

ILLINOIS INSURANCE LAW-HEALTH

PRESENTED BY

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(An Illinois Certified Provider since 1987)

SUGGESTED METHOD OF STUDY

Success on the law portion of your licensing exam is directly related to your ability to memorize information and to utilize a common sense approach to which behavior is right and which is wrong. The insurance laws of Illinois are in place to protect the consumer from wrongdoing by insurance carriers and the producers who represent them. The test simply is designed to measure whether or not you know certain facts (like dollar amounts of fines and number of days, months years of selected topics) rules, regulations and responsibilities the Illinois Department of Insurance requires of insurance producer.

Illinois insurance law is "Part 2" of your Pearson Vue examination. The number of questions you can expect to receive from each section is detailed as follows:

<u>TOPIC</u>	<u>PAGE NO.</u>	<u>NO. OF QUESTIONS</u>
Contract and Information Overview	2-3	
General Illinois Insurance		
Health Law applicable to all lines	4 - 17	22
General Law Quick Reference	18	
Law applicable to Acc. & Health Insurance Only	19 - 38	14
Law applicable to Managed Care	38-42	3
<u>EXAMINATION TEST</u> <u>TAKING SUGGESTIONS</u>	43	

Therefore, the **TOTAL NUMBER OF QUESTIONS, WHICH COUNT IN SCORING** your test, for THE HEALTH law exam is: **22 + 14 + 3 = 39**

You will be given more questions than the total shown above because the testing company, Pearson Vue, is allowed to insert **EXTRA QUESTIONS CALLED "pre-test" questions** into the exams of licensing candidates. There are 8 pretest law questions on the Health exam for Illinois. These extra "pre-test" questions are not identified **AND THEY DO NOT COUNT** as part of your test score. Therefore you must analyze each question seriously, even though some may not count for or against you.

ILLINOIS INSURANCE LAW - REVISED JANUARY 1, 2009

Common To All Lines of Insurance - 22 Total Questions

This section must be studied and mastered in order to pass PART 2 of any Illinois insurance examination. This first section applies to ALL lines of Insurance, whereas any section which follows pertains specifically to an individual line of insurance (i.e., Life, Accident & Health, Property or Casualty). *You must study BOTH these common laws AND the laws specific to the line of insurance for which you wish to obtain a license.*

OVERVIEW: THE NATURE OF A CONTRACT (OF INSURANCE) and TERMINOLOGY

There are Five essential elements of any contract:

- 1.) Need two or more competent parties (BE SANE & LEGAL AGE)
- 2.) Must have offer and acceptance
- 3.) Mutuality of assent (UNDERSTAND WHAT EACH PARTY GETS)
- 4.) Consideration (MONEY OR EXCHANGE OF PROMISES)
- 5.) Legal Purpose (ILLEGAL CONTRACTS ARE NOT ENFORCEABLE)

Types of Contracts - Insurance contracts may have one or more of the following characteristics:

- **Conditional** -- performance by one party is predicated upon the satisfaction of certain conditions first being met by the other party. **The insurance company will perform if the insured has met the condition of timely premium payment.**
- **Aleatory** -- means **unequal consideration** through an element of chance that one party may receive more in value than given. **The premium is less than the company agrees to pay in the event of loss.**
- **Executory** -- one party has duties which are unfulfilled and yet to be performed. **While the insured has done all required by him, the company does not do its part until expiration of policy term or benefit payoff.**
- **Personal** -- one party relies upon the individuality of the other party when agreeing to the terms of the contract. **Therefore no substitution of a party is allowable.** (You cannot take the insurance physical in place of your friend)
- **Adhesion** -- "**take it or leave it**" concept of contract; there is no give and take, therefore any contractual ambiguities are resolved in favor of the insured when the language of the contract, as written by the carrier is unclear or ambiguous. **The insured is in an unfair bargaining position** since an agent (producer) cannot vary or change ANY of the terms of the insurance contract offer.
- **Unilateral** -- only one of the parties to the contract is bound. **If the insured continues to pay the premium, the company is always bound. This is true of all life policies and guaranteed renewable health insurance contracts. If the carrier can terminate or not renew a health contract with proper notice then such a policy is an example of a Bilateral contract.**
- **Voluntary** -- Agreed upon conditions are included in the wording of the contract. **Both parties enter into the agreement freely upon issuance of coverage.**

TYPES OF INSURANCE COMPANIES

Stock VS Mutual Insurance Companies

- 1.) **Stock** - owned by shareholders of company. Policy holders in a stock company receive nothing more than the contract of insurance. All stock dividends are paid to stockholders.
- 2.) **Mutual** - is composed of/owned by policyholders who participate in the success (or failure) of the company through dividends (which are not taxable; they are deemed to be a refund of excess premium charged). There are no stockholders in a mutual insurance company (also called “participating” companies).

Domestic, Foreign and Alien Insurance Companies

- 1.) **Domestic** - is a company organized (incorporated) under the laws of the state in which it does business. (i.e. New York Life in NY)
- 2.) **Foreign** - a company organized under the laws of a state different than the one in which business is transacted. (New York Life in Illinois.)
- 3.) **Alien** - companies are organized under the laws of a country other than the United States.(New York Life in Canada).

Admitted and Non Admitted

- 1.) **Admitted** - licensed in the state in which it is doing business. Admitted companies are expected to adhere to all the insurance regulation in Illinois and to be financially responsible to policyholders.
- 2.) **Non-Admitted** - not licensed in a state. A Surplus Line Broker is the only way to transact business when the company is non-admitted. Such companies are out of the reach of Illinois policyholders in the event the Non-Admitted company becomes bankrupt (usually associated with medical malpractice insurance).

I) ILLINOIS STATUTES AND REGULATIONS COMMON TO LIFE, ACCIDENT & HEALTH, PROPERTY, CASUALTY AND PERSONAL LINES (22 QUESTIONS) FOR EXAMS ADMINISTERED ON OR AFTER 01/01/09

(THE FOLLOWING STATE STATUTES, RULES AND REGULATIONS OF ILLINOIS CORRESPONDS TO THE PEARSON VUE ILLINOIS SPECIFIC LAW CONTENT OUTLINE, ACCORDING TO CITATION)

A) THE INSURANCE DIRECTOR (1-2 Questions out of 22 Total)

1) General Powers of the Insurance Director (215 ILCS 5/401; 5/403; 5/401.1; 5/431)

The Illinois Code (Statutes) states the Director is "charged" with the rights, powers, and duties appertaining to the enforcement and execution of all the insurance laws of the state. The Director is appointed by the Governor (executive branch of government). Therefore, **the Director does not have the power or authority to imprison anyone.** The word "person" used below includes individuals and companies as "legal" persons.

Ref. 5/401 "General Powers":

- a) to *make reasonable rules and regulations* necessary for making insurance laws effective;
- b) to *conduct investigations* needed to determine whether any person (or company) has violated any laws;
- c) to *request the Attorney General to assist* the Director to enforce his lawful Orders;
- d) to *utilize criminal information* obtained under State Police Law to carry out his statutory powers

Ref. 5/401.1 Applies to All Companies and Persons Subject to Examination by the Director:

- a) *Anyone purporting to transact insurance business in Illinois or in the process or organizing with intent to transact insurance business in Illinois is subject to Director's Powers* (includes *those who have or had* a "Certificate of Authority" (which means a license) to operate in Illinois to do insurance business.
- b) The *Director can issue a Cease and Desist Order* (Stop the activity immediately) *to anyone whose behavior (the focus here is on hazardous and illegal activity) threatens insolvency of a company or otherwise endangers policyholders, creditors or the public.* This Cease and Desist order can be issued BEFORE any hearing is actually conducted.
- c) *If a Cease and Desist order is issued the Director must serve notice to the recipient* of the order a hearing to be held at a fixed time and place which *may not be less than 20 or more than 30 days after the notice of hearing is served to the recipient.*
- d) If, after the hearing, the allegations are found to be true the *Director may remedy the conduct with an order* or orders as he deems necessary.
- e) If any person or company violates the lawful and final order of the Director or fails to comply with such an order in the manner pursuant to this section (5/401.1) then *such person must pay a fine at the rate of \$100 per day not to exceed \$5,000 maximum.*

Ref. 5//431 Penalty for Cease and Desist Order Violation Relating to Unfair Competition

- a) Any person or company *violating a Cease and Desist, specifically relating to unfair marketing practices* as defined in Ref. 5/424(I) G) 5) "Other Unfair Practices" (found on page 17 of these materials) after it is final *must pay a fine not to exceed \$1,000 for each violation, which can be recovered in a civil action.*

Ref. 5/403 Power to Subpoena and Examine Witnesses

- a) To conduct a hearing, examination or investigation the *Director may subpoena any person and compel attendance* as well and require the production of any relevant records, books or papers.
- b) *Any person who fails to obey a subpoena or refuses to be sworn to be examined without a just reason can be fined a maximum of \$2,000.* Further, such person can have a petition filed by the Director against them in a Circuit Court to force cooperation and if they still fail to obey the court has statutory authority to punish such person with fine and/or imprisonment.

2) Examinations (215 ILCS 5/132; 5/402; 5/401; 5/500-110)

Ref. 5/132 Market Conduct and Non-Financial Examinations

- a) Any person being *examined for their conduct* (not related for financial matters) in the operation of insurance matters in Illinois *must give the Director easy and free access at all reasonable hours at its office* or location all books, records, papers, etc., relating to the business performance, operations and affairs of the company. *Directors and examiners can administer oaths* to examine any party under oath.
- b) The *Director must notify any person made the subject of a conduct examination of the contents* of a verified examination report *before making such a report public* and afford the person the opportunity to a hearing. The *person may request a hearing within 10 days after receiving the examination report* (and also include in their hearing request all written objections they had to the contents of the report).
- c) When the *Director conducts a hearing in accordance with Sections 5/402 and 5/403* he *must issue a written order based* on the examination report and hearing *within 90 days after the report is filed or within 90 days after the hearing*. If there was a determination by the Director of the violation of any law then the *Director may issue a written order to take any action deemed appropriate*. This order is subject to judicial review.
- d) *Any person that violates or aids and abets any violation of a written order issued under this non-financial market conduct statute shall be guilty of a BUSINESS offense for which they may be fined not more than \$5,000.*

Ref. 5/402 Examinations, Investigations and Hearings

- a) The Director may conduct any exam, hearing or investigations personally or appoint personnel retained by the Division of Insurance for such purpose. *If it is necessary to hire additional independent personnel to supplement its examination procedures then the person or company under investigation must bear the added expense*
- b) All hearings under this code shall be held at such time and place as designated in a notice which shall be *given by the Director to the person affected at least 10 days before the date designated* in the hearing notice.

Regulatory Examinations (Producers) (Ref. 5/500-110)

- a) The **Director can examine any holder of any type of producer license as well as any applicant of any type of producer license (including a business entity license)**. Any persons being examined must provide free and easy access to their office or location and all papers, books, records, etc., for examination. Again the director can appoint examiners who all have the power to administer an oath and examine all parties under oath.
- b) A report may be issued by an examiner alleging substantive violations of law and such report must be based on the testimony and evidence obtained as part of the examination procedure. **If a report is made, the Director must deliver or send by registered mail a copy of this report to the examined person's address of record.**
- c) The **person examined may request a hearing within 14 days after receiving a hearing report copy**. Such a request must be made in writing and contain a written statement of any objections to the report. **The Director must issue a written order within 90 days based on the report and on the hearing, if a hearing is held, within 90 days of the hearing date.**
- d) Based on either the report or hearing, if ***a violation of law stands the Director may issue a written order*** as he deems necessary or appropriate for the situation. ***Any person who violates or aids and abets any violation of a written order issued under this code Section shall be guilty of a business offense and his or her license may be revoked or suspended and subjected to a civil penalty not to exceed \$20,000.***

B) LICENSE AND REGISTRATION (3- 5 Questions out of 22 Total)

1) Persons required to be Licensed

a) INSURANCE PRODUCERS (Ref. 5/500-15)

If you sell, solicit or negotiate in Illinois for any class of insurance, then you must be licensed in the appropriate line or lines of PRODUCER authority as required by law (i.e. Life, Accident and Health, Property, Casualty or Personal Lines)

In addition to all other penalties proscribed by the insurance code for ***selling insurance without a license, it is also a Class A misdemeanor*** (can get up to one year in jail). **Anyone who** sells insurance with or without the appropriate license and who also misappropriates or converts (***steals***) ***any money collected is guilty of a Class 4 felony*** (subject to more than one year in jail).

b) LIMITED LINES PRODUCER (Ref.5/500-100): **Appointed by an Insurance Company to represent it, in a limited capacity as specified below) each bullet point represents a separate and distinct limited lines producer license:**

- Industrial Life Insurance
- Common Carrier (Coverage for trip cancellation, baggage and travel insurance)
- Industrial Accident and Health Insurance
- Legal expense insurance
- A company organized under the "Farm Mutual Insurance Company Act of 1986"
- Enrollments of public aid or Medicare recipients into a health maintenance organization (HMO)
- A limited health care plan issued under a certificate of authority granted by Limited Health Service Organization Act
- Car rental limited lines license available to representatives of car rental companies.

KEY TO LIMITED LINES PRODUCER LICENSES >> An exam is not required and limited lines producer reps can sell for more than one company at the same time (persons who get these license types are APPOINTED by a company). The LL producer must be at least 18 and have a good business reputation. The LL producer license is perpetual as long as the company pays the annual fee for the producer. Neither prelicensing nor continuing education requirements apply.

c) NON RESIDENT PRODUCER LICENSE (Ref. 5/500-40): Qualifications are::

- Person must be **currently licensed in good standing** in his or her home state.
- Submit the proper paperwork and pay the license fee (**\$250 biannually**)
- Illinois will **only grant this license if the other state accepts Illinois producers** in the same manner.
- The Director **can verify out-of-state producer** status using the National Producer Database
- If a *licensee moves* from one state to another must **notify Illinois within 30 days** after the change..
- Other *nonresident licenses available* include those for *Surplus Lines Brokers and Limited Lines Producers*.

d) BUSINESS ENTITIES (Ref.5/500-30; 5/500-35)

A **business entity** (i.e. corporation that is an agency for an insurance company or companies) acting as an insurance producer **must obtain a producer license. An application must be filed** (“Uniform Business Entity Application.”) and the appropriate fee must be paid (**\$150 biannually**). **The entity must designate a licensed producer to be responsible for compliance with Illinois insurance laws and rules. There must always be a licensed producer available as the contact and compliance person designated for the entity.** The Director can require any document needed to verify the information provided in the application as a business entity.

e) TEMPORARY INSURANCE PRODUCERS (Ref. 5/500-60; 5/500-65)

1) Temporary Licensing (5/500-60) may be issued up to 180 days and renewed for an additional 180 days, without an examination, in these cases:

- To a **surviving spouse or court appointed representative of an insurance producer who dies or, becomes mentally or physically disabled** so that enough time can be allowed for the sale of the insurance business owned by the producer or for the recovery of the producer or to provide for the training and licensing of new personnel to operate the disabled producer’s business.
- To a **member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application.**
- The **designee of a licensed insurance producer who enters active duty with the armed forces of the US military may also obtain this temporary 180 day license.**

A licensed sponsor may be required and the Director may limit the temporary license in any way he sees fit to protect the public or revoke it if he deems it necessary to protect the public. **A written application and \$50 fee is required.**

2) Temporary License for Producer Application (Ref. 5/500-65)

This rule allows a person to obtain a Short Term, 90 day temp license while preparing to pass the state exam. The holder must be in a qualified training course on behalf of an insurance company, with a supervisor or a company manager, and must be in the process of fulfilling the prelicensing requirement. The applicant must take the exam at the scheduled time. **This is a once in a lifetime opportunity. It cannot be renewed!**

If during any SIX month period, more than 50% of a company's temporary licensees fail to obtain their producer license prior to the end of the 90 day period; the Director may cancel the right of the company to hire producers with the temporary license. An insurance company must file a written form with, and be approved by, the Director before temporary licenses can be granted by the company and **a \$50 fee is required**.

f) EXCEPTIONS TO LICENSING (Ref. 5/500-15)

No person may, for a fee, engage in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages, or disadvantages under any policy of insurance that could be issued in Illinois with the following exceptions:

- 1) **An attorney**, licensed to practice law, performing duties incidental to that position;
- 2) A **licensed insurance producer**, limited lines producer insurance representative, or temporary insurance producer offering advice on a class of insurance for which he or she is licensed
- 3) **Public Adjusters**, while acting within the scope of their license.
- 4) **Trust officers** of banks, while performing incidental duties.
- 5) An **actuary or a certified public accountant** engaged or employed in a consulting capacity, performing duties incidental to those positions.

Other exceptions to producer licensing (Ref5/500-20):

•An insurance company is not required to obtain a producer license *nor are the insurer's officers, directors employees, subsidiaries or affiliates* (as long as these parties do not receive any commission on policies written or sold in this state). *This includes administrative, executive, managerial or clerical employees* as well. It also extends to those providing only technical advice about insurance product and those who furnish information for group life, property and casualty and health insurance for the sole purpose of enrolling individuals into the group plan. *Also people working with insurers belonging to the following organizations are excepted:*

- Employer's associations
- Personnel engaged in inspection, rating and underwriting functions
- Advertising and Marketing consultants

KEY CONCEPT> If a person is not receiving compensation directly from the sale solicitation or negotiation of an insurance product then they are not required to obtain a producer license

2) OBTAINING A LICENSE (1-3 QUESTIONS OUT OF 22 TOTAL)

a) Qualifications (Ref.500-30)

To be a qualified, successful candidate for producer licensing a candidate shall possess **ALL FIVE REQUIREMENTS** which follow:

- **Successful State Examination (Part I and Part II- valid for 12 months from passing date)**
- **Be at least 18 years old**
- **Has not committed any act that is grounds for denial, revocation or suspension**
- **Successfully completed the appropriate prelicensing course(s)**
- **Paid the appropriate fee (\$180.00 for biannual license).**

If a producer has their license suspended, revoked or denied they are no longer qualified to work for any carrier or agency in the capacity of insurance producer (See Section I) B. 4, below (page 11) for laws regarding this topic.

b) License Fees (Ref. 5/500-135)

Processing/Application Fee Amount	Category
\$ 180.00	Producer License (Biannual - once every two years)
\$ 360.00	Reinstating a Lapsed License/Late renewals (double renewal fee)
\$ 50.00	Limited Line Producer (Resident-annual)
\$ 250.00	Limited Line Producer (Non-Resident-biannual)
\$ 150.00	Business Entity Renewal (biannual fee)
\$ 50.00	Exam Fee Application for Illinois Law
\$ 50.00	Temporary License for Producer Application (90 days)
\$ 50.00	Temporary Producer License fee (180 days)
\$1,000.00	Certified Provider Reg. Fee (annual)
\$ 50.00	Course Certification Fee (Provider - annual)
\$ 20.00	Certified Course Renewal Fee (Provider -annual)

TESTING FEE --- (To Pearson Vue- paid separately- \$ 103.00, it includes Illinois Law exam fee which is \$50) (This \$103 fee includes full testing for up to two lines of authority – one or two lines, the same test fee).

All fees collected are placed into the “Insurance Producer Administration Fund.”

c) Pre-licensing (Ref. 5/500-30; Reg.3119)

Successful completion of a prelicensing course has the following minimum hours, by class, as follows

- **Life • Accident & Health • Property • Casualty• Personal Lines..... 15 hours for each line**
- **Motor Vehicle.... 7.5 hours**

Hours can be all classroom, all self-study or any combination of both. **Self-study prelicensing requires that an exam be successfully passed and graded by the course provider.** (Note: Casualty includes Motor Vehicle and Property and Casualty includes Personal Lines). Prelicensing course credit is valid for 12 months from the date of course completion.

d) Bond Requirements (Ref. 5/500-130)

An insurance **producer who places insurance either directly or indirectly with an insurer with which the insurance producer does not have an agent contact** must maintain in force while licensed a bond in favor of the people of the State of Illinois executed by an authorized surety company and payable to any party injured under the terms of the bond. *Such activity is considered to be “brokering business.”* Failure to maintain a bond when required will result in revocation or denial of license.

- 1.) **for \$2,500** (which is the bond "penalty" or face amount) **or**
- 2.) **5% of premium received in previous year**, whichever is greater (**not to exceed \$50,000** total aggregate liability).

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

- A **surety** (the insurance company who issued the bond to the producer) **may cancel the bond with 30 days** notice to the **principal** (purchaser of the bond).
- An **injured party can request that the producer provide the surety name and bond number** and the **producer must comply within 3 working days** of receiving such a request.

3) Maintaining The License (1-3 Questions out of 22 Total)

a) Continuing Education (Ref.5/500-35)

Currently, all producers are required to satisfactorily complete continuing education requirements and a Producer license will not be renewed if these requirements are not met (except for military waiver):

- **30 hours** of approved course study offered by a certified provider
- for **each biannual license renewal** (every two years).
- **No single continuing education course may be certified for more than 15 hours of credit.**
- Producer *must complete a CE course in advance of the renewal date so as to allow the education course provider time to report the course completion*
- **Failure to comply by the renewal due date** results in automatic license termination and subjects the producer to a **double renewal fee of \$360.**

If a producer license lapses (is not renewed on time), the producer has up until 12 months after lapse to comply and complete the 30 CE requirement but they will have to pay a double license fee. If it has been more than 12 months after lapse, the person must go through preclicensing and pass a state exam again.

CE course Programs can be all or part self-study (requires successful completion of an (open book) exam while programs offering all 15 hours of completion in a classroom have no exam requirement).

The producer license is perpetual (goes on forever) as long as the producer maintains and pays the required fees for the license in a timely fashion.

b) Controlled Business (Ref. 5/500-125)

Controlled business means insurance procured or to be procured by or through the person *upon* :

- His own life, person, property or risks, or those of his spouse; or
- The life, person, property, or risks of his employer or his own business.

The Director **may not grant or renew any license if he has reason to believe**

● that **during either** of the *preceding 2 years the total amount of controlled business premium collected was greater* than the premium amount collected for all other insurance business **or**

● *in the 12 months immediately following the issuance of the license the total amount of controlled business premium collected was greater* than the premium amount collected for all other insurance business.

KEY > A producer must sell more insurance on others than he/she does controlled business.

c) Change of Address (Ref. 5/500-35)

Licensees must **inform the Director by any means acceptable to the Director of a change of address within 30 days** after the change. (*Note: failure to comply with this is the #1 reason producers are late in renewing, thus costing them a double fee.*)

4) License Suspension, Revocation or Denial (Ref. 5/500-70)

The Director can place any license on suspension, revoke it or refuse to issue (Deny) a license or may levy a civil penalty or take any combination of these actions **for any one or more of the following reasons:**

- 1.) **Provide incorrect, misleading, incomplete or materially untrue information in the producer license application.**
- 2.) **Violate any** insurance law, rule, subpoena or order of the Director of Insurance of ANY state.
- 3.) **Knowingly accept any business from anyone who does not have a license.**
- 4.) **Intentionally misrepresenting the terms** of an actual or proposed insurance contract or application for insurance.
- 5.) Having admitted or been found to have committed **any insurance unfair trade practice or fraud.**
- 6.) **Forging a name** to an application for insurance or to a document related to an insurance transaction.
- 7.) **Had license revoked/suspended in any other jurisdiction** and the same result would occur in Illinois.
- 8.) **Try to get a license through misrepresentation or fraud.**
- 9.) Improperly **using notes** or any other reference material **to complete an examination** for an insurance license.
- 10.) Having been **convicted of a felony.**
- 11.) **Misappropriating**, improperly holding or converting any **business funds for personal use.**
- 12.) Be **fraudulent, coercive, or use dishonest practices**, be unworthy of trust or be incompetent in the transaction of business by way of the license.
- 13.) **Failing to comply with** an administrative or **court order imposing a child support** obligation
- 14.) **Failing to pay state income tax** or penalties or interest or to comply with a court order directing payment of state income tax or failure to file a tax return or to pay any tax due to the Illinois Department of Revenue.
- 15.) **Failing to make satisfactory repayment on an Illinois Student Loan.**

Once the Director takes action to Suspend, Deny or Revoke a license or application, the affected person is contacted in writing and the **applicant or licensee may make a written demand upon the Director within 30 days after the date of mailing informing him of the action against his license** for a hearing before the Director to determine the reasonableness of the Director's action. After this written request for a hearing is made by the producer:

- **The actual hearing date will be no less than 20 or more than-30 days** from the mailing of the notice of the hearing from the Director to the producer.
- Resulting **punishment for wrongdoers can include not only suspension, revocation or denial of license, but a civil penalty can also be imposed.** The civil penalty can run up to \$10,000 for each cause with a maximum civil penalty of \$100,000 for violations of the Director's lawful order.
- A person whose license is revoked or an applicant whose application is denied is **not eligible to apply for any license for 3 years after the revocation or denial.** A suspension is for a period deemed appropriate by the Director.
- Anyone who suffers Suspension/Revocation or Denial **may not be employed, contracted or engage in any insurance related capacity during the period** of imposed Suspension/Revocation or Denial.
- **All Licenses must be surrendered to the Director in person or by mail when suspended or revoked.** All terminated license actions are published and become public information.
- **The license of any business entity shall be suspended revoked or refused** where it was known or should have been known by officers, partners or managers of the entity (after a hearing is held) that an individual licensee engaged in a violation but it was no reported to the Director, nor was any corrective action taken by the entity.

C) Fiduciary Responsibilities Ref. 5/500-115) (2-3 Questions out of 22 Total)

Any licensed person who collects money in the course of their occupational duties is in a **fiduciary (trust) relationship with the public.** The insurance company expects a contracted insurance producer to deliver a policy in a timely fashion and expects the producer to act honestly and to forward any monies collected appropriately. **A violation of this trust is a serious offense** and violations and resulting consequences include:

Violations: ● *improperly holding monies* (hold client funds in excess of 15 days), ● *misappropriating or converting (stealing) client funds* and ● *not delivering an issued policy and collecting the first premium within 90 days of policy issuance* (in other words, once a policy is issued, don't keep it in your trunk for 3 months or longer without delivering it and collecting the first premium payment due).

Specific violations related to dollar amount include:

- \$150.00 or less stolen is a Class A misdemeanor
- Steal \$150.00 or less twice or more it is a Class 4 Felony
- Steal in excess of \$150.00 and it is a Class 3 Felony

■ **Any money collected by a producer is deemed to have been received by the insurance company** and the insurer is responsible to the insured for any return premium.

■ **For open accounts receivable** which have a balance due to the company within specified periods of 90 days or less, a service charge not exceeding 1.5% per month on amounts due may be assessed BY PRODUCERS to encourage timely premium payment.

■ **Premium Fund Trust Account (PFTA) – (Ref. Section 3113)**

This regulation establishes minimum standards of licensees in handling insurance premiums properly (and other monies) received from insurers, insureds, other licensees or registered firms and subjects those who violate these standards to penalties under law and proceedings of the Illinois Insurance code. Section 3113 applies to all licensed producers (both resident and non-resident) and to registered firms.

- Licensees maintaining a PFTA must do so in **a financial institution within the State of Illinois subject to the jurisdiction of Illinois courts** and PFTA must be printed on the face of checks and the account must be registered with the financial institution as a Premium Fund Trust Account.

- A **PFTA must be established if a producer holds any premiums for 15 days or more before remitting to another proper party** OR if a producer deposits any collected premiums into a financial institution account or other account or uses the premiums, even though the premiums are remitted within 15 days.

- All licensees who maintain or are required to maintain a PFTA **must deposit all premiums received into the PFTA. Non-premium monies collected may also be deposited** into a PFTA if received **for soliciting, negotiating, effecting, procuring, renewing, continuing or binding policies of insurance** (includes service fees, policy fees, late charges, inspection fees and surplus lines premium taxes).

- All monies deposited into the PFTA are considered fiduciary funds until lawfully withdrawn.

- The **disbursements which can be can legally withdrawn from a PFTA include** : 1) net or gross premiums due to insurers, 2) returned premiums due to insureds, 3) commissions due to producers, 4) banks fees and service charges, 5) non-premium monies when matched and identified with prior non-premium PFTA deposits, 6) interest or other revenue which the licensee is authorized to retain and 7) withdrawals allowed under this Act must be made payable to the licensee or another licensee

- **The PFTA account balance must at all times be equal to the amount deposited less any LAWFUL withdrawals.** If the balance comes up short, the licensee is deemed to have misappropriated (stolen) fiduciary funds.

- Licensees **may place PFTA funds in an interest bearing account and keep the interest PROVIDED THE LICENSEE HAS THE PRIOR WRITTEN AUTHORIZATION OF THE INSURER ON WHOSE BEHALF THE FUNDS ARE TO BE HELD!**

- A licensee can put interest bearing funds into: US Government securities maturing in not longer than one year, CD's with a one year max maturity time, highly rated commercial paper, conservative money market funds and highly rated municipal bonds maturing in no longer than a year. ***YOU CAN NEVER PUT PFTA FUNDS IN HIGH RISK ACCOUNTS SUCH AS BUYING OPTIONS, FUTURES OR BUYING EQUITIES ON MARGIN.***

- Any PFTA investment transaction must be made in the name of the PFTA and the licensee shall maintain evidence of any such investment that flows through the PFTA.

- The **minimum record keeping requirements of a PFTA are quite comprehensive** mandating that detailed records of all parties, dates, policy numbers, check numbers, amounts deposited and disbursed, etc., and all elements relating to any commission payment be meticulously recorded. **All accounting posting must be done no less timely than every 30 days. All books and records for a fiscal year must be maintained for at least 7 years.**

- All PFTA bank statements must be balanced monthly.

● Any return premiums must be paid or credited to the insured's account within 15 days of receipt from an insurance company or other licensee. If there is a credit balance to an insured's account that is kept past 15 days there must be written authorization from the insured and the credit cannot be retained for more than 12 months from authorization and the insured has the right to all credits at any time which must be refunded upon request within 15 days. Finally, any credits carried must be sent in writing at least monthly reflecting the total credit available.

D) Commissions and Compensation (Ref. 5/500-80) (0-1 Question out of 22 Total)

THE TWO MAIN RULES:

- 1) A person must have the appropriate producer license to receive commission and
- 2) A person cannot be paid directly from an insured with these **two exceptions:**

- Commission deductible from premium with net forwarded to the insurance company, or

● Service fee – There *must be a written document signed by both parties if the service fee or compensation exceeds 10% of the potential total premium amount* for an insurance related transaction. *A copy of this written disclosure must be kept for 7 years. If a policy or contract is canceled within 90 days of the inception date of the written agreement then the producer or business entity must refund a prorated amount within 30 days* to the consumer, Service fees may be considered fully earned as of inception if the insurance producer provides a written disclosure that such fees were fully earned as of inception miscellaneous related concepts:

- Renewal or deferred commissions may be paid to the selling producer at a later time when he is no longer licensed as long as the producer was properly licensed at the time of the sale.
- There can be no service fee or charge to the insured or producer or business entity for processing a cancellation.

E) Felony Convictions (ref. 5/500-95) (0-1 Question out of 22 Total)

An individual who, while licensed as an insurance producer, is convicted of a felony **must report the conviction to the Director within 30 days after the entry date of the judgment.** Within that 30 day period, the individual must also provide the Director with a copy of the judgment, the probation or commitment order, and any other relevant documents.

F) Disclosure (Ref. 5/500-75) (0-1 Question out of 22 Total)

Any policy solicited by a licensed producer must identify the name of the producer, representative or firm. An individual life or accident and health application and a master (Group) policy *application must bear the name and signature of the licensee who solicited and wrote the application.*

G) Marketing Practices (4-6 Questions out of 22 Total)

1) Unfair Claims Practices (Ref. 5/154.5; 5/154.6; REG. 919) - Specific improper claims practices for insurance companies include:

- 1.) Activity which results in **excessive valid complaints** made to the Department of Insurance.
- 2.) **Not having or acting upon reasonable standards** for fast investigation and settlement of claims.
- 3.) **Not acting in good faith to make settlement** when liability is reasonable clear.
- 4.) **Purposefully misrepresenting important policy coverage** and provisions to claimants or insureds.
- 5.) **Failing to acknowledge important communications** regarding claims in a timely manner.
- 6.) **Forcing policyholders to file lawsuits to recover** because a company made offers far too low compared to the amount that was actually received as a result of the lawsuit.
- 7.) **Failing to provide required claim forms** and proper instructions as to their completion.
- 8.) The **failure on the part of a company to identify the contractual reason for denial** of a claim.
- 9.) Activity on the part of a company which results in an **excessive number of lawsuits to be filed** against it.
- 10.) **Refusing claims without conducting a reasonable investigation** utilizing all available information.
- 11.) **Failing to provide a detailed explanation** referring a payment made to the appropriate coverage.
- 12.) **Making a claimant duplicate efforts in the claim verification process** in an effort to delay investigation of a claim.
- 13.) **Failure to deny or affirm coverage within a reasonable time** after a proof of loss has been filed.

REGULATION 919 is designed to help the Director determine which insurance companies operating in Illinois should be examined based on their business practices. The frequency of hearings can be based on many criteria including complaint volume ratios, randomly, specialty markets and claims handling procedures. **REG 919 also compels carriers to maintain detailed claims records retrievable for the current year AND the previous two years.**

Every carrier must give notice of availability informing the consumer making them aware of the Division of Insurance.

“Prompt Investigation” after notice of a loss by an insured is **21 days** for the company to communicate with all insureds when liability is reasonably clear.

"Reasonable Promptness" means a maximum of **15 days** from receipt of communication from a claimant or insured.

Required practices for all insurance companies demands that the company must affirm or deny claims liability and offer payment **within 30 days after affirming liability**, if the claimed amount is not disputed. The company must tender payment for nondisputed claims amounts within 30 days. Disputed amounts must be explained by the company and notify insureds of claims denials within 30 days.

REG 919 says that life claims require a carrier to search records for all other possible policies that may be carried on that life as well as search under any and all other names by which the deceased person may have been known. **If claims are unresolved for 45 days the company must give reasonable written explanation for the delay.**

2) Rebating (ref.5/151; 5/152; 5/153) is illegal and occurs when a producer **offers anything of value to a prospect as an inducement to place insurance business with that producer**. Essentially it means to bribe someone to get their insurance business. Any producer convicted of rebating will lose all commission otherwise earned and payable for any policies sold where a rebate was involved and their producer license is subject to suspension, revocation or denial in addition to a possible fine. (Class B misdemeanor).

Guilt of producer rebating is *not held against a carrier or general agent unless they were aware of the rebating by the producer*. Anyone participating in a hearing for producer rebating is immune from prosecution and cannot use self-incrimination as a defense and the only offence that could be used against such a participant is perjury occurring as a result of the rebate hearing.

The prohibition against providing any inducement beyond the insurance coverage is so broad it even extends to any offer, promise, give, option, sell purchase any stocks, bonds, securities or property or any dividends or profits accruing thereon. Rebating does not include policy dividends paid to a policyholder on a mutual policy. **Also the rebate law DOES ALLOW an insurance company to offer a child passenger restraint system or a discount from the purchase price of a child passenger restraint system to policyholders** when the purpose of such restraint systems is the safety of a child and compliance with the "Child Passenger Protections Act."

It is also illegal for an insurance applicant to accept a rebate in exchange for a policy purchase. The purchaser is entitled ONLY to what they get through the policy itself.

3) Misrepresentation (Ref. 5/149;5/154) occurs **when a producer makes Misleading comparisons** between what a prospect owns and what the producer is trying to sell. Such an inducement to switch companies is called "**Twisting**" when a misleading statement is made which results in the business changing hands to the new company that the producer is representing. Another **example of misrepresentation is making any statements that the Federal or State governments or agencies approve, guarantee or otherwise endorse your company or products when that is not the case (governments never endorse the products of one insurance company over the products of another).**

Misrepresentation is also prohibited for sales that do not involve replacement.

The media of communication subject to this Code includes written, verbal and via radio (regardless of the manner of communication) and the ***fine for misrepresentation is payment of a penalty of no less than \$200 nor more than \$10,000,*** recoverable and paid into the county in which the State Attorney completed successful prosecution.

No company or person may advertise or prospect for sales leads in Illinois ***unless they are authorized*** (licensed) in this state to transact insurance business.

4) Defamation (Ref.5/149) occurs when a **producer, while in the act of soliciting** or trying to procure business on behalf of one company, **intentionally provides untrue information** about the business practices of another company, or their representatives, designed to place the producer (who is making the untrue statements) and his company in a more favorable light. Any **untrue statements which unfairly damage the business reputation of another company or their representatives are strictly prohibited. The fine for guilty parties is a minimum of \$200 and a maximum of \$10,000.**

General Law Quick Reference – Time Periods & Dollar Amounts

Insurance Director – Hearings, Orders and Fines

Cease and Desist Order – notice served 20-30 days before hearing date	Violation of final Cease & Desist Order \$5,000 Max; \$100 per day	Cease/Desist Final Order specific to Unfair Competition - fine \$1,000 Max
Failure to Obey Subpoena or refuse to testify after service of Subpoena- \$2,000 Max	Market Conduct Exam –request hearing within 10 days of receipt of report	Market Conduct Exam- Dir. must issue written order within 90 days of hearing or report file date
Sec 402 Exam (Independent Personnel) – Dir. Must give at least 10 days hearing notice.	Exam of Producer – must request hearing within 14 days of receipt of copy of report	Producer Exam written order violation– Max of \$20,000 also applies to those who aid or abets

REFER TO PAGE 9 FOR LIST OF LICENSE FEES – KNOW LIST!

License Renewal Periods

Resident –Biannual Renewal (2 yrs)	Business Entity –Renewal (2 yrs)	Temp Prod License to sell– 90 days
Temp Prod License in the case of death or incapacity -180 days	Up to 12 Months to Reinstate a Lapsed Producer License	Resident LTD Lines – Renew 1 year Non-Res LTD Lines – Renew 2 yrs

Bond Requirements (Brokering Business) - \$2,500 or 5% previous year premium, which ever is greater

CE REQUIREMENT – 30 Hours Biannually, No SINGLE Course more than 15 Hours

Change of Address Notice: Producer’s Residence– 30 DAYS; Business Entity – 30 days

License Suspension, Revocation or Denial

Once Dir. Takes action, Producer has 30 days to request, in writing, a hearing	Once hearing requested, Dir. Must make hearing date within 20-30 days of mailing hearing notice to Prod.
Civil Penalty for S/R/D is \$10,000 per cause and \$100,000 Max for all Causes for order violation	Once Prod has S/R/D of license they may not apply for license again for at least 3 years

Producer Fiduciary Duties Violations

Improperly Holding client funds = more than 15 days	Steal less than \$150 it is a Misdemeanor
Steal less than \$150 twice or more or more than \$150 one time and it is a Class 3 or 4 Felony, Respectively	Must deliver a policy within 90 days of offer when first premium still needs to be collected by producer

Premium Fund Trust Accounts

If hold premiums for 15 days or more must have PFTA	Must Balance PFTA at least every 30 days
Must keep PFTA books & records for 7 yrs minimum	Must credit insured account for refunds w/in 15 days

Commissions and Compensation

IF Service fee exceeds 10% of policy premium then agreement must be written & signed by both parties
IF Policy is canceled within 90 days, prorated refund of service fee must be made within 30 days

Felony Conviction of Producer must be reported to DIR. W/in 30 days of Judgment of Conviction

REGULATION 919

Prompt Investigation = 21 days	When Liability is affirmed must offer payment within 30 days
Reasonable Promptness = 15 days	If claim is not resolved must write W/in 45 days and explain to insured

Fine for Misrepresentation or Defamation by producer is MIN of \$200 and MAX of \$10,000

This section must be added to **Illinois Insurance Law Common to All Lines** to complete the entire study guide for Part 2 of the state exam for ACCIDENT & HEALTH insurance licensing.

II) ILLINOIS LAW: ACCIDENT & HEALTH LAW SPECIFIC (14 QUESTIONS ON STATE EXAM)

A) Medicare Supplements (Ref. 5/363; 5/363a; 5/500-75; REG 2008 (2-3 Questions)

1) Minimum Standards (Apply to Individual and Not Group Insurance)

- Coverage that is either **ALL** or **NONE** of the Medicare Part A inpatient hospital deductible (this dollar amount changes each year based on inflation; \$1,068 for 2009)
- **Daily coverage for each day of the 61st-90th day of inpatient care** (\$267 for 2009 and increases with inflation, usually on annual basis)
- **Coverage for each day of inpatient care during the lifetime reserve** which are days 91-150 (\$534 in 2009 per day for days 91-150 of a hospital stay)
- **When inpatient coverage is exhausted after the lifetime reserve** is used (which occurs after 150 total inpatient coverage days) a Medicare Supplement **must pay 90% of ALL Part A eligible expenses up to a lifetime maximum benefit of an additional 365 days.**
- **Coverage under Medicare Part A for the reasonable cost of the first 3 pints of blood** (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;
- **Coverage for the coinsurance amount** or, in the case of **hospital outpatient** department services paid under a prospective payment system, the co-payment amount, **of Medicare eligible expenses under Part B regardless of hospital confinement**, subject to a **maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (\$100).** (The actual 2009 Part B deductible is \$135 but **the Illinois limits payment to \$100.**)
- **Coverage under Medicare Part B for the reasonable cost of the 3 pints of blood unless** replaced in accordance with federal regulations or **already paid for under Part A**, subject to the Medicare deductible amount..

Other marketing Prohibitions regarding Medicare Supplements:

- If one supplement is replaced for another, the replacing insurer must waive pre-existing conditions, elimination periods and probationary waiting periods in the previous supplement was in effect for at least six
- Supplements cannot base payments on standards described as “usual and customary” or “reasonable and customary or any such words to that effect.

2) Disclosure Requirements

- *If a supplement contains any limitations regarding preexisting conditions they must appear in a separate paragraph* and be labeled as such
- The *owner or a Medicare supplement is entitled to a 30 day Free Look* upon delivery and are entitled to a full refund upon exercising this right.
- Medicare *supplements must include a renewal or continuation provision.*
- *If there is a modification of coverage, the insurer must notify policyowners within 30 days* before the effective date of the benefit changes and such notice MAY NOT be accompanied by any solicitation (try and sell the customer more insurance of any kind).
- **Only the ownership of ONE supplement policy is necessary.**
- **Supplements CAN NOT duplicate coverage** that is already provided by Medicare.
- **If a supplement owner later qualifies for MEDICAID**, the benefits and premium cost under the *supplement may be suspended for 24 months upon request within 90 days* of becoming eligible for MEDICAID.
- Medicare *supplements must be issued as GUARANTEED RENEWABLE.*
- **The producer who solicited the sale must include his name and sign the individual or master application**

Advertising Disclosure Requirements

- **If a plan is being marketed to someone 65 years of age or older, the advertisement and the product must clearly state that it is not Medicare supplement coverage** (i.e. an Accidental Death & dismemberment policy is not a Medicare supplement).
- Agents must **always disclose:** (1) the company(s) represented and (2) fact that person is a licensed insurance produce **as well as all addresses of insurers..**
- **All printed materials must prominently state that the insurance has nothing to do with MEDICARE program** and the use of the word Medicare cannot appear on the mailing envelope or the return envelope. **Anything in the advertisement that would imply or mislead that the company sending it has any direct or indirect affiliation with the Medicare program is guilty of misrepresentation.**
- **Insurers must prominently state** in advertisements **that any information will be delivered in person** by an agent of the insurance company **when that, in fact, is the case.**
- Advertisements must state that neither the agent nor insurer is connected, in any way, with the Medicare program.

Prohibited Agent Practices - No agent engaged in a home solicitation sale may use any false, deceptive or misleading representations to induce a sale or to hide the true nature of the sales call or to represent either directly or indirectly that the agent (**THINGS AGENTS CANNOT DO**):

- is offering insurance either approved or recommended by the State or federal government to supplement Medicare;
- is in any manner representing, working for or being paid by a local, state or federal government agency
- is engaged in the advice business and whose pay is not related to an insurance sale or to **specifically use the terms "Medicare consultant", Medicare advisor", Medicare Bureau or disability consultant**
- to say that State, county or Federal Medicare assistance programs are to be discontinued or are in any way endangered

Mandatory Agent Practices – Any agent engaged in a “home solicitation sale” of any accident & health policy, including a Medicare supplement **shall promptly do ALL of the following** :

- Identify himself as an insurance agent;
- Identify any and all companies for whom he is an agent;
- Provide purchaser with a clearly typed ID of name, address, phone number and insurer name;
- Determine what, if any, policy is appropriate, suitable and does not duplicate coverage and to provide proof of these elements to the insurer for whom the application is being written;
- Fully and completely disclose the the purchaser’s medical history on the application if such information is required by the insurer for policy issue.
- **Complete a POLICY CHECK LIST** which must provide the following information:

POLICY CHECK LIST

Applicant's Name:
 Policy Number:
 Name of Existing Insurer:
 Expiration Date of Existing Insurance:

	Medicare Pays	Existing Coverage	Supplement Pays	Insured's Responsibility
<u>Service</u>				
Hospital				
Skilled				
Nursing				
Home Care				
Prescription				
Drugs				

This policy does/does not (circle one) comply with the minimum standards for Medicare supplements set forth in Section 363 of the Illinois Insurance Code.

Signature of Applicant
 Signature of Agent

This Policy Check List is to be completed in the presence of the purchaser at the point of sale, and copies of it, completed and duly signed, are to be provided to the purchaser and to the company.

Miscellaneous

- An "Outline of Coverage" must be given when an application is being taken for a Medicare Supplement, but this does not apply to those purchased by DIRECT RESPONSE.
- If a Coverage Outline given at application time does not exactly match coverage issued, then the insured must be made aware of this fact and such a statement must appear conspicuously in writing on a new Outline of Coverage.
- Supplements Can only exclude certain illness/treatments that are excludable under Medicare
- When writing a new Supplement **PREEXISTING Condition is defined as 6 MONTHS prior to the issue date of the supplement and after 6 months preexisting conditions are covered.**
- **If an agent or an insurer sells a supplement that has not been approved** by the Director for sale in Illinois **they can be fined up to \$10,000 maximum**
- **For all other violations** under these laws the **finest are no less than \$500 nor more than \$5,000**

3) Under Age 65 and Disabled

If an applicant is under 65 years of age and applies for a Medicare supplement the insurer **MUST NOT DENY COVERAGE** as long as the purchaser meets ANY of these requirements:

- **Becomes eligible for Medicare by reason of disability** if the person applies for the supplement **within 6 months of the first day the person enrolls for benefits under Medicare Part B** (*in cases where the Social Security Administration rules retroactively in favor of eligibility the supplement application must be made within 6 months beginning with the month in which the person received notice of his retroactive eligibility to enroll*).
- **Has Medicare and an employer group health plan** (as either primary or secondary coverage) *that either terminates or stops providing all supplemental health benefits*
- **Is insured by a Medicare Advantage Plan** (HMO, PPO and Private Fee-for-Service or Medicare Select Plan) *and the applicant moves out of the service area; the insurer goes out of business, withdraws from the market or has its Medicare contract terminate; or the plan violates its contract provisions or is misrepresented in its marketing.*
- **Is insured by a Medicare Supplement policy** and *the insurer goes out of business; withdraws from the market or agents misrepresent the plan and this causes the applicant to be without coverage.*

KEY IDEA>>> In the above cases, the insurance must supply supplement coverage without regard to age qualification and CANNOT charge more than they charge for supplements for people age 65 or older.

B) Long-Term Care Insurance (Ref.5/351A-1; 5/351A-3 thru 5/351A-11) (2-3 QUESTIONS)

- **Purpose of Act-** to promote LTC policies in the Public interest and to protect the public. Act applies to all LTC policies delivered or issued for delivery in Illinois. **LTC** includes any A&H policy or rider offered to provide **coverage for NOT LESS than 12 CONSECUTIVE MONTHS** for each individual covered on either a prepaid, expense incurred or indemnity basis.
- **THE FOLLOWING TYPES OF COVERAGE SPECIFICALLY MAY NOT BE MARKETED AS LTC:** Medicare supplement coverage, basic hospital expense, basic medical-surgical expense, hospital confinement indemnity, major medical expense, disability income, accident only, specified disease or specified accident coverage or limited benefit health coverage.
- LTC may include benefits for care and treatment which follows the tenets and practices of any established church or religious denomination teaching reliance on spiritual treatment through prayer for healing.
- Long Term Care coverage **can be sold on either a group or individual basis**. LTC policies offered for sale in Illinois on an **individual basis must be approved by the Director and must be issued as “guaranteed renewable” or “Noncancellable”**.
- **Association plans (an example of group coverage) are allowed** but must **originate with at least 100 members** and the association must have already existed for some purpose other than obtaining insurance coverage. The premium must be reasonable in relation to the benefits offered.

■ **Disclosures.** The *Director may adopt rules* that include standards *for full and fair disclosure* setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies and all riders and provisions.

- **The producer who solicited the sale must disclose his name and sign the individual or master application**
- Individual long-term care insurance policies *shall contain a renewability provision.*
- All *riders which require additional premium must be revealed.*
- Any *allowable reductions or eliminations in coverage must be stated.*
- All policies using a benefit payment basis of "*usual and customary*" or "*reasonable and customary*" *must be clearly defined and explained* in an accompanying outline of coverage.

■ **Limitation.** A long-term care insurance policy **CAN NOT**:

- Be cancelled, nonrenewed or otherwise *terminated on grounds of the age or the deterioration of the mental or physical health of the insured individual* or certificate holder.

- *Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form,* except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder.

- *Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care*

■ **Coverages.** An insurance company **can offer a long-term care** insurance policy that provides for *reimbursement of paid premiums in the event of cancellation or reduced benefits in the event the policyholder discontinues premium payments.*

■ **"PRE-EXISTING" under Illinois law related to LTC means:** the existence of symptoms which would cause an ordinary prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, **within 6 months preceding the effective date of coverage** for an insured person." After this 6 month waiting period preexisting conditions must be covered under individual policies (but do not have to be covered after 6 months in a group policy).

■ **Prior hospitalization; institutionalizations.** *No long-term care* insurance policy *may be delivered or issued* for delivery *in this State if such policy conditions eligibility for any benefits on a prior hospitalization requirement or conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.*

A long-term care insurance **policy** containing a benefit **advertised, marketed or offered** as a **home health care or home care** benefit **may not condition receipt of benefits on a prior institutionalization** requirement.

A long-term care insurance **policy which conditions eligibility of non-institutional benefits (home health care benefits) on the prior receipt of institutional care** (must first be in a nursing home) shall **not require a prior institutional stay of more than 30 days** for which benefits are paid.

■ **Free Look of a long term care policy is 30 days in Illinois** no matter if purchased from an agent directly or through direct response marketing. Purchaser receives a full refund and free look starts at policy delivery.

■ **Outline of coverage.** *An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation. In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form*

● **Outline of coverage shall include :** *A description of the principal benefits and coverage provided in the policy AND a statement of the principal exclusions reductions and limitations contained in the policy.*

● **For Group policies,** *a disclosure similar to the required outline of coverage as described above must be included with the certificate of coverage along with a statement that the group master policy determines governing contractual provisions.*

■ **Policy summary and Benefit Reports.** *If sale is by agent solicitation then at the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make such delivery *no later than at the time of policy delivery.**

The policy summary shall include these elements:

- Explain how LTC benefits interact with other policy parts, including any deductions of death benefits
- An illustration showing the benefit amount, length of coverage, and any guaranteed lifetime benefits included, for each covered person.
- List of all exclusions, reductions and limitation of benefits

■ **In the event the LTC benefit is funded through a LIFE INSURANCE VEHICLE BY THE ACCELERATION OF A DEATH BENEFIT,** and is in benefit payment status, the *insurer shall provide a MONTHLY report to the policyholder which shall include:*

- Any LTC benefits paid during the month.
- Explain any changes in the policy, including changes in death benefits or cash values due to LTC benefit payouts.
- Amounts of any LTC benefits existing or remaining.

■ **Delivery of policy.** *If an applicant for a long-term care insurance *contract or certificate is approved,* the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.*

■ **Claim Denial and Explanation.** *If a claim is denied under an LTC contract the *insurer must issue notice of the denial with explanation within 60 days of a request being made.**

■ **Rules and Regulations.** *The Director may adopt rules and regulations establishing minimum standards for marketing practices, reporting practices, penalties and for violating those standards.*

■ **Group Continuation/Conversion:**

There must be a basis for continuation by an individual leaving group LTC coverage. If the **individual was in a group plan for at least 6 months before termination from** the group, the individual can convert to an individual LTC policy without proof of insurability. The individual has 31 days to convert and the converted **policy must be guaranteed renewable**.

Conversions can use the insured's attained age when issuing a converted policy unless the conversion is due to group replacement of the existing coverage (in which case the conversion age must be the insured's age at inception of the policy being replaced. **No LTC policy can be canceled, nonrenewed or terminated because of the age or mental/physical deterioration of the insured.**

■ **MINIMUM STANDARDS FOR HOME HEALTH CARE BENEFITS IN LTC POLICIES:**

● Shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate, at the time covered home health or community care services are being received

LTC policies offering home care benefits CAN NOT LIMIT or exclude benefits BY:

- requiring insured would need skilled care in a skilled facility if home care services were not provided;
- requiring insured first or simultaneously receive nursing services in a nursing facility before home care is covered;
- limiting eligible services to only services provided by registered nurses or licensed practical nurses;
- requiring the insured to have an acute condition before home care is covered or
- limiting benefits to services provided by Medicare certified agencies or providers.

Remember, A LTC policy containing a benefit marketed or advertised as a home health care benefit **may not condition receipt of benefits on a prior hospitalization requirement.**

NOTE: (Also recall exception) A LTC policy which conditions eligibility of non-institutional benefits on the prior receipt of institutional care shall not require a prior institutional (hospital) stay of more than 30 days for which benefits are paid.

■ **Lapse or termination for nonpayment of premium.** *No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated at the address provided by the insured for purposes of receiving notice of lapse or termination. *Notice shall be given by first class United States mail, postage prepaid; and notice shall not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing. The *applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured.***

1)Traditional Long Term Care (Ref. REG 2012)

Traditional Long Term Care policies refer to pre-HIPPA contracts that were not tax qualified. However, as qualified long term care policies flooded the market beginning in 1997 the name “traditional” stuck and **this term is commonly used to refer to both qualified and nonqualified LTC plans. In no sense should the term “traditional long term care” ever be associated with a Partnership Program LTC policy.**

- **Non-tax qualified policies** (again those formerly referred to as “traditional long term care” insurance) also *includes the "trigger" of calling the insured condition a "medical necessity"* This means that the patient's own **doctor**, or that doctor in conjunction with someone from the insurance company, *can state that the patient needs care for any medical reason that is covered under the terms of the policy.*

- **Tax qualified policies.** *Federal law allows individuals to deduct a portion of the premium of a tax-qualified long-term care policy from federal income taxes if taxes are itemized above 7.5% adjusted gross income.* Also benefits received from a tax qualified long-term care policy are generally not treated as taxable income.

I● Traditional Long Term Care policies must offer Inflation Protection – Either **increased benefit** levels annually in a manner so that the increases are compounded **annually at a rate not less than 5% or guarantee the insured individual the right to periodically increase benefit levels without providing evidence of insurability** or health status so long as the option for the previous period has not been declined.

■ Incontestability Periods for Long Term Care Policies:

- If in force for *less than 6 months* the company **may rescind or deny** upon a *showing of misrepresentation that is material* to the acceptance for coverage

- If in force for *at least 6 months but less than 2 years*, the company **may rescind or deny** upon a *showing of misrepresentation that is both material to the acceptance for coverage and that pertains to the condition for which benefits are sought.*

- been *in force for 2 years*, it is *not contestable upon the grounds of misrepresentation alone*; may be contested only upon *a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health*

■ Suitability (applies to ALL LTC policies). Every insurer, health care service plan or other entity marketing long-term care insurance shall:

- *Develop and use suitability standards* to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;

- *Train its insurance producers in the use of its suitability standards*; and

- *The insurance producer and issuer shall develop procedures that take the following into consideration:*

- **The ability to pay for the proposed coverage** and other pertinent financial information related to the purchase of the coverage;

- The **applicant's goals or needs** with respect to long-term care and

- The **advantages and disadvantages of insurance to meet these goals or needs**; and

- **The values, benefits and costs of the applicant's existing insurance, if any**, when **compared to** the values, benefits and costs of **the recommended purchase or replacement**.

■ **Requirement to Deliver Shopper's Guide**. A long-term care insurance shopper's guide in the format developed by the National Association of Insurance Commissioners, or a guide developed or approved by the Director shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

- In the case of **insurance producer solicitations**, a producer **must deliver the shopper's guide prior to the presentation** of an application or enrollment form.
- In the **case of direct response solicitations**, the shopper's guide *must be presented in conjunction with any application or enrollment form*

■ **Penalties**

In addition to any other penalties provided by the laws of this State *any insurer or any insurance producer found to have violated any requirement* of this State relating to the regulation of long-term care insurance or the marketing of such insurance shall be **subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to \$10,000, whichever is greater.**

2) Partnership Long Term Care (Ref. REG 2012)

In an effort to enhance cooperation between a state government and private insurance companies a “Partnership Program” is offered to residents of a particular state who purchase a long-term care policy in that state.

■ The key concept that sets a partnership policy apart from a traditional long term care policy is **“asset disregard.”** A consumer who purchases a qualifying partnership long term care policy is *allowed to protect some assets after applying for Medicaid* for additional long term care expenses.

The goal of the design of the Partnership program is to make the policy attractive to consumers who would otherwise likely not purchase a long term care policy.

■ **Inflation Protection must be included** in a partnership policy, as follows:

- Anyone who is **under the age of 61** must have an *annually compounded rate of interest* for inflation protection (Deficit Reduction Act of 2005 requires *either a 3% or a 5% annual rate* in a Partnership Policy).
- Anyone who is **at least 61 years old but less than 76 years of age** must have *annual compounded interest inflation protection* in their Partnership policy.
- Anyone who is **76 years old or older**, as of the purchase date, *may not have inflation protection* in their partnership policy *but an insurance company may offer it* if they wish.

■ **Partnership policies can only be sold in a state by a producer who is specially trained** to sell partnership policies as the state has special training requirements for them. To be certified to sell Partnership policies a producer must:

- Successfully **complete course number 25008, an eight hour, once in a lifetime required continuing education** course (must be licensed first to earn credits) and
- **Complete an ongoing continuing education course of not less than 4 credit hours ever 24 months** (This is part of the 30 total CE hours required for biannual renewal).

C) Accident & Health Insurance Advertising (Ref. 5/149; REG 2002) **(2-3 Questions)**

No matter which type of A&H policy is being marketed to the consuming public, the following rules and ideas apply. This includes company brochures, other written materials and extends to what a producer tells a prospective insurance purchaser.

■ **Misrepresentation (Ref. 5/149)** occurs when a producer makes **Misleading comparisons** between what a prospect owns and what the producer is trying to sell. Such an inducement to switch companies **is called "Twisting"** when a misleading statement is made which results in the business changing hands to the new company that the producer is representing. An **example of misrepresentation** is making any **statements** that the **Federal or State governments** or agencies **approve**, guarantee or otherwise endorse your company or products when that is not the case (governments never endorse the products of one insurance company over the products of another).

The media of communication subject to this Code includes written, verbal and via radio (regardless of the manner of communication and the **fine for misrepresentation is payment of a penalty of no less than \$200 nor more than \$10,000,** recoverable and paid into the county in which the State Attorney completed successful prosecution.

No company or person may advertise or prospect for sales leads in Illinois unless they are authorized (licensed) in this state to transact insurance business.

■ **Defamation (Ref.5/149)** occurs when a **producer, while in the act of soliciting** or trying to procure business on behalf of one company, **intentionally provides untrue information** about the business practices of another company, or their representatives, designed to place the producer (who is making the untrue statements) and his company in a more favorable light. Any **untrue statements which unfairly damage the business reputation of another company or their representatives are strictly prohibited.** The fine for guilty parties is a minimum of \$200 and a maximum of \$10,000.

■ **ADVERTISING OF ACCIDENT AND SICKNESS INSURANCE (REG 2002)**

- Do Not Deceive or Mislead when advertising. Say what you mean and mean what you say.
- Detail **pre-existing condition (PEC)** when replacement is involved because a new policy may not cover a condition that is currently covered by an existing insurance policy. (PEC= any known condition which has been treated/ diagnosed or for which prescriptive medicine has been issued within the **previous 24 months**).

● **Any Advertisements** must (1) easily identify insurer(s) offering coverage (2) state it is an ad whose purpose is to obtain prospects for sale (3) clearly state that the material will be delivered by an agent, if indeed it will be (4) not make reference to the federal Medicare program on the envelope, reply envelope or the address side of the postal reply envelope if there is one (5) include a clear statement by insurer and or agent that neither is in any way affiliated with the federal Medicare program.

● **Mandatory Agent Practices** include (1) the identification of the agent/producer as such (2) identifying any/all insurance companies represented by the agent/producer (3) clearly state to the buyer the printed name, address & phone number of the agent as well as the name of the insurer(s) (4) the buyer's medical history (if required) on the application (fully and completely disclosed) (5) determining which policy (if any) is best suited to the buyer (6) providing a statement to the buyer that the supplement being offered does not comply will Section 363 if, in fact, it does not comply (7) sending any refunds due within 2 weeks of receipt by the agent from the insurer making a refund.

● **Advertising Wording for Accident & Sickness Insurance.** All ads must be clear/complete and avoid any deception; they must truthful and not misleading. (Director decides). Prohibited words include: (1) all (2) full (3) complete (4) comprehensive (5) “this policy will fill the gaps” (6) “this policy helps you pay your bills” –

AVOID ANYTHING TENDING TO EXAGGERATE POLICY BENEFITS PROVIDED!

● **Cannot advertise words "tax free" or "extra cash" or anything implying the buyer will profit if hospitalized.**

● **Cannot stress "weekly" or "monthly" benefits if said benefits are in fact paid daily.**

● **Limited disease policies** may not imply coverage beyond the actual coverage being offered.

● **Direct Mail/ TV ads with toll-free numbers etc., cannot imply lower cost because no salesperson is involved** or because no commissions are paid (since the cost of mailing/ advertising is substantial).

● **Third Party Endorsement/Testimonials must be genuine** and if individual(s) involved are compensated, this must be disclosed

● **An Advertising File must be maintained** at an insurer's home office that is complete with every printed, published or prepared advertisement of its individual (and blanket or group) policies for 4 years or the date of the next regular filing, whichever is longer.

D) Pre-Existing Illness (Ref. REG 2005 (1-2 Questions)

1) Minimum Definition: There are **three ways to define pre-existing condition** (or “preexisting illness”) according to statute:

● **actual diagnoses**, consultation, advice or treatment by a doctor within 24 MONTHS before policy effective date for any sickness, illness, malady or condition;

● **actual diagnoses**, consultation, advice or treatment by a doctor **within 24 MONTHS before policy effective date** for any sickness, illness, malady or condition where it is reasonable to assume a continuation of the condition even though there was no further contact with the doctor within 24 months prior to the effective date of coverage (***this means if you go back 25-48 months ago and a pre-existing condition was present but the party discontinued treatment but should have keep receiving help, then this period is tacked on to the last 24 months;***).

● **Evidence of any condition** (without actual diagnoses by a doctor) **whose symptoms manifested themselves within 12 MONTHS prior to the policy effective date such that a reasonable prudent person would have sought treatment.**

Since the above definitions are minimum and any definition that is more favorable may be used.

The above limitations do not apply to underwriting standards of a company while investigating the background of an applicant.

● **After the coverage for the insured has been in effect for two years, the coverage may not be rescinded except for fraud.** To establish fraud, the insurer must meet the requirements of Illinois law in this regard.

2) Applicability of Definition – the minimum standards for preexisting condition and preexisting illness as defined above **apply to all life and health insurance companies** operating under license in Illinois **and also applies to all “persons”** who are engaging in accident and health insurance business in this State.

E) Minimum Standards for Individual Policies (Ref. REG 2007) (1-2 Questions)

1) Purpose – to establish minimum standards for benefits, prohibit certain policy provisions and require disclosure provisions and replacement procedures in relation to policies of individual accident and health insurance.

2) Definitions - of home health care, hospital, nursing home, nurses, doctors total disability, partial disability, residual disability and sickness are provided. **No individual health contract may include an accidental means test and must instead use “result” language. Sickness must be defined more restrictively than: “sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.”** A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

3) Prohibited Provisions – ***Accident policies can not contain a probationary or waiting period.*** For ***other health contracts probationary or waiting period cannot exceed 6 months*** for losses resulting from hernia, varicose veins adenoids, appendix and tonsils. This six month exception is not permissible in contract where specified diseases are treated on an emergency basis. A&H contracts cannot exclude coverage for hospitals operated by a Federal, State or Local government.

Many types of exclusions are allowed including pre-existing conditions, mental disorders, alcoholism pregnancy (but not complication arising from pregnancy) self-inflicted injuries, cosmetic surgery, dental and eye care, territorial limitations for coverage, infertility, sex change surgery, treatments that are not medically necessary, smoking cessation classes and weight reduction procedures (except for the morbidly obese) to name a few.

4) Minimum Benefit Standards – there are reams of pages detailing the minimum coverage allowed under Illinois Law for various individual A&H contracts. Two or more categories of coverage can be offered in a single contract. **Here are many “General Rules” listed under benefit standards :**

- Policies that are noncancellable, guaranteed renewable or both cannot end coverage for a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.
- In a family policy covering both husband and wife, the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable."
- If a policy contains a status-type military service exclusion of a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rate basis.
- Policies providing normal pregnancy benefits shall provide that in the event the insurer cancels or refuses to renew the policy there shall be an extension of benefits for pregnancy commencing while the policy is in force and at the same level for which benefits would have been payable had the policy remained in force.
- A policy may contain a provision relating to recurrent disabilities provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.
- ***"Major Medical Expense Coverage"*** is an accident and health insurance policy which provides hospital, medical and surgical expense coverage, to an ***aggregate (total) maximum of not less than \$10,000.00.***
- All policies issued, whether or not such policy contains the refund provision, shall be administered to provide a refund of any unearned premiums upon death of any insured member from date of death if the Company receives a written request for unearned premium from the policy owner or the person entitled thereto.
- **DISABILITY INCOME- Must provided At least 6 months of coverage and** benefits may be reduced by the amounts paid by social security.
- **10 DAY FEE LOOK: EXCEPT HEALTH POLICIES SOLD BY DIRECT RESPONSE (i.e., DIRECT, MAIL, TV, ETC.--- 30 DAYS)**
- **When applying, all applicants** for Acc. & Health insurance (except for direct response policies) must be given an “Outline Of Coverage.”
- **When a policy is issued on a basis other than for which applied** (an exclusion or pre-existing condition is included) the applicant must be **given a "Revised Outline Of Coverage"**.

5) Requirements of Disclosure and Replacement

■ Disclosure

- (a) Each individual policy of accident and health insurance shall include a renewal, continuation, or nonrenewal provision.
- (b) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder.

- (c) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.
- (d) If a policy contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."
- (e) All accident only policies shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is an accident only policy and it does not pay benefits for loss from sickness."
- (f) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage. All specified disease policies shall contain a prominent statement on the first page of the policy in contrasting color and in bold face type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is a limited policy. Read it carefully."

■ **Replacement** - All applications for accident & sickness insurance must ask whether or not replacement of one policy for another is taking place. If replacement is taking place, then the insurance company has a **legal duty to provide a notice to the applicant of the following information:**

- **Pre-existing conditions may not be covered under the new policy** for some time, although they may currently be fully covered under an existing policy; and
- **A suggestion must be included for the insured to seek the advice of the present insurer** or agent regarding the proposed insurance. This is designed to make sure the insured understands fully the implications of the replacement.
- **It must be stressed that**
 - ➔ if you still want to replace an individual health contract then make certain to tell the truth, the whole truth and nothing but the truth in the application for the replacement policy and
 - ➔ **Failure to include all material medical information can result in the future denial of claims and a refund of premium** as though your policy had never been issued.

Replacement requirements do not apply to the solicitation of the following types of policies:

- +*accident only and*
- +*single premium nonrenewable policies.*

F) GROUP INSURANCE (2-3 QUESTIONS)

Applies to all group health or disability insurance contracts and group HMO contracts:

1) Discontinuance and Replacement Ref. 5/3671; 97/20-; REG 2013) (0-1 Question)

- **Discontinuance Due to Non-Payment of Premium** – an insurance carrier is liable for valid claims for covered losses which occur before the end of the grace period but the carrier is entitled to the premium due for any coverage provided during the grace period.
- **Requirements for Notice of Discontinuance** – When notice of *discontinuance is provided by the carrier to the contract holder* (employer), the *employer must notify all enrolled individuals covered within 10 working* days from when the employer is notified.
- Any Group Health Insurance (GHI) *discontinued or replaced shall provide a reasonable extension of benefits in the event of total disability* on the date the policy is discontinued for any reason. In hospital/medical expense coverages and HMO's this mean the earlier of 12 months or the date the maximum benefit is reached or the end of disability. For limited benefit plans (hospital/medical or surgical only plans) reasonable means the earlier of 90 days, the date maximum benefit is reached or the end of total disability.
- Benefit extensions *payable do not have to be provided when the individual's coverage was ending within the rights of the contract anyway.*
- **Liability of a Succeeding Carrier** - When a discontinued plan is replaced by another group policy, the **prior insurer shall be liable only to the extent of its accrued liabilities and extension of benefits.** All eligible persons shall be covered by the succeeding policy. All persons not eligible for immediate coverage under the succeeding policy shall become eligible and treated no less favorably than had the change not occurred. Also where similar deductibles and copays are involved the new carrier shall give credit for the satisfaction of these payments in that calendar year.
- **Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than 2 employees, members, or employees of members, written under a master policy**

2) Illinois Health Insurance Portability and Accountability Act (Ref. ILCS 97/1 thru 50) (1-2 QUESTIONS)

The HIPPA law basically helps small employers and those covered under group plans to maintain coverage when moving from one carrier or plan to another by limiting preexisting condition exclusions and thereby INCREASING PORTABILITY OF COVERAGE.

- **"Small employer"** means, in connection with a group health plan with respect to a calendar year and a plan year, **an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.** This Act applies to all health insurance policies and all health service contracts issued, renewed, or delivered for issuance or renewal in this State by a health insurance issuer. **The Act does not apply to individual health insurance policies.**

- **"Enrollment date"** means, with respect to an individual covered under a group health plan or group health insurance coverage, the date of enrollment of the individual in the plan or coverage, or if earlier, the first day of the waiting period for enrollment.

- **"Late enrollee"** means with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the plan other than during: (1) the first period in which the individual is eligible to enroll under the plan; or (2) special enrollment period.

- **"PORTABILITY"** is increased through this law, meaning the employer can switch small group insurers (as can the employee when changing jobs) because of the limitation of the preexisting condition exclusion period and crediting for periods of previous coverage.

- ***preexisting condition exclusion can be imposed on a condition only if medical advice, diagnosis, care, or treatment was recommended or received during the 6 months prior to your enrollment date in the plan***

- ***If you have a preexisting condition that can be excluded*** from your plan coverage, then there is a **limit to the preexisting condition exclusion** period that can be applied. HIPAA limits the preexisting condition exclusion period for most people to ***12 months (18 months if you enroll late)***.

- **Preexisting condition exclusion for pregnancy** - A group health plan, and health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

- **"Creditable Break" exception** - The ***break in coverage between one period of health coverage and another can be no longer than 63 days*** (just over 2 months). If you are between jobs and do not have health coverage for 63 days or more, ***then you may lose the ability to use the coverage you had before the break to offset a preexisting condition exclusion period in a new health plan.***

- **Genetic information** shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.

- Persons who may not be excluded from coverage include newborns and children adopted who are under the age of 18.

- **Prohibiting discrimination against individual participants.**

Subject to established HIPPA pre-existing condition laws, group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

- Health status.
- Medical condition (including both physical and mental illnesses).
- Claims experience.
- Receipt of health care.
- Medical history.
- Genetic information.
- Evidence of insurability (including conditions arising out of acts of domestic violence).
- Disability

■ ***For purposes of HIPPA the following benefits are not subject to this portability law***

- Coverage only for accident, or disability income insurance, or any combination thereof.
- Coverage issued as a supplement to liability insurance.
- Liability insurance, including general liability insurance and automobile liability insurance
- Workers' compensation or similar insurance.
- Automobile medical payment insurance.
- Credit-only insurance.
- Coverage for on-site medical clinics.
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

■ **Guaranteed Small Group Continuation**

*If a health insurance issuer offers health insurance coverage in the small or large group market in connection with a group health plan, **the issuer must renew or continue in force** such coverage **at the option of the plan sponsor**, according to HIPPA, but the following exceptions apply*

- Nonpayment of premiums
- Fraud
- Violation of participation or contribution rules
- The issuer is ceasing to offer coverage in the market
- There is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the issuer
- Association membership ceases uniformly without regard to any health status-related factor relating to any covered individual

IF A CARRIER ELECTS NOT TO RENEW THE ENTIRE STATE, THAT CARRIER IS BARRED FROM WRITING IN THE NEW SMALL EMPLOYER MARKET IN ILLINOIS FOR A PERIOD OF 5 YEARS FROM THE DATE OF THE ORIGINAL NOTICE TO THE DIRECTOR.

■ **Guaranteed renewability of INDIVIDUAL health insurance coverage.**

- 1) A health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual
- 2) **Exceptions:** health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more of the following:

- Nonpayment of premiums
- Fraud
- The issuer is ceasing to offer coverage in the market
- Association membership ceases

(3) **Requirements for uniform termination** of coverage: In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if

- The issuer provides notice to each covered individual of such discontinuation at least 90 days prior to the date of the discontinuation.
- Issuer offers to each individual the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market and
- The issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

4) If the health insurer is going **to discontinue offering ALL health insurance coverage** in the individual market in **Illinois then 180 days notice prior to discontinuance must be given** to all individual insureds.

G) Unfair Practices (Ref. 364) (0-1 Question)

● **Discrimination Prohibited.** No company, in any policy of accident or health insurance issued in this State, shall make or permit any distinction or discrimination against individuals *solely because of handicaps or disabilities* in the amount of payment of premiums or rates charged for policies of insurance, The only exception is if the discrimination is based on sound actuarial principles.

Specifically mentioned in this code is the *prohibition against discriminating on rates or coverage against a person because they are fully or partially blind.*

H) Life and Health Guarantee Association (Ref. 5/531.01 - 5/531.19) (0-1 Question)

This is set up to make certain that claims will be paid in the event financial insolvency (bankruptcy) strikes an insurance company. This law applies to the failure in the performance of contractual obligations, under life or health insurance policies, annuity contracts and health or medical care service contracts. All admitted/licensed companies in Illinois agree to help pay off the claims to policy holders who have purchased a contract with an insurer who becomes insolvent.

This association applies to most Life and Health contracts but DOES NOT apply to:

- **Burial Life policies, Fraternal Benefit Society or Mutual Benefit Society;**
- **HMO's – Health Maintenance Organizations (which has its own separate Guaranty Association);**
- **Limited Health Services Organizations such as Dental Service Plans, Vision Service Plans or Drug Service Plans; or**
- **Variable Life contracts, specifically that portion NOT guaranteed by an insurance company.**

■ **The restricted coverage amounts available under the Association, regardless of the number of policies owned by a single person, are:**

- **\$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;**
- **\$300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values.**
- **\$100,000 in the present value of annuity benefits (includes net cash surrender and withdrawal values).**

This Association is created as a non-profit legal entity and ALL member insurers are and must remain members of the Association as a condition of their authority to transact insurance in Illinois

The Director must notify the Association 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. The Director must also serve notice to an impaired insurer. Further the Director can terminate the license of any member company who does not pay Association assessments in a timely fashion as prescribed by law.

KEY>> No agent or company may use the existence of the Association for the purpose of a solicitation or sale of insurance by use of any media whatsoever (can't tell or advertise to a prospect that they need not worry if the insurer goes broke that the Association will make good on their policy).

The Association shall prepare a summary document describing the general purposes and current limitations of Association. This document shall be delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract. The document should also be available upon request by a policyholder. The distribution, delivery, or contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. Failure to receive this document does not give the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in law

This summary document shall contain a clear and conspicuous disclaimer on its face. 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 or contract holder that the Life and Health Insurance Guaranty Association may not cover the policy*** or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the State.

I) Health Maintenance Organization Guaranty Association
(Ref. 125/6-1 thru 6-19 (0-1 Question))

This Act under Illinois law specifically protects those people covered under individual and group HMO's who have financial problems and who therefore may not be able to fulfill their contractual obligations (since the Life and Health Guaranty Association specifically excludes HMO's from protection under that statute - See "G" above) this separate Association becomes necessary.

This Association is created as a non-profit legal entity and ALL member insurers are and must remain members of the Association as a condition of their authority to transact business in Illinois.

- **\$300,000 is the aggregate limit per natural person.**

The Association must guarantee, assume or reinsure or cause to be guaranteed, assumed, or reinsured the certificates of covered persons of the impaired organization; assure payment of the contractual obligations of the organization to covered persons; provide such monies, pledges, notes, guaranties, or other means as are reasonably necessary to discharge such duties; or with respect to certificates of coverage granted under the HMO..

No agent or company may use the existence of the Association for the purpose of a solicitation or sale of insurance by use of any media whatsoever (can't tell or advertise to a prospect that they need not worry if the insurer goes broke that the Association will make good on their policy).

III) ILLINOIS STATUTES PERTINENT TO MANAGED CARE
(3 QUESTIONS)

A) HEALTH MAINTENANCE ORGANIZATIONS (HMO) Ref. 125/1-2; 125/4-1 thru 125/4-16; 25/5-3; 5421.100 thru 141 (1-2 QUESTIONS)

Definitions:

- **"Basic Health Care Services"** means emergency care, and inpatient hospital and physician care, outpatient medical services, mental health services and care for alcoholic and drug abuse, including any reasonable deductibles and co-payments, as determined by the Director.
- **"Enrollee"** is an individual who has enrolled in a health care plan.
- **"Health Maintenance Organization"** means any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers.
- **"Per Capita prepaid"** a basis of prepayment by which a fixed amount of money is prepaid per individual or any other enrollment unit to the HMO or for the health services which are provided during a definite time period regardless of frequency or extent of the services rendered, except for copayments and deductibles, by the HMO.
- **"Subscriber"** means a person who has entered into a contractual relationship with the HMO for the provision of or arrangement of at least basic health care services to the beneficiaries of such contract.

■ **HMO DELIVERY OF SERVICES - REQUIRED PROVISIONS AND MARKETING**

1) Securing Services- the HMO shall at the time of enrollment and annually thereafter provide to enrollees a description of services and information as to how to obtain those services. Group contracts or evidence of coverage shall be delivered to an enrollee within 30 days from the later of the effective date of coverage OR the date on which the HMO is provided completed notification of enrollment. A group HMO must provide service for at least 12 months.

2) Medical assistance exclusion is prohibited - HMO's can't refuse to pay benefits because the enrollee or dependents are eligible or are receiving Public Aid (welfare).

3) Medical assistance exclusions are void - HMO's can't limit or exclude payments because an enrollee or dependent is eligible for or is receiving medical assistance benefits under the Illinois Public Aid Code.

4) Sexual Assault or abuse victims - HMO's must pay, without co-payments or deductibles, for the examination (including treatment of injuries and trauma sustained) and testing of victims of sexual assault or abuse (testing to determine if sexual contact did or did not occur and to test for venereal diseases). For purposes of recovering state funds, the HMO must disclose the names and identities of enrollees entitled to public aid. The state can require the HMO to reimburse the state if the health services provided by the state belong to an HMO enrollee.

5) Organ Transplants - HMO's can't refuse to pay for transplant just because they are experimental unless supported by the determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services. Upon written request to the above agency to see if a procedure is clinically acceptable, if the agency fails to respond to the request within 90 days, the HMO may take it to mean the procedure is experimental.

6) Complaint handling procedure - HMO's must establish a complaint/grievance system for disgruntled enrollees. When the department of Insurance is involved they notify the HMO and the HMO has 21 days to respond in writing.

7) Mammograms - HMO's must provide coverage for low-dose mammography of all women 35 years or older for the presence of occult breast cancer, as follows:

- ➔ a baseline mammogram for woman 35 to 39 years of age
- ➔ a mammogram every 1 to 2 years for women 40 to 49 years old, even if no symptoms are present
- ➔ annual mammograms for women 50 or older

8) Breast Implant removal - HMO's must pay for removal of breast implants when deemed medically necessary treatment, unless the implants were originally implanted solely for cosmetic reasons unrelated to a reconstruction resulting from sickness or injury.

9) Prescription drugs: cancer treatment - as long as the FDA has approved a drug for use, the HMO must pay even if the approved drug has not been previously used for a particular type of cancer as long as the drug is recommended for treatment in recognized reference compendia. HMO's do not have to pay for investigational/experimental drugs or any drug the FDA says is contraindicated for treatment of a specific type of cancer.

10) Solicitation of Enrollees - no advertisements which is untrue or misleading is knowingly permitted. If such an advertisement has been cited and is revised, it cannot be used without first filing a copy with the Director within 30 days prior to publication. Any order issued by the Director is effective for 12 months from issuance and may be renewed.

11) Newborn infants- newborns are covered completely from the moment of birth. If premium payments relating to the birth are required, then the HMO must be notified within 31 days of the birth and allow premium to be paid within 30 days of birth notification.

12) Adopted children - HMO's can't exclude adopted children from coverage, including interim court orders leading to adoption, regardless of whether or not a final order granting adoption is ultimately issued.

13) Dependent Coverage termination - HMO's may terminate dependent coverage upon attainment of a specified adult age, except if the adult dependent is incapable of self-sustaining employment due to mental retardation or physical handicap and is chiefly dependent upon the enrollee for support and maintenance. Enrollees are 31 days to provide proof of such dependency when requested by the HMO and such proof cannot be requested any more frequently than annually. Without proof being tendered within 31 days, the HMO may terminate dependent coverage.

14) Medical Necessity - in the event of dispute, the HMO must have a method for the timely disposition of the dispute by paying for the second opinion of a reviewing physician (who is not part of the HMO). If the second opinion determines the covered service to be medically necessary, then the HMO must provide the service. The HMO can't use previous reviews against physicians if these doctors subsequently seek to become a provider in the HMO. ***Benefits must be paid upon referral to an out-of-network physician.***

15) Limited insurance representative - can enroll recipients of Public Aid into HMO's without being required to pass a written insurance exam.

16) Changes in rate methodology - HMO's must file a notice with the Director for any change in rate calculating methods or benefits provided and explain the change or modification.

17) Prior approval of policy forms - is required before an HMO can market a policy. The Director shall approve or disapprove of any form within 60 days of submission with the possibility of an additional 30 day extension. If a once approved form is withdrawn by the Director, the withdrawal order takes effect within 30 days from the date of the mailing BUT would be stayed if the HMO requests a hearing within those 30 days.

18) Evidence of Coverage - every subscriber shall receive a written evidence of coverage stating:

→ all health services each enrollee owns → all limitations of services and benefits
 → eligibility requirements of enrollment → conditions under which coverage may be canceled or terminated → information on where and how services may be obtained → the method for resolving complaints → any amendment of evidence of coverage can be provided to a subscriber in a separate document

19) Emergency transportation - by ambulance must be covered by the HMO and paid promptly upon the reasonable demand of the ambulance provider and the ambulance provider cannot collect again directly from the enrollee.

20) Fibrocystic condition - HMO's must cover an enrollee who has been diagnosed with a fibrocystic condition, **EXCEPT** if the condition is diagnosed with a breast biopsy demonstrating an increased disposition to the development of cancer.

■ INSURANCE CODE PROVISIONS

- HMO's (and LHSO's) are "domestic" companies when organized under the law of Illinois or when organized under the laws of a different state but 30% or more of all enrollees of the HMO are Illinois residents.
- For the good of protecting the public the *Director can approve mergers, acquisitions and consolidations of HMO's.*

Financial statements must reflect projected combined operations for a period of 2 years and a 3 year business plan must be provided. The Director does not have to take into account what effect a merger will have on competitors.

B) LIMITED HEALTH SERVICE ORGANIZATIONS (LHSO) (Ref. 130/1002; 130/3001 thru 130/3005; 130/3008 thru 4003 (1-2 QUESTIONS)

- **"In-plan covered services"** means covered limited health services obtained from providers who are employed by, under contract with, referred by, or otherwise affiliated with the LHSO and emergency services.
- **"Limited health care plan"** means any arrangement whereby an organization undertakes to provide or arrange for and, pay for or reimburse the cost of any limited health services from providers selected by the LHSO on a per capita prepaid basis.
- **"Limited health service"** means *services for ambulance care, dental care, vision care, pharmaceutical and podiatric care. Limited health services do not include hospital, medical, surgical or emergency services except when those services are essential to the delivery of the limited health service.*
- **"LHSO"** means any organization formed under the laws of this or another state to provide or arrange for one or more limited health care plans under a system which causes any part of the risk of limited health care delivery to be borne by the organization or its providers.
- **"Per Capita prepaid"** a basis of prepayment by which a fixed amount of money is prepaid per individual or any other enrollment unit to the LHSO or for the health services which are provided during a definite time period regardless of frequency or extent of the services rendered, except for fixed copayments of by the LHSO.
- **"Provider"** means any physician, dentist, health facility, or other person or institution which is duly licensed or otherwise authorized to deliver or furnish limited health services and also includes any other entity that arranges for the delivery or furnishing of limited health service.
- **"Subscriber"** is the person whose employment or other status, other than family dependency, is the basis for the entitlement to limited health services.
- **"Uncovered expense"** means the cost of limited health services that are the obligation of a LHSO for which an enrollee may be liable in the event of the insolvency of the LHSO.

■ LHSO DELIVERY OF SERVICES - REQUIRED PROVISIONS AND MARKETING

1) **Securing Services-** the LHSO shall provide limited health services for a period of 12 months from the date of issuance; and shall provide for renewal unless there is a 31 day notice of termination prior to the annual renewal of the contract. Group contracts or evidence of coverage shall be delivered to an enrollee within 30 days from the later of the effective date of coverage OR the date on which the LHSO is provided notification of enrollment.

2) **Complaint handling procedure -** LHSO's must establish a complaint system for disgruntled enrollees. This does not prevent an enrollee from filing a complaint with the department of insurance or limit the Director from investigating such complaints. When the department of Insurance is involved they notify the LHSO and the LHSO has 21 days to respond in writing.

3) **Solicitation of Enrollees -** no advertisements which is untrue or misleading is knowingly permitted. If such an advertisement has been cited and is revised, it cannot be used without first filing a copy with the Director within 30 days prior to publication. Any order issued by the Director is effective for 12 months from issuance and may be renewed.

4) **Producers -** all coverage for LHSO must be procured by either a limited insurance representative or the holder of an accident and health insurance producer license.

5) **Evidence of Coverage -** every subscriber shall receive a written evidence of coverage which clearly states:

- the limited health services each enrollee owns
- all limitations of services and benefits
- eligibility requirements of enrollment
- conditions under which coverage may be canceled or terminated
- information on where and how services may be obtained
- the method for resolving complaints
- any amendment of evidence of coverage can be provided to a subscriber in a separate document

6) **Delays -** no action can be brought for an unreasonable delay in the settling of a claim if the delay is caused by the failure of an enrollee to execute a lien as requested by the health care plan.

PEARSON VUE TEST TAKING
SUGGESTIONS follow on the next page.
Be sure to check them out!

PEARSON VUE TEST TAKING SUGGESTIONS >>>> KEYS TO SUCCESS!

Remember the simple rules that follow and apply them to any multiple choice test.

- 1) **RELAX!** Once you arrive at the test center take time to get familiar with the equipment.
- 2) **LET YOUR MIND ADJUST** to taking a test. Since you likely do not take tests every day during the course of your employment, you must use a basic strategy that has been time tested for its success.

LET THE TEST (AND TIMING) BEGIN WITH A THREE “ROUND” APPROACH:

ROUND 1) ANSWER ALL THE EASY ONES FIRST. IF YOU ARE NOT POSITIVE YOU ARE RIGHT, SKIP IT AND COME BACK TO IT IN ROUND

ROUND 2). READ EACH QUESTION THAT YOU SKIPPED THE FIRST TIME AND ANSWER ONLY IF YOU ARE CERTAIN TO FAIRLY SURE THAT YOU KNOW THE CORRECT ANSWER AND SKIP ANY THAT SEEM DIFFICULT.

ROUND 3) ALL THE QUESTIONS THAT YOU SKIPPED TWICE REMAIN. THE GOAL IS TO DO THE BEST YOU CAN. BY NARROWING EACH REMAINING QUESTION TO ONE OR TWO ANSWERS AND THEN AND GO WITH YOUR BEST INTUITION. GUESS IF YOU MUST AND USE THE SAME LETTER CHOICE WHEN PURELY GUESSING (ALWAYS USE “B” FOR INSTANCE).

BY USING THE ABOVE THREE “ROUND PROCESS, YOU WILL ACCOMPLISH THE FOLLOWING OBJECTIVES:

- 1) YOU WILL GET ALL THE EASY ONES RIGHT AND BUILD ALL IMPORTANT CONFIDENCE IN THE EARLY MINUTES OF THE TEST; AND
- 2) YOU ARE REVIEWING THE ENTIRE TEST AS YOU GO THROUGH ROUND ONE. THIS OFTEN HELPS YOU ANSWER QUESTIONS LATER WHICH WERE SKIPPED THE FIRST TIME.
- 3) EVERY ANSWER YOU KNEW IS “IN THE BANK” AND IF YOU RUN SHORT OF TIME LATER IT WILL BE ON THE TOUGH ONES YOU SKIPPED TWICE.

USING THE METHOD DESCRIBED ABOVE WILL ENABLE YOU TO AVOID THE FOLLOWING CLASSIC THREE TEST TRAPS

- 1) SPENDING TOO MUCH TIME EARLY IN A TEST ON A QUESTION YOU CANNOT HOPE TO ANSWER CORRECTLY AT THAT POINT. THE MIND MUST BE “WARMED UP” NOT UNLIKE STRETCHING PRIOR TO VIFOROUS EXERCISE.
- 2) NOT UNDERSTANDING WHAT YOU ARE READING. IF A QUESTION SEEMS HARD, JUST SKIP IT AND READ IT AGAIN LATER. IT WILL SURPRISE YOU HOW EASY SOME WILL SEEM THE SECOND TIME AROUND.
- 3) **IF YOU ARE DONE WITH YOU TEST –STOP AND GET OUT OF THE TEST CENTER!** PEOPLE WHO ARE DONE, STILL HAVE TIME REMAINING AND THEN DECIDE TO REDO QUESTIONS THAT HAVE ALREADY BEEN ANSWERED SHOULD SERVE JAIL TIME. **IT IS SIMPLY THE SINGLE GREATEST TEST TAKING ERROR YOU CAN MAKE.**

FINALLY, LEAVE THE NEGATIVE/BAD ATTITUDE AT HOME. IF YOU GO TO A TEST WITH THE EXPECTATION OF FAILURE YOU PROBABLY WILL FAIL. ON THE OTHER HAND, IF YOU HAVE A POSITIVE OUTLOOK AND KNOW YOU HAVE PREPARED WELL, NO SET OF QUESTIONS CAN STOP YOU FROM SUCCEEDING. GOOD LUCK AND HAVE A GREAT INSURANCE CAREER.

SINCERELY YOURS, DOUG DOHRN SR., PRESIDENT, DOHRN INSURANCE TRAINING, INC