

Article 65.

Hospital Service Corporations.

Part 1. In General.

§ 58-65-1. Regulation and definitions; application of other laws; profit and foreign corporations prohibited.

(a) Any corporation organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit dental, health care, medical, or vision service plan whereby dental, health care, medical, or vision care or services may be provided in whole or in part by the corporation or by hospitals, physicians, optometrists, or dentists participating in the plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, unless otherwise provided.

(a1) With the approval of the Commissioner, any corporation organized and subject to the provisions of this Article, the certificate of authority of which authorizes the operation of either a dental, health care, medical, or vision service plan, or any combination of those plans, may do both of the following:

- (1) Issue subscribers' contracts or certificates for the provision of, or the payment of fees for, dental, health care, medical, or vision service or care, or any or all of those services or care as applicable.
- (2) Enter into contracts with hospitals, physicians, dentists, optometrists, or any or all of those health care providers, for the provision of, or the payment of fees for, services or care under a dental, health care, medical, or vision service plan, or any combination of those plans.

(b) through (c) Repealed by Session Laws 2001-297.

(d) No foreign or alien hospital service corporation shall be authorized to do business in this State. (1941, c. 338, s. 1; 1943, c. 537, s. 1; 1953, c. 1124, s. 1; 1961, c. 1149; 1965, c. 396, s. 1; c. 1169, s. 1; 1967, c. 690, s. 1; 1973, c. 642; 1977, c. 601, ss. 1, 31/2; 1985, c. 735, s. 2; 1993, c. 347, s. 3; c. 375, s. 4; 464, s. 3.1; 1995, c. 223, s. 2; c. 406, s. 4; 1997-197, ss. 1, 2; 1999-186, s. 1; 1999-199, s. 2; 1999-210, ss. 5, 6; 2001-297, s. 2; 2001-487, ss. 40(h), 105(a), 105(b); 2003-212, s. 17; 2009-451, s. 21.13(a); 2018-120, s. 4.6(c); 2021-169, s. 1.)

§ 58-65-1.1. Definitions applicable to this Article.

The following definitions apply in this Article:

- (1) Dental service plan. – A contract for the provision of, or the payment of fees for, dental care or dental services, including any other professional services authorized or permitted to be provided by a duly licensed dentist.
- (2) Full-service corporation. – Any corporation organized under the provisions of this Article that offers a medical service plan or a health care service plan.
- (3) Health care service plan. – Any contract for the provision of, or the payment of fees for, hospital care, laboratory facilities, X-ray facilities, drugs, health care appliances, anesthesia, nursing care, operating and obstetrical equipment, or health care accommodations, including any other services permitted to be provided by a hospital under the laws of this State and approved by the North Carolina Hospital Association or the American Medical Association.
- (4) Hospital service corporation. – Any nonprofit corporation that operates one or any combination of the following:

- a. Dental service plan.
 - b. Health care service plan.
 - c. Medical service plan.
 - d. Vision service plan.
- (5) Medical service plan. – Any contract for the furnishing of, or the payment of fees for, any of the following:
- a. Medical, obstetrical, surgical, or any other professional services authorized or permitted to be provided by a duly licensed physician or other provider listed in G.S. 58-50-30.
 - b. Professional medical services authorized or permitted to be provided by a health care provider licensed under Chapter 90 of the General Statutes.
- (6) Preferred provider. – A health care provider who has agreed to accept, from a corporation organized for the purposes authorized by this Article, special reimbursement terms in exchange for providing services to beneficiaries of a plan administered pursuant to this Article.
- (7) Single-service corporation. – Any corporation organized under the provisions of this Article that offers any of the following:
- a. Only a dental service plan.
 - b. Only a vision service plan.
 - c. Both a dental service plan and a vision service plan, but no other plans.
- (8) Vision service plan. – Any contract for the provision of, or the payment of fees for, vision care or vision services, including any other professional services permitted to be provided by a duly licensed optometrist or ophthalmologist. (2021-169, s. 1.)

§ 58-65-2. Other laws applicable to all service corporations.

The following provisions of this Chapter are applicable to hospital service corporations that are subject to this Article:

G.S. 58-2-125.	Authority over all insurance companies; no exemptions from license.
G.S. 58-2-150.	Oath required for compliance with law.
G.S. 58-2-155.	Investigation of charges.
G.S. 58-2-160.	Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
G.S. 58-2-162.	Embezzlement by insurance producers or administrators.
G.S. 58-2-185.	Record of business kept by companies and insurance producers; Commissioner may inspect.
G.S. 58-2-190.	Commissioner may require special reports.
G.S. 58-2-195.	Commissioner may require records, reports, etc., for agencies, insurance producers and others.
G.S. 58-2-200.	Books and papers required to be exhibited.
G.S. 58-3-50.	Companies must do business in own name; emblems, insignias, etc.
G.S. 58-3-100(c), (e).	Insurance company licensing provisions.

G.S. 58-3-115.	Twisting with respect to insurance policies; penalties.
G.S. 58-7-46.	Notification to Commissioner for president or chief executive officer changes.
Part 7 of Article 10.	Annual Financial Reporting.
G.S. 58-50-35.	Notice of nonpayment of premium required before forfeiture.
G.S. 58-50-290.	Health benefit plans or insurers contracting for the provision of dental services; no limitation on fees for noncovered services.
G.S. 58-50-300.	Health benefit plans or insurers contracting for the provision of vision services or materials; no limitation on fees for noncovered services or materials.
G.S. 58-51-15(a)(2)b.	Accident and health policy provisions.
G.S. 58-51-17.	Portability for accident and health insurance.
G.S. 58-51-25.	Policy coverage to continue as to children with an intellectual or physical disability or dependent students on medically necessary leave of absence.
G.S. 58-51-95(h), (i), (j).	Approval by Commissioner of forms, classification and rates; hearings; exceptions. (1999-244, s. 1; 2005-215, s. 17; 2005-412, s. 3; 2009-382, s. 6; 2009-384, s. 3; 2010-138, s. 2; 2018-47, s. 7(d); 2021-169, s. 1; 2022-46, s. 14(cccc).)

§ 58-65-5. Contract for joint assumption or underwriting of risks.

Any hospital service corporation organized or regulated by the provisions of this Article and Article 66 of this Chapter is authorized to enter into contracts with any other firm or corporation for joint assumption or underwriting of any part, or all, of any risks undertaken upon terms and conditions that are approved by the Commissioner of Insurance. (1955, c. 894, s. 1; 2021-169, s. 1.)

§ 58-65-10. Premium or dues paid.

(a) Any premium or dues charged by a corporation regulated under the provisions of this Article and Article 66 of this Chapter may be paid by the employer, employee, principal, or agent. The term "employer" as used in this section includes counties, municipal corporations, and all departments or subdivisions of the State, county, municipal corporation, and official boards including city and county boards of alcoholic control, together with all others occupying the status of employer and employee, principal and agent.

(b) Any premium or dues charged by a corporation regulated under the provisions of this Article and Article 66 of this Chapter may be paid jointly and severally. (1955, c. 894, s. 2; 2021-169, s. 1.)

§ 58-65-15. Incorporation.

Any number of persons not less than seven, desiring to form a nonprofit hospital service corporation, shall incorporate under the provisions of the general laws of the State of North Carolina governing corporations, but subject to the following provisions:

- (1) The certificate of incorporation of each such corporation shall have endorsed thereon or attached thereto, the consent of the Commissioner of Insurance, if he

shall find the same to be in accordance with the provisions of this Article and Article 66 of this Chapter.

- (2) A statement of the services to be rendered by the corporation and the rates currently to be charged therefor which said statement shall be accompanied by two copies of each contract for services which the corporation proposes to make with its subscribers, and two copies of the type of contract which said corporation proposes to make with participating hospitals, shall have been furnished the Commissioner of Insurance; provided, however, that if the articles of incorporation of any such corporation within the meaning of this Article and Article 66 of this Chapter shall have been filed with the Secretary of State prior to March 15, 1941, the approval thereof by the Commissioner of Insurance shall be evidenced by a separate instrument in writing filed with the Secretary of State. (1941, c. 338, s. 2.)

§ 58-65-20. Members of governing boards.

(a) For the purpose of this section the words "board of directors" includes the board of directors, trustees, or other governing board.

(b) The board of directors of each hospital service corporation subject to the provisions of this Article shall include persons who are representative of its subscribers and the general public. Less than one half of the directors of any such corporation shall be persons who are licensed to practice medicine in this State or who are paid directors or employees of a corporation organized for hospital purposes. (1979, c. 538, s. 1.)

§ 58-65-25. Hospital, physician, dentist, and optometrist contracts.

(a) Any full-service corporation organized under this Article may enter into contracts for the rendering of hospital service to any of its subscribers by hospitals approved by the American Medical Association or the North Carolina Hospital Association.

(a1) Any hospital service corporation may enter into contracts for the provision of, or the payment in whole or in part for, medical, dental, or vision services rendered to any of its subscribers by duly licensed physicians, dentists, or optometrists in accordance with this Article.

(a2) All obligations arising under contracts issued by a hospital service corporation to its subscribers shall be satisfied by payments made (i) directly to the hospitals or physicians, dentists, or optometrists rendering the service, or (ii) directly to the subscriber or the subscriber's legal representatives upon the receipt by the corporation from the subscriber of a statement marked paid by the hospitals, physicians, dentists, or optometrists rendering the applicable service. Nothing in this section shall be construed to discriminate against hospitals conducted by other schools of medical practice.

(b) All certificates, plans or contracts issued to subscribers or other persons by hospital service corporations operating under this Article shall contain in substance a provision as follows: "After two years from the date of issue of this certificate, contract or plan no misstatements, except fraudulent misstatements made by the applicant in the application for such certificate, contract or plan, shall be used to void said certificate, contract or plan, or to deny a claim for loss incurred or disability (as therein defined) commencing after the expiration of such two-year period." (1941, c. 338, s. 3; 1943, c. 537, s. 2; 1947, c. 820, s. 1; 1955, c. 850, s. 7; 1961, c. 1149; 1979, c. 755, s. 17; 1997-259, s. 16; 2021-169, s. 1.)

§ 58-65-30. Dentists' services.

Any corporation organized under the provisions of this Article and Article 66 of this Chapter may, in addition to its authority to contract under G.S. 58-65-25, enter into contracts to pay duly licensed dentists for treatment of fractures and dislocations of the jaw, and cutting procedures in the oral cavity other than extractions, repairs and care of the teeth and gums. (1957, c. 987.)

§ 58-65-35. Nurses' services.

No agency, institution or physician providing a service for which payment or reimbursement is required to be made under a contract governed by this Article and Article 66 of this Chapter shall be denied such payment or reimbursement on account of the fact that the service was rendered through a registered nurse acting under authority of rules and regulations adopted by the North Carolina Medical Board and the Board of Nursing pursuant to G.S. 90-6 and 90-171.23. (1973, c. 436; 1991, c. 720, s. 37; 1993, c. 347, s. 4; 1995, c. 94, s. 4; 1997-197, s. 1.)

§ 58-65-36. Physician services provided by physician assistants.

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a contract governed by this Article or Article 66 of this Chapter shall be denied the payment or reimbursement on account of the fact that the service was rendered through a physician assistant acting under authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1. (1999-210, s. 4.)

§ 58-65-40. Supervision of Commissioner of Insurance; form of contract with subscribers; schedule of rates.

No hospital service corporation shall enter into any contract with subscribers unless and until it shall have filed with the Commissioner of Insurance a specimen copy of the contract or certificate and of all applications, riders, and endorsements for use in connection with the issuance or renewal thereof to be formally approved by him as conforming to the section of this Article entitled "Subscribers' contracts," and conforms to all rules and regulations promulgated by the Commissioner of Insurance under the provisions of this Article and Article 66 of this Chapter. The Commissioner of Insurance shall, within a reasonable time after the filing of any such form, notify the corporation filing the same either of his approval or of his disapproval of such form.

No corporation subject to the provisions of this Article and Article 66 of this Chapter shall enter into any contract with a subscriber after the enactment hereof unless and until it shall have filed with the Commissioner of Insurance a full schedule of rates to be paid by the subscribers to such contracts and shall have obtained the Commissioner's approval thereof. The Commissioner may refuse approval if he finds that such rates are excessive, inadequate, or unfairly discriminatory; or do not exhibit a reasonable relationship to the benefits provided by such contracts. At all times such rates and form of subscribers' contracts shall be subject to modification and approval of the Commissioner of Insurance under rules and regulations adopted by the Commissioner, in conformity to this Article and Article 66 of this Chapter. (1941, c. 338, s. 4; 1989, c. 485, s. 57.)

§ 58-65-45. Public hearings on revision of existing schedule or establishment of new schedule; publication of notice.

Whenever any hospital service corporation licensed under this Article and Article 66 of this Chapter makes a rate filing or any proposal to revise an existing rate schedule or contract form, the effect of which is to increase or decrease the charge for its contracts, or to set up a new rate

schedule, and such rate schedule is subject to the approval of the Commissioner, such hospital service corporation shall file its proposed rate change or contract form and supporting data with the commissioner, who shall review the filing in accordance with the standards in G.S. 58-65-40. Such rate revision or new rate schedule with respect to individual subscriber contracts shall be guaranteed by the insurer, as to the contract and certificate holders thereby affected, for a period of not less than 12 months; or with respect to individual subscriber contracts as an alternative to giving such guarantee, such rate revision or new rate schedule may be made applicable to all individual contracts at one time if the corporation chooses to apply for such relief with respect to such contracts no more frequently than once in any 12-month period. Such rate revision or new rate schedule shall be applicable to all contracts of the same type; provided that no rate revision or new rate schedule may become effective for any contract holder unless the corporation has given written notice of the rate revision or new rate schedule not less than 30 days prior to the effective date of such revision or new rate schedule. The contract holder thereafter must pay the revised rate or new rate schedule in order to continue the contract in force. The Commissioner may promulgate reasonable rules, after notice and hearing, to require the submission of supporting data and such information as is deemed necessary to determine whether such rate revisions meet these standards. At any time within 60 days after the date of any filing under this section or G.S. 58-65-40, the Commissioner may give written notice to the corporation of a fixed time and place for a hearing on the filing, which time shall be no less than 20 days after notice is given. In the event no notice of hearing is issued within 60 days from the date of any filing, the filing shall be deemed to be approved, subject to modification by the Commissioner as authorized by G.S. 58-65-40. In the event the Commissioner gives notice of a hearing, the corporation making the filing shall, not less than 10 days before the time of the hearing, cause to be published in a daily newspaper or newspapers published in North Carolina, and in accordance with the rules and regulations of the Commissioner of Insurance, a notice, in the form and content approved by the Commissioner, setting forth the nature and effect of such proposal and the time and place of the public hearing to be held. If the Commissioner does not issue an order within 45 days after the day on which the hearing began, the filing shall be deemed to be approved, subject to modification by the Commissioner as authorized by G.S. 58-65-40. (1953, c. 1118; 1985, c. 666, s. 60; 1989, c. 485, s. 58.)

§ 58-65-50. Application for certificate of authority or license.

No corporation subject to the provisions of this Article and Article 66 of this Chapter shall issue contracts for the rendering of dental, health care, medical, or vision service to subscribers, until the Commissioner of Insurance has, by formal certificate or license, authorized it to do so. Application for a certificate of authority or license shall be made on forms to be supplied by the Commissioner of Insurance and containing any information required by the Commissioner. Each application for a certificate of authority or license shall include duplicate copies of the following documents duly certified by at least two of the executive officers of the corporation:

- (1) Certificate of incorporation, including any amendments.
- (2) Bylaws, including any amendments.
- (3) Each contract executed or proposed to be executed by and between the corporation and any participating hospital or physician, dentist, or optometrist under the terms of which dental, health care, medical, or vision service is to be furnished to subscribers to the plan.

- (4) Each form of contract, application, rider, and endorsement, issued or proposed to be issued to subscribers to the plan, or in renewal of any of contracts with subscribers to the plan, together with a table of rates charged or proposed to be charged to subscribers for each form of the contract.
- (5) Financial statement of the corporation which shall include the amounts of each contribution paid or agreed to be paid to the corporation for working capital, the name or names of each contributor, and the terms of each contribution. (1941, c. 338, s. 5; 1943, c. 537, s. 3; 1961, c. 1149; 2021-169, s. 1.)

§ 58-65-55. Issuance and continuation of license.

(a) Every corporation subject to this Article shall pay to the Commissioner a fee of two hundred fifty dollars (\$250.00) for filing an application for a license. Fee payment shall be contemporaneous with the filing. Before issuing or continuing any license or certificate under this Article, the Commissioner may make an examination or investigation as the Commissioner deems expedient. The Commissioner shall issue a license upon the payment of a fee of one thousand five hundred dollars (\$1,500) for a single-service corporation or two thousand five hundred dollars (\$2,500) for a full-service corporation and upon being satisfied on the following points:

- (1) The applicant is established as a bona fide nonprofit hospital service corporation as defined by this Article and Article 66 of this Chapter.
- (2) The rates charged and benefits to be provided are fair and reasonable.
- (3) The amounts provided as working capital of the corporation are repayable only out of earned income in excess of amounts paid and payable for operating expenses and dental, health care, medical, or vision expenses, and the reserve is deemed adequate by the Department.
- (4) The amount of money actually available for working capital is sufficient to carry all acquisition costs and operating expenses for a reasonable period of time from the date of the issuance of the certificate.

(b) The license shall continue in full force and effect, subject to payment of an annual license continuation fee of one thousand five hundred dollars (\$1,500) for a single-service corporation or two thousand five hundred dollars (\$2,500) for a full-service corporation, subject to all other provisions of subsection (a) of this section and subject to any other applicable provisions of the insurance laws of this State. (1941, c. 338, s. 6; 1943, c. 537, s. 4; 1947, c. 820, s. 2; 1961, c. 1149; 1989 (Reg. Sess., 1990), c. 1069, s. 5; 1995, c. 507, s. 11A(c); 1999-435, s. 5; 2003-212, s. 26(j); 2005-424, s. 1.5; 2009-451, s. 21.13(b); 2021-169, s. 1.)

§ 58-65-60. Subscribers' contracts; required and prohibited provisions.

(a) Every contract made by a corporation subject to the provisions of this Article and Article 66 of this Chapter shall be for a period not to exceed 12 months, and no contract shall be made providing for the inception of benefits at a date later than one year from the date of the contract. Any such contract may provide that it shall be automatically renewed for a similar period unless there shall have been one month's prior written notice of termination by either the subscriber or the corporation.

(b) Contracts may be issued that entitle one or more persons to benefits under those contracts. Persons entitled to benefits under those contracts, other than the certificate holder, may only be the certificate holder's spouse, lawful or legally adopted child of the certificate holder or

the certificate holder's spouse, or any other person who resides in the same household with the certificate holder and is dependent upon the certificate holder.

(c) Every contract entered into by any corporation subject to the provisions of this Article and Article 66 of this Chapter with any subscriber of the corporation shall be in writing and a certificate stating the terms and conditions of the contract shall be furnished to the subscriber to be kept by the subscriber. No such certificate form, other than to group subscribers of groups of 10 or more certificate holders or those issued pursuant to a master group contract covering 10 or more certificate holders shall be made, issued or delivered in this State unless it contains the following provisions, provided, however, groups between five and 10 certificate holders complying with and maintaining eligibility status under regulations approved by the Commissioner of Insurance for group enrollment may be cancelled if the group participation falls below the minimum participation of five certificate holders; or if the group takes other group hospital, medical or surgical coverage:

- (1) A statement of the amount payable to the corporation by the subscriber and the times at which and manner in which the required amount is to be paid; this provision may be inserted in the application rather than in the certificate. The application need not be attached to the certificate.
- (2) A statement of the nature of the benefits to be furnished and the period during which they will be furnished.
- (3) A statement of the terms and conditions, if any, upon which the contract may be cancelled or otherwise terminated at the option of either party. The statement shall be in the following language:
 - a. Renewability. – Any contract subject to the provisions of this subdivision is renewable at the option of the subscriber unless sufficient notice in writing of nonrenewal is mailed to the subscriber by the corporation addressed to the last address recorded with the corporation.
 - b. Sufficient notice. – The notice required shall be as follows:
 1. During the first year of any contract, or during the first year following any lapse and reinstatement, or reenrollment, a period of 30 days.
 2. During the second and subsequent years of continuous coverage, a number of full calendar months most nearly equivalent to one fourth the number of months of continuous coverage from the first anniversary of the date of issue or reinstatement or reenrollment, whichever date is more recent, to the date of mailing of the 30-day notice.
 3. No period of required notice shall exceed two years, and no renewal hereunder shall renew any contract for any period beyond the required period of notice except by written agreement of the subscriber and corporation.
 - c. Modifications, terminations, and cancellations. – The contract may be modified, terminated or cancelled by the corporation at any time at its option, upon any of the following:
 1. Nonpayment by the subscriber of fees or dues as required.
 2. Failure or refusal by the subscriber to comply with rate or benefit changes approved by the Commissioner under G.S. 58-65-45.

3. Failure or refusal by the subscriber after 30 days' written notice to subscriber to transfer into a dental, health care, medical, or vision service plan serving the area to which the subscriber has changed residence and is eligible for or to which corporation is required to transfer by interplan agreement of transfer.
 - (4) A statement that the contract includes the endorsement thereon and attached papers, if any, and together with the applications contains the entire contract.
 - (5) A statement that if the subscriber defaults in making any payment under the contract, then the subsequent acceptance of a payment by the corporation at its home office shall reinstate the contract, but with respect to sickness and injury, only to cover such sickness as may be first manifested more than 10 days after the date of acceptance of the payment.
- (d) In every such contract made, issued or delivered in this State:
 - (1) All printed portions shall be plainly printed;
 - (2) The exceptions from the contract shall appear with the same prominence as the benefits to which they apply; and
 - (3) If the contract contains any provision purporting to make any portion of the articles, constitution or bylaws of the corporation a part of the contract, such portion shall be set forth in full.

(e) A service corporation may issue a master group contract with the approval of the Commissioner if the contract and the individual certificates issued to members of the group comply in substance to the other provisions of this Article and Article 66 of this Chapter. The contract may provide for the adjustment of the rate of the premium or benefits conferred as provided in the contract, and in accordance with an adjustment schedule filed with and approved by the Commissioner. If the contract is issued, altered or modified, the subscribers' contracts issued under that contract are altered or modified accordingly, all laws and clauses in subscribers' contracts to the contrary notwithstanding. Nothing in this Article and Article 66 of this Chapter shall be construed to prohibit or prevent the same. Forms of such contract shall at all times be furnished upon request of subscribers thereto.

(e1) Employees shall be added to the master group coverage no later than 90 days after their first day of employment. Employment shall be considered continuous and not be considered broken except for unexcused absences from work for reasons other than illness or injury. The term "employee" is defined as a nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage, but does not include a person who works on a part-time, temporary, or substitute basis.

(e2) Whenever an employer master group contract replaces another group contract, whether this contract was issued by a corporation under Articles 1 through 67 of this Chapter, the liability of the succeeding corporation for insuring persons covered under the previous group contract is (i) each person is eligible for coverage in accordance with the succeeding corporation's plan of benefits with respect to classes eligible and activity at work and nonconfinement rules must be covered by the succeeding corporation's plan of benefits; and (ii) each person not covered under the succeeding corporation's plan of benefits in accordance with (i) above must nevertheless be covered by the succeeding corporation if that person was validly covered, including benefit extension, under the prior plan on the date of discontinuance and if the person is a member of the class of persons eligible for coverage under the succeeding corporation's plan.

(e3) When determining employee eligibility for a large employer, as defined in G.S. 58-68-25(10), an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees.

(f) Any hospitalization contract renewed in the name of the subscriber during the grace period shall be construed to be a continuation of the contract first issued. (1941, c. 338, s. 7; 1947, c. 820, ss. 3, 4; 1955, c. 679, ss. 1-3; 1957, c. 1085, s. 1; 1961, c. 1149; 1989, c. 775, s. 4; 1991, c. 720, ss. 38, 88; 1991 (Reg. Sess., 1992), c. 837, s. 4; 1993, c. 408, s. 4; c. 409, s. 24; 1995, c. 507, s. 23A.1(e); 1997-259, s. 17; 2001-417, s. 12; 2005-223, s. 2(a); 2021-169, s. 1.)

§ 58-65-65. Coverage for active medical treatment in tax-supported institutions.

(a) No dental, health care, medical, or vision service plan, contract, or certificate governed by this Article and Article 66 of this Chapter shall be delivered, issued, executed, or renewed in this State, or approved for issuance or renewal in this State, unless it provides for the payment of benefits for charges made for medical care rendered by duly licensed State tax-supported institutions on a basis no less favorable than the basis that would apply had the medical care been rendered by any other public or private institution or provider. The term "State tax-supported institutions" includes community mental health centers and other health clinics that are certified as Medicaid providers.

(b) No plan, contract, or certificate shall exclude payment for charges of a duly licensed State tax-supported institution because of its being a specialty facility for one particular type of illness nor because it does not have an operating room and related equipment for the performance of surgery, but it is not required that benefits be payable for domiciliary or custodial care, rehabilitation, training, schooling, or occupational therapy.

(c) This section does not apply to any plan, contract, or certificate that is individually underwritten or provided for a specific individual and the members of the individual's family as a nongroup policy. (1975, c. 345, s. 2; 2018-47, s. 7(e); 2021-169, s. 1.)

§ 58-65-70. Contracts to cover any person possessing the sickle cell trait or hemoglobin C trait.

No hospital service corporation governed by this Article and Article 66 of this Chapter shall do either of the following:

- (1) Refuse to issue or deliver any individual or group hospital, dental, medical, vision, or health service contract in this State that provides benefits or coverage for any health care treatment or service authorized or permitted to be provided by a hospital, health care facility, or health care personnel, on account of the fact that the person who is to be insured possesses sickle cell trait or hemoglobin C trait.
- (2) Issue and deliver a policy that has a higher premium rate or charge on account of the fact that the person who is to be insured possesses sickle cell trait. (1975, c. 599, s. 2; 2021-169, s. 1.)

§ 58-65-75. Coverage for chemical dependency treatment.

(a) As used in this section, the term "chemical dependency" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal,

social, or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

(b) Every group insurance certificate or group subscriber contract under any hospital or medical plan governed by this Article and Article 66 of this Chapter that is issued, renewed, or amended on or after January 1, 1985, shall offer to its insureds benefits for the necessary care and treatment of chemical dependency that are not less favorable than benefits for physical illness generally. Except as provided in subsection (c) of this section, benefits for chemical dependency shall be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as are benefits for physical illness generally.

(c) Every group insurance certificate or group subscriber contract that provides benefits for chemical dependency treatment and that provides total annual benefits for all illnesses in excess of eight thousand dollars (\$8,000) is subject to the following conditions:

- (1) The certificate or contract shall provide, for each 12-month period, a minimum benefit of eight thousand dollars (\$8,000) for the necessary care and treatment of chemical dependency.
- (2) The certificate or contract shall provide a minimum benefit of sixteen thousand dollars (\$16,000) for the necessary care and treatment of chemical dependency for the life of the certificate or contract.

(d) Provisions for benefits for necessary care and treatment of chemical dependency in group certificates or group contracts shall provide for benefit payments for the following providers of necessary care and treatment of chemical dependency:

- (1) The following units of a general hospital licensed under Article 5 of General Statutes Chapter 131E:
 - a. Chemical dependency units in facilities licensed after October 1, 1984;
 - b. Medical units;
 - c. Psychiatric units; and
- (2) The following facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C:
 - a. Chemical dependency units in psychiatric hospitals;
 - b. Chemical dependency hospitals;
 - c. Residential chemical dependency treatment facilities;
 - d. Social setting detoxification facilities or programs;
 - e. Medical detoxification facilities or programs; and
- (3) Duly licensed physicians and duly licensed psychologists and certified professionals working under the direct supervision of such physicians or psychologists in facilities described in (1) and (2) above and in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C. After January 1, 1995, "duly licensed psychologists" shall be defined as licensed psychologists who hold permanent licensure and certification as health services provider psychologist issued by the North Carolina Psychology Board.

Provided, however, that nothing in this subsection shall prohibit any certificate or contract from requiring the most cost effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(e) Coverage for chemical dependency treatment as described in this section shall not be applicable to any group certificate holder or group subscriber contract holder who rejects the coverage in writing.

(f) Notwithstanding any other provisions of this section, a group health benefit plan that covers both medical and surgical benefits and chemical dependency treatment benefits shall, with respect to the chemical dependency treatment benefits, comply with all applicable standards of Subtitle B of Title V of Public Law 110-343, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

(g) Subsection (f) of this section applies only to a group health benefit plan covering a large employer as defined in G.S. 58-68-25(a)(10). (1983 (Reg. Sess., 1984), c. 1110, s. 8; 1985, c. 589, s. 43(a), (b); 1989, c. 175, s. 2; 1991, c. 720, s. 64; 1993, c. 375, s. 5; 2009-382, s. 21.)

§ 58-65-80. Meaning of terms "accident", "accidental injury", and "accidental means".

(a) This section applies to the provisions of all subscriber contracts under this Article and Article 66 of this Chapter that are issued on or after October 1, 1989, and preferred provider arrangements under this Article and Article 66 of this Chapter that are entered into on or after October 1, 1989.

(b) "Accident", "accidental injury", and "accidental means" shall be defined to imply "result" language and shall not include words that establish an accidental means test. (1989, c. 485, s. 11.)

§ 58-65-85. Discriminatory practices prohibited.

No person subject to this Article and Article 66 of this Chapter shall refuse to issue or refuse to reissue to an individual any certificate, plan, or contract governed by this Article and Article 66 of this Chapter; limit the amount, extent, or kind of services available to an individual; or charge an individual a different rate for the same services, because of the race, color, or national or ethnic origin of that individual. (1989, c. 485, s. 23.)

§ 58-65-90. No discrimination against mentally ill or chemically dependent individuals.

(a) Definitions. – As used in this section, the term:

(1) "Mental illness" has the same meaning as defined in G.S. 122C-3(21), with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or subsequent editions published by the American Psychiatric Association, except those mental disorders coded in the DSM-5 or subsequent editions as substance-related disorders (291.0 through 292.9 and 303.0 through 305.9), those coded as autism spectrum disorder (299.00), sexual dysfunctions not due to organic disease (302.70 through 302.79), and those coded as "V" codes.

(2) "Chemical dependency" has the same meaning as defined in G.S. 58-65-75, with a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-5, or subsequent editions published by the American Psychiatric Association.

(b) Coverage of Physical Illness. – No service corporation governed by this Chapter shall, solely because an individual to be insured has or had a mental illness or chemical dependency:

- (1) Refuse to issue or deliver to that individual any individual or group subscriber contract in this State that affords benefits or coverage for medical treatment or service for physical illness or injury;
 - (2) Have a higher premium rate or charge for physical illness or injury coverages or benefits for that individual; or
 - (3) Reduce physical illness or injury coverages or benefits for that individual.
- (b1) [Expired October 1, 2001.]
- (c) Chemical Dependency Coverage Not Required. – Nothing in this section requires a service corporation to offer coverage for chemical dependency, except as provided in G.S. 58-65-75.
- (d) Applicability. – This section applies only to group health insurance contracts, other than excepted benefits as defined in G.S. 58-68-25. For purposes of this section, "group health insurance contracts" include MEWAs, as defined in G.S. 58-50A-1.
- (e) Nothing in this section requires an insurer to cover treatment or studies leading to or in connection with sex changes or modifications and related care. (1989, c. 369, s. 1; 1991, c. 720, s. 82; 1997-259, s. 22; 1999-132, s. 4.3; 2007-268, s. 3; 2015-271, s. 5; 2019-202, s. 8; 2020-69, s. 3(g).)

§ 58-65-91. Coverage for certain treatment of diabetes.

- (a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider plan under G.S. 58-50-56 that is issued, renewed, or amended on or after October 1, 1997, shall provide coverage for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a physician or a health care professional designated by the physician. The hospital or medical service plan shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to the diabetes coverage required under this section.
- (b) For the purposes of this section, "physician" is a person licensed to practice in this State under Article 1 or Article 7 of Chapter 90 of the General Statutes. (1997-225, s. 2; 1997-519, s. 3.12.)

§ 58-65-92. Coverage for mammograms and cervical cancer screening.

- (a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1992, shall provide coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and for low-dose screening mammography. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for examinations and laboratory tests for the screening for the early detection of cervical cancer and low-dose screening mammography.
- (a1) As used in this section, "examinations and laboratory tests for the screening for the early detection of cervical cancer" means conventional PAP smear screening, liquid-based

cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

(b) As used in this section, "low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

(c) Coverage for low-dose screening mammography shall be provided as follows:

- (1) One or more mammograms a year, as recommended by a physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
 - a. The woman has a personal history of breast cancer;
 - b. The woman has a personal history of biopsy-proven benign breast disease;
 - c. The woman's mother, sister, or daughter has or has had breast cancer; or
 - d. The woman has not given birth prior to the age of 30;
- (2) One baseline mammogram for any woman 35 through 39 years of age, inclusive;
- (3) A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a physician; and
- (4) A mammogram every year for any woman 50 years of age or older.

(d) Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards established by the North Carolina Medical Care Commission.

(e) Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission. (1991, c. 490, s. 2; 1997-519, s. 3.6; 2003-186, s. 3.)

§ 58-65-93. Coverage for prostate-specific antigen (PSA) tests.

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the certificate or contract shall apply to coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer.

(b) As used in this section, "prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer" means serological tests for determining the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease.

(c) Coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer shall be provided when recommended by a physician. (1993, c. 269, s. 2; 1997-519, s. 3.7.)

§ 58-65-94. Coverage of certain prescribed drugs for cancer treatment.

(a) No insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

- (1) The National Comprehensive Cancer Network Drugs & Biologics Compendium;
- (2) The Micromedex DrugDex System;
- (3) The Elsevier Gold Standard's Clinical Pharmacology; or
- (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition. (1993, c. 506, s. 4.2; 1997-519, s. 3.8; 2009-170, s. 2; 2023-133, s. 2(b).)

§ 58-65-95. Investments and reserves.

(a) Corporations subject to this Article shall invest in or hold only those assets permitted by Article 7 of this Chapter for life and health insurance companies.

(b) Every such corporation shall accumulate and maintain, in addition to proper reserves for current administrative liabilities and whatever reserves are deemed to be adequate and proper by the Commissioner for unpaid dental, health care, medical, or vision bills and unearned membership dues, a special contingent surplus or reserve at the following rates annually of its gross annual collections from membership dues, exclusive of receipts from cost plus plans, until the reserve equals an amount that is three times its average monthly expenditures for claims and administrative and selling expenses:

- | | | |
|-----|---------------------|----|
| (1) | First \$200,000 | 4% |
| (2) | Next \$200,000 | 2% |
| (3) | All above \$400,000 | 1% |

(c) Any corporation subject to this Article may accumulate and maintain a contingent reserve in excess of the reserve required in subsection (b) of this section, not to exceed an amount

equal to six times the average monthly expenditures for claims and administrative and selling expenses.

(d) If the Commissioner finds that special conditions exist warranting an increase or decrease in the reserves or schedule of reserves in subsection (b) of this section, the Commissioner may modify them accordingly. Provided, however, when special conditions exist warranting an increase in the schedule of reserves, the schedule shall not be increased by the Commissioner until a reasonable length of time has elapsed after the Commissioner gives notice of the increase. (1941, c. 338, s. 8; 1943, c. 537, s. 5; 1947, c. 820, s. 5; 1961, c. 1149; 1991, c. 720, s. 79; 1999-244, s. 6; 2003-212, s. 18; 2021-169, s. 1.)

§ 58-65-96. Coverage for reconstructive breast surgery following mastectomy.

(a) Every insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and every preferred provider benefit plan under G.S. 58-50-56 that provides coverage for mastectomy shall provide coverage for reconstructive breast surgery following a mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a nondiseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. The same deductibles, coinsurance, and other limitations as apply to similar services covered under the policy, contract, or plan shall apply to coverage for reconstructive breast surgery. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician.

(b) As used in this section, the following terms have the meanings indicated:

- (1) "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer or breast disease.
- (2) "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. "Reconstructive breast surgery" also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the nondiseased breast.

(c) A policy, contract, or plan subject to this section shall not:

- (1) Deny coverage described in subsection (a) of this section on the basis that the coverage is for cosmetic surgery;
- (2) Deny to a woman eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract, policy, or plan, solely for the purpose of avoiding the requirements of this section;
- (3) Provide monetary payments or rebates to a woman to encourage her to accept less than the minimum protections available under this section;
- (4) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider provided care to an individual participant or beneficiary in accordance with this section; or
- (5) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section.

(d) Written notice of the availability of the coverage provided by this section shall be delivered to every subscriber under an individual certificate, contract, or plan and to every certificate holder under a group policy, contract, or plan upon initial coverage under the certificate, contract, or plan and annually thereafter. The notice required by this subsection may be included as a part of any yearly informational packet sent to the subscriber or certificate holder. (1997-312, s. 2; 1997-519, s. 3.10; 1999-351, s. 3.2; 2001-334, s. 13.2.)

§ 58-65-100. Statements filed with Commissioner.

Every service corporation subject to this Article is subject to G.S. 58-2-165. (1941, c. 338, s. 9; 1999-244, s. 11.)

§ 58-65-105. Visitations and examinations.

Service corporations subject to this Article shall be examined under G.S. 58-2-131, 58-2-132, 58-2-133, and 58-2-134. (1941, c. 338, s. 10; 1995, c. 360, s. 2(1); 1999-244, s. 5.)

§ 58-65-110. Expenses.

All acquisition expenses in connection with the solicitation of subscribers to a dental, health care, medical, or vision service plan and administration costs including salaries paid to officers of the corporations, if any, shall at all times be subject to inspection by the Commissioner of Insurance. (1941, c. 338, s. 11; 1943, c. 537, s. 6; 1961, c. 1149; 2021-169, s. 1.)

§ 58-65-115. Licensing and regulation of agents.

Every agent of any service corporation authorized to do business in this State under this Article is subject to the licensing provisions of Article 33 of this Chapter and all other provisions in this Chapter applicable to life and accident and health or sickness insurance producers. (1941, c. 338, s. 12; 1943, c. 537, s. 7; 1947, c. 1023, s. 1; 1961, c. 1149; 1971, c. 1080, s. 2; 1983, c. 790, s. 5; 1985 (Reg. Sess., 1986), c. 928, s. 4; 1987, c. 629, s. 2; 1999-244, s. 7; 2022-46, s. 14(dddd).)

§ 58-65-120. Dental, health care, medical, and vision service associations and agent to transact business through licensed producers only.

No dental, health care, medical, or vision service association, nor any agent of the association, shall on behalf of the association or agent knowingly permit any person not licensed as an insurance producer as required by law, to solicit, negotiate for, collect or transmit a premium for a new contract of dental, health care, medical, or vision service certificate or to act in any way in the negotiation for any contract or policy. No license shall be required of any of the following:

- (1) Persons designated by the association or subscriber to collect or deduct or transmit premiums or other charges for dental, health care, medical, or vision contracts, or to perform any acts as may be required for providing coverage for additional persons who are eligible under a master contract.
- (2) An agency office employee acting in the confines of the insurance producer's office, under the direction and supervision of the duly licensed insurance producer and within the scope of that insurance producer's license, in the acceptance of request for insurance and payment of premiums, and the performance of clerical, stenographic, and similar office duties. (1955, c. 1268; 1961, c. 1149; 2021-169, s. 1; 2022-46, s. 14(eeee).)

§ 58-65-125. Revocation and suspension of license; unfair trade practices.

- (a) The Commissioner may revoke or suspend the license of any service corporation if:
- (1) The service corporation fails or refuses to comply with any law, order, or rule applicable to the service corporation.
 - (2) The service corporation's financial condition is unsound.
 - (3) The service corporation has published or made to the Department or to the public any false statement or report.
 - (4) The service corporation refuses to submit to any examination authorized by law.
 - (5) The service corporation is found to make a practice of unduly engaging in litigation or of delaying the investigation of claims or the adjustment or payment of valid claims.

(b) Any suspension or revocation of a service corporation's license under this section may also be made applicable to the license or registration of any natural person regulated under this Chapter who is a party to any of the causes for licensing sanctions listed in subsection (a) of this section.

(c) Article 63 of this Chapter applies to service corporations and their agents and representatives. (1941, c. 338, s. 13; 1943, c. 537, s. 8; 1971, c. 1080, s. 3; 1999-244, s. 3; 1999-351, s. 8; 2003-212, s. 26(k).)

§ 58-65-130. Amendments to certificate of incorporation.

Any corporation subject to the provisions of this Article and Article 66 of this Chapter may hereafter amend its charter in the following manner only:

- (1) a. A meeting of the board of directors, trustees or other governing authority shall be called in accordance with the bylaws specifying the amendment to be voted upon at such meeting.
- b. If at such meeting two thirds of the directors, trustees or other governing authority present vote in favor of the proposed amendment, then the president and secretary shall under oath make a certificate to this effect, which certificate shall set forth the call for such meeting, a statement showing service of such call upon all directors, and a certified copy of so much of the minutes of the meeting as relate to the adoption of the proposed amendment.
- c. Said officers shall cause said certificate to be published once a week for two consecutive weeks in a newspaper in Raleigh and in the county where the corporation's principal office is located, or posted at the courthouse door if no newspaper be published within the county. Said printed or posted notices shall be in such form and of such size as the Commissioner may approve, and in addition to setting forth in full the certificate required in paragraph b shall state that application for amending the corporation's charter in the manner specified has been proposed by the board of directors, trustees, or other governing authority, and shall also state the time set for the meeting of certificate holders thereby called to be held at the principal office of the corporation to take action on the proposed amendment. A true copy of such notice shall be filed with the Commissioner. Such publication and filing of notice shall be completed at least 30 days prior to the date set

therein for the meeting of the certificate holders and due proof thereof shall be filed with the Commissioner at least 15 days prior to the date of such meeting. If the meeting at which the proposed amendment is to be considered is a special meeting, rather than a regular annual meeting of certificate holders, such special meeting can be called only after the Commissioner has given his approval in writing, and the published notice shall show the fact of such approval. At said meeting those present in person or represented by proxy shall constitute a quorum.

- d. If at such certificate holders' meeting two thirds of those present in person or by proxy shall vote in favor of any proposed amendment, the president and secretary shall make a certificate under oath setting forth such fact together with the full text of the amendment thus approved. Said certificate shall, within 30 days after such meeting, be submitted to the Commissioner for his approval as conforming to the requirement of law, and it shall be the duty of the Commissioner to act upon all proposed amendments within 10 days after filing of such certificates with him. Should the Commissioner approve the proposed amendment or amendments, he shall certify this fact, together with the full text of such amendments as are approved by him, to the Secretary of State who shall thereupon issue the charter amendment in the usual form. Should the Commissioner disapprove of any amendment, then the same shall not be allowed.
- (2) All charters and charter amendments heretofore issued upon application of the board of directors, trustees or other governing authority of any corporations subject to the provisions of this Article and Article 66 of this Chapter are hereby validated.
 - (3) The charter of any corporation subject to the provisions of this Article and Article 66 of this Chapter may be amended to convert that corporation, so amending its charter, into a stock accident and health insurance company or stock life insurance company subject to the provisions of Articles 1 through 64 of this Chapter provided the contractual rights of the subscribers and certificate holders of the corporation are adequately protected. The proposed amendment shall be considered pursuant to G.S. 58-65-131, 58-65-132, and 58-65-133. Other provisions of this section and this Article relating to the procedure for amending the charter shall not apply. (1941, c. 338, s. 15; 1947, c. 820, s. 6; 1953, c. 1124, s. 2; 1998-3, s. 1.)

§ 58-65-131. Findings; definitions; conversion plan.

(a) Intent and Findings. – It is the intent of the General Assembly by the enactment of this section, G.S. 58-65-132, and G.S. 58-65-133 to create a procedure for a hospital service corporation to convert to a stock accident and health insurance company or stock life insurance company that is subject to the applicable provisions of Articles 1 through 64 of this Chapter. Except as provided in this section, it is not the intent of the General Assembly to supplant, modify, or repeal other provisions of this Article and Article 66 of this Chapter or the provisions of Chapter 55A of the General Statutes, the Nonprofit Corporation Act, that govern other transactions and the

procedures relating to those transactions that apply to corporations governed by the provisions of this Article and Article 66 of this Chapter.

The General Assembly recognizes the substantial and recent changes in market and health care conditions that are affecting these corporations and the benefit of equal regulatory treatment and competitive equality for health care insurers. The General Assembly finds that a procedure for conversion is in the best interest of policyholders because it will provide greater financial stability for these corporations and a greater opportunity for the corporations to remain financially independent. The General Assembly also finds that if a hospital service corporation converts to a stock accident and health insurance company or stock life insurance company, the conversion plan must provide a benefit to the people of North Carolina equal to one hundred percent (100%) of the fair market value of the corporation.

(b) Definitions. – The following definitions apply in this section, G.S. 58-65-132, and G.S. 58-65-133:

- (1) Certificate holder. – An enrollee, as defined in Article 67 of this Chapter, in a health maintenance plan provided by the corporation or a subsidiary or by the new corporation or a subsidiary.
- (2) Code. – Title 26 of the United States Code, the United States Internal Revenue Code of 1986, as amended.
- (3) Conversion. – The conversion of a hospital service corporation to a stock accident and health insurance company or stock life insurance company subject to the applicable provisions of Articles 1 through 64 of this Chapter.
- (4) Corporation. – A hospital service corporation governed by this Article that files or is required to file a plan of conversion with the Commissioner under subsection (d) of this section to convert from a hospital service corporation to a stock accident and health insurance company or stock life insurance company.
- (5) Foundation. – A newly formed tax-exempt charitable social welfare organization formed and operating under section 501(c)(4) of the Code and Chapter 55A of the General Statutes.
- (6) New corporation. – A corporation originally governed by this Article that has had its plan of conversion approved by the Commissioner under G.S. 58-65-132 and that has converted to a stock accident and health insurance company or stock life insurance company.

(c) Compliance Required in Certain Events. – A corporation governed by this Article shall comply with the provisions of this section, G.S. 58-65-132, and G.S. 58-65-133 before it may do any of the following:

- (1) Sell, lease, convey, exchange, transfer, or make other disposition, either directly or indirectly in a single transaction or related series of transactions, of ten percent (10%) of the corporation's assets, as determined by statutory accounting principles, to, or merge or consolidate or liquidate with or into, any business corporation or other business entity, except a business corporation or other business entity that is a wholly owned subsidiary of the corporation. The ten percent (10%) asset limitation in this subdivision does not apply to:
 - a. The purchase, acquisition by assignment or otherwise by the corporation of individual accident and health policies or contracts insuring North Carolina residents, or with respect to accident and health group master policies or contracts, only the percentage portion of those

policies or contracts covering North Carolina resident certificate holders, and that are issued by a company domiciled or licensed to do business in North Carolina, if the purchase is first approved by the Commissioner after notice to the Attorney General, no profit will inure to the benefit of any officer, director, or employee of the corporation or its subsidiaries, the purchase is transacted at arm's length and for fair value, and the purchase will further the corporation's ability to fulfill its purposes;

- b. In the case of a purchase by the corporation of all the common stock of a company domiciled or licensed to do business in North Carolina, that portion of the value of the company which is determined by the Commissioner to be attributable to individual accident and health policies or contracts insuring North Carolina residents or, in the case of accident and health group master policies or contracts, the percentage portion of those policies or contracts covering North Carolina resident certificate holders, if the purchase is first approved by the Commissioner after notice to the Attorney General, no profit will inure to the benefit of any officer, director, or employee of the corporation or its subsidiaries, the purchase is transacted at arm's length and for fair value, and the purchase will further the corporation's ability to fulfill its purposes;
 - c. Granting encumbrances such as security interests or deeds of trust with respect to assets owned by the corporation or any wholly owned subsidiary to secure indebtedness for borrowed money, the proceeds of which are paid solely to the corporation or its wholly owned subsidiaries and remain subject to the provisions of this section; and
 - d. Sales or other transfers in the ordinary course of business for fair value of any interest in real property or stocks, bonds, or other securities within the investment portfolio owned by the corporation or any wholly owned subsidiary, the proceeds of which are paid solely to the corporation or any wholly owned subsidiary and remain subject to the provisions of this section.
- (2) Directly or indirectly issue, sell, convey, exchange, transfer, or make other disposition to any party of any equity or ownership interest in the corporation or in any business entity that is owned by or is a subsidiary of the corporation, including stock, securities, or bonds, debentures, notes or any other debt or similar obligation that is convertible into any equity or ownership interest, stock or securities. This subdivision shall not be construed to prohibit the corporation or a wholly owned subsidiary, with the approval of the Commissioner after notice to the Attorney General, from investing in joint ventures or partnerships with unrelated third parties, if no profit will inure to the benefit of any officer, director, or employee of the corporation or its subsidiaries, the transaction is conducted at arm's length and for fair value, and the transaction furthers the corporation's ability to fulfill its purposes.
- (3) Permit its aggregate annual revenues, determined in accordance with statutory accounting principles, from all for-profit activities or operations, including but

not limited to those of the corporation, any wholly owned subsidiaries, and any joint ventures or partnerships, to exceed forty percent (40%) of the aggregate annual revenues, excluding investment income, of the corporation and its subsidiaries and determined in accordance with statutory accounting principles; or

- (4) Permit its aggregate assets for four consecutive quarters, determined in accordance with statutory accounting principles, employed in all for-profit activities or operations, including, but not limited to, those assets owned or controlled by any for-profit wholly owned subsidiaries, to exceed forty percent (40%) of the aggregate admitted assets of the corporation and its subsidiaries for four consecutive quarters, determined in accordance with statutory accounting principles.

In determining whether the corporation must comply with the provisions of this section, G.S. 58-65-132, and G.S. 58-65-133, the Commissioner may review and consolidate actions of the corporation, its subsidiaries, and other legal entities in which the corporation directly or indirectly owns an interest, and treat the consolidated actions as requiring a conversion. An appeal of the Commissioner's order that consolidated actions require a conversion shall lie directly to the North Carolina Court of Appeals. Appeals under this subsection must be filed within 30 days of the Commissioner's order and shall be considered in the most expeditious manner practical. The corporation must file a plan of conversion within 12 months of the later of the issuance of the Commissioner's order or a final decision on appeal.

(d) Charter Amendment for Conversion. – A corporation may propose to amend its charter pursuant to this Article to convert the corporation to a stock accident and health insurance company or stock life insurance company subject to the applicable provisions of Articles 1 through 64 of this Chapter. The proposed amended charter and a plan for conversion as described in subsection (e) of this section shall be filed with the Commissioner for approval.

(e) Filing Conversion Plan; Costs of Review. – A corporation shall file a plan for conversion with the Commissioner and submit a copy to the Attorney General at least 120 days before the proposed date of conversion. The corporation or the new corporation shall reimburse the Department of Insurance and the office of the Attorney General for the actual costs of reviewing, analyzing, and processing the plan. The Commissioner and the Attorney General may contract with experts, consultants, or other professional advisors to assist in reviewing the plan. These contracts are personal professional service contracts exempt from Articles 3 and 3C of Chapter 143 of the General Statutes. Contract costs for these personal professional services shall not exceed an amount that is reasonable and appropriate for the review of the plan.

(f) Plan Requirements. – A plan of conversion submitted to the Commissioner shall state with specificity the following terms and conditions of the proposed conversion:

- (1) The purposes of the conversion.
- (2) The proposed articles of incorporation of the new corporation.
- (3) The proposed bylaws of the new corporation.
- (4) A description of any changes in the new corporation's mode of operations after conversion.
- (5) A statement describing the manner in which the plan provides for the protection of all existing contractual rights of the corporation's subscribers and certificate holders to medical or hospital services or the payment of claims for reimbursement for those services. The corporation's subscribers and certificate

holders shall have no right to receive any assets, surplus, capital, payment or distribution or to receive any stock or other ownership interest in the new corporation in connection with the conversion.

- (6) A statement that the legal existence of the corporation does not terminate and that the new corporation is subject to all liabilities, obligations, and relations of whatever kind of the corporation and succeeds to all property, assets, rights, interests, and relations of the corporation.
- (7) Documentation showing that the corporation, acting by its board of directors, trustees, or other governing authority, has approved the plan. It shall not be necessary for the subscribers or certificate holders of the corporation to vote on or approve the plan of conversion, any amendments to the corporation's articles of incorporation or bylaws, or the articles of incorporation or the bylaws of the new corporation, notwithstanding any provision to the contrary in this Article or Article 66 of this Chapter or in the articles of incorporation or bylaws of the corporation.
- (8) The business plan of the new corporation, including, but not limited to, a comparative premium rate analysis of the new corporation's major plans and product offerings, that, among other things, compares actual premium rates for the three-year period before the filing of the plan for conversion and forecasted premium rates for a three-year period following the proposed conversion. This rate analysis shall address the forecasted effect, if any, of the proposed conversion on the cost to policyholders or certificate holders of the new corporation and on the new corporation's underwriting profit, investment income, and loss and claim reserves, including the effect, if any, of adverse market or risk selection upon these reserves. Information provided under this subsection is confidential pursuant to G.S. 58-19-40.
- (9) Any conditions, other than approval of the plan of conversion by the Commissioner, to be fulfilled by a proposed date upon which the conversion would become effective.
- (10) The proposed articles of incorporation and bylaws of the Foundation, containing the provisions required by G.S. 58-65-133(h).
- (11) Any proposed agreement between the Foundation and the new corporation, including, but not limited to, any agreement relating to the voting or registration for sale of any capital stock to be issued by the new corporation to the Foundation.

(g) Public Comment. – Within 20 days of receiving a plan to convert, the Commissioner shall publish a notice in one or more newspapers of general circulation in the corporation's service area describing the name of the corporation, the nature of the plan filed under G.S. 58-65-131(d), and the date of receipt of the plan. The notice shall indicate that the Commissioner will solicit public comments and hold three public hearings on the plan. The public hearings must be completed within 60 days of the filing of the conversion plan. The written public comment period will be held open until 10 days after the last public hearing. For good cause the Commissioner may extend these deadlines once for a maximum of 30 days. The Commissioner shall provide copies of all written public comments to the Attorney General.

(h) Public Access to Records. – All applications, reports, plans, or other documents under this section, G.S. 58-65-132, and G.S. 58-65-133 are public records unless otherwise provided in

this Chapter. The Commissioner shall provide the public with prompt and reasonable access to public records relating to the proposed conversion of the corporation. Access to public records covered by this section shall be made available for at least 30 days before the end of the public comment period. (1998-3, s. 2; 2016-125, 4th Ex. Sess., s. 22(e); 2021-169, s. 1.)

§ 58-65-132. Review and approval of conversion plan; new corporation.

(a) Approval of Plan of Conversion. – The Commissioner shall approve the plan of conversion and issue a certificate of authority to the new corporation to transact business in this State only if the Commissioner finds all of the following:

- (1) The plan of conversion meets the requirements of G.S. 58-65-131, this section, and G.S. 58-65-133.
- (2) Upon conversion, the new corporation will meet the applicable standards and conditions under this Chapter, including applicable minimum capital and surplus requirements.
- (3) The plan of conversion adequately protects the existing contractual rights of the corporation's subscribers and certificate holders to dental, health care, medical, or vision services and payment of claims for reimbursement for those services.
- (4) No director, officer, or employee of the corporation will receive:
 - a. Any fee, commission, compensation, or other valuable consideration for aiding, promoting, or assisting in the conversion of the corporation other than compensation paid to any director, officer, or employee of the corporation in the ordinary course of business; or
 - b. Any distribution of the assets, surplus, capital, or capital stock of the new corporation as part of a conversion.
- (5) The corporation has complied with all material requirements of this Chapter, and disciplinary action is not pending against the corporation.
- (6) The plan of conversion is fair and equitable and not prejudicial to the contractual rights of the policyholders and certificate holders of the new corporation.
- (7) The plan of conversion is in the public interest. The Commissioner shall find that the plan is in the public interest only if it provides a benefit for the people of North Carolina equal to the value of the corporation at the time of conversion, in accordance with the criteria set out in this subdivision. In determining whether the plan of conversion is in the public interest, the Commissioner may also consider other factors, including, but not limited to, those relating to the accessibility and affordability of health care. The Commissioner must determine that the plan of conversion meets all of the following criteria:
 - a. Consideration, determined by the Commissioner to be equal to one hundred percent (100%) of the fair market value of the corporation, will be conveyed or issued by the corporation to the Foundation at the time the new corporation files its articles of incorporation. If the consideration to be conveyed is all of the common stock of the new corporation that is then issued and outstanding at the time of conversion, and there is no other capital stock of any type or nature then outstanding, it is conclusively presumed that the Foundation will acquire the fair market value of the corporation.

b. At any time after the conversion, the new corporation may issue, in a public offering or a private placement, additional shares of common stock of the same class and having the same voting, dividend, and other rights as that transferred to the Foundation, subject to the applicable provisions of Chapter 55 of the General Statutes and any voting and registration agreements.

(8) The plan of conversion contains a proposed voting agreement and registration agreement between the Foundation and the proposed new corporation that meets the requirements of G.S. 58-65-133.

(9) The Attorney General has given approval pursuant to G.S. 58-65-133(h).

(b) New Corporation. – After issuance of the certificate of authority as provided in subsection (a) of this section, the new corporation shall no longer be subject to this Article and Article 66 of this Chapter but shall be subject to and comply with all applicable laws and regulations applicable to domestic insurers and Chapter 55 of the General Statutes, except that Articles 9 and 9A of Chapter 55 shall not apply to the new corporation. The new corporation shall file its articles of incorporation, as amended and certified by the Commissioner, with the North Carolina Secretary of State. The legal existence of the corporation does not terminate, and the new corporation is a continuation of the corporation. The conversion shall only be a change in identity and form of organization. Except as provided in subdivision (a)(7) of this subsection, all property, assets, rights, liabilities, obligations, interests, and relations of whatever kind of the corporation shall continue and remain in the new corporation. All actions and legal proceedings to which the corporation was a party prior to conversion shall be unaffected by the conversion.

(c) Final Decision and Order; Procedures. – The Commissioner's final decision and order regarding the plan of conversion shall include findings of fact and conclusions of law. Findings of fact shall be based upon and supported by substantial evidence, including evidence submitted with the plan by the corporation and evidence obtained at hearings held by the Commissioner. A person aggrieved by a final decision of the Commissioner approving or disapproving a conversion may petition the Superior Court of Wake County within 30 days thereafter for judicial review. An appeal from a final decision and order of the Commissioner under this section shall be conducted pursuant to G.S. 58-2-75. Chapter 150B of the General Statutes does not apply to the procedures of G.S. 58-65-131, this section, and G.S. 58-65-133. This subsection does not apply to appeal of an order of the Commissioner issued pursuant to G.S. 58-65-131(c).

(d) Attorney General's Enforcement Authority; Legal Action on Validity of Plan of Conversion. –

(1) Nothing in this Chapter limits the power of the Attorney General to seek a declaratory judgment or to take other legal action to protect or enforce the rights of the public in the corporation.

(2) Any legal action with respect to the conversion must be filed in the Superior Court of Wake County. (1998-3, s. 2; 2021-169, s. 1.)

§ 58-65-133. Creation and operation of foundation.

(a) Creation. – A Foundation shall be created to receive the fair market value of the corporation as provided in G.S. 58-65-132(a)(7) when the corporation converts.

(b) Purpose. – The charitable purpose of the Foundation shall be to promote the health of the people of North Carolina. For a period of 10 years from the effective date of the conversion, the Foundation may not, without the consent of the Attorney General, establish or operate any entity

licensed pursuant to Chapter 58 of the General Statutes that would compete with the new corporation or any of its subsidiaries.

(c) Board of Directors. – The initial board of directors of the foundation shall consist of 11 members appointed by the Attorney General from a list of nominees recommended pursuant to subsection (d) of this section. The Attorney General shall stagger the terms of the initial appointees so that six members serve two-year terms and five members serve four-year terms. The board shall fill a vacancy in an initial term. Their successors shall be chosen by the board of directors of the Foundation in accordance with the bylaws of the Foundation and shall serve four-year terms. No member may serve more than two consecutive full terms nor more than 10 consecutive years. The Foundation may increase or decrease the size of the board in accordance with its bylaws, provided that the board shall have no fewer than nine directors and no more than 15 directors and that a decrease in size does not eliminate the then current term of any director.

(d) Advisory Committee. – An advisory committee shall be formed to (i) develop, subject to the approval of the Attorney General, the criteria for selection of the Foundation's initial board of directors and (ii) nominate candidates for the initial board of directors. The advisory committee shall be comprised of the following 11 members: three representatives of the business community selected by the North Carolina Chamber, three representatives of the public and private medical school community selected by The University of North Carolina Board of Governors, three representatives of private foundations and other nonprofit organizations selected by the North Carolina Center for Nonprofits, a representative of NCHA, Inc., and a representative of the North Carolina Medical Society. After receiving a copy of the proposed plan of conversion, the Attorney General shall immediately notify these organizations, and the advisory committee shall be constituted within 45 days thereafter.

The advisory committee's criteria shall ensure an open recruitment process for the directors. The advisory committee shall nominate 22 residents of North Carolina for the 11 positions to be filled by the Attorney General. The Attorney General shall retain an independent executive recruiting firm or firms to assist the advisory committee in its work.

(e) Foundation and New Corporation Independent. – The Foundation and its directors, officers, and employees shall be and remain independent of the new corporation and its affiliates. No director, officer, or employee of the Foundation shall serve as a director, officer, or employee of the new corporation or any of its affiliates. No director, officer, or employee of the new corporation or any of its affiliates shall serve as a director, officer, or employee of the Foundation. This subsection shall no longer apply after (i) 10 years following the effective date of the conversion or (ii) the divestment by the Foundation of at least ninety-five percent (95%) of the stock of the new corporation received pursuant to G.S. 58-65-132(a)(7)a. and subsection (a) of this section, whichever occurs later.

(f) Voting and Stock Registration Agreement. – The Foundation and the new corporation shall operate under a voting agreement and a stock registration agreement, approved by the Commissioner and the Attorney General, that provides at a minimum for the following:

- (1) The Foundation will vote the common stock in the new corporation for directors of the new corporation nominated by the board of directors of the new corporation to the extent provided by the terms of the voting agreement.
- (2) The voting restrictions will not apply to common stock of the new corporation sold by the Foundation.
- (3) The board of directors of the new corporation will determine the timing of any initial public offering of the new corporation's common stock, either by the new

corporation or by the Foundation, and the Foundation shall have demand registration rights and optional "piggy-back" or "incidental" registration rights in connection with any offerings of the new corporation's common stock by the new corporation, on the terms and conditions set forth in a stock registration agreement and agreed upon by the new corporation and the Foundation and approved by the Commissioner and the Attorney General.

- (4) The voting agreement may contain additional terms, including (i) voting and ownership restrictions with regard to the common stock of the new corporation and (ii) provisions for the voting or registration for sale of any common stock to be issued to the Foundation by the new corporation.

(g) **Costs.** – The corporation shall pay the reasonable expenses of the advisory committee and executive search firm and the costs of any consultants, experts, or other professional advisors retained by the Attorney General incident to review under this section.

(h) **Attorney General's Approval.** – Before the Commissioner approves a plan of conversion pursuant to G.S. 58-65-132, the Attorney General, on behalf of the public and charitable interests in this State, must approve the determination relating to the fair market value of the corporation under G.S. 58-65-132(a)(7), the articles of incorporation and bylaws of the foundation, and all proposed agreements between the new corporation and the Foundation, including stock voting or registration agreements. The Attorney General may seek advice on these matters from consultants, investment bankers, and other professional advisors engaged by the Commissioner or Attorney General incident to review of the plan. The proposed articles of incorporation of the Foundation shall provide for all of the following:

- (1) State that the Foundation is organized and operated exclusively for charitable purposes and for the promotion of social welfare.
- (2) State that no part of the net earnings of the Foundation shall inure to the benefit of any private shareholder or individual.
- (3) State that the Foundation shall not engage in any political campaign activity or the making of political contributions.
- (4) Prohibit the Foundation from paying or incurring any amount that, if paid by an organization classified as a "private foundation" under section 509(a) of the Code, would constitute a "taxable expenditure" as defined by sections 4945(d)(1) and (2) of the Code.
- (5) Prohibit the Foundation from engaging in any self-dealing for the benefit of its directors, officers, or employees.
- (6) Provide for an ongoing community advisory committee to offer broad public input to the Foundation concerning its operations and activities.
- (7) Provide that the Foundation, after its first three years of operation, will pay out the lesser of (i) "qualifying distributions" of "distributable amounts," as defined in section 4942 of the Code, as if the Foundation were classified as a private Foundation subject to the distribution requirements, but not the taxes imposed, under that section or (ii) substantially all of its income, less qualifying expenses. In no event shall the Foundation be required to invade its corpus to meet the distribution requirements under this subdivision.
- (8) State that provisions in the articles of incorporation that are either required by this subdivision or designated by the Attorney General cannot be amended without the prior written approval of the Attorney General.

Within 120 days of the end of its fiscal year, the Foundation shall provide the Attorney General, the Commissioner, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate its State and federal tax returns for the preceding fiscal year. The tax returns shall be made available for public inspection. (1998-3, s. 2; 1998-217, s. 56; 2009-570, s. 8(b).)

§ 58-65-135. Cost plus plans.

(a) Any corporation organized under the provisions of this Article and Article 66 of this Chapter shall be authorized as agent of any other corporation, firm, group, partnership, or association, or any subsidiary or subsidiaries thereof, municipal corporation, State, federal government, or any agency thereof, to administer on behalf of such corporation, firm, group, partnership, or association, or any subsidiary or subsidiaries thereof, municipal corporation, State, federal government, or any agency thereof, any group dental, health care, medical, or vision service plan, promulgated by the corporation, firm, group, partnership, or association, or any subsidiary or subsidiaries thereof, municipal corporation, State, federal government, or any agency thereof, on a cost plus administrative expense basis, only if all of the following apply:

- (1) The other corporation, firm, group, partnership, or association, or any subsidiary or subsidiaries thereof, municipal corporation, State, federal government, or any agency thereof shall have had an active existence for at least one year preceding the establishment of the plan, and was formed for purposes other than procuring the group dental, health care, medical, or vision service coverage in a cost plus administrative expense basis.
- (2) Administrative costs of the cost plus plan administered by a corporation organized under the provisions of this Article and Article 66 of this Chapter, acting as an agent as provided by this section, shall not exceed the remuneration received.
- (3) The corporation organized under this Article and Article 66 of this Chapter administering the cost plus plan shall have no liability to the subscribers or to the hospitals or health care providers for the success or failure, liquidation or dissolution of the group dental, health care, medical, or vision service plan.

(b) Nothing in this section shall be construed to require that a corporation, firm, group, partnership, or association, or any subsidiary or subsidiaries thereof, municipal corporation, State, federal government, or any agency thereof, conform to the provisions of this Article and Article 66 of this Chapter if a group hospitalization service plan is administered by a corporation organized under this Article and Article 66 of this Chapter, on a cost plus expense basis.

(c) The administration of any cost plus plans as provided for by this section shall not be subject to regulation or supervision by the Commissioner of Insurance. (1941, c. 338, s. 16; 1943, c. 537, s. 9; 1947, c. 820, s. 7; 1961, c. 1149; 2021-169, s. 1.)

§ 58-65-140: Repealed by Session Laws 1997-519, s. 3.16.

§ 58-65-145. Preexisting hospital service corporations.

No corporations organized under the laws of this State prior to the ratification of this Article and Article 66 of this Chapter, for the purposes herein provided, shall be required to reincorporate as provided for herein, and the provisions of this Article and Article 66 of this Chapter shall apply to said corporations only with regard to operations by said corporations with respect to subscribers' contracts, participating hospital contracts, reserves, investments, reports, visitations, expenses,

taxation, amendments to charters, supervision of Commissioner of Insurance, application for certificate, issuance of certificates, licensing of agents after the date of the passage of this Article and Article 66 of this Chapter, provided, however, as soon as practical hereafter and in accordance with rules and regulations adopted by the Commissioner of Insurance said corporations shall conform to this Article and Article 66 of this Chapter as near as practical with respect to subscribers' contracts, endorsements, riders, and applications entered into prior to the ratification of this Article and Article 66 of this Chapter. (1941, c. 338, s. 17.)

§ 58-65-150. Construction of Chapter as to single employer plans; associations exempt.

(a) Nothing in this Article and Article 66 of this Chapter shall be construed to affect or apply to dental, health care, medical, or vision service plans which limit their membership to employees and the immediate members of the families of the employees of a single employer or his or its subsidiary or subsidiaries and which plans are operated by such employer of such limited group of the employees.

(b) Nothing in this Article and Article 66 of this Chapter [shall] be construed to affect or apply to any nonstock, nonprofit medical service association which was, on January 1, 1943, organized solely for the purpose of, and actually engaged in, the administration of any medical service plan in this State upon contracts and participating agreements with physicians, surgeons, or medical societies that underwrite the medical service plan by contributing their services to members of the association upon agreement with the association as to the schedule of fees to apply and the rate and method of payment by the association from the common fund paid in periodically by the members for medical, surgical and obstetrical care.

(c) All service plans described in subsection (a) of this section and all medical service associations described in subsection (b) of this section are exempt from the provisions of this Article and Article 66 of this Chapter.

(d) The Commissioner of Insurance may require from any full-service or single-service plan or medical service association any information necessary to enable the Commissioner to determine whether the service plan or medical service association is exempt from the provisions of this Article and Article 66 of this Chapter. (1941, c. 338, s. 18; 1943, c. 537, s. 10; 1947, c. 140; 1961, c. 1149; 2021-169, s. 1.)

§ 58-65-155. Merger or consolidation, proceedings for.

(a) Mergers and Consolidations Allowed. – Any two or more hospital service corporations organized under or subject to the provisions of this Article and Article 66 of this Chapter, as determined by the Commissioner of Insurance may be (i) merged into one of the constituent corporations, designated as the surviving corporation, or (ii) consolidated into a new corporation to be formed by the means of such consolidation of the constituent corporations, designated as the resulting or consolidated corporation, and the directors, the trustees, or a majority of directors or trustees, of the merging or consolidating corporations may enter into an agreement signed by them and under the corporate seals of the respective corporations.

(b) Written Agreement Required. – The terms of any merger or consolidation allowed under this section shall be contained in a written agreement. All written agreements shall contain the following:

- (1) The terms and conditions of the consolidation or merger.
- (2) The mode of carrying the consolidation or merger into effect.

- (3) Any facts as can be stated in the case of a consolidation or merger, and other details as to conversion of certificates of the subscribers as are deemed necessary or proper.

(c) Notice of Agreement. – Agreements for any merger or consolidation allowed under this section shall be submitted to the certificate holders of each constituent corporation, at a separate meeting thereof, called for the purpose of taking the consolidation or merger into consideration. Notice of place and subject of the meeting shall be required and shall meet all of the following requirements:

- (1) The notice shall be given by publication once a week for two consecutive weeks in some newspaper published in Raleigh, North Carolina, and in the counties in which the principal offices of the constituent corporations are located. If there is no paper published in the county of the principal office of the constituent corporations, then the required notice shall be posted at the courthouse door of the applicable county or counties for a period of two weeks.
- (2) The required printed or posted notices shall be in a form and of a size as the Commissioner of Insurance may approve.
- (3) A true copy of the required notices shall be filed with the Commissioner of Insurance.
- (4) The publication and filing of notices shall be completed at least 15 days prior to the date set for the meeting, and due proof thereof shall be filed with the Commissioner of Insurance at least 10 days prior to the date of the meeting.

(d) Meeting to Adopt Agreement. – At the meeting required for an agreement for any merger or consolidation allowed under this section, those present in person or represented by proxy shall constitute a quorum and the agreement for consolidation or merger shall be considered and voted upon by ballot in person or by proxy or both taken for the adoption or rejection of the same. If the votes of two thirds of those at the meeting voting shall be for the adoption of the agreement, then that fact shall be certified on the agreement by the president and secretary of each corporation, under the seal of each corporation.

The adopted and certified agreement shall be signed by the president or vice-president and secretary or assistant secretary of each of corporation under the corporate seals and acknowledged by the president or vice-president of each corporation before any officer authorized by the laws of this State to take acknowledgement of deeds to be the respective act, deed, and agreement of each of the corporations.

(e) Commissioner Approval of Merger or Consolidation Agreements. – In advance of any merger or consolidation allowed under this section, the agreement shall be submitted to and approved by the Commissioner of Insurance for approval. The Commissioner's approval shall be indicated by his or her signature being affixed to the agreement under the seal of the office.

The Commissioner shall not approve any consolidation or merger agreement or plans, unless, after a hearing, the Commissioner finds that it is fair, equitable to certificate holders and members, consistent with law, and will not conflict with the public interest.

(f) Filing of Agreement With Secretary of State. – Certified and acknowledged agreements for mergers or consolidations allowed under this section with the approval of the Commissioner of Insurance noted thereon, shall be filed in the office of the Secretary of State. The agreement on file shall be deemed to be the agreement and act of consolidation or merger of the corporations. A copy of the agreement and act of consolidation or merger duly certified by the Secretary of State under the seal of the office shall also be recorded in the office of the register of deeds of the county of this

State in which the principal office of the surviving or consolidated corporation is, or is to be established, and in the office of the registers of deeds of the counties of this State in which the respective corporations so merging or consolidating shall have their original certificates of incorporation recorded, and also in the office of the register of deeds in each county in which either or any of the corporations entering into merger or consolidation owns any real estate. This record, or a certified copy of the record, shall be evidence of the agreement and act of consolidation or merger of the applicable corporations, and of the observance and performance of all acts and conditions necessary to have been observed and performed precedent to the consolidation or merger.

For the filing of the agreement as provided for by this subsection, the Secretary of State is entitled to receive such fees only in the amount that would have been received had a new corporation been formed.

(g) Effect of Filing and Recording. – When an agreement shall have been signed, authorized, adopted, acknowledged, approved, and filed and recorded as required by this section, for all purposes of the laws of this State, the separate existence of all constituent corporations, parties to the agreement, or of all of the constituent corporations, except the one into which the other or others of the constituent corporations have been merged, as the case may be, shall cease and the constituent corporations shall become a new corporation, or be merged into one of the corporations, as the case may be, in accordance with the provisions of the filed and recorded agreement, possessing all the rights, privileges, powers and franchises as well of a public as of a private nature, of each of the constituent corporations, and all and singular, the rights, privileges, powers and franchises of each of the corporations, and all property, real, personal and mixed, and all debts due to any of the constituent corporations on whatever account, shall be vested in the corporation resulting from or surviving such consolidation or merger, and all property, rights, privileges, powers, and franchises and all and every other interest shall be thereafter as effectually the property of the resulting or surviving corporation as they were of the several and respective constituent corporations, and the title to any real estate, whether vested by deed or otherwise, under the laws of this State, vested in any constituent corporations shall not revert or be in any way impaired by reason of consolidation or merger; provided, however, that all rights of creditors and all liens upon the property of either of or any of the constituent corporations shall be preserved, unimpaired, limited in lien to the property affected by any lien at the time of the merger or consolidation, and all debts, liabilities, and duties of the respective constituent corporations shall thenceforth attach to the resulting or surviving corporation, and may be enforced against it to the same extent as if the debts, liabilities, and duties had been incurred or contracted by it; and further provided that notice of any liens, debts, liabilities, and duties is given in writing to the resulting or surviving corporation within six months after the date of the filing of the agreement of merger in the office of the Secretary of State. All applicable liens, debts, liabilities, and duties of which notice is not given as required by this subsection are forever barred. The certificate of incorporation of the surviving corporation shall be deemed to be amended to the extent, if any, that the changes in its certificates of incorporation are stated in the agreement of merger. All certificates theretofore issued and outstanding by each constituent corporation in good standing upon the date of the filing of the agreement with the Secretary of State without reissuance thereof by the resulting or surviving corporation shall be the contract and agreement of the resulting or surviving corporation with each of the certificate holders thereof and subject to all terms and conditions thereof and of the agreement of merger filed in the office of the Secretary of State.

Any action or proceeding pending by or against any of the corporations consolidated or merged may be prosecuted to judgment as if such consolidation or merger had not taken place, or the corporations resulting from or surviving the consolidation or merger may be substituted in its place.

(h) **Liability.** – The liability of the constituent corporations to the certificate holders thereof, and the rights or remedies of the creditors thereof, or persons doing or transacting business with the corporations, shall not, in any way, be lessened or impaired by the consolidation or merger of two or more corporations under the provisions of this section, except as provided in this section.

(i) **Power and Authority of New or Surviving Corporation.** – When two or more corporations are consolidated or merged, the corporation resulting from or surviving the consolidation or merger shall have the power and authority to continue any contracts which any of the constituent corporations might have elected to continue. All contracts entered into between any constituent corporations and any other persons shall be and become the contract of the resulting corporations according to the terms and conditions of said contract and the agreement of consolidation or merger.

(j) **Objection to Merger or Consolidation.** – Any agreement for merger or consolidation as shall conform to the provisions of this section, shall be binding and valid upon all the subscribers, certificate holders and members of the constituent corporations, provided only that any subscriber, certificate holder or member who shall so indicate a disapproval of the consolidation or merger to the resulting, consolidated, or surviving corporation within 90 days after the filing of required agreement with the Secretary of State shall be entitled to receive all unearned portions of premiums paid on his or her certificate from and after the date of the receipt of the application by the resulting, surviving, or consolidated corporation. Each subscriber, certificate holder, or member who shall not so indicate his or her disapproval of the required agreement and the merger or consolidation within the required period of 90 days is deemed and presumed to have approved the agreement and the merger or consolidation and shall have waived his or her right to question the legality of the merger or consolidation.

(k) **Prohibition on Compensation.** – No director, officer, subscriber, certificate holder, or member of any corporation entering into an agreement under this section, except as is expressly provided by the plan of merger or consolidation, shall receive any fee, commission, other compensation or valuable consideration whatever, for in any manner aiding, promoting or assisting in the merger or consolidation. (1947, c. 820, s. 8; 1961, c. 1149; 1967, c. 823, s. 25; 2021-169, s. 1.)

§ 58-65-160: Repealed by Session Laws 1998-3, s. 3.

§ 58-65-165. Commissioner of Insurance determines corporations exempt from this Article and Article 66 of this Chapter.

The Commissioner of Insurance may require from any corporation writing dental, health care, medical, or vision service contracts or any or all of them, any information that will enable the Commissioner to determine whether the corporation is subject to the provisions of this Article and Article 66 of this Chapter. (1947, c. 820, s. 9; 1961, c. 1149; 2021-169, s. 1.)

Part 2. Indemnification.

§ 58-65-166. Policy statement and definitions.

(a) It is the public policy of this State to enable corporations organized under this Chapter to attract and maintain responsible, qualified directors, officers, employees, and agents, and, to that end, to permit corporations organized under this Chapter to allocate the risk of personal liability of directors, officers, employees, and agents through indemnification and insurance as authorized in this Part.

(b) Definitions in this Part:

- (1) "Corporation" includes any not for profit domestic hospital service corporation, or successor of a corporation in a merger or other transaction in which the predecessor's existence ceased upon consummation of the transaction.
- (2) "Director" or "Trustee" means an individual who is or was a director of a corporation or an individual who, while a director of a corporation, is or was serving at the corporation's request as a director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plan, or other enterprise. A director is considered to be serving an employee benefit plan at the corporation's request if his duties to the corporation also impose duties on, or otherwise involve services by, him to the plan or to participants in or beneficiaries of the plan. "Director" or "Trustee" includes, unless the context requires otherwise, the estate or personal representative of a director or trustee.
- (3) "Expenses" means expenses of every kind incurred in defending a proceeding, including counsel fees.
- (4) "Liability" means the obligation to pay a judgment, settlement, penalty, fine (including an excise tax assessed with respect to an employee benefit plan), or reasonable expenses incurred with respect to a proceeding.
- (5) "Official capacity" means: (i) when used with respect to a director or trustee, the office of director or trustee in a corporation; and (ii) when used with respect to an individual other than a director or trustee, as contemplated in G.S. 58-65-172, the office in a corporation held by the officer or the employment or agency relationship undertaken by the employee or agent on behalf of the corporation. "Official capacity" does not include service for any other foreign or domestic corporation or any partnership, joint venture, trust, employee benefit plan, or other enterprise.
- (6) "Party" includes an individual who was, is, or is threatened to be made a named defendant or respondent in a proceeding.
- (7) "Proceeding" means any threatened, pending, or completed action, suit, or proceeding, whether civil, criminal, administrative, or investigative and whether formal or informal.
- (8) "Trustee". Whenever the term "director" or "directors" is used herein it shall include the term "trustee", or a person who is designated as a "trustee" under a corporation governed by this Article. (1989 (Reg. Sess., 1990), c. 1071, s. 1; 2021-169, s. 2.)

§ 58-65-167. Authority to indemnify.

(a) Except as provided in subsection (d), a corporation may indemnify an individual made a party to a proceeding because he is or was a director against liability incurred in the proceeding if:

- (1) He conducted himself in good faith; and

- (2) He reasonably believed (i) in the case of conduct in his official capacity with the corporation, that his conduct was in its best interests; and (ii) in all other cases, that his conduct was at least not opposed to its best interests; and
- (3) In the case of any criminal proceeding, he had no reasonable cause to believe his conduct was unlawful.

(b) A director's conduct with respect to an employee benefit plan for a purpose he reasonably believed to be in the interests of the participants in and beneficiaries of the plan is conduct that satisfies the requirement of subsection (a)(2)(ii).

(c) The termination of a proceeding by judgment, order, settlement, conviction, or upon a plea of no contest or its equivalent is not, of itself, determinative that the director did not meet the standard of conduct described in this section.

(d) A corporation may not indemnify a director under this section:

- (1) In connection with a proceeding by or in the right of the corporation in which the director was adjudged liable to the corporation; or
- (2) In connection with any other proceeding charging improper personal benefit to him, whether or not involving action in his official capacity, in which he was adjudged liable on the basis that personal benefit was improperly received by him.

(e) Indemnification permitted under this section in connection with a proceeding by or in the right of the corporation that is concluded without a final adjudication on the issue of liability is limited to reasonable expenses incurred in connection with the proceeding.

(f) The authorization, approval or favorable recommendation by the board of directors of a corporation of indemnification, as permitted by this section, shall not be deemed an act or corporate transaction in which a director has a conflict of interest, and no such indemnification shall be void or voidable on such ground. (1989 (Reg. Sess., 1990), c. 1071, s. 1.)

§ 58-65-168. Mandatory indemnification.

Unless limited by its articles of incorporation, a corporation shall indemnify a director who was wholly successful, on the merits or otherwise, in the defense of any proceeding to which he was a party because he is or was a director of the corporation against reasonable expenses incurred by him in connection with the proceeding. (1989 (Reg. Sess., 1990), c. 1071, s. 1.)

§ 58-65-169. Advance for expenses.

Expenses incurred by a director in defending a proceeding may be paid by the corporation in advance of the final disposition of such proceeding as authorized by the board of directors in the specific case or as authorized or required under any provision in the articles of incorporation or bylaws or by any applicable resolution or contract upon receipt of an undertaking by or on behalf of the director to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the corporation against such expenses. (1989 (Reg. Sess., 1990), c. 1071, s. 1.)

§ 58-65-170. Court-ordered indemnification.

Unless a corporation's articles of incorporation provide otherwise, a director of the corporation who is a party to a proceeding may apply for indemnification to the court conducting the proceeding or to another court of competent jurisdiction. On receipt of an application, the court after giving any notice the court considers necessary may order indemnification if it determines:

- (1) The director is entitled to mandatory indemnification under G.S. 58-65-168, in which case the court shall also order the corporation to pay the director's reasonable expenses incurred to obtain court-ordered indemnification; or
- (2) The director is fairly and reasonably entitled to indemnification in view of all the relevant circumstances, whether or not he met the standard of conduct set forth in G.S. 58-65-167 or was adjudged liable as described in G.S. 58-65-167(d), but if he was adjudged so liable his indemnification is limited to reasonable expenses incurred. (1989 (Reg. Sess., 1990), c. 1071, s. 1.)

§ 58-65-171. Determination and authorization of indemnification.

(a) A corporation may not indemnify a director under G.S. 58-65-167 unless authorized in the specific case after a determination has been made that indemnification of the director is permissible in the circumstances because he has met the standard of conduct set forth in G.S. 58-65-167.

(b) The determination shall be made:

- (1) By the board of directors by majority vote of a quorum consisting of directors not at the time parties to the proceeding;
- (2) If a quorum cannot be obtained under subdivision (1), by majority vote of a committee duly designated by the board of directors (in which designation directors who are parties may participate), consisting solely of two or more directors not at the time parties to the proceeding;
- (3) By special legal counsel (i) selected by the board of directors or its committee in the manner prescribed in subdivision (1) or (2); or (ii) if a quorum of the board of directors cannot be obtained under subdivision (1) and a committee cannot be designated under subdivision (2), selected by majority vote of the full board of directors (in which selection directors who are parties may participate); or
- (4) By the shareholders, but shares owned by or voted under the control of directors who are at the time parties to the proceeding may not be voted on the determination.

(c) Authorization of indemnification and evaluation as to reasonableness of expenses shall be made in the same manner as the determination that indemnification is permissible, except that if the determination is made by special legal counsel, authorization of indemnification and evaluation as to reasonableness of expenses shall be made by those entitled under subsection (b)(3) to select counsel. (1989 (Reg. Sess., 1990), c. 1071, s. 1.)

§ 58-65-172. Indemnification of officers, employees, and agents.

Unless a corporation's articles of incorporation provide otherwise:

- (1) An officer of the corporation is entitled to mandatory indemnification under G.S. 58-65-168 and is entitled to apply for court-ordered indemnification under G.S. 58-65-170, in each case to the same extent as a director;
- (2) The corporation may indemnify and advance expenses under this Part to an officer, employee, or agent of the corporation to the same extent as to a director; and
- (3) A corporation may also indemnify and advance expenses to an officer, employee, or agent who is not a director to the extent, consistent with public policy, that may be provided by its articles of incorporation, bylaws, general or

specific action of its board of directors, or contract. (1989 (Reg. Sess., 1990), c. 1071, s. 1; 1995, c. 193, s. 56.)

§ 58-65-173. Additional indemnification and insurance.

(a) In addition to and separate and apart from the indemnification provided for in G.S. 58-65-167, 58-65-168, 58-65-170, 58-65-171, and 58-65-172, a corporation may in its articles of incorporation or bylaws or by contract or resolution indemnify or agree to indemnify any one or more of its directors, officers, employees, or agents against liability and expenses in any proceeding (including without limitation a proceeding brought by or on behalf of the corporation itself) arising out of their status as such or their activities in any of the foregoing capacities; provided, however, that a corporation may not indemnify or agree to indemnify a person against liability or expenses he may incur on account of his activities which were at the time taken known or believed by him to be clearly in conflict with the best interests of the corporation. A corporation may likewise and to the same extent indemnify or agree to indemnify any person who, at the request of the corporation, is or was serving as a director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust or other enterprise or as a trustee or administrator under an employee benefit plan. Any provision in any articles of incorporation, bylaw, contract, or resolution permitted under this section may include provisions for recovery from the corporation of reasonable costs, expenses, and attorneys' fees in connection with the enforcement of rights to indemnification granted therein and may further include provisions establishing reasonable procedures for determining and enforcing the rights granted therein.

(b) The authorization, adoption, approval, or favorable recommendation by the board of directors of a corporation of any provision in any articles of incorporation, bylaw, contract or resolution, as permitted in this section, shall not be deemed an act or corporate transaction in which a director has a conflict of interest, and no such articles of incorporation or bylaw provision or contract or resolution shall be void or voidable on such grounds. The authorization, adoption, approval, or favorable recommendation by the board of directors of a corporation of any provision in any articles of incorporation, bylaw, contract or resolution, as permitted in this section, which occurred on or prior to the effective date of this act, shall not be deemed an act or corporate transaction in which a director has a conflict of interest, and no such articles of incorporation, bylaw provision, contract or resolution shall be void or voidable on such grounds.

(c) A corporation may purchase and maintain insurance on behalf of an individual who is or was a director, officer, employee, or agent of the corporation, or who, while a director, officer, employee, or agent of the corporation, is or was serving at the request of the corporation as a director, officer, partner, trustee, employee, or agent of another foreign or domestic corporation, partnership, joint venture, trust, employee benefit plan, or other enterprise, against liability asserted against or incurred by him in that capacity or arising from his status as a director, officer, employee, or agent, whether or not the corporation would have power to indemnify him against the same liability under any provision of this Chapter. (1989 (Reg. Sess., 1990), c. 1071, s. 1; 1991, c. 172.)

§ 58-65-174. Application of Part.

(a) If articles of incorporation limit indemnification or advance for expenses, indemnification and advance for expenses are valid only to the extent consistent with the articles.

(b) This Part does not limit a corporation's power to pay or reimburse expenses incurred by a director in connection with his appearance as a witness in a proceeding at a time when he has not been made a named defendant or respondent to the proceeding.

(c) This Part shall not affect rights or liabilities arising out of acts or omissions occurring before October 1, 1990. (1989 (Reg. Sess., 1990), c. 1071, s. 1.)

Part 3. Nonprofit Holding Corporations.

§ 58-65-175. Definitions.

The following definitions apply in this Part:

- (1) Affiliate. – As defined in G.S. 58-19-5.
- (2) Control. – As defined in G.S. 58-19-5.
- (3) Executive officer. – As defined in G.S. 58-19-5.
- (4) Nonprofit holding corporation. – A domestic corporation formed in connection with a reorganization and operating under Chapter 55A of the General Statutes that directly or indirectly through another domestic corporation operating under Chapter 55A of the General Statutes holds all the membership interests in a hospital service corporation and is the ultimate controlling person of the hospital service corporation. A nonprofit holding corporation is not (i) a "company," "insurance company," or "insurer," as those terms are defined in G.S. 58-1-5, or (ii) a "hospital service corporation," as defined in G.S. 58-65-1.1.
- (5) Reorganization. – A transaction or series of transactions in which a nonprofit holding corporation is created by or on behalf of a hospital service corporation to hold, directly or indirectly through another domestic corporation operating under Chapter 55A of the General Statutes, membership interests in the hospital service corporation and becomes the ultimate controlling person of the hospital service corporation.
- (6) Subsidiary. – As defined in G.S. 58-19-5.
- (7) Ultimate controlling person. – As defined in G.S. 58-19-5. (2023-33, s. 1.)

§ 58-65-177. Reorganization.

(a) Hospital Service Corporation to Be Held by Nonprofit Holding Corporation. – Notwithstanding any other provision of this Article, a hospital service corporation may have a nonprofit holding corporation as its ultimate controlling person.

(b) Reorganization Not a Change of Control. – A reorganization shall be considered an internal restructuring that does not have the effect of changing or influencing the control of the hospital service corporation. A reorganization shall not be considered a change of control of the hospital service corporation and shall not be subject to the provisions of G.S. 58-19-15.

(c) Transfers in Connection with Reorganization. – Notwithstanding any other provision of this Article, as part of a reorganization, a hospital service corporation may transfer cash, investments, or equity ownership interests in affiliates or subsidiaries to the nonprofit holding corporation and its subsidiaries by dividend, distribution, or otherwise. The total statutory value of cash, investments, and ownership interests in affiliates or subsidiaries, net of liabilities, transferred as part of a reorganization shall not exceed twenty-five percent (25%) of the hospital service corporation's admitted assets as of its most current annual statement filed with the Commissioner.

Any affiliate or subsidiary of the hospital service corporation transferred as part of a reorganization shall not be an insurer engaged in the issuance of health insurance policies.

(d) Compensation. – A director, officer, or employee of the hospital service corporation shall not receive any fee, commission, additional compensation, or other valuable consideration for aiding, promoting, or assisting in a reorganization. This subsection does not apply to compensation paid in the ordinary course of business. (2023-33, s. 1.)

§ 58-65-178. Approval by Commissioner.

Compliance with G.S. 58-19-30 and this Part shall be the exclusive means of approval to permit a reorganization, and the provisions of G.S. 58-19-10(b), 58-65-131, 58-65-132, and 58-65-133 shall not apply to a reorganization. (2023-33, s. 1.)

§ 58-65-179. Charter amendments.

(a) Notwithstanding (i) any law of this State to the contrary or (ii) anything to the contrary in the bylaws or charter of the hospital service corporation, a hospital service corporation may, by action of its governing board, authorize a reorganization and propose corresponding amendments to its charter. Proposed amendments shall be submitted to the Commissioner for approval, and the Commissioner shall approve the proposed amendments no later than 30 days after receiving the application unless the proposed amendments do not comply with Chapter 55A of the General Statutes.

(b) Any provision of this Article relating to the procedure for amending a charter, other than the provisions of this Part, is inapplicable. (2023-33, s. 1.)

§ 58-65-180. Information to be provided by a hospital service corporation.

(a) A hospital service corporation reorganizing pursuant to this Part shall file the following information with the Commissioner:

- (1) A description of the transactions that effectuate the reorganization.
- (2) A copy of any proposed amendments to the hospital service corporation's charter.
- (3) A copy of the nonprofit holding corporation's articles of incorporation.
- (4) If applicable, any information required by G.S. 58-19-30.
- (5) A pro forma balance sheet and income statement for the hospital service corporation prepared in accordance with statutory accounting principles, demonstrating the hospital service corporation's financial position at the effective time of the reorganization.
- (6) A pro forma balance sheet and income statement for the nonprofit holding corporation prepared in accordance with generally accepted accounting principles, demonstrating the nonprofit holding corporation's financial position at the effective time of the reorganization.
- (7) A certification by an executive officer of the hospital service corporation that at the time of the reorganization the subscribers' contracts and certificates issued by the hospital service corporation shall remain in full force and effect.
- (8) A certification by an executive officer of the hospital service corporation that at the time of the reorganization the governing board of the nonprofit holding corporation will be comprised solely of individuals on the governing board of the hospital service corporation.

(b) The Commissioner may contract, at the expense of the hospital service corporation, with professional advisors not otherwise a part of the Commissioner's staff to assist the Commissioner in reviewing the materials submitted pursuant to this section. These contracts are personal professional service contracts exempt from Articles 3 and 3C of Chapter 143 of the General Statutes.

(c) Upon completion of a reorganization, the hospital service corporation shall provide a notice of completion of the reorganization to the Commissioner.

(d) Information submitted as part of a reorganization that constitutes trade secrets or personal information, including addresses, shall be confidential by law and privileged, shall not be considered a public record under either G.S. 58-2-100 or Chapter 132 of the General Statutes, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. (2023-33, s. 1.)

§ 58-65-181. Operation of nonprofit holding corporation and subsidiaries.

(a) Except as provided in this Part, a nonprofit holding corporation shall not be subject to this Article or Article 66 of this Chapter.

(b) The following shall apply to a nonprofit holding corporation upon and after a reorganization:

- (1) The nonprofit holding corporation shall remain a nonprofit corporation subject to Chapter 55A of the General Statutes with no members. The nonprofit holding corporation shall remain the ultimate controlling person of the hospital service corporation. The nonprofit holding corporation shall support the purposes of the hospital service corporation such that at all times all or substantially all of the net worth of the nonprofit holding corporation, as determined by generally accepted accounting principles, other than its investment portfolio held in the ordinary course of business, shall be invested in insurance companies or other affiliates or subsidiaries that (i) engage in operations permitted pursuant to G.S. 58-19-10(a), (ii) contribute to the health needs of customers, subscribers, or the people of this State, including those in rural communities of this State, or (iii) promote affordability, access, better health, or customer experience. The Commissioner may waive the foregoing restriction upon a showing of good cause. Other than as set forth in this subdivision, the nonprofit holding corporation's investments in affiliates and subsidiaries shall not be subject to any of the restrictions set forth in G.S. 58-19-10. This subdivision shall not apply if a plan of conversion of the hospital service corporation is approved pursuant to G.S. 58-65-131, 58-65-132, or 58-65-133.
- (2) The nonprofit holding corporation and its direct or indirect subsidiaries that are not hospital service corporations or subsidiaries of hospital service corporations are not subject to G.S. 58-65-131, 58-65-132, or 58-65-133, and the actions of the nonprofit holding corporation and such subsidiaries will not constitute or require a conversion of the hospital service corporation under those sections or any other law of this State.
- (3) The nonprofit holding corporation and its subsidiaries shall automatically be a party to any delinquency proceeding under Article 30 of this Chapter involving a hospital service corporation which, as a result of a reorganization, is a subsidiary of the nonprofit holding corporation. In any delinquency proceeding

under Article 30 of this Chapter involving the hospital service corporation, the assets of the nonprofit holding corporation are deemed to be assets of the estate of the hospital service corporation for purposes of satisfying the claims of the hospital service corporation's subscribers. The nonprofit holding corporation shall not dissolve or liquidate without the approval of the Commissioner or as ordered by the court pursuant to Article 30 of this Chapter.

- (4) The nonprofit holding corporation shall file annually with the Commissioner by June 1 of each year consolidated audited financial statements for the nonprofit holding corporation for the preceding calendar year. The nonprofit holding corporation shall also file annually with this financial statement executive compensation information for its Chief Executive Officer, Chief Financial Officer, and the next eight highest paid executive officers.
- (5) The nonprofit holding corporation shall file annually with the Commissioner by June 1 of each year a report describing the nonprofit holding corporation's strategic investment activities for the preceding calendar year.

(c) The governing board of the nonprofit holding corporation shall be comprised solely of individuals on the governing board of the hospital service corporation. No equity or ownership interest in the nonprofit holding corporation or any of its subsidiaries shall be granted to any executive officer or any member of the governing board of the nonprofit holding corporation or the hospital service corporation.

(d) The Commissioner is empowered to exercise the authority provided under G.S. 58-2-40 and G.S. 58-2-60 for purposes of enforcing the nonprofit holding corporation's compliance with this Part. (2023-33, s. 1.)

§ 58-65-183. Operation of hospital service corporation.

(a) A reorganization does not change (i) the legal form of the hospital service corporation or (ii) the hospital service corporation's license to do business in North Carolina. Any subscribers' contracts and certificates issued by the hospital service corporation shall remain in full force and effect.

(b) The hospital service corporation shall continue to be subject to this Article and Article 66 of this Chapter, except for the following:

- (1) Neither a reorganization nor any other transaction permitted by this Part shall constitute or require a conversion of the hospital service corporation pursuant to G.S. 58-65-131, 58-65-132, 58-65-133, or any other law of this State.
- (2) Neither a reorganization nor any other transaction permitted by this Part shall require the nonprofit holding corporation, hospital service corporation, or any affiliate of either to make any distribution or payment to any person or entity. This subdivision shall not apply to distributions or payments between a nonprofit holding corporation or hospital service corporation and any of its affiliates.
- (3) The hospital service corporation may make and pay direct or indirect dividends or distributions to the nonprofit holding corporation, and G.S. 58-19-10(b), 58-65-131, 58-65-132, and 58-65-133 shall not apply to such dividends or distributions, provided that such dividends or distributions satisfy the applicable standards for payment of a dividend or distribution set forth in G.S. 55A-13-02, 58-7-130, 58-19-25(d), and 58-19-30.

- (4) If the hospital service corporation undertakes a conversion pursuant to G.S. 58-65-131, 58-65-132, and 58-65-133 at any time following a reorganization, then, for the purposes of that conversion, the references in G.S. 58-65-131, 58-65-132, and 58-65-133 to "fair market value of the corporation" or "value of the corporation" shall mean the fair market value of the nonprofit holding corporation and its consolidated subsidiaries. (2023-33, s. 1.)