certification by an independent actuary of the adequacy of the reserves of the Health

Maintenance Organization sought to be acquired;

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

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

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

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

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

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health

Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

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

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

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

or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

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

(Source: P.A. 91-357, eff. 7-29-99; 91-406, eff. 1-1-00; 91-549, eff. 8-14-99; 91-605, eff. 12-14-99; 91-788, eff. 6-9-00; 92-764, eff. 1-1-03.)

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

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

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

(2) The requirements of this Section shall apply to all such contracts delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of

this Section.

(Source: P.A. 82-498.)

Section 95. If and only if House Bill 1640 of the 93rd General Assembly becomes law in the form it passed the House, the Use of Credit Information in Personal Insurance Act is amended by changing Section 20 as follows:

(093 HB 1640 eng, Sec. 20)

Sec. 20. Use of credit information. An insurer authorized to do business in this State that uses credit information to underwrite or rate risks shall not:

(1) Use an insurance score that is calculated using income, gender, address, ethnic group, religion, marital status, or nationality of the consumer as a factor.

(2) Deny, cancel, or nonrenew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by item (1). An insurer shall not be considered to have denied, cancelled, or nonrenewed a policy if coverage is available through an affiliate.

(3) Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information. An insurer shall not be considered to have based rates solely on credit information if coverage is available in a different tier of the same insurer.

(4) Take an adverse action against a consumer solely because he or she does not have a credit card account, without consideration of any other applicable factor independent of credit information.

(5) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

(A) Treats the consumer as otherwise filed with ~~approved--by~~ the Department, if the insurer presents information that such an absence or inability relates to the risk for the insurer and submits a filing certification form signed by an officer for the insurer certifying that such treatment is actuarially justified.

(B) Treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer.

(C) Excludes the use of credit information as a factor and uses only other underwriting criteria.

(6) Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days from the date the policy is first written or renewal is issued.

(7) Use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the other requirements of this Section:

(A) At annual renewal, upon the request of a consumer or the consumer's agent, the insurer shall re-underwrite and re-rate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a 12-month period.

(B) The insurer shall have the discretion to obtain current credit information upon any renewal before the expiration of 36 months, if consistent with its underwriting guidelines.

(C) An insurer is not required to obtain current credit information for an insured, despite the requirements of subitem (A) of item (7) of this Section if one of the following applies:

(a) The insurer is treating the consumer as otherwise filed with ~~approved by~~ the Department.

(b) The insured is in the most favorably-priced tier of the insurer, within a group of affiliated insurers. However, the insurer shall have the discretion to order credit information, if consistent with its underwriting guidelines.

(c) Credit was not used for underwriting or rating the insured when the policy was initially written. However, the insurer shall have the discretion to use credit for underwriting or rating the insured upon renewal, if consistent with its underwriting guidelines.

(d) The insurer re-evaluates the insured beginning no later than 36 months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

(8) Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

(A) Credit inquiries not initiated by the

consumer or inquiries requested by the consumer for his or her own credit information.

(B) Inquiries relating to insurance coverage, if so identified on a consumer's credit report.

(C) Collection accounts with a medical industry code, if so identified on the consumer's credit report.

(D) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within 30 days of one another, unless only one inquiry is considered.

(E) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered.

(Source: 093 HB 1640 eng, Sec. 20)

Section 99. Effective date. This Section and the changes made to Sec. 143.17a of the Illinois Insurance Code in Section 5 of this Act take effect upon becoming law. Section 95 of this Act takes effect on October 1, 2003. The rest of this Act takes effect on the uniform effective date provided by law.