# INSURANCE
# (215 ILCS 5/) Illinois Insurance Code.

(215 ILCS 5/Art. XXXIII.5 heading)

ARTICLE XXXIII 1/2. LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

(215 ILCS 5/531.01) (from Ch. 73, par. 1065.80-1)

Sec. 531.01. Title.) This Article is known and may be cited as the Illinois Life and Health Insurance Guaranty Association Law.

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

(215 ILCS 5/531.01a) (from Ch. 73, par. 1065.80-1a)

Sec. 531.01a. Existing Liability. Any liabilities of the Association for any member company which was an insolvent insurer as defined by this Article prior to January 1, 1986 shall be determined under the law which was in effect at the time the member company became an insolvent insurer as if there had been no amendment to that law. Any liabilities of the Association for a member company which became an insolvent insurer on or after January 1, 1986, shall be determined under the law in effect at the time when the member became an insolvent insurer, notwithstanding any prior law.

On or after January 1, 1986, any assessments made against other member companies to meet Association liabilities shall be made based on the law which was in effect when the member company was an impaired or insolvent insurer as defined by this Article. If different assessment methods are used in any one year, those assessments shall be aggregated for purposes of calculating the aggregate assessment under Sections 531.09 and 531.13.

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

(215 ILCS 5/531.02) (from Ch. 73, par. 1065.80-2)

Sec. 531.02. Purpose. The purpose of this Article is to protect, subject to certain limitations, the persons specified

in paragraph (1) of Section 531.03 against failure in the performance of contractual obligations, under life, health, and annuity policies, plans, or contracts and health or medical care service contracts specified in paragraph (2) of Section 531.03, due to the impairment or insolvency of the member insurer issuing such policies, plans, or contracts. To provide this protection, (1) an association of member insurers is created to enable the guaranty of payment of benefits and of continuation of coverages, (2) members of the Association are subject to assessment to provide funds to carry out the purpose of this Article, and (3) the Association is authorized to assist the Director, in the prescribed manner, in the detection and prevention of member insurer impairments or insolvencies.
(Source: P.A. 100-687, eff. 8-3-18.)

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

Sec. 531.03. Coverage and limitations.

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

(a) to persons who, regardless of where they reside (except for non-resident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees, including health care providers rendering services covered under a health insurance policy or certificate, of the persons covered under paragraph (b) of this subsection, and

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

(i) are residents; or

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

(A) the member insurer that issued the policies or contracts is domiciled in this State;

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

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

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

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

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

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

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

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

(A) with regard to residency:

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

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

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

(e) This Article shall not provide coverage to:

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

(ii) a person covered under paragraph (c) of this subsection (1), if any coverage is provided by the association of another state to that person.

(f) This Article is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this Article is provided coverage under the laws of any other state, then the person shall not be provided coverage under this Article. In determining the

application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this Article shall be construed in conjunction with other state laws to result in coverage by only one association.

(2)(a) This Article shall provide coverage to the persons specified in subsection (1) of this Section for policies or contracts of direct, (i) nongroup life insurance, health insurance (that, for the purposes of this Article, includes health maintenance organization subscriber contracts and certificates), annuities and supplemental contracts to any of these, (ii) for certificates under direct group policies or contracts, (iii) for unallocated annuity contracts and (iv) for contracts to furnish health care services and subscription certificates for medical or health care services issued by persons licensed to transact insurance business in this State under this Code. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts and any immediate or deferred annuity contracts.

(b) Except as otherwise provided in paragraph (c) of this subsection, this Article shall not provide coverage for:

(i) that portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

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

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

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

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

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

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

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

(A) a claim based on marketing materials;

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

(C) a misrepresentation of or regarding policy or contract benefits;

(D) an extra-contractual claim; or

(E) a claim for penalties or consequential or incidental damages;

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

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

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

(x) any portion of a policy or contract issued to a plan or program of an employer, association, or other

person to provide life, health, or annuity benefits to its employees, members, or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:

(A) a multiple employer welfare arrangement as defined in 29 U.S.C. Section 1002;

(B) a minimum premium group insurance plan;

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

(D) an administrative services only contract;

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

(A) dividends or experience rating credits;

(B) voting rights; or

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

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

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

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

(xv) that portion or part of a variable life insurance or variable annuity contract not guaranteed by a

member insurer.

(c) The exclusion from coverage referenced in subdivision (iii) of paragraph (b) of this subsection shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or other health insurance benefits.

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

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

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

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

(B) for health insurance benefits:

(I) $100,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(II) $300,000 for disability income insurance and $300,000 for long-term care insurance; and

(III) $500,000 for health benefit plans;

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

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

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

(iv) with respect to either (1) one contract owner provided coverage under subparagraph (ii) of paragraph (c) of subsection (1) of this Section or (2) one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subparagraph (ii) of paragraph (b) of this subsection, $5,000,000 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in

the case where one or more unallocated annuity contracts are covered contracts under this Article and are owned by a trust or other entity for the benefit of 2 or more plan sponsors, coverage shall be afforded by the Association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this State. In no event shall the Association be obligated to cover more than $5,000,000 in benefits with respect to all these unallocated contracts.

In no event shall the Association be obligated to cover more than (1) an aggregate of $300,000 in benefits with respect to any one life under subparagraphs (i), (ii), and (iii) of this paragraph (b) except with respect to benefits for health benefit plans under item (B) of subparagraph (i) of this paragraph (b), in which case the aggregate liability of the Association shall not exceed $500,000 with respect to any one individual or (2) with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person and whether the persons insured are officers, managers, employees, or other persons, $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

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

For purposes of this Article, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

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

(Source: P.A. 100-687, eff. 8-3-18; 100-863, eff. 8-14-18.)

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

Sec. 531.04. Construction. This Article shall be construed

to effect the purpose under Section 531.02.
(Source: P.A. 96-1450, eff. 8-20-10.)

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

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

"Account" means either of the 2 accounts created under Section 531.06.

"Association" means the Illinois Life and Health Insurance Guaranty Association created under Section 531.06.

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

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

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

"Director" means the Director of Insurance of this State.

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

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

"Covered contract" or "covered policy" means any policy or contract within the scope of this Article under Section 531.03.

"Extra-contractual claims" shall include, but are not limited to, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.

"Health benefit plan" means any hospital or medical expense policy or certificate or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include:

(1) accident only insurance;

(2) credit insurance;

(3) dental only insurance;

(4) vision only insurance;

(5) Medicare supplement insurance;

(6) benefits for long-term care, home health care, community-based care, or any combination thereof;

(7) disability income insurance;

(8) coverage for on-site medical clinics; or

(9) specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

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

"Insolvent insurer" means a member insurer that, after the effective date of this amendatory Act of the 96th General Assembly, is placed under a final order of liquidation by a court of competent jurisdiction with a finding of insolvency.

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

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

(2) (blank);

(3) any burial society organized under Article XIX of this Code, any fraternal benefit society organized under Article XVII of this Code, any mutual benefit association organized under Article XVIII of this Code, and any foreign fraternal benefit society licensed under Article VI of this Code;

(4) a mandatory State pooling plan;

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

(6) an insurance exchange;

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

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

(9) any dental service plan corporation

established pursuant to the Dental Service Plan Act; or

(10) an entity similar to any of the above.

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

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

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

"Plan sponsor" means:

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

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

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

"Premiums" mean amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits.

"Premiums" does not include:

(A) amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 531.03 of this Code except that assessable premium shall not be reduced on account of the provisions of subparagraph (iii) of paragraph (b) of subsection (2) of Section 531.03 of this Code relating to interest limitations and the provisions of paragraph (b) of subsection (3) of Section 531.03 relating to limitations with respect to one individual, one participant, and one policy owner or contract owner;

(B) premiums in excess of $5,000,000 on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee)

established under Section 401, 403(b) or 457 of the United States Internal Revenue Code; or

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

"Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

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

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

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

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

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

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

The principal place of business of a plan sponsor of a benefit plan described in paragraph (3) of the definition of "plan sponsor" shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

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

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

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

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

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

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

(Source: P.A. 100-687, eff. 8-3-18.)

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

Sec. 531.06. Creation of the Association. There is created a non-profit legal entity to be known as the Illinois Life and Health Insurance Guaranty Association. All member insurers are and must remain members of the Association as a condition of their authority to transact insurance or a health maintenance organization business in this State. The Association must perform its functions under the plan of operation established and approved under Section 531.10 and must exercise its powers through a board of directors established under Section 531.07. For purposes of administration and assessment, the Association must maintain 2 accounts:

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

(a) Life Insurance Account;

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

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

(2) The health account.

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

(Source: P.A. 100-687, eff. 8-3-18.)

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

Sec. 531.07. Board of Directors.) The board of directors of the Association consists of not less than 7 nor more than 11 members serving terms as established in the plan of operation. The insurer members of the board are to be selected by member insurers subject to the approval of the Director. In addition, 2 persons who must be public representatives may be appointed by the Director to the board of directors. A public representative may not be an officer, director, or employee of an insurance company or a health maintenance organization or any person engaged in the business of insurance. Vacancies on the board must be filled for the remaining period of the term in the manner described in the plan of operation.

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

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

(Source: P.A. 100-687, eff. 8-3-18.)

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

Sec. 531.08. Powers and duties of the Association.

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

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

the contractual obligations of the impaired insurer and that are approved by the Director:

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

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

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

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

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

(i) with respect to policies and contracts, ensure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

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

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

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

(iii) with respect to nongroup policies and

contracts covered by the Association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured, enrollee, or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subsection (b), if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class.

(b) In providing the substitute coverage required under subparagraph (iii) of paragraph (B) of item (2) of subsection (a) of this Section, the Association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the Director.

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

The Association may reinsure any alternative or reissued policy or contract.

Alternative policies or contracts adopted by the Association shall be subject to the approval of the Director. The Association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

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

Any alternative policy or contract issued by the Association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as

determined by the Association.

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

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

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

(f) Nonpayment of premiums thirty-one days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the Association's obligations under such policy, contract, or coverage under this Act with respect to such policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this Act.

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

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

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

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

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

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

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

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

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

(m)(1) A person receiving benefits under this Article shall be deemed to have assigned the rights under and any causes of action against any person for losses arising under, resulting from, or otherwise relating to the covered policy or contract to the Association to the extent of the benefits received because of this Article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The Association may require an assignment to it of such rights and cause of action by any enrollee, payee, policy, or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Article upon the person.

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

(3) In addition to paragraphs (1) and (2), the Association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts, including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary, enrollee, or payee of the annuity to the extent of benefits received pursuant to this Article, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130.

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

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

(n) The Association may:

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

Article.

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

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

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

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

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

(7) Exercise, for the purposes of this Article and to the extent approved by the Director, the powers of a domestic life insurer, health insurer, or health maintenance organization, but in no case may the Association issue policies or contracts other than those issued to perform the contractual obligations of the impaired or insolvent insurer.

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

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

(9.5) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this Article.

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

(o) With respect to covered policies for which the Association becomes obligated after an entry of an order of liquidation or rehabilitation, the Association may elect to succeed to the rights of the insolvent insurer arising after the date of the order of liquidation or rehabilitation under any

contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the Association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

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

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

(r) Where the Association has arranged or offered to provide the benefits of this Article to a covered person under a plan or arrangement that fulfills the Association's obligations under this Article, the person shall not be entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.

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

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

(u) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections (1) or (2), the Association may

issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

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

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

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

(Source: P.A. 100-687, eff. 8-3-18.)

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

Sec. 531.09. Assessments.

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

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

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

(b) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under Section 531.08 with regard to an impaired or insolvent domestic insurer or insolvent foreign or alien insurers.

(3)(a) The amount of any Class A assessment shall be determined at the discretion of the board of directors and such assessments shall be authorized and called on a non-pro rata basis. The amount of any Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes among the accounts and subaccounts pursuant to an allocation formula which may be based

on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

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

(b-5) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the Director. The methodology shall provide for 50% of the assessment to be allocated to accident and health member insurers and 50% to be allocated to life and annuity member insurers.

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

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

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

If 2 or more assessments are authorized in one calendar year

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

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

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

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

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

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

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

(9) The Association must issue to each member insurer paying a Class B assessment under this Article a certificate of contribution, in a form acceptable to the Director, for the amount of the assessment so paid. All outstanding certificates

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

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

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

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

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

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

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

(Source: P.A. 100-687, eff. 8-3-18.)

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

Sec. 531.10. Plan of operation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) The plan of operation may provide that any or all powers and duties of the Association, except those under paragraph (3) of subsection (n) of Section 531.08 and Section 531.09 are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this Association, or its equivalent, in 2 or more states. Such a

corporation, association or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection shall take effect only with the approval of both the Board of Directors and the Director, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this Act.
(Source: P.A. 100-687, eff. 8-3-18.)

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

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

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

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

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

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

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

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

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

is subject to judicial review in a court of competent jurisdiction.

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

(Source: P.A. 100-687, eff. 8-3-18.)

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

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

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

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

(i) revocation of license;

(ii) suspension of license;

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

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

(b) To report to the board of directors when he has taken any of the actions set forth in subparagraph (a) of this paragraph or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

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

(d) To furnish to the board of directors the National Association of Insurance Commissioners Insurance Regulatory Information System ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners. The board may use the information

contained therein in carrying out its duties and responsibilities under this Section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the Director or other lawful authority.

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

(3) The board of directors may, upon majority vote, make reports and recommendations to the Director upon any matter germane to the liquidation, rehabilitation or conservation of any member insurer and insurers or health maintenance organizations seeking admission to transact business in this State. Such reports and recommendations shall not be considered public documents.

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

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

(Source: P.A. 100-687, eff. 8-3-18.)

(215 ILCS 5/531.13) (from Ch. 73, par. 1065.80-13)

Sec. 531.13. Tax offset. In the event the aggregate Class A, B and C assessments for all member insurers do not exceed $3,000,000 in any one calendar year, no member insurer shall receive a tax offset. However, for any one calendar year before 1998 in which the total of such assessments exceeds $3,000,000, the amount in excess of $3,000,000 shall be subject to a tax offset to the extent of 20% of the amount of such assessment for each of the 5 calendar years following the year in which such assessment was paid, and ending prior to January 1, 2003, and each member insurer may offset the proportionate amount of such excess paid by the member insurer against its liabilities for the tax imposed by subsections (a) and (b) of Section 201 of the Illinois Income Tax Act. The provisions of this Section shall expire and be given no effect for any tax period commencing on

and after January 1, 2003.
(Source: P.A. 100-687, eff. 8-3-18.)

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

Sec. 531.14. Miscellaneous provisions.

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

(2) Records must be kept of all negotiations and meetings in which the Association or its representatives are involved to discuss the activities of the Association in carrying out its powers and duties under Section 531.08. Records of such negotiations or meetings may be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this paragraph (2) limits the duty of the Association to render a report of its activities under Section 531.15.

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

(4) (a) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders, contract owners, certificate holders, enrollees, and policy owners of the impaired or insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such impaired or insolvent insurer. In such a determination, consideration must be given to the welfare of the policy owners, contract owners, certificate holders, and enrollees of the continuing or successor insurer.

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until and unless the total

amount of valid claims of the Association for funds expended with interest in carrying out its powers and duties under Section 531.08, with respect to such member insurer have been fully recovered by the Association.

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

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

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

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

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

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

the Association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.
(Source: P.A. 100-687, eff. 8-3-18.)

(215 ILCS 5/531.15) (from Ch. 73, par. 1065.80-15)

Sec. 531.15. Examination of the Association - Annual Report. The Association shall be subject to examination and regulation by the Director. The board of directors must submit to the Director, not later than the first day of the fifth month following the end of the Association's fiscal year, a financial report for such fiscal year in a form acceptable to the Director and a report of its activities during such fiscal year.
(Source: P.A. 86-753.)

(215 ILCS 5/531.16) (from Ch. 73, par. 1065.80-16)

Sec. 531.16. Tax Exemptions.) The Association is exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real property.
(Source: P.A. 81-899.)

(215 ILCS 5/531.17) (from Ch. 73, par. 1065.80-17)

Sec. 531.17. Immunity.) There is no liability on the part of and no cause of action of any nature may arise against any member insurer or its agents or employees, the Association or its agents or employees, members of the board of directors, or the Director or his representatives, for any action taken by them in the performance of their powers and duties under this Article.
(Source: P.A. 81-899.)

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

Sec. 531.18. Stay of Proceedings - Reopening Default Judgments.) All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed 180 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict, or finding based on default the Association may apply to have such judgment set aside by the same court that made such judgment and must be permitted to defend against such suit on the merits.
(Source: P.A. 96-1450, eff. 8-20-10.)

(215 ILCS 5/531.19) (from Ch. 73, par. 1065.80-19)

Sec. 531.19. Prohibited advertisement of action of the Insurance Guaranty Association in sale of insurance.

(a) No person, including a member insurer, agent or affiliate of a member insurer shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the Insurance Guaranty Association of this State for the purpose of sales, solicitation or inducement to purchase any form of insurance or other coverage covered by this Article; provided, however, that this Section shall not apply to the Illinois Life and Health Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

(b) Within 180 days of August 16, 1993, the Association shall prepare a summary document describing the general purposes and current limitations of this Article and complying with subsection (c). This document shall be submitted to the Director for approval. Sixty days after receiving approval, no member insurer may deliver a policy or contract described in subparagraph (a) of paragraph (2) of Section 531.03 and not excluded under subparagraph (b) of that Section to a policy owner, contract owner, certificate holder, or enrollee unless the document is delivered to the policy owner, contract owner, certificate holder, or enrollee prior to or at the time of delivery of the policy or contract. The document should also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, or contents or interpretation of this document shall not mean that either the policy or the contract or the policy owner, contract owner, certificate holder, or enrollee thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the Association as amendments to this Article may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this Article.

(c) The document prepared under subsection (b) shall contain a clear and conspicuous disclaimer on its face. The Director shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the Life and Health Insurance Guaranty Association and of the Department.

(2) Prominently warn the policy owner, contract owner, certificate holder, or enrollee that the Life and Health Insurance Guaranty Association may not cover the policy or contract or, if coverage is available, it will be

subject to substantial limitations and exclusions and conditioned on continued residence in the State.

(3) State that the member insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage.

(4) Emphasize that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer or health maintenance organization.

(5) Provide other information as directed by the Director.

(d) (Blank).

(Source: P.A. 100-687, eff. 8-3-18.)

(215 ILCS 5/531.20)

Sec. 531.20. Merger of Illinois Health Maintenance Organization Guaranty Association with and into the Illinois Life and Health Insurance Guaranty Association. In order to provide for the merger of the Illinois Health Maintenance Organization Guaranty Association with and into the Illinois Life and Health Insurance Guaranty Association, the following shall apply:

(1) The Illinois Health Maintenance Organization Guaranty Association is merged with and into the Illinois Life and Health Insurance Guaranty Association, which shall then continue to be known as the Illinois Life and Health Insurance Guaranty Association.

(2) All premerger rights, powers, privileges, assets, property, duties, debts, obligations, and liabilities of each association related to a liquidated member shall remain with the members of the respective association prior to merger and subject to the laws in effect at the time the order of liquidation was entered with respect to the liquidated member, but shall be administered by the Illinois Life and Health Insurance Guaranty Association. The Illinois Life and Health Insurance Guaranty Association shall adopt changes to its plan of operation which reasonably accomplish this.

(3) Subject to paragraph (2), the Illinois Life and Health Insurance Guaranty Association shall succeed, without other transfer, to all the rights, powers, privileges, assets, and property of the Illinois Health Maintenance Organization Guaranty Association and shall be subject to all duties, debts, obligations, and liabilities of the Illinois Health Maintenance Organization that exist

as of the date of the merger of the Illinois Health Maintenance Organization Guaranty Association into the Illinois Life and Health Insurance Guaranty Association. Without limiting the generality of the foregoing, the Illinois Life and Health Insurance Guaranty Association shall succeed to (A) all collected, uncollected, or unbilled assessments of the Illinois Health Maintenance Organization Guaranty Association, (B) all cash, bank accounts, accrued interest, and tangible property of the Illinois Health Maintenance Organization Guaranty Association, (C) all rights, powers, privileges, duties, and obligations of the Illinois Health Maintenance Organization Guaranty Association under any of its contracts or commitments, and (D) all subrogations, assignments, and creditor rights and interests of the Illinois Health Maintenance Organization Guaranty Association.

(4) All rights of creditors and all liens upon the property of the Illinois Health Maintenance Organization Guaranty Association shall be preserved unimpaired, provided that the liens upon property of the Illinois Health Maintenance Organization Guaranty Association shall be limited to the property affected thereby immediately prior to the effective date of this amendatory Act of the 100th General Assembly.

(5) Any action or proceeding pending by or against the Illinois Health Maintenance Organization Guaranty Association may be prosecuted to judgment.

(6) Notwithstanding any other provision to the contrary in this Article:

(A) It is the intent of this Section to preserve only the rights, powers, privileges, assets, property, debts, obligations, and liabilities of the Illinois Health Maintenance Organization Guaranty Association as they existed on the date of its merger into the Illinois Life and Health Insurance Guaranty Association, and not to provide contract owners, certificate holders, enrollees and policy owners, or their respective payees, beneficiaries, or assignees, with duplicative or new rights, powers, privileges, assets, or property.

(B) Accordingly, no contract owner, certificate holder, enrollee and policy owner, and no contract owner's, certificate holder's, enrollee's or policy owner's payee, beneficiary, or assignee, shall be entitled to (i) a recovery from the Illinois Life and Health Insurance Guaranty Association that is duplicative of a previous recovery from the Illinois Health Maintenance Organization Guaranty Association or (ii) a recovery from the Illinois Life and Health

Insurance Guaranty Association on account of a claim against the Illinois Health Maintenance Organization Guaranty Association where the Illinois Life and Health Insurance Guaranty Association is liable with respect to a claim under the same policy or contract under this Article.

(Source: P.A. 100-687, eff. 8-3-18.)