Article 62.

Life and Health Insurance Guaranty Association.

§ 58-62-1: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-2. Title.

This Article shall be known and may be cited as the North Carolina Life and Health Insurance Guaranty Association Act. (1991, c. 681, s. 56.)

§ 58-62-5: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-6. Purpose.

(a) The purpose of this Article is to protect, subject to certain limitations, the persons specified in G.S. 58-62-21(a) against failure in the performance of contractual obligations, under life, health, and annuity policies, plans, or contracts specified in G.S. 58-62-21(b), because of the delinquency of the member insurer that issued the policies, plans, or contracts.

(b) To provide this protection, an association of member insurers is created to pay benefits and to continue coverages as limited herein, and members of the Association are subject to assessment to provide funds to carry out the purpose of this Article. (1991, c. 681, s. 56; 2018-120, s. 1.1(a).)

§ 58-62-10: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-11. Construction.

This Article shall be liberally construed to effect the purpose under G.S. 58-62-6, which shall constitute an aid and guide to interpretation. (1991, c. 681, s. 56.)

§ 58-62-15: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-16. Definitions.

As used in this Article:

(1) "Account" means any of the two accounts created under G.S. 58-62-26.

(2) "Association" means the North Carolina Life and Health Insurance Guaranty Association created under G.S. 58-62-26.

(2a) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the Board has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(2b) "Benefit plan" means a specific employee, union, or association of natural persons benefit plan.

(3) "Board" means the board of directors of the Association established under G.S. 58-62-31.

(3a) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the Association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the Association to member insurers.

(4) "Contractual obligation" means any obligation under a policy, contract, or certificate under a group policy, or contract, or part thereof, for which coverage is provided under G.S. 58-62-21.

(5) "Covered contract" or "covered policy" means any policy, contract, or portion of a policy or contract for which coverage is provided under G.S. 58-62-21.

(6) "Delinquent insurer" means an impaired insurer or an insolvent insurer; and "delinquency" means an insurer impairment or insolvency.

(6a) "Extra-contractual claims" shall include claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs.

(6b) "Health benefit plan" means any hospital or medical expense policy or certificate or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include any of the following:

a. Accident only insurance.
b. Credit insurance.
c. Dental only insurance.
d. Vision only insurance.
e. Medicare Supplement insurance.
f. Benefits for long-term care, home health care, community-based care, or any combination thereof.
g. Disability insurance.
h. Coverage for on-site medical clinics.
i. Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(7) "Health insurance" includes hospital or medical service corporation contracts, health maintenance organization subscriber contracts and certificates, accident and health insurance, accident insurance, and disability insurance.

(8) "Impaired insurer" means a member insurer that, after the effective date of this Article, is not an insolvent insurer, and (i) is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations or (ii) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(9) "Insolvent insurer" means a member insurer that, after the effective date of this Article, is placed under an order of liquidation with a finding of insolvency by a court of competent jurisdiction.

(10) "Insurance regulator" means the official or agency of another state that is responsible for the regulation of a foreign insurer.

(11) "Member insurer" means any insurer, health maintenance organization that is governed by Article 67 of this Chapter, and any full-service corporation that is governed by Article 65 of this Chapter and that is licensed or that holds a license to transact in this State any kind of insurance or health maintenance organization business for which coverage is provided under G.S. 58-62-21; and includes any insurer or health maintenance organization whose license in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include a fraternal order or fraternal benefit society; mandatory State pooling plan; mutual assessment company or any entity that

operates on an assessment basis; insurance exchange; or any entity similar to any of the foregoing.

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

(12a) "Owner" of a policy or contract and "policyholder," "policy owner," and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder, and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(13) "Person" includes an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(14) "Plan" means the plan of operation established under G.S. 58-62-46.

(14a) "Plan sponsor" means any of the following:

a. The employer in the case of a benefit plan established or maintained by a single employer.

b. The employee organization in the case of a benefit plan established or maintained by an employee organization.

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

(15) Repealed by Session Laws 2018-120, s. 1.1(b), effective June 28, 2018.

(16) "Premiums" means amounts or considerations received on covered policies or contracts less returned premiums, considerations, and deposits, and less dividends and experience credits. "Premiums" does not include any amounts or considerations received for any policies, contracts, or portions of policies or contracts for which coverage is not provided under G.S. 58-62-21(b); except that assessable premium shall not be reduced on account of G.S. 58-62-21(c)(3) relating to interest limitations and G.S. 58-62-21(d)(2) relating to limitations with respect to any one individual, any one participant, and any one policy or contract owner. Premiums shall not include premiums in excess of five million dollars ($5,000,000) on an unallocated annuity contract not issued under a governmental retirement benefit plan or its trustee established under Section 401, 403(b), or 457 of the United States Internal Revenue Code of 1954, or with respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(16a) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control, and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

a. The state in which the primary executive and administrative headquarters of the entity is located.
b. The state in which the principal office of the chief executive officer of the entity is located.
c. The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings.
d. The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings.
e. The state from which the management of the overall operations of the entity is directed.
f. In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor. The principal place of business of a plan sponsor of a benefit plan described in G.S. 58-62-16(14a)c. shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(16b) "Receivership court" means the court in the delinquent insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

(17) "Resident" means any person who resides in this State when a member insurer is determined to be a delinquent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. "Resident" also means a U.S. citizen residing outside of the United States who owns a covered policy that was purchased from a member insurer while that person resided in this State. Citizens of the United States that are either (i) residents of foreign countries or (ii) residents of United States possessions, territories, or protectorates that do not have an association similar to the Association created by this Article shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(17a) "Structured settlement annuities" means any contracts or certificates for annuities issued to fund, in whole or in part, a settlement agreement for a matter

involving personal injury or illness, including any settlement agreement permitted under Chapter 97 of the General Statutes.

(17b) "State" means any state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(17c) "Subaccount" means any of the subaccounts created under G.S. 58-62-26.

(17d) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(18) "Unallocated annuity contract" means any annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate. (1991, c. 681, s. 56; 1993, c. 452, s. 60; 1995, c. 177, s. 1; 2009-448, s. 1; 2018-120, s. 1.1(b); 2022-46, s. 20.)

§ 58-62-20: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-21. Coverage and limitations.

(a) This Article provides coverage for the policies and contracts specified in subsection (b) of this section to all of the following:

(1) To persons other than persons specified in subdivisions (2a), (3) and (4) of this subsection who, regardless of where they reside, except for nonresident certificate holders or enrollees under group policies or contracts, are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subdivision (2) of this subsection.

(2) To persons other than persons specified in subdivisions (2a), (3) and (4) of this subsection who are owners of or certificate holders or enrollees under the policies or contracts, and who are residents of this State, or who are not residents of this State, but only under all of the following conditions: (i) the member insurer that issued the policies or contracts is domiciled in this State; (ii) the states in which the persons reside have associations similar to the association created by this Article; and (iii) the persons are not eligible for coverage by an association in any other state due to the fact that the insurer or the health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(2a) To persons who are the owners of unallocated annuity contracts, provided that the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this State, and persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents of this State, unless coverage is excluded pursuant to subsection (a1) or (a2) of this section.

(3) To persons who are payees, or beneficiaries of payees if the payees are deceased, under structured settlement annuities, except as provided in subsections (a1) and (a2) of this section, if the payees are residents of this State, regardless of where the contract owners of the structured settlement annuities reside.

(4) To persons who are payees, or beneficiaries of payees if the payees are deceased, under structured settlement annuities, except as provided in subsections (a1) and (a2) of this section, if the payees are not residents of this State, but only if all of the following conditions are met:

a. The contract owners of the structured settlement annuities are residents of this State or, if not residents of this State, (i) the insurers that issued the structured settlement annuities are domiciled in this State and (ii) the state in which the contract owners reside has an association similar to the Association created by this Article.

b. Neither the payees, or beneficiaries of payees if the payees are deceased, nor the contract owners of the structured settlement annuities are eligible for coverage by an association of the state in which the payees or contract owners reside.

(a1) This Article shall not provide coverage to any of the following:

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

(2) A person covered under subdivision (2a) of subsection (a) of this section, if any coverage is provided by the association of another state to the person.

(3) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(a2) This Article is intended to provide coverage to a person who is a resident of this State and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this Article is provided coverage under the laws of any other state, the person shall not be provided coverage under this Article. In determining the application of the provisions of subsection (a) of this section in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this Article shall be construed in conjunction with other state laws to result in coverage by only one association.

(b) This Article provides coverage to the persons specified in subsection (a) of this section for policies or contracts of direct, nongroup life insurance, health insurance, or annuities, and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this Article. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued in connection with government lotteries, and any immediate or deferred annuity contracts.

(c) Except as provided for in subsection (c1) of this section, this Article does not provide coverage for any of the following:

(1) Any part of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner.

(2) Any policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract.

(3) Any part of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by the use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:
   a. Averaged over the period of four years before the date on which the member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for a lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier; and
   b. On and after the date on which the member insurer becomes an impaired or insolvent insurer under this Article, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available.

(4) Any portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other entity under any of the following:
   a. A multiple employer welfare arrangement as defined in 29 U.S.C. § 1002(40).
   b. A minimum premium group insurance plan.
   c. A stop-loss group insurance plan.
   d. An administrative services only contract.

(5) Any part of a policy or contract to the extent that it provides dividends or experience-rating credits, voting rights, or provides that any fees or allowances be paid to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract.

(6) Any policy or contract issued in this State by a member insurer at a time when it was not licensed to issue the policy or contract in this State.

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

(8) Any part of any unallocated annuity contract that is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery.

(8a) Any part of a policy or contract to the extent that the assessments required by G.S. 58-62-41 with respect to the policy or contract are preempted by federal or state law.

(8b) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including, without limitation:
   a. Claims based on marketing materials.

b. Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements.
c. Misrepresentations of or regarding policy or contract benefits.
d. Extra-contractual claims.
e. A claim for penalties or consequential or incidental damages.

(8c) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer.

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

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

(11) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits under the State's Medicaid program.

(12) Structured settlement annuity benefits to which a payee or beneficiary has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.

(c1) The exclusion for coverage referenced in subdivision (3) of subsection (c) of this section shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

(d) The benefits for which the Association is liable do not, in any event, exceed the lesser of:

(1) The contractual obligations for which the member insurer is liable or would have been liable if it were not a delinquent insurer.

(2) With respect to any one life, regardless of the number of policies or contracts, three hundred thousand dollars ($300,000) for all benefits, including cash values.

(2a) With respect to health insurance benefits for any one life, regardless of the number of policies:

a. Three hundred thousand dollars ($300,000) for coverages not defined as health benefit plans.
b. Five hundred thousand dollars ($500,000) for health benefit plans.

(3) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the Internal Revenue Code covered by an unallocated annuity contract, or the beneficiaries of each individual if deceased, in the aggregate, three hundred thousand dollars ($300,000) in present value annuity benefits, including net cash surrender and net cash withdrawal values; or

(4) With respect to any one contract holder covered by any unallocated annuity contract not included in subdivision (3) of this subsection, five million dollars ($5,000,000) in benefits, regardless of the number of such contracts held by that contract holder; or

(5) With respect to any one payee (or beneficiaries of one payee if the payee is deceased) of a structured settlement annuity, one million dollars ($1,000,000) for all benefits, including cash values.

(6) However, in no event shall the Association be obligated to cover more than (i) an aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one life under subdivisions (2) and (3) and sub-subdivision (2a)a. except with respect to benefits for health benefit plans under sub-subdivision (2a)b. of this subsection, in which case the aggregate liability of the Association shall not exceed five hundred thousand dollars ($500,000) with respect to any one life.

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

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

(e) Repealed by Session Laws 2010-11, s. 2, effective June 23, 2010, and applicable to claims submitted to the North Carolina Life and Health Insurance Guaranty Association on or after August 7, 2009. (1991, c. 681, s. 56; c. 720, s. 93; 1993, c. 452, s. 61; 2009-448, ss. 2, 3, 4; 2010-11, ss. 1, 2; 2013-136, s. 1; 2018-49, s. 2(b); 2018-120, s. 1.1(c); 2022-74, s. 9D.15(z).)

§ 58-62-25: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-26. Creation of the Association.

(a) There is created a nonprofit legal entity to be known as the North Carolina Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance or a health maintenance organization business in this State. The Association shall perform its functions under the Plan established and approved under G.S. 58-62-46 and shall exercise its powers through the Board

established under G.S. 58-62-31. For purposes of administration and assessment, the Association shall maintain two accounts:

(1) The life insurance and annuity account, which includes the following subaccounts:
   a. Life insurance account.
   b. Annuity account, which shall include annuity contracts owned by a governmental retirement plan or its trustee established under Section 401, 403(b), or 457 of the United States Internal Revenue Code 1954, but shall otherwise exclude unallocated annuities.
   c. Unallocated annuity account, which shall exclude contracts owned by a governmental retirement benefit plan or its trustee established under Section 401, 403(b), or 457 of the United States Internal Revenue Code 1954.

(2) The health account.

(b) The Association is under the immediate supervision of the Commissioner and is subject to the applicable provisions of this Article. Meetings or records of the Association may be opened to the public upon majority vote of the Board. (1991, c. 681, s. 56; 2018-120, s. 1.1(d).)

§ 58-62-30: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-31. Board of directors.

(a) The Board shall consist of not less than seven nor more than 11 member insurers serving terms as established in the Plan. The members of the Board shall be selected by member insurers, subject to the Commissioner's approval. Vacancies on the Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members, subject to the Commissioner's approval. In addition, two persons who must be public representatives shall be appointed by the Commissioner to the Board. A public representative may not be an officer, director, or employee of an insurance company or health maintenance organization or any person engaged in insurance or health maintenance organization business. To select the initial Board, and initially organize the Association, the Board's predecessor shall notify all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer is entitled to one vote in person or by proxy. If the Board is not selected within 60 days after notice of the organizational meeting, the Commissioner may appoint the initial members.

(b) In approving selections or in appointing members to the Board, the Commissioner shall ensure that all member insurers are fairly represented between member insurers that write primarily life insurance and annuity contracts and member insurers that write primarily health benefit plans.

(c) Members of the Board may be reimbursed from the assets of the Association for expenses they incur as members of the Board, but they shall not otherwise be compensated by the Association for their services. (1991, c. 681, s. 56; 2018-120, s. 1.1(e).)

§ 58-62-35: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-36. Powers and duties of the Association.

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

(1) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired insurer.

(2) Provide such monies, pledges, loans, notes, guarantees, or other means as are proper to carry out subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (1) of this subsection.

(3) Repealed by Session Laws 2018-120, s. 1.1(d), effective June 28, 2018.

(b), (c) Repealed by Session Laws 2013-136, s. 2, effective July 1, 2013.

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

(1) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer, or assure payment of the contractual obligations of the insolvent insurer, and provide such monies, pledges, loans, notes, guarantees, or other means as are reasonably necessary to discharge the Association's duties.

(2) through (4) Repealed by Session Laws 2018-120, s. 1.1(d), effective June 28, 2018.

(5) Provide benefits and coverages in accordance with the following provisions:

a. With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

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

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

b. Make diligent efforts to provide all known insureds, enrollees, or, in the case of nongroup policies and contracts, annuitants, or group policy or contract owners with respect to group policies and contracts 30 days' notice of the termination of the benefits provided.

c. With respect to nongroup policies and contracts covered by the Association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured, enrollee, or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of sub-subdivision d. of this

subdivision, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class.

d. In providing the substitute coverage required under sub-subdivision c. of this subdivision, the Association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the Commissioner. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract. The Association may reinsure any alternative or reissued policy or contract.

e. Alternative policies or contracts adopted by the Association are subject to the Commissioner's approval. The Association may adopt alternative policies or contracts of various types for future issuance without regard to any particular delinquency. Alternative policies or contracts shall contain at least the minimum statutory provisions required in this State and provide benefits that are not unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates, which it shall adopt. The premium shall reflect the amount of insurance or coverage to be provided and the age and class of risk of each insured or enrollee but shall not reflect any changes in the health of the insured or enrollee after the original policy or contract was last underwritten. Any alternative policy or contract issued by the Association shall provide coverage of a type similar to that of the policy or contract issued by the delinquent insurer, as determined by the Association.

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

g. The Association's obligations with respect to coverage under any policy or contract of the delinquent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the Association.

h. When proceeding under subdivision (5) of this subsection with respect to any policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with G.S. 58-62-21(c)(3).

(d1) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections (a) and (d) of this section, the Association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with all of the following provisions:

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

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

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

(e) through (j) Repealed by Session Laws 2018-120, s. 1.1(d), effective June 28, 2018.

(k) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy, contract, or substitute coverage terminates the Association's obligations under the policy, contract, or coverage under this Article with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value that may be due under this Article.

(*l*) Premiums due for coverage after an entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the Association. If the liquidator of an insolvent insurer requests, the Association shall provide a report to the liquidator regarding such premium collected by the Association. The Association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(m) The protection provided by this Article does not apply where any similar guaranty protection is provided to residents of this State by the laws of the domiciliary state or jurisdiction of a delinquent foreign or alien member insurer.

(n) In carrying out its duties under subsection (d) of this section, the Association may, subject to approval by a court in this State:

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

(2) Impose temporary moratoria or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the delinquent insurer, the Association may defer the payment of cash values, policy loans, or other rights by the Association for the period of the moratorium or moratorium charge imposed by the court, except

for claims covered by the Association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(o) If the Association fails to act within a reasonable period of time as provided in subsection (d) of this section, the Commissioner has the powers and duties of the Association under this Article with respect to delinquent insurers.

(p) The Association may render assistance and advice to the Commissioner, upon the Commissioner's request concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any delinquent insurer.

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

(r) Any person receiving benefits under this Article is considered to have assigned the rights under, and any causes of action against any person for losses arising under, resulting, from or otherwise relating to, the covered policy or contract to the Association to the extent of the benefits received because of this Article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The Association may require an assignment to it of such rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this Article upon the person. The subrogation rights of the Association under this subsection have the same priority against the delinquent insurer's assets as that possessed by the person entitled to receive benefits under this Article. In addition to other provisions of this subsection, the Association has all common-law rights of subrogation and any other equitable or legal remedy that would have been available to the delinquent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts, including in the case of a structured settlement annuity, any rights of the owner, beneficiary, or payee of the annuity, to the extent of benefits received pursuant to this Article, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130. If the provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the Association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts or portion thereof covered by the Association. If the Association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the Association has rights as described in this subsection, the person shall pay to the Association the portion of the recovery attributable to the policies or contracts or portion thereof covered by the Association.

(s) In addition to the rights and powers elsewhere in this Article, the Association may do all of the following:

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

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under G.S. 58-62-41 and to settle claims or potential claims against it.

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

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

(5) Take legal action that may be necessary to avoid or recover payment of improper claims.

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

(7) Organize itself as a corporation or in other legal form permitted by the laws of this State.

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

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

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

(t) The Association may join an organization of one or more other state associations of similar purposes, in order to further the purposes of this Article and administer the powers and duties of the Association.

(u) Reinsurance Contracts.

(1) At any time within 180 days of the date of the order of liquidation, the Association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts, or annuities covered, in whole or in part, by the Association in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the Association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the Association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(2) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the

estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the Association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings (i) copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed and (ii) notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(3) The following shall apply to reinsurance contracts so assumed by the Association:

a. The Association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation in each case which relate to policies, contracts, or annuities covered, in whole or in part, by the Association. The Association may charge policies, contracts, or annuities covered in part by the Association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association and shall provide notice and an accounting of these charges to the liquidator.

b. The Association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, provided that, upon receipt of any such amounts, the Association shall be obliged to pay to the beneficiary under the policy, contracts, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

1. The amount received by the Association.
2. The excess of the amount received by the Association over the amount equal to the benefits paid by the Association on account of the policy, contracts, or annuity less the retention of the insurer applicable to the loss or event.

c. Within 30 days following the Association's election (the "election date"), the Association and each reinsurer under contracts assumed by the Association shall calculate the net balance due to or from the Association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the Association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the Association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the Association

or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the Association pursuant to subdivision (2) of this subsection, the receiver shall remit the same to the Association as promptly as practicable.

d. If the Association or receiver, on the Association's behalf, within 60 days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or in part, by the Association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premium insofar as the reinsurance contracts relate to policies, contracts, or annuities covered, in whole or in part, by the Association, and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the Association, against amounts due the Association.

(4) During the period from the date of the order of liquidation until the election date or, if the election date does not occur, until 180 days after the date of the order of liquidation, neither the Association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the Association has the right to assume under this subsection, whether for periods prior to or after the date of the order of liquidation; and the reinsurer, the receiver, and the Association shall, to the extent practicable, provide each other data and records reasonably requested; provided that once the Association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by this subsection.

(5) If the Association does not elect to assume a reinsurance contract by the election date pursuant to this subsection, the Association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

(6) When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts, or annuities may also be transferred by the Association, in the case of contracts assumed under this subsection, subject to the following:

a. Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts, or annuities in addition to those transferred.

b. The obligations described in this subsection shall no longer apply with respect to matters arising after the effective date of the transfer.

c. Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than 30 days prior to the effective date of the transfer.

(7) The provisions of this subsection shall supersede the provisions of any state law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer

or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions.

(8) Except as otherwise provided in this subsection, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this subsection shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this subsection shall give a policyholder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this subsection shall limit or affect the Association's rights as a creditor of the estate against the assets of the estate. Nothing in this subsection shall apply to reinsurance agreements covering property or casualty risks.

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

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

(x) Venue in a suit against the Association arising under this Article shall be in the Superior Court of Wake County. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this Article. (1991, c. 681, s. 56; c. 720, s. 94; 2013-136, s. 2; 2018-120, s. 1.1(f).)

§ 58-62-40: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-41. Assessments.

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the Board shall assess the member insurers, separately for each account, at such time and for such amounts as the Board finds necessary. Assessments are due not less than 30 days after prior written notice to the member insurers and shall accrue interest at the rate of one percent (1%) per month, or any part thereof, after the due date.

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

(1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular delinquent insurer.

(2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the Association under G.S. 58-62-36 with regard to a delinquent insurer.

(c) The amount of any Class A assessment shall be determined by the Board and may or may not be prorated. If prorated, the Board may provide that it be credited against future Class B assessments. The amount of any Class B assessment, except for assessments relating to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula, which

may be based on the premiums or reserves of the delinquent insurer or any other standard considered by the Board in its sole discretion to be fair and reasonable under the circumstances.

(c1) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the Plan and approved by the Commissioner. The methodology shall provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

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

(e) Assessments for funds to meet the requirements of the Association with respect to a delinquent insurer shall not be authorized or called until necessary to implement the purposes of this Article. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

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

(g) The total of all assessments authorized by the Association upon a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in any one calendar year exceed two percent (2%) of the member insurer's average annual premiums received in this State on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the member insurer became a delinquent insurer. If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this subsection. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in either account an amount sufficient to carry out the Association's responsibilities, the necessary additional funds shall be assessed as soon thereafter as permitted by this Article.

(h) The Board may provide in the Plan a method of allocating funds among claims, whether relating to one or more delinquent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(i) If the maximum assessment for a subaccount of the life and annuity account in any one year does not provide an amount sufficient to carry out the Association's responsibilities, then

under subsection (d) of this section, the Board shall access the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection (g) of this section.

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

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

(*l*) The Association shall issue to each member insurer paying an assessment under this Article, other than a Class A assessment, a certificate of contribution, in a form prescribed by the Commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the Commissioner may approve.

(m) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the Association. The payment shall be available to meet Association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest. Within 60 days following the payment of an assessment under protest by a member insurer, the Association shall notify the member insurer in writing of its determination with respect to the protest unless the Association notifies the member insurer that additional time is required to resolve the issues raised by the protest. Within 30 days after a final decision has been made, the Association shall notify the protesting member insurer in writing of that final decision. Within 60 days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the Commissioner. In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the Association may refer protests to the Commissioner for a final decision, with or without a recommendation from the Association. If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the Association.

(n) The Association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request. (1991, c. 681, s. 56; 1993, c. 452, ss. 61.1, 62; 1995, c. 193, ss. 47, 48; 2013-136, s. 3; 2018-120, s. 1.1(g).)

§ 58-62-45: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-46. Plan of operation.

(a) The Association shall submit to the Commissioner a Plan and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The Plan and any amendments shall become effective upon the Commissioner's written approval or unless the Commissioner has not disapproved it within 30 days.

(b) If the Association fails to submit a suitable Plan within 120 days after the effective date of this Article or if at any time thereafter the Association fails to submit suitable amendments to the Plan, the Commissioner shall, after notice and hearing, adopt rules that are necessary or advisable to carry out the provisions of this Article. The rules shall continue in force until modified by the Commissioner or superseded by a Plan submitted by the Association and approved by the Commissioner.

(c) All member insurers shall comply with the Plan.

(d) The Plan shall, in addition to other requirements specified in this Article, establish all of the following:

(1) Procedures for handling the assets of the Association.

(2) The amount and method of reimbursing members of the Board under G.S. 58-62-31.

(3) Regular places and times for meetings, including telephone conference calls, of the Board.

(4) Procedures for records to be kept of all financial transactions of the Association, its agents, and the Board.

(5) Procedures whereby selections for the Board will be made and submitted to the Commissioner.

(6) Any additional procedures for assessments under G.S. 58-62-41.

(7) Additional provisions necessary or proper for the execution of the powers and duties of the Association.

(8) Procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes a delinquent insurer.

(9) Policies and procedures for the Board to address conflicts of interests.

(e) The Plan may provide that any or all powers and duties of the Association, except those under G.S. 58-62-36(r) and G.S. 58-62-41, may be delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the Association, or its equivalent, in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association. A delegation under this subsection is effective only with the approval of both the Board and the Commissioner, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this Article. (1991, c. 681, s. 56; 2018-120, s. 1.1(h).)

§ 58-62-50: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-51. Duties and powers of the Commissioner.

(a) In addition to other duties and powers specified in this Article, the Commissioner shall do all of the following:

(1) Upon request of the Board, provide the Association with a statement of the premiums in this State and any other appropriate states for each member insurer.

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the impaired insurer to comply promptly with the demand does not excuse the Association from the performance of its powers and duties under this Article.

(3) Repealed by Session Laws 2018-120, s. 1.1(i), effective June 28, 2018.

(b) The Commissioner may suspend or revoke, after notice and hearing, the license to transact business in this State of any member insurer that fails to pay an assessment when due or fails to comply with the Plan. As an alternative the Commissioner may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

(c) Any action of the Board or the Association may be appealed to the Commissioner by any member insurer if the appeal is taken within 60 days of its receipt of notice of the final action being appealed. If a member insurer is appealing an assessment, the amount assessed shall be paid to the Association and available to meet Association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. No later than 20 days before each hearing, the appellant shall file with the Commissioner or the Commissioner's designated hearing officer and shall serve on the appellee a written statement of the appellant's case and any evidence the appellant intends to offer at the hearing. No later than five days before the hearing, the appellee shall file with the Commissioner or the Commissioner's designated hearing officer and shall serve on the appellant a written statement of the appellee's case and any evidence the appellee intends to offer at the hearing. Each hearing shall be recorded and transcribed. The cost of the recording and transcribing shall be borne equally by the appellant and appellee; however, upon any final adjudication the prevailing party shall be reimbursed for that party's share of the costs by the other party. Each party shall, on a date determined by the Commissioner or the Commissioner's designated hearing officer, but not sooner than 15 days after delivery of the completed transcript to the party, submit to the Commissioner or the Commissioner's designated hearing officer and serve on the other party, a proposed order. The Commissioner or the Commissioner's designated hearing officer shall then issue an order. Any final action or order of the Commissioner or the Commissioner's designated hearing officer is subject to judicial review under G.S. 58-2-75.

(d) The liquidator, rehabilitator, or conservator of any impaired or insolvent insurer may notify all interested persons of the effect of this Article. (1991, c. 681, s. 56; 2018-120, s. 1.1(i).)

§ 58-62-55: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-56. Prevention of delinquencies.

(a) To aid in the detection and prevention of member insurer delinquencies, it is the Commissioner's duty to:

(1) Notify insurance regulators of all the other states, territories of the United States, and the District of Columbia within 30 days when revoking or suspending the license of a member insurer, or making any formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from this State, reinsure all or any part of its business, or

increase capital, surplus, or any other account for the security of policy owners, contract owners, certificate holders or creditors.

(2) Report to the Board when the Commissioner has taken any of the actions in subdivision (1) of this subsection or has received a report from another insurance regulator indicating that any such action has been taken in another state. The report to the Board shall contain all significant details of the action taken or the report received from another insurance regulator.

(3) Report to the Board when the Commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that the member insurer may be delinquent.

(4) Furnish the Board with the NAIC Insurance Regulatory Information System financial test ratios and a listing of companies that are not included in the ratios developed by the NAIC; and the Board may use that data in carrying out its duties and responsibilities under this section. The data shall be kept confidential by the Board until it is made public by the Commissioner or another lawful authority.

(b) The Commissioner may seek the advice and recommendations of the Board concerning any matter affecting the Commissioner's duties and responsibilities regarding the financial condition of member insurers and insurers or health maintenance organizations seeking admission to transact business in this State.

(c) The Board may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any insurer or health maintenance organization seeking to do business in this State. The reports and recommendations are not public records.

(d) The Board shall, upon majority vote, notify the Commissioner of any information indicating that any member insurer may be delinquent.

(e) Repealed by Session Laws 2018-120, s. 1.1(j), effective June 28, 2018.

(f) The Board may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of member insurer insolvencies.

(g) Repealed by Session Laws 2018-120, s. 1.1(j), effective June 28, 2018. (1991, c. 681, s. 56; 1995, c. 360, s. 2(k); 2018-120, s. 1.1(j).)

§ 58-62-60: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-61. Miscellaneous provisions.

(a) Nothing in this Article reduces the liability for unpaid assessments of the insureds or enrollees of a delinquent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all negotiations and meetings in which the Association or its representatives are involved and in which the activities of the Association in carrying out its powers and duties under G.S. 58-62-36 are discussed. Records of those negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the delinquent insurer, upon the termination of the delinquency of the member insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection limits the duty of the Association to render a report of its activities under G.S. 58-62-66.

(c) For the purpose of carrying out its obligations under this Article, the Association is a creditor of the delinquent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee under G.S. 58-62-36(r). Assets of the delinquent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the delinquent insurer as required by this Article. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets that the reserves that should have been established for the policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the delinquent insurer.

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

(e) No distribution to stockholders, if any, of a delinquent insurer shall be made until and unless the Association has fully recovered the total amount of its valid claims with interest thereon for funds expended in carrying out its powers and duties under G.S. 58-62-36 with respect to the member insurer.

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

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

(h) Any person who was an affiliate that controlled the member insurer when the distributions were paid is liable up to the amount of distributions it received. Any person who was an affiliate that controlled the member insurer when the distributions were declared is liable up to the amount of distributions it would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

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

(j) If any person liable under subsection (h) of this section is insolvent, all of its affiliates that controlled it when the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate. (1991, c. 681, s. 56; 2018-120, s. 1.1(k).)

§ 58-62-65: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-66. Examination of the Association; annual report.

The Association is subject to examination and regulation by the Commissioner. The Board shall submit to the Commissioner each year, not later than 120 days after the Association's fiscal year, a financial report in a form approved by the Commissioner and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the Association shall provide the member insurer with a copy of the report. (1991, c. 681, s. 56; 2018-120, s. 1.1(*l*).)

§ 58-62-70: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-75. Tax exemptions.

The Association shall be exempt from payment of all fees and all taxes levied by this State or any of its subdivisions, except taxes levied on real property. (1973, c. 1438, s. 1.)

§ 58-62-76. Immunity.

There is no liability by, and no cause of action of any nature arises against, any member insurer or its agents or employees, the Association or its agents or employees, members of the Board, the Commissioner or the Commissioner's representatives, or insurance regulators or their representatives, for any act or omission by them in the performance of their powers and duties under this Article. This immunity extends to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees. (1991, c. 681, s. 56.)

§ 58-62-77. Actions not precluded.

Nothing in this Article precludes any resident from bringing any action against the Association in any court of competent jurisdiction with respect to any contractual obligation arising under covered policies. (1993 (Reg. Sess., 1994), c. 678, s. 26.)

§ 58-62-80: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-81. Stay of proceedings; reopening default judgments.

All proceedings in which the insolvent insurer is a party in any court in this State shall be stayed 180 days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to a judgment under any decision, order, verdict or finding based on default, the Association may apply to have the judgment set aside by the same court that made the judgment and may defend against such suit on the merits. (1991, c. 681, s. 56; 2018-120, s. 1.1(m).)

§ 58-62-85: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-86. Prohibited advertisement of Article in insurance sales; notice to policyholders.

(a) No person, including a member insurer, agent, or affiliate of a member insurer, shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any oral or written advertisement, announcement, or statement that uses the existence of the Association or this Article for the purpose of sale or solicitation of or inducement to purchase any kind of insurance or other coverage

covered by this Article. However, this subsection does not apply to the Association or any other person who does not sell or solicit insurance or coverage by a health maintenance organization.

(b) Within 180 days after the effective date of this Article, the Association shall prepare a summary document that describes the general purposes and current limitations of this Article and that complies with subsection (c) of this section. This summary document shall be submitted to the Commissioner for the Commissioner's approval. Sixty days after receiving approval, no member insurer may deliver a policy or contract to a policy owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder, or enrollee before or at the time of delivery of the policy or contract, unless subsection (d) of this section applies. The summary document shall also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, contents, or interpretation of this summary document does not mean that either the policy or the contract or the policy owner, contract owner, certificate holder, or enrollee would be covered in the event of the impairment or insolvency of a member insurer. The summary document shall be revised by the Association as amendments to this Article require. Failure to receive this summary document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this Article.

(c) The summary document prepared under subsection (b) of this section shall contain a clear and conspicuous disclaimer on its face. The Commissioner shall prescribe the form and content of the disclaimer. The disclaimer shall do all of the following:

(1) State the name and addresses of the Association and Department.

(2) Prominently warn the policy owner, contract owner, certificate holder, or enrollee that the Association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this State.

(2a) State the types of policies or contracts for which guaranty funds will provide coverage.

(3) State that the member insurer and its agents are prohibited by law from using the existence of the Association for the purpose of sale or solicitation of or inducement to purchase any kind of insurance or health maintenance organization coverage.

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

(4a) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this Article.

(5) Provide other information as directed by the Commissioner, including, but not limited to, sources for information about the financial condition of member insurers provided that the information is not proprietary and is subject to disclosure under public records law.

(d) No insurer, health maintenance organization, or agent may deliver a policy or contract described in G.S. 58-62-21(b) and excluded under G.S. 58-62-21(c) from coverage under this Article unless the insurer, health maintenance organization, or agent, before or at the time of delivery, gives the policy or contract owner, certificate holder, or enrollee a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the

Association. The Commissioner shall prescribe the form and content of the notice. (1991, c. 681, s. 56; 2018-120, s. 1.1(n).)

§ 58-62-90: Repealed by Session Laws 1991, c. 681, s. 57.

§ 58-62-92: Repealed by Session Laws 1993 (Reg. Sess., 1994), c. 678, s. 27.

§ 58-62-95. Use of deposits made by impaired or insolvent insurer.

Notwithstanding any other provision of this Chapter pertaining to the use of deposits made by insurance or health maintenance organization companies for the protection of policy or contract owners, certificate holders, or enrollees, the Association shall receive, upon its request, from the Commissioner and may expend, any deposit or deposits made, whether or not made pursuant to statute, by a member insurer determined to be impaired or insolvent under this Article to the extent those deposits are needed by the Association to pay contractual obligations of that impaired or insolvent insurer owed under covered policies as required by this Article, and to the extent those deposits are needed to pay all expenses of the Association relating to the impaired or insolvent insurer: Provided that the Commissioner may retain and use an amount of the deposit up to ten thousand dollars ($10,000) to defray administrative costs to be incurred by the Commissioner in carrying out his powers and duties with respect to the impaired or insolvent insurer, notwithstanding G.S. 58-5-70. The Association shall account to the Commissioner and the impaired or insolvent insurer for all deposits received from the Commissioner under this section. After the deposits of the impaired or insolvent insurer received by the Association under this section have been expended by the Association for the purposes set out in this section, the member insurers shall be assessed as provided by this Article to pay any remaining liabilities of the Association arising under this Article. (1979, c. 418; 1985, c. 666, s. 42; 1989, c. 452, s. 6; 1993 (Reg. Sess., 1994), c. 678, s. 28; 2018-120, s. 1.1(o).)