"CHAPTER 432 [OLD]
TITLE INSURANCE AND TITLE INSURERS

REPEALED. L 1987, c 347, §1.

Cross References

For present provisions, see chapter 431, article 20.
For disposition of repealed provisions, see also Insurance Law Revision reference table at the end of chapter 435.

CHAPTER 432
BENEFIT SOCIETIES

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Conformance to federal law, see §431:2-201.5.
Health care provider network adequacy, see chapter 432F.
Health insurance rate regulation, see chapter 431, article 14F.
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Medicaid-related mandates, see chapter 431L.
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Prescription drugs; mail order opt out option, see §87A-16.3.

Attorney General Opinions

Section 431:10A-601 applied only to insurers, and not mutual benefit societies or health maintenance organizations. Att. Gen. Op. 97-5.

"ARTICLE 1
MUTUAL BENEFIT SOCIETIES

Cross References

Assessments of health insurers, see §431:2-216.

PART I. GENERAL PROVISIONS

§432:1-101 Scope; exemptions. The provisions of this article shall apply to mutual benefit societies as defined herein. Except as expressly provided in this article, mutual benefit societies shall be exempt from the provisions of the insurance code. No law enacted after July 1, 1988, shall apply to mutual benefit societies unless such societies are expressly designated therein. [L 1987, c 347, pt of §2]

Revision Note

"July 1, 1988," substituted for "the effective date of this article".

Attorney General Opinions

Based on provision, the requirement of §431:10A-601 as set forth in §4 of reciprocal beneficiaries act [L 1997, c 383] cannot be interpreted to apply to mutual benefit societies. Att. Gen. Op. 97-5.

Case Notes

Section 431:15-102 creates an exception to the general rule established by this section that mutual benefit societies are typically exempt from provision of the Insurance Code; thus, article 15 of chapter 431 applies to mutual benefit societies. 99 H. 53, 52 P.3d 823.

" **§432:1-101.5 Disclosure of health care coverage and benefits.** In order to ensure that all individuals understand their health care options and are able to make informed decisions, all mutual benefit societies shall provide current and prospective members with written disclosure of coverages and benefits, including information on coverage principles and any exclusions or restrictions on coverage.

The information provided shall be current, understandable, and available prior to membership, and upon request after membership. A policy provided to a member which describes coverages and benefits shall be in conformance with part I of article 10 of chapter 431. [L 1996, c 274, §2; am L 1999, c 246, §3]

" **§432:1-101.6 Policies relating to domestic abuse cases.** (a) No mutual benefit society shall deny or refuse to accept an application for insurance, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage, on the basis that the member or prospective member is, has been, or may be a victim of domestic abuse.

(b) Nothing in this section shall prevent a mutual benefit society from taking any of the actions set forth in subsection (a) on the basis of loss history or medical condition, or for any other reason not otherwise prohibited by this section or any other law, regulation, or rule.

(c) Any form filed or filed after July 15, 1998 or subject to a rule adopted under chapter 91 may exclude coverage for losses caused by intentional or fraudulent acts of any member of the society.

(d) Nothing in this section prohibits a mutual benefit society from investigating a claim and complying with chapter 432.

(e) As used in this section, "domestic abuse" means:

(1) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members;

(2) Sexual assault of one family or household member by another;

(3) Stalking of one family or household member by another family or household member; or
(4) Intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another household member. [L 1998, c 171, §3; am L 2004, c 122, §84]

Revision Note

"July 15, 1998" substituted for "the effective date of this section".

" **§432:1-102 Applicability of other laws.** (a) Part III of article 10A, and article 10H of chapter 431 shall apply to nonprofit medical indemnity or hospital service associations. Such associations shall be exempt from the provisions of part I of article 10A; provided that such exemption is in compliance with applicable federal statutes and regulations.

(b) Article 2, article 2D, parts II and IV of article 3, article 6, part III of article 7, article 9A, article 13, article 14G, and article 15 of chapter 431, sections 431:3-301, 431:3-302, 431:3-303, 431:3-304, 431:3-305, 431:10-102, 431:10-225, 431:10-226.5, and 431:10A-116(1) and (2), and the powers granted by those provisions to the commissioner, shall apply to managed care plans, health maintenance organizations, or medical indemnity or hospital service associations that are owned or controlled by mutual benefit societies so long as the application in any particular case is in compliance with and is not preempted by applicable federal statutes and regulations.

(c) The commissioner may adopt rules pursuant to chapter 91 for the implementation and administration of this chapter. [L 1987, c 347, pt of §2; am L 1998, c 178, §3; am L 1999, c 93, §6; am L 2002, c 74, §§3, 6; am L 2003, c 3, §22; am L 2007, c 175, §3 and c 227, §2; am L 2011, c 80, §7; am L 2012, c 251, §2; am L 2013, c 56, §1; am L 2015, c 63, §11; am L 2016, 141, §16]

Note

The repeal and reenactment note at subsection (b) in the main volume took effect on June 30, 2006, pursuant to L 2002, c 74, §6 and L 2003, c 3, §22.

" **§432:1-103 Applicability of this article to existing societies and union mutual benefit societies.** (a) None of the provisions of this article shall apply to, or in any way be held

to affect, mutual benefit and fraternal societies which have been in existence and functioning within the State continuously for ten years prior to May 8, 1937.

(b) The provisions of this article shall apply to labor union mutual benefit societies, which are also regulated by Public Law 85-836, but the commissioner may waive any of the specific requirements of this article if the commissioner is satisfied that the labor union members and their dependents belonging to the mutual benefit society will not be adversely affected by the waiver. Each labor union mutual benefit society shall file with the commissioner annually a copy of the report filed under Public Law 85-836 and a complete financial report prepared by a certified public accountant. [L 1987, c 347, pt of §2]

" **§432:1-104 Definitions.** For the purposes of this article:

(1) "Commissioner" means the insurance commissioner of the State of Hawaii.

(2) "Mutual benefit society" is any corporation, unincorporated association, society, or entity:

(A) Organized and carried on for the primary benefit of its members and their beneficiaries and not for profit, and:

(i) Making provision for the payment of benefits in case of sickness, disability, or death of its members, or disability, or death of its members' spouses or reciprocal beneficiaries or children, or

(ii) Making provision for the payment of any other benefits to or for its members,

whether or not the amount of the benefits is fixed or rests in the discretion of the society, its officers, or any other person or persons; and the fund from which the payment of the benefits shall be defrayed is derived from assessments or dues collected from its members, and the payment of death benefits is made to the families including reciprocal beneficiaries, heirs, blood relatives, or persons named by its members as their beneficiaries; or

(B) Organized and carried on for any purpose, which:

(i) Regularly requires money to be paid to it by its members, whether the money be in the form of dues, subscriptions, receipts, contributions, assessments or otherwise, and

(ii) Provides for the payment of any benefit or benefits or the payment of any money or the

delivery of anything of value to its members or their relatives including reciprocal beneficiaries, or to any person or persons named by its members as their beneficiaries, or to any class of persons which includes or may include its members,

whether or not the amount or value of the benefit, benefits, money, or thing of value is fixed, or rests in the discretion of the society, its officers, or any other person or persons; or

(C) Organized and carried on for any purpose, whose requirements and provisions although not identical with, are determined by the commissioner to be substantially similar to, those enumerated in subparagraphs (A) and (B).

Participating in a legal service plan subject to chapter 488 shall not in itself make a corporation, unincorporated association, society, or entity a mutual benefit society and subject to this article. [L 1987, c 347, pt of §2; am L 1993, c 350, §18; am L 1997, c 383, §60; am L 2012, c 34, §23]

Attorney General Opinions

Effect of amendment to section [by L 1997, c 383] was to allow, but not require, a mutual benefit society to make provision for payment of benefits to reciprocal beneficiaries. Att. Gen. Op. 97-5.

" **[§432:1-104.5] Bona fide trade associations.** (a) At the option of a bona fide trade association, or its designated agent, a mutual benefit society that operates a health plan and sells health insurance to the bona fide trade association shall treat the bona fide trade association and its members as a group for the purpose of issuing a group hospital or medical service plan, policy, contract, or agreement; provided that:

(1) The bona fide trade association shall have been formed for purposes other than obtaining insurance;

(2) The mutual benefit society shall be prohibited from restricting, in any manner, the number or types of health plans issued by another insurance entity that the bona fide trade association may offer to its members, including but not limited to such restrictions as clauses that reduce competition between insurers or clauses that require a bona fide

trade association to allow an insurer to match the price or terms offered by another insurer; and

(3) Each member of the bona fide trade association shall not be required to be insured under the group policy;

and provided further that this section shall be inapplicable if less than two persons from the bona fide trade association seek to be insured under the group policy.

(b) As used in this section:

"Bona fide trade association" means an association of persons organized to promote common interests and comprised of persons engaged in a business, trade, or profession that:

(1) Has been actively in existence for five years;
(2) Has been formed and maintained in good faith for purposes other than obtaining insurance;
(3) Does not condition membership in the association on any health status related factor pertaining to an individual (including an employee of an employer or a dependent of an employee);
(4) Makes health insurance coverage offered through the association available to all members regardless of any health status related factor pertaining to such members (or individuals eligible for coverage through a member);
(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and
(6) Meets such additional requirements as may be imposed under state law. [L 2004, c 118, §§2, 5; am L 2006, c 41, §2]

" **§432:1-105 Penalty.** There shall be a fine of not more than $1,000 or imprisonment of not more than one year, or both, for:

(1) Any person who is found in the State as officer, member, principal, agent, or in any other capacity, soliciting or conducting or operating the business of a mutual benefit society, as defined in section 432:1-104, not qualified and licensed to operate the business in conformity with this article, or
(2) Any trustee, officer, or other person in charge of the affairs of any such society, who authorizes, sanctions, or permits the issuance of any certificate, policy, or contract, for the payment of benefits in violation of this article, or

(3) Any person who violates any other provision of this article relating to mutual benefit societies. [L 1987, c 347, pt of §2; am L 2002, c 155, §103]

" **§432:1-106 REPEALED.** L 2009, c 149, §12.

Cross References

Insurance fraud, see §§431:2-401 to 431:2-410.

" **[§432:1-107] Federal law compliance.** A mutual benefit society shall comply with applicable federal law. The commissioner shall enforce the consumer protections and market reforms relating to insurance as set forth in the federal Patient Protection and Affordable Care Act, Public Law 111-148. [L 2011, c 15, §2]

" **[§432:1-107.5] Prohibition on rescissions of coverage.** (a) Notwithstanding sections 431:10-226.5 and 431:10A-106 to the contrary, a society shall not rescind coverage under a health benefit plan with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, after the individual is covered under the plan, unless:

(1) The individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud;
(2) The individual makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage; or
(3) The individual fails to timely pay required premiums or contributions toward the cost of coverage; provided that the rescission is in compliance with federal regulations.

As used in this subsection, "a person seeking coverage on behalf of the individual" shall not include an insurance producer or employee or authorized representative of the health carrier.

(b) A society shall provide at least thirty days advance written notice to each plan enrollee or, for individual health insurance coverage, to each primary subscriber, who would be affected by the proposed rescission of coverage before coverage under the plan may be rescinded in accordance with subsection (a) regardless of whether, in the case of group health insurance

coverage, the rescission applies to the entire group or only to an individual within the group.

(c) This section applies regardless of any applicable contestability period. [L 2014, c 186, §2]

" **[§432:1-108] Fees.** (a) The commissioner shall collect, in advance, the following fees:

(1) Certificate of authority:
  (A) Application for a certificate of authority: $900; and
  (B) Issuance of certificate of authority: $600;
(2) Organization of domestic mutual benefit societies:
  (A) Application for a certificate of registration: $1,500; and
  (B) Issuance of certificate of registration: $150; and
(3) For all services subsequent to the issuance of a certificate of authority, including extension of the certificate of authority: $600 per year.

(b) No certificate of authority shall contain an expiration date, but all certificates of authority shall be extended by the commissioner from time to time in order to continue to be valid. When the commissioner issues or extends a certificate of authority, the commissioner shall determine the date prior to which the certificate of authority shall be extended and shall so notify the insurer in writing. This date is called the extension date. The extension date shall be any date not less than one year and not more than three years after date of issue or extension of the certificate of authority. If the insurer qualifies, its certificate of authority shall be extended. The commissioner shall provide each holder of a certificate of authority at least thirty days' advance written notice of the applicable extension date. If the fee for the extension of the certificate of authority is not paid before or on the extension date, a penalty shall be imposed in the amount of fifty per cent of the fee. The commissioner shall provide notice in writing of the delinquency of extension and the imposition of the authorized penalty. If the fee and the penalty are not paid within thirty days immediately following the date of the notice of delinquency, the commissioner may revoke the certificate of authority and may not reinstate the certificate of authority until the fee and penalty have been paid.

(c) All fees and penalties collected pursuant to this section and penalties collected pursuant to sections 432:1-105, 432:1-405, and 432:1-407 shall be deposited to the credit of the

compliance resolution fund. [L 2012, c 251, §1; am L 2015, c 63, §12]

"PART II. ORGANIZATION

§432:1-201 Incorporation by charter. Any mutual benefit society may be or become incorporated by charter, notwithstanding any limitations under the corporation law as to the purposes for which charters may be granted. Any society so chartered as a corporation shall be subject in all respects to this article. [L 1987, c 347, pt of §2; am L 2001, c 217, §1]

" **§432:1-202 Constitution and bylaws; officers; government of society.** (a) Mutual benefit societies promising or offering to pay death, sick, disability, or other benefits in an amount equal to or in excess of $25 shall, subject to the approval of the commissioner, have the power to make a constitution and bylaws for the government of the society, the admission of its members, the management of its affairs, and the fixing and readjusting of the rates of contribution of its members. The societies shall have the power to amend the constitution and bylaws and such other powers as are necessary to carry into effect the object and purpose of the society, but shall not suspend temporarily any part of its constitution or bylaws as the same are governed by this article.

(b) Each mutual benefit society shall elect or otherwise appoint among its officers a president and a treasurer, who shall be residents of the State.

(c) After the organization of a society is completed and a certificate of registration is granted by the commissioner, the society shall be governed by its administrative board or body in accordance with its constitution and bylaws.

(d) Upon compliance with this article any society engaged in transacting business or operating in this State may exercise all of the rights conferred by this article, and all of the rights, powers and privileges possessed by it under its constitution and bylaws, rules and regulations, or articles of incorporation or charter not inconsistent with this article. [L 1987, c 347, pt of §2; am L 2012, c 251, §3]

" **§432:1-203 Actions or proceedings.** (a) An action or special proceeding may be maintained, by the president or treasurer of the society, to recover any property, or upon any cause of action, for or upon which all the associates may maintain an action or special proceeding, by reason of their

interest or ownership therein, either jointly or in common. An action may likewise be maintained by the president or treasurer to recover from one or more members of the society such member's or members' proportionate share of any moneys lawfully expended by the society for the benefit of the associates, or to enforce any lawful claim of the society against its member or members.

(b) An action or special proceeding may be maintained, against the president or treasurer of the society, to recover any property, or upon any cause of action, for or upon which the plaintiff may maintain an action or special proceeding, against all the associates, by reason of their interest or ownership, or claim of ownership therein, either jointly or in common, or their liability therefor, either jointly or severally, and any order, decree, judgment, or other ruling in any such case shall be binding upon the society and the members thereof.

(c) The death or legal incapacity of a member of the society shall not affect an action or special proceeding, brought as prescribed in subsections (a) and (b). If the officer, by or against whom it is brought, dies, is removed, resigns, or becomes otherwise incapacitated, during the pendency thereof, the court shall make an order, directing it to be continued by or against such officer's successor in office, or any other officer, by or against whom it might have been originally commenced.

(d) In such an action, the officer against whom it is brought cannot be arrested; and a judgment against such officer shall not authorize an execution to be issued against the officer's property, or the officer's person; nor shall the docketing thereof bind the officer's real property or personal property. Where the judgment is for a sum of money, an execution issued thereupon shall require the levying officer to satisfy the judgment out of any personal or real property belonging to the society, or owned, jointly or in common, by all the members thereof.

(e) Where an action has been brought against an officer, or a counterclaim has been made, in an action brought by an officer, as prescribed in this section, another action, for the same cause, shall not be brought against the members of the society, or any of them, until after final judgment in the first action, and the return, wholly or partly unsatisfied or unexecuted, of an execution issued thereupon. After the return, the party in whose favor the execution was issued, may maintain an action, as follows:

(1) Where such party was the plaintiff, or a defendant recovering upon a counterclaim, such party may maintain an action against the members of the society, or, in a proper case, against any of them, as if the

first action had not been brought, or the counterclaim had not been made, as the case requires; and such party may recover, as part of such party's damages, the costs of the first action, or so much thereof, as the sum, collected by virtue of the execution, was insufficient to satisfy; and

(2) Where such party was a defendant, and the case is not within paragraph (1), such party may maintain an action, to recover the sum remaining uncollected, against the persons who composed the society, when the action against such party was commenced, or the survivors of them.

(f) This section shall not affect the right of the person, in whose favor the judgment in the first action was rendered, to enforce a bond or undertaking, given in the course of the proceedings therein.

(g) This section shall not prevent an action from being brought by or against all the members of a society, except as prescribed in this section. Where an action is brought against the members of the society, as prescribed in this section, the time between the commencement of the action by or against the officer, and the return of the first execution issued upon the final judgment rendered therein, shall not be a part of the time limited by law, for the commencement of the second action. [L 1987, c 347, pt of §2; am L 2004, c 122, §85]

" **§432:1-204 Foreign societies.** Any foreign society subject to this article shall not be excused or relieved from compliance with this article by reason of the nonresidence of its members. Upon a showing to the satisfaction of the commissioner that it is impracticable and would work a hardship to comply with section 432:1-202(b) the commissioner shall permit the society to qualify in this respect upon its appointment of a resident agent, in the same manner and subject to the same conditions as are provided for in the case of foreign corporations under the general laws on corporations. Section 432:1-202(b) shall likewise be applicable to the agent. [L 1989, c 195, §9]

"**PART III. AUTHORITY TO OFFER BENEFITS**

§432:1-301 Registration with commissioner: certificate of registration and certificate of authority. (a) Before doing business or engaging in any act, any society as defined in section 432:1-104(2) shall file with the commissioner:

(1) Copies of its constitution or organic instrument under which it purports to operate, and the bylaws, and rules and regulations, if any;

(2) If a society promising or offering to pay death, sick, disability, or other benefits in an amount equal to or in excess of $25:
   (A) Copies of all proposed forms of benefit certificates, applications, and circulars to be issued by the society; and
   (B) A bond in the sum of $25,000 with sureties approved by the commissioner. The bond shall be conditioned upon the return of the advance payments referred to in section 432:1-304, if the organization is not completed within one year; and
(3) Any additional information as the commissioner may require.

(b) Except as provided in section 432:1-302, upon the filing of the information required by subsection (a), if it appears to the commissioner's satisfaction that the purposes of the society are lawful, not for profit, and for the benefit of its members, the commissioner shall issue a certificate of registration authorizing the society to solicit members as provided in section 432:1-303.

(c) Upon issuance of a certificate of registration pursuant to subsection (b), the society may apply for a certificate of authority. The applicant society shall provide to the commissioner:
(1) Evidence of compliance with the special deposit requirements of section 432:1-304; and
(2) A description of the procedures, approved by the society's administrative board or body in accordance with its constitution and bylaws, to be implemented to comply with the protection against insolvency requirements of section 432:1-407.

(d) The applicant society that satisfies the requirements of this chapter shall be issued a certificate of authority in accordance with part II of article 3 of chapter 431. Societies that are currently authorized to transact business in this State may continue to transact business until August 16, 2013. The authority of societies and all societies hereafter issued a certificate of authority may thereafter be extended in accordance with section 432:1-108.

The applicant society may appeal a denial of its application pursuant to chapter 91. [L 1987, c 347, pt of §2; am L 2004, c 122, §86; am L 2012, c 251, §4; am L 2015, c 63, §13]

" **§432:1-302 Commissioner refusal to authorize certificate or solicitation; appeal to circuit court.** (a) If the

commissioner reasonably believes that the financial plan of the society is unsound or not feasible from an actuarial or other accounting standpoint, the commissioner shall refuse to issue a certificate, authorize the society to solicit members, or engage in business.

(b) Any person aggrieved by the decision of the commissioner refusing to issue the certificate, or to authorize the society to solicit members, or to engage in business, may within twenty days after the decision appeal to the circuit court of the circuit in which the society proposes to have its principal place of business. The procedure upon appeal shall be the same as in the case of other appeals to the circuit court in civil cases. The court shall hear the appeal without a jury. [L 1987, c 347, pt of §2]

" **§432:1-303 Authority to offer death, sick, disability, or other benefits; conditions.** (a) Each society promising or offering to pay death, sick, disability, or other benefits in an amount equal to or in excess of $25 may solicit members for the purpose of completing its organization upon receipt from the commissioner of the certificate of registration required in section 432:1-301, and may collect from each applicant the amount of not more than one regular monthly payment and shall issue to each applicant a receipt for the amount so collected.

(b) Except as hereinafter provided, no society shall incur any liability other than for the advance payments, nor issue any benefit certificate, nor allow, or offer or promise to pay, or allow to any person any death benefit until:

(1) Actual bona fide applications for death certificates have been secured upon at least one hundred lives for at least $25 each, and all the applicants for death benefits have been regularly examined by a qualified practicing physician, and certificates of the examination have been duly filed with and approved by the administrative board or body of the society; and
(2) At least one hundred applicants have been accepted for membership; and
(3) There has been submitted to the commissioner, under oath of the president and secretary, or corresponding officers of the society, a list of applicants including the following information about each applicant:
    (A) Name and address,
    (B) Date examined,
    (C) Date of approval,
    (D) Date accepted as member,

(E) If subordinate branches have been established, the name and number of the subordinate branch of which each applicant is a member,

(F) Amount of benefits to be granted, and

(G) The rate of stated periodical contributions which shall be sufficient to provide for meeting the mortuary obligations contracted when valued for death purposes upon the basis of a recognized table of mortality or any mutual benefit standard based on at least twenty years' experience, and for disability benefits by tables based upon reliable experience, and for combined death and permanent total disability benefits by tables based upon reliable experience; and

(4) It has been shown to the commissioner by the sworn statement of the treasurer or corresponding officer of the society that at least one hundred applicants have paid in cash at least one regular monthly payment as provided under subsection (a), which payments in the aggregate shall amount to at least five times the maximum amount of death benefit offered or promised to be paid to any one member.

(c) If the society does not offer or promise to pay any death benefits in excess of $25 upon the death of a member, but merely offers or promises to pay disability benefits by reason of sickness or injury, or to pay any other benefits, with or without provision of death benefit in excess of $25, the society shall apply for a certificate of authority from the commissioner. [L 1987, c 347, pt of §2; am L 2012, c 251, §5]

" **§432:1-304 Authority to offer death, sick, disability, or other benefits; special deposit and control of certain funds.** Except as provided in this section and section 432:1-305, all regular payments received for account of death benefit, accident and health or sickness, or other benefits, during the period of organization of a society, shall not be used for the payment of any expenses of the society, but shall be placed on deposit or in trust in some bank or trust company approved by the commissioner, payable to the society but under the joint control with the commissioner. In case the organization of the society is not completed within one year, the funds shall be returned to the applicants or members who made payments of the respective amounts. If, however, the organization is completed and the commissioner issues a certificate of authority, the funds so deposited in trust, together with interest, if any, shall be

released by the commissioner in favor of the society. [L 1987, c 347, pt of §2; am L 2004, c 122, §87; am L 2012, c 251, §6]

" **§432:1-305 Authority to offer death, sick, disability, or other benefits; restrictions on use of funds.** (a) At no time shall the society, except as provided in subsection (c), use more than twenty-five per cent of the payments up to $100,000 and seven per cent of the payments in excess of $100,000, received from its members or applicants in the form of admission fees, dues, contributions, or assessments of any nature for expenses other than taxes, in connection with its management or operations.

(b) Any commissions or other payments or allowances to persons soliciting membership in or making collections for the society shall be included in the foregoing expenditures and no part of the commissions, payments or allowances may be in addition thereto; provided, that any society which exacts a membership fee of its new members not in excess of $10 for each membership may pay commissions or other payments to persons soliciting membership out of the fund created by the membership fees, and the amounts so paid as commissions or as such other payments out of such fund shall not be considered as expenses within the meaning of section 432:1-304 and section [432:1-305].

(c) Any association or society organized and operating solely as a nonprofit medical indemnity or hospital service association or society may use for such expenses, in addition to taxes, not more than thirty-five per cent of the payments received from its members or applicants in the form of admission fees, dues, contributions, or assessments of any nature. [L 1987, c 347, pt of §2; am L 2012, c 251, §7]

" **§432:1-306 Authority to offer death, sick, disability, or other benefits; deposit or bond.** (a) The society shall deposit with the commissioner fifty per cent of the minimum net worth requirement provided in section 432:1-407(a)(2), either in cash or in securities approved by the commissioner; provided that the deposit shall be no less than $1,000,000 and shall not exceed $20,000,000.

(b) In lieu of such deposit, the society shall file with the commissioner a good and sufficient bond in the amount prescribed in subsection (a), signed by the society as principal with one or more sureties to be approved by the commissioner and running to the commissioner and the commissioner's successors in office. The bond shall be conditioned that the surety or sureties on the bond shall be answerable in the amount of the

bond for all judgments, decrees or orders given, made or rendered against the principal on the bond by any court of the State for payment of money. [L 1987, c 347, pt of §2; am L 2011, c 81, §11]

" **§432:1-307 REPEALED.** L 2012, c 251, §15.

" **[§432:1-308] Suspension, revocation, or denial of certificate of authority.** (a) Any certificate of authority issued under this chapter may be suspended or revoked and any application for a certificate of authority may be denied if the commissioner finds that any of the conditions listed below exists:

(1) The mutual benefit society is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under section 432:1-301, unless amendments to the submissions have been filed with and approved by the commissioner;

(2) The mutual benefit society is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to its members and beneficiaries or prospective members;

(3) The mutual benefit society has failed to correct, within the time prescribed by subsection (c), any deficiency occurring due to the mutual benefit society's prescribed minimum net worth being impaired;

(4) The mutual benefit society, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner;

(5) The continued operation of the mutual benefit society would be hazardous to its members; or

(6) The mutual benefit society has otherwise failed to substantially comply with this chapter.

(b) In addition to, or in lieu of, suspension or revocation of a certificate of authority pursuant to this section, the commissioner may levy an administrative fine upon the mutual benefit society in an amount not less than $500 and not more than $50,000 pursuant to section 431:3-221.

(c) The following shall pertain when insufficient net worth is maintained:

(1) Whenever the commissioner finds that the net worth maintained by any mutual benefit society subject to this chapter is less than the minimum net worth

required, the commissioner shall give written notice to the mutual benefit society of the amount of the deficiency and require the mutual benefit society to:

(A) File with the commissioner a plan for correction of the deficiency acceptable to the commissioner; and

(B) Correct the deficiency within a reasonable time, not to exceed sixty days, unless an extension of time, not to exceed sixty additional days, is granted by the commissioner. The deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the mutual benefit society in conservation, rehabilitation, or liquidation; and

(2) Unless allowed by the commissioner, no mutual benefit society or person acting on its behalf, directly or indirectly, may renew, issue, or deliver any certificate, agreement, or contract of coverage in this State for which a premium is charged or collected, when the mutual benefit society writing the coverage is impaired and the fact of the impairment is known to the mutual benefit society or to the person; provided that the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement, or contract when the member exercises an option granted under the plan to obtain a new, renewed, or converted coverage.

(d) A certificate of authority shall be suspended or revoked, an application for a certificate of authority denied, or an administrative fine imposed, only after compliance with the requirements of this section, including the following:

(1) Suspension or revocation of a certificate of authority, denial of an application, or imposition of an administrative fine pursuant to this section shall be by written order and shall be sent to the mutual benefit society or applicant by certified or registered mail. The written order shall state the grounds, charges, or conduct on which suspension, revocation, denial, or administrative penalty is based. The mutual benefit society or applicant, in writing, may request a hearing pursuant to section 431:2-308; and

(2) If the mutual benefit society or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing and send it to

the mutual benefit society or applicant by certified or registered mail and to the director of labor and industrial relations stating:

(A) A specific time for the hearing, which may not be less than twenty nor more than thirty days after mailing of the notice of hearing; and

(B) A specific place for the hearing.

(e) When the certificate of authority of a mutual benefit society is suspended, the mutual benefit society shall not, during the period of the suspension, enroll any additional members except newborn children or other newly acquired dependents of existing members and shall not engage in any advertising or solicitation whatsoever.

(f) When the certificate of authority of a mutual benefit society is revoked, the society, immediately following the effective date of the order of revocation, shall proceed to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the society. The mutual benefit society shall engage in no further advertising or solicitation whatsoever. The commissioner, by written order, may permit further operation of the society as the commissioner may find to be in the best interest of the members, to the end that members will be afforded the greatest practical opportunity to obtain continuing coverage and benefits. [L 2015, c 63, §23]

"**PART IV. FINANCIAL AND REPORTING REQUIREMENTS**

§432:1-401 REPEALED. L 2011, c 81, §12.

" **§432:1-402 Investments of certain mutual benefit societies.** No domestic mutual benefit society promising or offering to pay death, sick, disability, or other benefits in an amount equal to or in excess of $25 shall invest any of its assets other than as authorized and provided for in respect to domestic insurance companies and societies under the provisions of article 6 of the insurance code, which provisions are hereby extended to and made applicable to the mutual benefit societies. [L 1987, c 347, pt of §2]

" **§432:1-403 Nonprofit medical, hospital indemnity associations; tax exemption.** Every association or society organized and operating under this article solely as a nonprofit medical indemnity or hospital service association or society or both shall be, from the time of such organization, exempt from

every state, county and municipal tax, except unemployment compensation tax. Nothing in this section shall be deemed to exempt the association or society from liability to withhold the taxes payable by its employees and to pay the same to the proper collection officers, and to keep such records, and make such returns and reports, as may be required in the case of other corporations, associations or societies similarly exempted from such taxes. [L 1987, c 347, pt of §2]

" **§432:1-404 Annual exhibits.** (a) Each society shall file with the commissioner annually, on or before March 1 in each year, a statement under oath, and in such form and detail as the commissioner shall prescribe; provided that any association or society organized and operating as a nonprofit medical indemnity or hospital service association shall file a report with the commissioner covering the preceding calendar year and verified by at least two principal officers. Each mutual benefit society shall file quarterly with the commissioner, on or before the forty-fifth day after each quarter, a copy of its quarterly report verified by at least two principal officers. The report shall comply with sections 431:3-301 and 431:3-302. The commissioner may prescribe the forms on which the report is to be filed.

In addition, any association or society organized and operating as a nonprofit medical indemnity or hospital service association annually shall file with the commissioner the following by the dates specified:

(1) An audit, by an independent certified public accountant or an accounting firm designated by the association or society, of the financial statements, reporting the financial condition and results of operations of the association or society on or before June 1, or a later date as the commissioner upon request or for cause may specify. The association or society, on an annual basis and prior to the commencement of the audit, shall notify the commissioner in writing of the name and address of the person or firm retained to conduct the annual audit. The commissioner may disapprove the association's or society's designation within fifteen days of receipt of the association's or society's notice, and the association or society shall be required to designate another independent certified public accountant or accounting firm. The audit required by this paragraph shall be prepared in accordance with the National Association of Insurance Commissioners' accounting practices and procedures manual and rules adopted by

the commissioner following the practices and procedures prescribed by the National Association of Insurance Commissioners; and

(2) A description of the available grievance procedures, the total number of grievances handled through those procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances on or before March 1.

(b) Labor union mutual benefit societies shall file annually a copy of the report filed under Public Law 85-836 and a complete financial report prepared by a certified public accountant. [L 1987, c 347, pt of §2; am L 2000, c 74, §3; am L 2003, c 212, §121; am L 2010, c 116, §2]

" **§432:1-405 Annual audit.** (a) Annually on or before June 1, or such later date as the commissioner upon request or for cause may specify, each domestic mutual benefit society shall file an audit by a designated independent certified public accountant or accounting firm of the financial statements reporting the financial condition and the results of operations of the mutual benefit society. The audited financial statement may use either generally accepted accounting principles (GAAP) or statutory accounting principles (SAP). If the generally accepted accounting principles method is used, a reconciliation of the financial statement to the statutory accounting principles must be provided to the commissioner. The mutual benefit society, on an annual basis and prior to the commencement of the audit, shall notify the commissioner in writing of the name and address of the person or firm retained to conduct the annual audit. The commissioner may disapprove the mutual benefit society's designation within fifteen days of receipt of the mutual benefit society's notice, and the mutual benefit society shall be required to designate another independent certified public accountant or accounting firm.

(b) The commissioner may suspend or revoke the certificate of authority of any mutual benefit society that fails to file any of the documents required in subsection (a). In lieu of or in addition to suspension or revocation of the certificate of authority of any mutual benefit society, the commissioner may impose on the mutual benefit society a penalty in the amount of not less than $100 and not more than $500 for each day of delinquency. [L 1995, c 110, §1; am L 2012, c 251, §8]

" **§432:1-406 Definitions.** As used in this article:

"Health care expenditures" means claims incurred.

"Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

"Member" means an individual who is covered by a mutual benefit society.

"Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

"Operating expenses" means claims adjustment, administrative, soliciting, and reinsurance allowances.

"Society" means mutual benefit society.

"Uncovered expenditures" means the costs to the mutual benefit society for health care services that are the obligation of the mutual benefit society, for which a member may be liable in the event of the mutual benefit society's insolvency, and for which no alternative arrangements have been made that are acceptable to the commissioner. Uncovered expenditures include but are not limited to out-of-area services, referral services, and hospital services. Uncovered expenditures do not include expenditures for services when a provider has agreed not to bill the member even though the provider is not paid by the mutual benefit society, or for services that are guaranteed, insured, or assumed by a person or organization other than a mutual benefit society. [L 1997, c 367, pt of §1; am L 2014, c 186, §13]

" **§432:1-407 Protection against insolvency.** (a) Net worth requirements are as follows:

(1) Before issuing a certificate of authority pursuant to section 432:1-301, the commissioner shall require that the mutual benefit society has an initial net worth of $2,000,000 and the society shall thereafter maintain the minimum net worth required under paragraph (2); and

(2) Every mutual benefit society shall maintain a minimum net worth equal to the greater of:

(A) $2,000,000;

(B) Two per cent of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first $150,000,000 of premium revenues and one per cent of annual premium revenues on the premium revenues in excess of $150,000,000; or

(C) An amount equal to eight per cent of the sum of annual health care expenditures and operating

expenses as reported on the most recent financial statement filed with the commissioner.

(b) Deposit requirements are as follows:

(1) Unless otherwise provided below, each mutual benefit society shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the commissioner which at all times shall have a value of not less than $300,000;

(2) A mutual benefit society that is in operation on July 3, 1997 shall make a deposit equal to $150,000. Within one year after July 3, 1997, a society that is in operation on July 3, 1997 shall make an additional deposit of $150,000 for a total of $300,000;

(3) Deposits shall be an admitted asset of the mutual benefit society in the determination of net worth;

(4) All income from deposits shall be an asset of the mutual benefit society. A society that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be subject to approval by the commissioner before being deposited or substituted;

(5) The deposit shall be used to protect the interests of the mutual benefit society's members and to assure continuation of health care services to members of a society which is in rehabilitation, liquidation, or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If a society is placed in receivership or liquidation, the deposit shall be an asset subject to article 15 of chapter 431; and

(6) The commissioner may reduce or eliminate the deposit requirement if the mutual benefit society deposits with the director of finance or the insurance commissioner, for the protection of all subscribers and members, wherever located, cash, acceptable securities, or surety, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

(c) Every mutual benefit society, when determining liabilities, shall include an amount estimated in the aggregate

to provide for any unearned premium, and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of claims. The liabilities shall be computed in accordance with rules adopted by the commissioner upon reasonable consideration of the ascertained experience and character of the society.

(d) Every contract between a mutual benefit society and a participating provider of health care services shall be in writing and shall set forth that in the event the society fails to pay for health care services as set forth in the contract, the subscriber or member shall not be liable to the provider for any sums owed by the society. If a contract with a participating provider has not been reduced to writing as required by this subsection, or if a contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or member sums owed by the society. No participating provider, or agent, trustee, or assignee thereof, may maintain any action at law against a subscriber or member to collect sums owed by the society.

(e) The commissioner shall require that each mutual benefit society have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the commissioner may require:

(1) Insurance to cover the expenses to be paid for continued benefits after the insolvency;

(2) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the society's insolvency for which premium payment has been made and until the members' discharge from inpatient facilities;

(3) Insolvency reserves;

(4) Acceptable letters of credit; or

(5) Any other arrangements acceptable to the commissioner to assure that benefits are continued as specified above.

(f) An agreement to provide health care services between a provider and a mutual benefit society shall require that a provider shall give the organization at least sixty days' advance notice in the event of termination.

(g) Each domestic mutual benefit society shall prepare for review by the commissioner on or before the forty-fifth day of each quarter, a copy of its quarterly net solvency report verified by at least two principal officers. The commissioner may prescribe the forms on which the reports are to be prepared. Each domestic mutual benefit society shall maintain a copy of its current net solvency report on the premises of its primary place of business. The commissioner may order an examination, subject to article 2 of chapter 431, to determine whether a domestic mutual benefit society is in compliance with this section. Any domestic mutual benefit society that fails or refuses to prepare or produce for review the quarterly net solvency report as required by this subsection shall be liable for a penalty in an amount not less than $100 and not more than $500 per day. [L 1997, c 367, pt of §1; am L 2001, c 185, §1; am L 2012, c 251, §9]

Note

L 1997, c 367, §3 provides:

"SECTION 3. This Act [enacting §§432:1-406 to 409 and amending §432:1-502] shall not apply to:

(1) Societies that do not operate as a hospital, medical or indemnity society, or corporation; and

(2) Labor union mutual benefit societies under section 432:1-103(b)."

" **[§432:1-408] Uncovered expenditures insolvency deposit.** (a) If, at any time, uncovered expenditures exceeds ten per cent of total health care expenditures, a mutual benefit society shall place with the commissioner or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, an uncovered expenditures insolvency deposit consisting of cash or securities that are acceptable to the commissioner. The deposit shall have, at all times, a fair market value in an amount of one hundred twenty per cent of the society's outstanding liability for uncovered expenditures for members in this State, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a society is not otherwise required to file a quarterly report, it shall file a report within forty-five days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(b) The deposit required under this section is in addition to the deposit required under section 432:1-407 and is an

admitted asset of the mutual benefit society in the determination of net worth. All income from the deposits or trust accounts shall be assets of the society and may be withdrawn from the deposit or account quarterly with the approval of the commissioner.

(c) A mutual benefit society that has made a deposit may withdraw that deposit or any part of the deposit if:

(1) A substitute deposit of cash or securities of equal amount and value is made;

(2) The fair market value exceeds the amount of the required deposit; or

(3) The required deposit under subsection (a) is reduced or eliminated.

Deposits, substitutions, or withdrawals may be made with the prior written approval of the commissioner.

(d) The deposit under this section shall be held in trust and may be used only as provided in this section. The commissioner may use the deposit of an insolvent mutual benefit society for administrative costs associated with administering the deposit and payment of claims of members of this State for uncovered expenditures in this State. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay such ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the society.

(e) The commissioner may prescribe by rule the time, manner, and form for filing claims under subsection (d).

(f) The commissioner may require by rule or order mutual benefit societies to file annual, quarterly, or more frequent reports as the commissioner deems necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit option. [L 1997, c 367, pt of §1]

" **[§432:1-409] Rehabilitation, liquidation, or conservation of mutual benefit societies.** (a) Any rehabilitation, liquidation, or conservation of a mutual benefit society shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a mutual benefit society upon any one or more grounds set out in article 15 of chapter 431, or, when in the commissioner's opinion, the continued operation of the society would be

hazardous either to the members or to the general public. Members shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(b) For purposes of determining the priority of distribution of general assets, claims of members and members' beneficiaries shall have the same priority as established by article 15 of chapter 431 for policyholders and beneficiaries of insureds of insurance companies. If a member is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of a member claim for distribution of general assets. Any provider who is obligated by statute or agreement to hold members harmless from liability for services provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of members and members' beneficiaries as described in this subsection, and immediately preceding the priority of distribution described in article 15 of chapter 431. [L 1997, c 367, pt of §1]

" **[§432:1-410] Reserve credit for reinsurance.** Any society that takes credit for reserves on risks ceded to a reinsurer shall be subject to provisions of chapter 431 related to credit for reinsurance. [L 2000, c 74, §1]

"**PART V. EXAMINATION POWERS AND RECEIVERSHIP**

§432:1-501 Examination by commissioner, assistance of other officers. (a) The powers, authorities, and duties relating to examinations vested in and imposed upon the commissioner under article 2 of the insurance code are extended to and imposed upon the commissioner in respect to examinations of mutual benefit societies.

(b) The commissioner in the exercise of any of the commissioner's functions, powers and duties under this article, may use the staff or any members of the staff of the commissioner of financial institutions and may appoint and constitute them as agents for such purpose. [L 1987, c 347, pt of §2; am L 1993, c 350, §19]

" **§432:1-502 Summary orders and supervision.** (a) Whenever the commissioner determines that the financial condition of any mutual benefit society is such that its continued operation might be hazardous to its members, creditors, or the general public, or that it has violated any provision of this chapter, the commissioner, after notice and hearing, may order the

society to take such action as may be reasonably necessary to rectify such condition or violation, including but not limited to one or more of the following:

(1) Reducing the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;

(2) Reducing the volume of new business being accepted;

(3) Reducing expenses by specified methods;

(4) Suspending or limiting the writing of new business for a period of time;

(5) Increasing the society's capital and surplus by contribution; or

(6) Taking such other steps as the commissioner may deem appropriate under the circumstances.

(b) For purposes of this section, the violation by a society of any law of this State to which such society is subject shall be deemed a violation of this chapter.

(c) The commissioner, by rule, may set uniform standards and criteria for early warning that the continued operation of any society might be hazardous to its members, creditors, or the general public and to set standards for evaluating the financial condition of any society, which standards shall be consistent with the purposes expressed in subsection (a).

(d) The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under article 15 of chapter 431. [L 1987, c 347, pt of §2; am L 1993, c 350, §20; am L 1997, c 367, §2]

Note

L 1997, c 367, §3 provides:

"SECTION 3. This Act [enacting §§432:1-406 to 409 and amending §432:1-502] shall not apply to:

(1) Societies that do not operate as a hospital, medical or indemnity society, or corporation; and

(2) Labor union mutual benefit societies under section 432:1-103(b)."

" **§432:1-503 Closing of doors without notice.** If, upon the examination of any society, it is found to be insolvent, or if it is deemed necessary by the commissioner for the protection of the interests of its members or the public, the commissioner may at once close the doors of the society without any notice and take charge of the books, assets and affairs of the society until the appointment of a receiver as provided by law. [L 1987, c 347, pt of §2]

"**PART VI. REQUIRED PROVISIONS AND BENEFITS**

§432:1-601 Contract limitations for handicapped children and children with intellectual disabilities. All individual and group hospital or medical service plan contracts, delivered or issued for delivery in this State after May 8, 1968, which provide that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (1) incapable of self-sustaining employment by reason of intellectual disability or physical handicap, and (2) chiefly dependent upon the policyholder, subscriber or employee as the case may be, for support and maintenance, provided proof of such incapacity and dependency is furnished to the hospital service or medical indemnity association by the policyholder, subscriber or employee within thirty-one days of the child's attainment of the limiting age and subsequently as may be required by such association. [L 1987, c 347, pt of §2; am L 2011, c 220, §§7, 12]

" **§432:1-601.5 Coverage for telehealth.** *[Section effective until December 31, 2016. For section effective January 1, 2017, see below.]* (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the provider.

(b) No mutual benefit society plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the mutual benefit society, and the provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. There shall be no reimbursement for a telehealth consultation between health care providers unless a health care provider-patient relationship exists between the patient and one

of the health care providers involved in the telehealth interaction and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical or other health services, as defined in 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider to be involved in a telehealth interaction between the patient and health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) For the purposes of this section, "telehealth" means the use of telecommunications services, as defined in section 269-1, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information to parties separated by distance. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter. [L 1998, c 278, §3; am L 2006, c 219, §3; am L 2009, c 20, §4; am L 2014, c 159, §4]

§432:1-601.5 Coverage for telehealth. *[Section effective January 1, 2017. For section effective until December 31, 2016, see above.]* (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the health care provider.

(b) No mutual benefit society plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the mutual benefit society, and the health care provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider to be involved in a telehealth interaction between the patient and health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) All insurers shall provide current and prospective enrollees or subscribers with written disclosure of coverages and benefits associated with telehealth services, including information on copayments, deductibles, or coinsurance requirements under a policy, contract, plan, or agreement. The information provided shall be current, understandable, and available prior to the issuance of a policy, contract, plan, or agreement, and upon request after the policy, contract, plan, or agreement has been issued.

(f) Services provided by telehealth pursuant to this section shall be consistent with all federal and state privacy, security, and confidentiality laws.

(g) For the purposes of this section:

"Health care provider" means a provider of services, as defined in title 42 United States Code section 1395x(u), a provider of medical and other health services, as defined in title 42 United States Code section 1395x(s), other practitioners licensed by the State and working within their scope of practice, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter

453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

"Originating site" means the location where the patient is located, whether accompanied or not by a health care provider, at the time services are provided by a health care provider through telehealth, including but not limited to a health care provider's office, hospital, health care facility, a patient's home, and other nonmedical environments such as school-based health centers, university-based health centers, or the work location of a patient.

"Telehealth" means the use of telecommunications services, as defined in section 269-1, to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information while a patient is at an originating site and the health care provider is at a distant site. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter. [L 1998, c 278, §3; am L 2006, c 219, §3; am L 2009, c 20, §4; am L 2014, c 159, §4; am L 2016, c 226, §7]

Note

Applicability of L 2016, c 226 requirement for reimbursement for telehealth services to health benefits plans under chapter 87A. L 2016, c 226, §13.

Cross References

Practice of telehealth, see §453-1.3.

" **§432:1-602 Newborn children coverage.** (a) All individual and group hospital and medical service corporation contracts which provide coverage for a family member of the subscriber shall, as to such family member's coverage, also provide that the benefits applicable for children shall be payable or provided with respect to a newly born child of the subscriber from the moment of birth; provided that the coverage for newly

born children shall be limited to the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific subscription fee or premium is required to provide coverage for the child, the contract may require that notification of birth of a newly born child and payment of the required fee or premium must be furnished to the service corporation within thirty-one days after the date of birth in order to have coverage continue beyond such thirty-one-day period. The requirements of this section shall apply to all subscriber contracts delivered or issued for delivery in this State more than one hundred twenty days after July 1, 1988.

(b) No provision in subsection (a) shall be construed to provide or include coverage for routine well-baby services. [L 1987, c 347, pt of §2]

Revision Note

"July 1, 1988" substituted for "the effective date of this section".

" **§432:1-602.5 Coverage for child health supervision services.** (a) All individual and group hospital and medical service corporation contracts which provide coverage for the children of the subscriber shall provide coverage for child health supervision services from the moment of birth through age five years. These services shall be exempt from any deductible provisions, and immunizations shall be exempt from any copayment provisions, which may be in force in these policies or contracts.

(b) Child health supervision services shall include twelve visits at approximately the following intervals: birth; two months; four months; six months; nine months; twelve months; fifteen months; eighteen months; two years; three years; four years; and five years. Services to be covered at each visit shall include a history, physical examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests, in keeping with prevailing medical standards. For purposes of this subsection, the term "prevailing medical standards" means the recommendations of the Immunizations Practices Advisory Committee of the United States Department of Health and Human Services and the American Academy of Pediatrics; provided that in the event that the recommendations of the committee and the academy differ, the department of health shall determine which recommendations shall apply.

(c) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit

cited in this section, except that the limitations authorized by this subsection shall not apply to immunizations recommended by the Immunizations Practices Advisory Committee of the United States Department of Health and Human Services and the American Academy of Pediatrics; provided that in the event that the recommendations of the committee and the academy differ, the department of health shall determine which recommendations shall apply.

(d) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(e) For the purposes of this section, "child health supervision services" means physician-delivered, physician-supervised, physician assistant-delivered, or nurse-delivered services as defined by section 457-2 ("registered nurse"), which shall include as the minimum benefit coverage for services delivered at intervals and scope stated in this section. [L 1988, c 201, §3; am L 1993, c 83, §3 and c 362, §5; am L 2016, c 141, §17]

" **[§432:1-602.6] Newborn adoptee; coverage.** (a) Notwithstanding any provision to the contrary, whenever a policy, contract, plan, or agreement provides coverage for the children of the insured, that coverage shall also extend to the date of birth of any newborn child to be adopted by the insured; provided that the insured gives written notice to the society of the insured's intent to adopt the child prior to the child's date of birth or within thirty days after the child's birth or within the time period required for enrollment of a natural born child under the policy, contract, plan, or agreement of the insured, whichever period is longer; provided, however, if the adoption proceedings are not successful, the insured shall reimburse the society for any expenses paid for the child.

Where notification has not been received by the society prior to the child's birth or within the specified period following the child's birth, insurance coverage shall be effective from the first day following the society's receipt of legal notification of the insured's ability to consent for treatment of the infant whom coverage is sought.

(b) When the insured is a member of a health maintenance organization (HMO), coverage of an adopted newborn is effective:

(1) From the date of birth of the adopted newborn when the newborn is treated from birth pursuant to a provider contract with the health maintenance organization, and written notice of enrollment in accord with the health maintenance organization's usual enrollment process is

provided within thirty days of the date the insured notifies the health maintenance organization of the insured's intent to adopt the infant for whom coverage is sought; or

(2) From the first day following receipt by the health maintenance organization of written notice of the insured's ability to consent for treatment of the infant for whom coverage is sought and enrollment of the adopted newborn in accord with the health maintenance organization's usual enrollment process if the newborn has been treated from birth by a provider not contracting or affiliated with the health maintenance organization. [L 1991, c 268, §§2, 5; am L 1995, c 47, §1]

" **§432:1-603 Reimbursement for psychological services.** Notwithstanding any provision of any individual or group hospital or medical service plan contract, whenever the contract provides reimbursement or payment for any service which is within the lawful scope of practice of a psychologist licensed in this State, the person entitled to benefits or performing the service shall be entitled to reimbursement or payment whether the service is performed by a licensed physician or licensed psychologist. [L 1987, c 347, pt of §2]

" **§432:1-604 In vitro fertilization procedure coverage.** (a) All individual and group hospital or medical service plan contracts which provide pregnancy-related benefits shall include in addition to any other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures performed on the subscriber or member or the subscriber's or member's dependent spouse; provided that:

(1) Benefits under this section shall be provided to the same extent as the benefits provided for other pregnancy-related benefits;
(2) The patient is a subscriber or member or covered dependent of the subscriber or member;
(3) The patient's oocytes are fertilized with the patient's spouse's sperm;
(4) The:
    (A) Patient and the patient's spouse have a history of infertility of at least five years' duration; or
    (B) Infertility is associated with one or more of the following medical conditions:
        (i) Endometriosis;

(ii) Exposure in utero to diethylstilbestrol, commonly known as DES;
(iii) Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
(iv) Abnormal male factors contributing to the infertility;

(5) The patient has been unable to attain a successful pregnancy through other applicable infertility treatments for which coverage is available under the contract; and
(6) The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

(b) For the purposes of this section, the term "spouse" means a person who is lawfully married to the patient under the laws of the State.

(c) The requirements of this section shall apply to all hospital or medical service plan contracts delivered or issued for delivery in this State after June 26, 1987. [L 1987, c 332, §2 and L 1989, c 276, §4; am L 2003, c 212, §122; am L 2013, c 47, §2]

" **§432:1-604.5 Contraceptive services.** (a) Notwithstanding any provision of law to the contrary, each employer group health policy, contract, plan, or agreement issued or renewed in this State on or after January 1, 2000, shall cease to exclude contraceptive services or supplies, and contraceptive prescription drug coverage for the subscriber or any dependent of the subscriber who is covered by the policy, subject to the exclusion under section 431:10A-116.7.

(b) Except as provided in subsection (c), all policies, contracts, plans, or agreements under subsection (a), that provide contraceptive services or supplies, or prescription drug coverage, shall not exclude any prescription contraceptive supplies or impose any unusual copayment, charge, or waiting requirement for such drug or device.

(c) Coverage for contraceptives shall include at least one brand from the monophasic, multiphasic, and the progestin-only categories. A member shall receive coverage for any other oral contraceptive only if:

(1) Use of brands covered has resulted in an adverse drug reaction; or

(2) The member has not used the brands covered and, based on the member's past medical history, the prescribing health care provider believes that use of the brands covered would result in an adverse reaction.

(d) Coverage required by this section shall include reimbursement to a prescribing health care provider or dispensing entity for prescription contraceptive supplies intended to last for up to a twelve-month period for a member.

(e) For purposes of this section:

"Contraceptive services" means physician-delivered, physician-supervised, physician assistant-delivered, advanced practice registered nurse-delivered, nurse-delivered, or pharmacist-delivered medical services intended to promote the effective use of contraceptive supplies or devices to prevent unwanted pregnancy.

"Contraceptive supplies" means all Food and Drug Administration-approved contraceptive drugs or devices used to prevent unwanted pregnancy.

(f) Nothing in this section shall be construed to extend the practice or privileges of any health care provider beyond that provided in the laws governing the provider's practice and privileges. [L 1993, c 365, §2; am L 1999, c 267, §3; am L 2016, c 141, §18 and c 205, §3]

Note

Applicability of L 2016, c 205 amendment. L 2016, c 205, §§4, 5, and 7.

" **§432:1-605 Mammogram screening.** (a) Notwithstanding any provision to the contrary, each policy, contract, plan, or agreement issued on or after February 1, 1991, except for policies that only provide coverage for specified diseases or other limited benefit coverage, but including policies issued by companies subject to chapter 431, article 10A, part II and chapter 432, article 1 shall provide coverage for screening by low-dose mammography for occult breast cancer as follows:

(1) For women forty years of age and older, an annual mammogram; and

(2) For a woman of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer, a mammogram upon the recommendation of the woman's physician.

(b) The services provided in subsection (a) are subject to any coinsurance provisions that may be in force in these policies, contracts, plans, or agreements.

(c) For purposes of this section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

(d) An insurer may provide the services required by this section through contracts with providers; provided that the contract is determined to be a cost-effective means of delivering the services without sacrifice of quality and meets the approval of the director of health. [L 1990, c 112, §3; am L 1994, c 279, §3; am L 1999, c 13, §3]

Note

Director of health to monitor the mammogram screening services to assure that the demand for screening does not exceed the ability of the medical community to safely provide the services. L 1990, c 112, §5.

Cross References

Sunset evaluations modified, see §§26H-4, 5.

" **[§432:1-605.5] Mammograms; referral not required.** (a) For purposes of the annual screening mammogram coverage required under section 432:1-605, no mutual benefit society shall require a covered person forty years of age and older to obtain a referral from a primary care provider or other physician for an annual screening mammogram.

(b) If the screening mammogram indicates that follow up services are advisable, a referral shall be made to the patient's primary care physician or other physician, as designated by the patient. [L 2012, c 92, §2]

" **[§432:1-606] Qualified medical child support order.** (a) An employer, who provides health coverage to dependent children of an employee, shall recognize a child identified in a qualified medical child support order as an eligible dependent without regard to any enrollment season restrictions.

(b) A qualified medical child support order shall:

(1) Specify the name and last known mailing address, if any, of the plan member and the name and mailing address of each recipient child covered by the order;

(2) Include a reasonable description of the type of coverage to be provided to the recipient child, or the manner in which the type of coverage is to be determined;
(3) State the period during which it applies;
(4) Specify the plan to which it applies; and
(5) Not require a plan to provide any type or form of benefit or option that the plan does not otherwise provide. [L 1994, c 145, §3]

" **[§432:1-607] Genetic information nondiscrimination in health insurance coverage.** (a) No mutual benefit society may:
(1) Use an individual's or a family member's genetic information, or request for genetic services, to deny or limit any coverage or establish eligibility, continuation, enrollment, or premium payments;
(2) Request or require collection or disclosure of an individual's or a family member's genetic information; or
(3) Disclose an individual's or a family member's genetic information without the written consent of the person affected, the person's legal guardian, or a person with power of attorney for health care for the person affected. This consent shall be required for each disclosure and shall include the name of each person or organization to whom the disclosure will be made.

(b) As used in this section:

"Family member" means, with respect to the individual, another individual related by blood to that individual.

"Genetic information" means information about genes, gene products, hereditary susceptibility to disease, or inherited characteristics that may derive from the individual or family member.

"Genetic services" means health services to obtain, assess, or interpret genetic information for diagnosis, therapy, or genetic counseling. [L 1997, c 91, §2]

Law Journals and Reviews

Privacy and Genetics: Protecting Genetic Test Results in Hawai‘i. 25 UH L. Rev. 449.

" **[§432:1-607.3] Nondiscrimination on the basis of actual gender identity or perceived gender identity; coverage for services.** (a) No individual and group hospital and medical service policy, contract, plan, or agreement that provides health care coverage shall discriminate with respect to

participation and coverage under the policy, contract, plan, or agreement against any person on the basis of actual gender identity or perceived gender identity.

(b) Discrimination under this section includes the following:

(1) Denying, canceling, limiting, or refusing to issue or renew an insurance policy, contract, plan, or agreement on the basis of a person's or the person's family member's actual gender identity or perceived gender identity;

(2) Demanding or requiring a payment or premium that is based on a person's or the person's family member's actual gender identity or perceived gender identity;

(3) Designating a person's or the person's family member's actual gender identity or perceived gender identity as a preexisting condition to deny, cancel, or limit coverage; and

(4) Denying, canceling, or limiting coverage for services on the basis of actual gender identity or perceived gender identity including but not limited to the following:

(A) Health care services related to gender transition; provided that there is coverage under the policy, contract, plan, or agreement for the services when the services are not related to gender transition; and

(B) Health care services that are ordinarily or exclusively available to individuals of one sex.

(c) The medical necessity of any treatment shall be determined pursuant to the insurance policy, contract, plan, or agreement and shall be defined in a manner that is consistent with other covered services.

(d) Any coverage provided shall be subject to copayment, deductible, and coinsurance provisions of an individual and group hospital and medical service policy, contract, plan, or agreement that are no less favorable than the copayment, deductible, and coinsurance provisions for substantially all other medical services covered by the policy, contract, plan, or agreement.

(e) As used in this section unless the context requires otherwise:

"Actual gender identity" means a person's internal sense of being male, female, a gender different from the gender assigned at birth, a transgender person, or neither male nor female.

"Gender transition" means the process of a person changing the person's outward appearance or sex characteristics to accord with the person's actual gender identity.

"Perceived gender identity" means an observer's impression of another person's actual gender identity or the observer's own impression that the person is male, female, a gender different from the gender designed at birth, a transgender person, or neither male nor female.

"Transgender person" means a person who has gender identity disorder or gender dysphoria, has received health care services related to gender transition, adopts the appearance or behavior of the opposite sex, or otherwise identifies as a gender different from the gender assigned to that person at birth. [L 2016, c 135, §3]

Note

Applicability of section. L 2016, c 135, §§5, 7.

" **§432:1-608 Hospice care coverage.** (a) Any other law to the contrary notwithstanding, commencing on January 1, 2000, all mutual benefit societies issuing or renewing an individual and group hospital or medical service plan, policy, contract, or agreement in this State that provides for payment of or reimbursement for hospice care shall reimburse hospice care services for each insured member covered for hospice care according to the following:

(1) A minimum daily rate as set by the Centers for Medicare and Medicaid Services for hospice care;
(2) Reimbursement for residential hospice room and board expenses directly related to the hospice care being provided; and
(3) Reimbursement for each hospice referral visit during which a patient is advised of hospice care options, regardless of whether the referred patient is eventually admitted to hospice care.

(b) Every insurer shall provide notice to its members regarding the coverage required by this section. Notice shall be in writing and in literature or correspondence sent to members, beginning with calendar year 2000, along with any other mailing to members, but in no case later than July 1, 2000. [L 1999, c 77, §5; am L 2011, c 43, §17]

" **§432:1-609 Medical foods and low-protein modified food products; treatment of inborn error of metabolism; notice.** (a) All individual and group hospital and medical service plan contracts and medical service corporation contracts under this chapter shall provide coverage for medical foods and low-protein

modified food products for the treatment of an inborn error of metabolism for its members or dependents of the member in this State; provided that the medical food or low-protein modified food product is:

(1) Prescribed as medically necessary for the therapeutic treatment of an inborn error of metabolism; and

(2) Consumed or administered enterally under the supervision of a physician or osteopathic physician licensed under chapter 453.

Coverage shall be for at least eighty per cent of the cost of the medical food or low-protein modified food product prescribed and administered pursuant to this subsection.

(b) Every mutual benefit society shall provide notice to its members regarding the coverage required by this section. The notice shall be in writing and prominently placed in any literature or correspondence sent to members and shall be transmitted to members during calendar year 2000 when annual information is made available to members, or in any other mailing to members, but in no case later than December 31, 2000.

(c) For the purposes of this section:

"Inborn error of metabolism" means a disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient metabolism, originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat.

"Low-protein modified food product" means a food product that:

(1) Is specially formulated to have less than one gram of protein per serving;

(2) Is prescribed or ordered by a physician or osteopathic physician as medically necessary for the dietary treatment of an inherited metabolic disease; and

(3) Does not include a food that is naturally low in protein.

"Medical food" means a food that is formulated to be consumed or administered enterally under the supervision of a physician or osteopathic physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. [L 1999, c 86, §3; am L 2009, c 11, §53]

" **[§432:1-610] Federally funded programs; exemption.** Requirements relating to mandated coverages shall not be applicable to any mutual benefit society offering health insurance under a federally funded program under the Social

Security Act, as amended; provided that this exemption shall apply only to that part of the mutual benefit society's business under the federally funded program. [L 1999, c 159, §2]

" **§432:1-611 Reimbursement for services of advanced practice registered nurses.** All individual and group hospital and medical service plan contracts and medical service corporation contracts under this article shall provide reimbursement for health plan-covered services provided by advanced practice registered nurses licensed pursuant to chapter 457. [L 1999, c 222, §1; am L 2015, c 35, §48]

" **[§432:1-612] Diabetes coverage.** All group health care contracts under this chapter shall provide, to the extent provided under section 431:10A-121, coverage for outpatient diabetes self-management training, education, equipment, and supplies. [L 2000, c 243, §3]

" **[§432:1-613] Orthodontic services for orofacial anomalies; benefits and coverage; notice.** (a) Notwithstanding any law to the contrary, each individual and group hospital or medical service plan contract issued or renewed in this State after December 31, 2015, shall provide to the member and individuals under twenty-six years of age covered under the plan contract coverage for medically necessary orthodontic services for the treatment of orofacial anomalies resulting from birth defects or birth defect syndromes. Coverage required by this section shall be paid for by medical insurance.

(b) Every mutual benefit society shall provide written notice to its members regarding the coverage required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to members and shall be transmitted to members within calendar year 2016 when annual information is made available to members or in any other mailing to members, but in no case later than December 31, 2016.

(c) Coverage provided under this section shall be subject to a maximum benefit of $5,500 per treatment phase but shall not be subject to any limits on the number of visits to an orthodontist. After December 31, 2016, the insurance commissioner, on an annual basis, shall adjust the maximum benefit for inflation, using the medical care component of the United States Department of Labor Consumer Price Index for all urban consumers. The commissioner shall publish the adjusted maximum benefit annually no later than April 1 of each calendar year, which shall apply during the following calendar year to

the plan contracts subject to this section. Payments made by a mutual benefit society on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's orofacial anomaly, shall not be applied toward any maximum benefit established under this subsection.

(d) Coverage under this section shall be subject to copayment, deductible, and coinsurance provisions of a plan contract to the extent that other medical services covered by the plan contract are subject to these provisions.

(e) This section shall not be construed as limiting benefits that are otherwise available to an individual under a plan contract.

(f) This section shall not apply to limited benefit health insurance as provided pursuant to section 431:10A-102.5.

(g) As used in this section, unless the context clearly requires otherwise:

"Orofacial anomalies" means cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration.

"Orthodontic services" means direct or consultative services provided by a licensed dentist with a certification in orthodontics by the American Board of Orthodontics.

"Treatment of orofacial anomalies" includes the care prescribed, provided, or ordered for an individual diagnosed with an orofacial anomaly by a craniofacial team that includes a licensed dentist, orthodontist, oral surgeon, and physician, and is coordinated between specialists and providers. [L 2015, c 213, §4]

" **[§432:1-614] Autism benefits and coverage; notice; definitions.** (a) Each hospital and medical service plan contract issued or renewed in this State after January 1, 2016, shall provide to the member and individuals under fourteen years of age covered under the plan contract coverage for the diagnosis and treatment of autism.

(b) This section shall not apply to disability, accident-only, medicare, medicare supplement, student accident and health or sickness insurance, dental-only, and vision-only policies or policies or renewals of six months or less.

(c) Every mutual benefit society shall provide written notice to its members regarding the coverage required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to members and shall be transmitted to members within calendar year 2016

when annual information is made available to members or in any other mailing to members, but in no case later than December 31, 2016.

(d) Coverage for applied behavioral analysis provided under this section shall be subject to a maximum benefit of $25,000 per year for services for children ages thirteen and under. This section shall not be construed as limiting benefits that are otherwise available to a member under a hospital and medical service plan contract. Payments made on behalf of a member for any care, treatment, intervention, or service other than applied behavioral analysis shall not be applied toward the maximum benefit established under this subsection.

(e) Coverage under this section may be subject to copayment, deductible, and coinsurance provisions of a policy that are no less favorable than the copayment, deductible, and coinsurance provisions for substantially all medical services covered by the plan contract.

(f) Treatment for autism requests shall include a treatment plan. Except for inpatient services, if an individual is receiving treatment for autism, a mutual benefit society may request a review of the treatment plan for continued authorization of coverage for treatment for autism at the mutual benefit society's discretion.

(g) The medical necessity of treatment covered by this section shall be determined pursuant to the plan contract and shall be defined in the plan contract in a manner that is consistent with other services covered under the plan contract. Except for inpatient services, if an individual is receiving treatment for autism, a mutual benefit society may request a review of the medical necessity of that treatment at the society's discretion.

(h) This section shall not be construed as reducing any obligation to provide services to an individual under any publicly funded program, an individualized family service plan, an individualized education program, or an individualized service plan.

(i) Coverage under this section shall exclude coverage for:

(1) Care that is custodial in nature;

(2) Services and supplies that are not clinically appropriate;

(3) Services provided by family or household members;

(4) Treatments considered experimental; and

(5) Services provided outside of the State.

(j) Mutual benefit societies shall include in their network of approved autism service providers only those

providers who have cleared state and federal criminal background checks as determined by the society.

(k) If an individual has been diagnosed as having autism meeting the diagnostic criteria described in the Diagnostic and Statistical Manual of Mental Disorders available at the time of diagnosis, upon publication of a more recent edition of the Diagnostic and Statistical Manual of Mental Disorders, that individual may be required to undergo repeat evaluation to remain eligible for coverage under this section.

(l) Treatment for autism shall not be covered pursuant to this section unless provided by an autism service provider that is licensed by a state licensure board. If a state licensure board that licenses providers to provide autism services is unavailable, the autism service provider shall:

(1) Be certified by the Behavior Analyst Certification Board, Inc.; provided that certification by the Behavior Analyst Certification Board, Inc., shall be valid for purposes of this subsection for no more than one year; or

(2) Meet any existing credentialing requirements determined by the mutual benefit society.

(m) As used in this section, unless the context clearly requires otherwise:

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

"Autism" means autism spectrum disorder as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

"Autism service provider" means any person, entity, or group that provides treatment for autism and meets the minimum requirements pursuant to subsection (l).

"Behavioral health treatment" means evidence based counseling and treatment programs, including applied behavior analysis, that are:

(1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and

(2) Provided or supervised by an autism service provider.

"Diagnosis of autism" means medically necessary assessments, evaluations, or tests conducted to diagnose whether an individual has autism.

"Pharmacy care" means medications prescribed by a licensed physician or registered nurse practitioner and any health-

related services that are deemed medically necessary to determine the need or effectiveness of the medications.

"Psychiatric care" means direct or consultative services provided by a licensed psychiatrist.

"Psychological care" means direct or consultative services provided by a licensed psychologist.

"Therapeutic care" means services provided by licensed speech pathologists, registered occupational therapists, licensed social workers, licensed clinical social workers, or licensed physical therapists.

"Treatment for autism" includes the following care prescribed or ordered for an individual diagnosed with autism by a licensed physician, psychiatrist, psychologist, licensed clinical social worker, or registered nurse practitioner if the care is determined to be medically necessary:

(1) Behavioral health treatment;
(2) Pharmacy care;
(3) Psychiatric care;
(4) Psychological care; and
(5) Therapeutic care. [L 2015, c 235, §4]

" **[§432:1-615] Primary care provider; advanced practice registered nurse.** (a) Each policy of insurance delivered or issued for delivery in this State by a mutual benefit society shall recognize advanced practice registered nurses, as defined under section 457-8.5(a), as participating providers, and shall include coverage for care provided by participating advanced practice registered nurses practicing within the scope of their licenses for purposes of health maintenance, diagnosis, or treatment, to the extent that the policy provides benefits for identical services rendered by another health care provider.

(b) Notwithstanding any other law to the contrary, an insurer may recognize a participating advanced practice registered nurse as a primary care provider if the insured's policy requires the selection of a primary care provider. The insurer shall include participating advanced practice registered nurses who practice as primary care providers on any publicly available list of participating primary care providers; provided that the insurer retains the right to determine the contracting criteria for a participating primary care provider.

(c) For the purposes of this section, "participating advanced practice registered nurse" means an advanced practice registered nurse who has contracted with the insurer to provide health care services to its insureds. [L 2009, c 169, §3]

" **§432:1-616 Cancer treatment.** (a) All individual and group hospital and medical service plan contracts that include coverage or benefits for the treatment of cancer shall provide payment or reimbursement for all types of chemotherapy that are considered medically necessary as defined in section 432E-1.4.

(b) The cost-sharing for generic and non-generic oral chemotherapy shall be provided at the same or lower amount or percentage as is applied to generic and non-generic intravenously administered chemotherapy; provided that an insurer shall not increase the cost-share for intravenously administered chemotherapy in order to achieve compliance with this subsection.

(c) Individual and group hospital and medical service plan contracts shall not increase enrollee cost-sharing for non-generic medications used for the treatment of cancer to any greater extent than such policies increase enrollee cost-sharing for other covered non-generic medication.

(d) For the purposes of this section:

"Cost-share" or "cost-sharing" means copayment, coinsurance, or deductible provisions applicable to coverage for medications or treatments.

"Intravenously administered chemotherapy" means a physician-prescribed cancer treatment that is administered through injection directly into the patient's circulatory system by a physician, physician assistant, nurse practitioner, nurse, or other medical personnel under the supervision of a physician and in a hospital, medical office, or other clinical setting.

"Oral chemotherapy" means a United States Food and Drug Administration-approved, physician-prescribed cancer treatment that is taken orally in the form of a tablet or capsule and may be administered in a hospital, medical office, or other clinical setting or may be delivered to the patient for self-administration under the direction or supervision of a physician outside of a hospital, medical office, or other clinical setting.

(e) This section shall not apply to an accident-only, specified disease, hospital indemnity, long-term care, or other limited-benefit health insurance policy. [L 2009, c 168, §2; am L 2012, c 30, §2]

" **[§432:1-617] Colon cancer screening coverage.** (a) All individual and group hospital and medical service contracts providing health care coverage shall provide coverage for colorectal-cancer screening by all A and B grade screening modalities as recommended by the United States Preventive Services Task Force.

(b) Beginning March 1, 2011, all health insurance providers in Hawaii shall inform their insured of the risk associated with undiagnosed colorectal cancer and encourage the insured to consult with the insured's physician about available screening options. [L 2010, c 157, §2]

Note

Section applies to policies, contracts, and plans of health insurance issued or renewed after January 1, 2011. L 2010, c 157, §5.

" **[§432:1-618] Human immunodeficiency virus and acquired immunodeficiency syndrome screening coverage.** (a) Each hospital or medical service plan contract issued or renewed in this State, except for plan contracts that only provide coverage for specified diseases or other limited benefit coverage, shall provide coverage for annual screenings for sexually transmitted diseases, including screenings for human immunodeficiency virus and acquired immunodeficiency syndrome.

(b) Each mutual benefit society shall reimburse all costs associated with the coverage under subsection (a) to any physician or health care provider complying with this section. [L 2016, c 204, §3]

Note

Applicability of section. L 2016, c 204, §§6, 8.

" **[§432:1-620] Formulary; accessibility requirements.** (a) Each mutual benefit society offering or renewing an individual and group hospital or medical service plan contract on or after January 1, 2017, shall provide the following information via a public website and through a toll-free number that is posted on the mutual benefit society's website:

(1) Its formulary; provided that notice of any changes due to the addition of a new drug or deletion of any existing drug shall be made available no later than seventy-two hours after the effective date of the change; provided further that notice of other changes, including drug strength or form, shall be made available within fourteen calendar days of the effective date of the change;
(2) Provide a system that allows a subscriber or potential subscriber to determine whether prescription drugs are

covered under the plan's medical benefits and typically administered by a provider, along with any cost-sharing imposed on such drugs;

(3) Indicate a dollar amount range of cost-sharing typically paid by a subscriber of each specific drug included on the formulary based on the information the mutual benefit society has available, as follows:

(A) $100 and under: $;

(B) Over $100 to $250: $$;

(C) Over $250 to $500: $$$;

(D) Over $500 to $1,000: $$$$; and

(E) Over $1,000: $$$$$; and

(4) Display standardized content for the formulary for each product offered by the plan pursuant to recommendations made by the formulary accessibility working group established pursuant to Act 197, Session Laws of Hawaii 2015.

(b) For the purposes of this section, "formulary" means the complete list of drugs preferred for use and eligible for coverage under a policy, including drugs covered under the policy's pharmacy benefit and medical benefit as defined by the health care service plans.

(c) This section shall not apply to limited benefit health insurance as provided in section 431:10A-102.5; provided further that this section shall not apply to medicare, medicaid, or other federally financed plans. [L 2015, c 197, §2]

"**ARTICLE 2**
FRATERNAL BENEFIT SOCIETIES

PART I. STRUCTURE AND PURPOSE

§432:2-101 Scope of article. This article relates only to fraternal benefit societies, as defined herein, which desire to be authorized to pay benefits in accordance with this article after July 10, 1961. This article shall not apply to legal service plans subject to chapter 488 even though the plan may be offered by a fraternal benefit society. [L 1987, c 347, pt of §2; am L 2012, c 34, §24]

" **§432:2-102 Applicability of other laws.** (a) Except as herein provided, societies shall be governed by this article and shall be exempt from all other provisions of the insurance laws of this State unless they are expressly designated therein, or unless it is specifically made applicable by this article.

(b) Nothing in this article shall exempt fraternal benefit societies from the provisions and requirements of part IV of article 2, part IV of article 3, and article 15 of chapter 431, and sections 431:2-215, 431:3-303, 431:3-304, and 431:3-305. [L 1987, c 347, pt of §2; am L 2000, c 182, §15; am L 2009, c 149, §5; am L 2011, c 80, §8; am L 2014, c 186, §14]

" **§432:2-103 Definitions.** For the purposes of this article:

(1) Benefit contract shall mean the agreement for provision of benefits authorized by section 432:2-401, as that agreement is described in section 432:2-404(a).
(2) Benefit member shall mean an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.
(3) Certificate shall mean the document issued as written evidence of the benefit contract.
(4) Commissioner means the insurance commissioner of this State.
(5) Laws shall mean the society's articles of incorporation, constitution and bylaws, however designated.
(6) Lodge shall mean subordinate member units of the society, known as camps, courts, councils, branches, or by any other designation.
(7) Premiums shall mean premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.
(8) Rules shall mean all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.
(9) Society shall mean fraternal benefit society, unless otherwise indicated. [L 1987, c 347, pt of §2]

" **§432:2-103.5 Policies relating to domestic abuse cases.** (a) No fraternal benefit society shall deny or refuse to accept an application for insurance, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage, on the basis that the member or prospective member is, has been, or may be a victim of domestic abuse.

(b) Nothing in this section shall prevent a fraternal benefit society from taking any of the actions set forth in subsection (a) on the basis of loss history or medical

condition, or for any other reason not otherwise prohibited by this section or any other law, regulation, or rule.

(c) Any form filed or filed after July 15, 1998 or subject to a rule adopted under chapter 91 may exclude coverage for losses caused by intentional or fraudulent acts of any benefit member.

(d) Nothing in this section prohibits a fraternal benefit society from investigating a claim and complying with chapter 431.

(e) As used in this section, "domestic abuse" means:

(1) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury, or assault between family or household members;

(2) Sexual assault of one family or household member by another;

(3) Stalking of one family or household member by another family or household member; or

(4) Intentionally, knowingly, or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another household member. [L 1998, c 171, §4; am L 2004, c 122, §88]

Revision Note

"July 15, 1998" substituted for "the effective date of this section".

" **§432:2-104 Fraternal benefit societies.** Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of section 432:2-704(a)(2) whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this article, is hereby declared to be a fraternal benefit society. [L 1987, c 347, pt of §2]

" **§432:2-105 Lodge system.** (a) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(b) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society. [L 1987, c 347, pt of §2]

" **§432:2-106 Representative form of government.** A society has a representative form of government when:

(1) It has a supreme governing body constituted in one of the following ways:

(A) Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected, shall meet at least once every four years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

(B) Direct election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(2) The officers of the society are elected either by the supreme governing body or by the board of directors;

(3) Only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly; and

(4) Each voting member shall have one vote; no vote may be cast by proxy. [L 1987, c 347, pt of §2]

" **§432:2-107 Purposes and powers.** (a) A society shall operate for the benefit of members and their beneficiaries by:

(1) Providing benefits as specified in section 432:2-401; and

(2) Operating for one or more lawful, social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others.

Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(b) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society. [L 1987, c 347, pt of §2]

" **[§432:2-108] Fees.** (a) The commissioner shall collect, in advance, the following fees:

(1) Certificate of authority:
    (A) Application for a certificate of authority: $900;
    (B) Issuance of certificate of authority: $600;

(2) Organization of domestic fraternal benefit societies:
    (A) Application for a preliminary certificate of authority: $1,500;
    (B) Issuance of preliminary certificate of authority: $150; and

(3) For all services subsequent to the issuance of a certificate of authority, including extension of the certificate of authority: $600 per year.

(b) No certificate of authority shall contain an expiration date, but all certificates of authority shall be extended by the commissioner from time to time in order to continue to be valid. When the commissioner issues or extends a certificate of authority, the commissioner shall determine the date prior to which the certificate of authority shall be extended and shall so notify the insurer in writing. This date

is called the extension date. The extension date shall be any date not less than one year and not more than three years after date of issue or extension of the certificate of authority. If the insurer qualifies, its certificate of authority shall be extended. The commissioner shall provide each holder of a certificate of authority at least thirty days' advance written notice of the applicable extension date. If the fee for the extension of the certificate of authority is not paid before or on the extension date, a penalty shall be imposed in the amount of fifty per cent of the fee. The commissioner shall provide notice in writing of the delinquency of extension and the imposition of the authorized penalty. If the fee and the penalty are not paid within thirty days immediately following the date of the notice of delinquency, the commissioner may revoke the certificate of authority and may not reinstate the certificate of authority until the fee and penalty have been paid.

(c) All fees and penalties collected pursuant to this section shall be deposited to the credit of the compliance resolution fund. [L 2015, c 63, §2]

"**PART II. MEMBERSHIP**

§432:2-201 Qualifications for membership. (a) A society shall specify in its laws or rules:

(1) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen and not greater than age twenty-one;

(2) The process for admission to membership for each membership class; and

(3) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) A society may also admit social members who shall have no voice or vote in the management of its insurance affairs.

(c) Membership rights in the society are personal to the member and are not assignable. [L 1987, c 347, pt of §2]

" **§432:2-202 Location of office, meetings, communications to members, grievance procedures.** (a) The principal office of any domestic society shall be located in this State. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at

least one subordinate lodge, or in such other location as determined by the supreme governing body. All business transacted at such meetings shall be as valid in all respects as if such meetings were held in this State. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(b)(1) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two or more members have the same mailing address, an official publication mailed to one member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(2) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

(c) A society may provide in its laws or rules for grievance or complaint procedures for members. [L 1987, c 347, pt of §2]

" **§432:2-203 No personal liability.** (a) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(b) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit, or proceeding, whether civil, criminal, administrative, or investigative, or threat thereof, in which the person may be involved by reason of the fact that the person is or was a director, officer, employee, or agent of the society or of any firm, corporation, or organization that the person served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed:

(1) In relation to any matter in such action, suit, or proceeding as to which the person shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee, or agent of the society; or

(2) In relation to any matter in such action, suit, or proceeding, or threat thereof, which has been made the subject of a compromise settlement;

unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that the person's conduct was unlawful.

The determination whether the conduct of such person met the standard required to justify indemnification and reimbursement in relation to any matter described in paragraph (1) or (2) may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit, or proceeding, or by a court of competent jurisdiction. The termination of any action, suit, or proceeding by judgment, order, settlement, or conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of the person's heirs and personal representatives.

(c) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee, or agent of the society, or who is or was serving at the request of the society as a director, officer, employee, or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by the person in any such capacity or arising out of the person's status as such, whether or not the society would have the power to indemnify the person against such liability under this section. [L 1987, c 347, pt of §2; am L 2004, c 122, §89]

" **§432:2-204 Waiver.** The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member. [L 1987, c 347, pt of §2]

"PART III. GOVERNANCE

§432:2-301 Organization. A domestic society organized on or after July 1, 1988, shall be formed as follows:

(1) Seven or more citizens of the United States, a majority of whom are residents of this State, who desire to form a fraternal benefit society, may make, sign and acknowledge before an officer competent to take acknowledgements of deeds, articles of incorporation, in which shall be stated:
  (A) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;
  (B) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this article;
  (C) The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one year from the date of issuance of the permanent certificate of authority.

(2) Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications and circulars to be issued by the society, and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one year shall be filed with the commissioner, who may require such further information as the commissioner deems necessary. The bond with sureties approved by the commissioner shall be in such amount, not less than $300,000 nor more than $1,500,000, as required by the commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this article and all provisions of the law have been complied with, the commissioner shall so certify, retain and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(3) No preliminary certificate of authority granted under the provisions of this section shall be valid after

one year from its date or after such further period, not exceeding one year, as may be authorized by the commissioner upon cause shown, unless the five hundred applicants hereinafter required have been secured and the organization has been completed as herein provided. The articles of incorporation and all other proceedings thereunder shall become null and void in one year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

(4) Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

- (A) Actual bona fide applications for benefits have been secured on not less than five hundred applicants, and any necessary evidence of insurability has been furnished to and approved by the society;
- (B) At least ten subordinate lodges have been established into which the five hundred applicants have been admitted;
- (C) There has been submitted to the commissioner under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and
- (D) It shall have been shown to the commissioner, by sworn statement of the treasurer, or corresponding officer of such society, that at least five hundred applicants have each paid in cash at least one regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least $150,000. Said advance premiums shall be held in trust during the period

of organization and if the society has not qualified for a certificate of authority within one year, such premiums shall be returned to said applicants.

(5) The commissioner may make such examination and require such further information as the commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this article. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The commissioner shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(6) Any incorporated society authorized to transact business in this State at the time this article becomes effective shall not be required to reincorporate. [L 1987, c 347, pt of §2]

Revision Note

"July 1, 1988," substituted for "the effective date of this article".

" **§432:2-302 Amendments to laws.** (a) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting, or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members, or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one of the methods herein specified.

(b) No amendment to the laws of any domestic society shall take effect unless approved by the commissioner who shall approve such amendment if the commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this State or with the character, objects and purposes of the society. Unless the commissioner shall

disapprove any such amendment within sixty days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the commissioner shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the commissioner disapproved such amendment, the reasons therefor shall be stated in such written notice.

(c) Within ninety days from the approval by the commissioner, all such amendments, or a synopsis thereof, shall be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society, or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof, have been furnished the addressee.

(d) Every foreign or alien society authorized to do business in this State shall file with the commissioner a duly certified copy of all amendments of, or additions to, its laws within ninety days after the enactment of same.

(e) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof. [L 1987, c 347, pt of §2]

" **§432:2-303 Institutions.** A society may create, maintain and operate, or may establish organizations to operate, not-for-profit institutions to further the purposes permitted by section 432:2-107(a)(2). Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement. [L 1987, c 347, pt of §2]

" **§432:2-304 Reinsurance.** (a) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this State, or if not so authorized, one which is approved by the commissioner. No such society may reinsure substantially all of its insurance in force without the written permission of the commissioner. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after July 1, 1988, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the

ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(b) Notwithstanding the limitation in subsection (a), a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under section 432:2-305. [L 1987, c 347, pt of §2]

Revision Note

"July 1, 1988" substituted for "the effective date of this article".

" **§432:2-305 Consolidations and mergers.** (a) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the commissioner:

(1) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;
(2) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the commissioner but not earlier than December 31 next preceding the date of the contract;
(3) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and
(4) Evidence that at least sixty days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(b) If the commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect, unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a

certificate of such approval filed with the commissioner of this State, or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the commissioner of insurance of such state or territory and a certificate of such approval filed with the commissioner of this State.

(c) Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument; except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this State in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall be vested absolutely in the society resulting from or remaining after such consolidation or merger.

(d) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees. [L 1987, c 347, pt of §2]

" **§432:2-306 Conversion of fraternal benefit society into mutual life insurance company.** Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of chapter 431 pertaining to mutual life insurers. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds of all members of the supreme governing body at a regular or special meeting shall be necessary for the approval of such plan. No such conversion shall take effect unless and until approved by the commissioner who may give such approval if the commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society. [L 1987, c 347, pt of §2]

"**PART IV. CONTRACTUAL BENEFITS**

§432:2-401 Benefits. (a) A society may provide the following contractual benefits in any form:

(1) Death benefits;

(2) Endowment benefits;
(3) Annuity benefits;
(4) Temporary or permanent disability benefits;
(5) Hospital, medical or nursing benefits;
(6) Monument or tombstone benefits to the memory of deceased members; and
(7) Such other benefits as authorized for life insurers and which are not inconsistent with this article.

(b) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (a), consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person. [L 1987, c 347, pt of §2]

" **§432:2-402 Beneficiaries.** (a) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society, unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the portion so paid shall not exceed the sum of $500.

(c) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid as provided in subsection (b), shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner. [L 1987, c 347, pt of §2]

" **§432:2-403 Benefits not attachable.** No money or other benefit, charity, relief or aid to be paid, provided or rendered by a society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other

person who may have a right thereunder, either before or after payment by the society. [L 1987, c 347, pt of §2]

" **§432:2-404 The benefit contract.** (a) Every society authorized to do business in this State shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(b) Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(c) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(d) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made either:

(1) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or
(2) In lieu of or in combination with paragraph (1), the owner may accept a proportionate reduction in benefits under the certificate.

The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(e) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(f) No certificate shall be delivered or issued for delivery in this State unless a copy of the form has been filed with the commissioner. Each filing shall be accompanied by a $20 fee payable to the commissioner, which fee shall be deposited in the commissioner's education and training fund. Every life, accident, health, or disability insurance certificate and every annuity certificate issued on or after July 1, 1989, shall meet the standard contract provision requirements not inconsistent with this article for like policies, except that a society may provide for a grace period for payment of premiums of one full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(g) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control or ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

(h) A society may specify the terms and conditions on which benefit contracts may be assigned. [L 1987, c 347, pt of §2; am L 1988, c 363, §2(6); am L 2004, c 122, §90]

"   **[§432:2-404.5] Genetic information nondiscrimination in health insurance coverage.** (a) No fraternal benefit society may:

(1) Use an individual's or a family member's genetic information, or request for genetic services, to deny or limit any coverage or establish eligibility, continuation, enrollment, or premium payments;

(2) Request or require collection or disclosure of an individual's or a family member's genetic information; or

(3) Disclose an individual's or a family member's genetic information without the written consent of the person affected, the person's legal guardian, or a person with power of attorney for health care for the person affected. This consent shall be required for each disclosure and shall include the name of each person or organization to whom the disclosure will be made.

(b) As used in this section:

"Family member" means, with respect to the individual, another individual related by blood to that individual.

"Genetic information" means information about genes, gene products, hereditary susceptibility to disease, or inherited characteristics that may derive from the individual or family member.

"Genetic services" means health services to obtain, assess, or interpret genetic information for diagnosis, therapy, or genetic counseling.

(c) This section shall not apply to any action taken in connection with policies of life insurance, disability income insurance, and long-term care insurance delivered or issued for delivery in this State. [L 2002, c 217, §3]

Law Journals and Reviews

Privacy and Genetics: Protecting Genetic Test Results in Hawaiʻi. 25 UH L. Rev. 449.

"   **§432:2-405 Nonforfeiture benefits, cash surrender values, certificate loans and other options.** (a) For certificates issued prior to one year after July 1, 1988, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable immediately prior to July 1, 1988.

(b) For certificates issued on or after one year from July 1, 1988, for which reserves are computed on the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941

Standard Industrial Table or the Commissioner's 1958 Standard Ordinary Mortality Table, or the Commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this State applicable to life insurers issuing policies containing like benefits based upon such tables. [L 1987, c 347, pt of §2]

Revision Note

"July 1, 1988" substituted for "the effective date of this article".

" **[§432:2-406] Mammogram coverage required; referral not required.** (a) A fraternal benefit society shall provide coverage for an annual screening mammogram to the same extent as required under section 431:10A-116; provided that no fraternal benefit society shall require a covered person forty years of age and older to obtain a referral from a primary care provider or other physician for an annual screening mammogram.

(b) If the screening mammogram indicates that follow up services are advisable, a referral shall be made to the patient's primary care physician or other physician, as designated by the patient. [L 2012, c 92, §3]

" **[§432:2-410] Primary care provider; advanced practice registered nurse.** (a) Each policy of insurance delivered or issued for delivery in this State by a fraternal benefit society shall recognize advanced practice registered nurses, as defined under section 457-8.5(a), as participating providers, and shall include coverage for care provided by participating advanced practice registered nurses practicing within the scope of their licenses for purposes of health maintenance, diagnosis, or treatment, to the extent that the policy provides benefits for identical services rendered by another health care provider.

(b) Notwithstanding any other law to the contrary, an insurer may recognize a participating advanced practice registered nurse as a primary care provider if the insured's policy requires the selection of a primary care provider. The insurer shall include participating advanced practice registered nurses who practice as primary care providers on any publicly available list of participating primary care providers; provided that the insurer retains the right to determine the contracting criteria for a participating primary care provider.

(c) For the purposes of this section, "participating advanced practice registered nurse" means an advanced practice registered nurse who has contracted with the insurer to provide health care services to its insureds. [L 2009, c 169, §4]

"PART V. FINANCIAL

§432:2-501 Investments. A society shall invest its funds only in such investments as are authorized by the laws of this State for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this State which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds. [L 1987, c 347, pt of §2]

" **§432:2-502 Funds.** (a) All assets shall be held, invested and disbursed for the use and benefit of the society. No member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

(c) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which section 432:2-404(b) and section 432:2-404(d) shall not apply. [L 1987, c 347, pt of §2]

" **§432:2-503 Taxation.** Every society organized and operating or licensed under this article shall be, from the time of such organization, exempt from every state, county, and

municipal tax, except real property taxes and unemployment compensation taxes; provided that nothing in this section shall be deemed to exempt the association or society from liability to withhold such taxes payable by its employees and pay the same to the proper collection officers, and to keep such records and make such returns and reports, as may be required in the case of other corporations, associations, or societies similarly exempt from the taxes hereinabove first mentioned; provided further, that the exemption hereby granted as to general excise taxes under chapter 237 shall not apply to any activity the primary purpose of which is to produce income. [L 1987, c 347, pt of §2]

"**PART VI. REGULATION**

§432:2-601 Valuations. (a) Standards of valuation for certificates issued prior to one year after July 1, 1988, shall be those provided by the laws applicable immediately prior to July 1, 1988.

(b) The minimum standards of valuation for certificates issued on or after one year from July 1, 1988, shall be based on the following tables:

(1) For certificates of life insurance the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Mortality Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table or any more recent table made applicable to life insurers.

(2) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancellable accident and health benefits, such tables as are authorized for use by life insurers in this State.

All of the above shall be under valuation methods and standards (including interest assumptions) in accordance with the laws of this State applicable to life insurers issuing policies containing like benefits.

(c) The commissioner may, in the commissioner's discretion, accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The commissioner may, in the commissioner's discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by a society authorized to do business in this State.

(d) Any society, with the consent of the commissioner of insurance of the state of domicile of the society and under such conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby. [L 1987, c 347, pt of §2]

Revision Note

"July 1, 1988" substituted for "the effective date of this article".

" **§432:2-602 Reports.** (a) Every society transacting business in this State shall annually, on or before March 1, unless for cause shown such time has been extended by the commissioner, file with the commissioner a true statement of its financial condition, transactions and affairs for the preceding calendar year. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(b) As part of the annual statement required, each society shall, on or before March 1, file with the commissioner a valuation of its certificates in force on December 31 last preceding; provided that the commissioner may, in the commissioner's discretion for cause shown, extend the time for filing the valuation for not more than two calendar months. The valuation shall be done in accordance with the standards specified in section 432:2-601. The valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(c) A society neglecting to file the annual statement in the form and within the time provided by this section shall be liable for a penalty of $100 for each day during which the neglect continues, and, upon notice by the commissioner to that effect, its authority to do business in this State shall cease while the default continues. [L 1987, c 347, pt of §2; am L 2012, c 251, §10; am L 2015, c 63, §14]

" **§432:2-603 Annual license.** Societies that are now authorized to transact business in this State may continue to transact business until August 16, 2016. The authority of societies and all societies hereafter issued a certificate of

authority, may thereafter be extended in accordance with section 432:2-108. [L 1987, c 347, pt of §2; am L 1988, c 363, §2(7); am L 2012, c 251, §11; am L 2015, c 63, §15]

" **§432:2-604 Examination of societies; no adverse publications.** (a) The commissioner, or any person the commissioner may appoint, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this State in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(b) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the commissioner. [L 1987, c 347, pt of §2]

" **§432:2-605 Foreign or alien society, admission.** No foreign or alien society shall transact business in this State without a license issued by the commissioner. Any such society desiring admission to this State shall comply substantially with the requirements and limitations of this article applicable to domestic societies. Any such society may be licensed to transact business in this State upon filing with the commissioner:

(1) A duly certified copy of its articles of incorporation;
(2) A copy of its bylaws, certified by its secretary or corresponding officer;
(3) A power of attorney to the commissioner as prescribed in section 432:2-701;
(4) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the commissioner of this State;
(5) Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;
(6) Copies of its certificate forms; and

(7) Such other information as the commissioner may deem necessary; and upon a showing that its assets are invested in accordance with the provisions of this article. [L 1987, c 347, pt of §2]

" **§432:2-606 Injunction, liquidation, receivership of domestic society.** (a) When the commissioner upon investigation finds that a domestic society:

(1) Has exceeded its powers;
(2) Has failed to comply with any provision of this article;
(3) Is not fulfilling its contracts in good faith;
(4) Has a membership of less than four hundred after an existence of one year or more; or
(5) Is conducting business fraudulently or in a manner hazardous to its members, creditors, the public or the business;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for the commissioner's dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty-day period in which to comply with the commissioner's request for correction. If the society fails to comply, the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

(b) If on such date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the commissioner may present the facts relating thereto to the attorney general who shall, if the attorney general deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(c) The court shall thereupon notify the officers of the society of a hearing. If after a full hearing it appears that the society should be so enjoined or liquidated or a receiver appointed, the court shall enter the necessary order. No society so enjoined shall have the authority to do business until:

(1) The commissioner finds that the violation complained of has been corrected;

(2) The costs of such action shall have been paid by the society if the court finds that the society was in default as charged;
(3) The court has dissolved its injunction; and
(4) The commissioner has reinstated the certificate of authority.

(d) If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and other assets of the society and, under the direction of the court, proceed forthwith to close the affairs of the society and to distribute its funds to those entitled thereto.

(e) No action under this section shall be recognized in any court of this State unless brought by the attorney general upon request of the commissioner. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the commissioner as such receiver.

(f) The provisions of this section relating to hearing by the commissioner, action by the attorney general at the request of the commissioner, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business. [L 1987, c 347, pt of §2]

" **§432:2-607 Suspension, revocation or refusal of license of foreign or alien society.** (a) When the commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this State:
(1) Has exceeded its powers;
(2) Has failed to comply with any of the provisions of this article;
(3) Is not fulfilling its contracts in good faith; or
(4) Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for the commissioner's dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty-day period in which to comply with the commissioner's request for correction. If the society fails to comply the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to

do business in this State should not be suspended, revoked or refused, the commissioner may suspend or refuse the license of the society to do business in this State until satisfactory evidence is furnished to the commissioner that such suspension or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this State.

(b) Nothing contained in this section shall be taken or construed as preventing any society from continuing in good faith all contracts made in this State during the time the society was legally authorized to transact business in this State. [L 1987, c 347, pt of §2]

" **§432:2-608 Injunction.** No application or petition for injunction against any domestic, foreign or alien society, or lodge, shall be recognized in any court of the State unless made by the attorney general upon request of the commissioner. [L 1987, c 347, pt of §2]

" **§432:2-609 Licensing of producers.** (a) Fraternal benefit society producers shall be licensed in accordance with the provisions governing producers in articles 7 and 9A of chapter 431, except that the appointment shall be made by the fraternal benefit society. Fraternal benefit society producers are not prohibited from obtaining additional licenses provided for in article 9 of chapter 431. No examination shall be required of an individual licensed to represent a fraternal benefit society prior to July 1, 1988.

(b) No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of the officer's, employee's or member's services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

(c) Any producer, representative, or member of a society who devotes, or intends to devote, less than fifty per cent of one's time to the solicitation and procurement of insurance contracts for such society shall be exempt from the requirements of subsection (a). Any person who in the preceding calendar year has solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of $50,000, or, in the case of any other kind or kinds of insurance which the society might write, on the persons of more than twenty-five individuals and who has received or will receive a commission or other compensation therefor, shall be presumed to be devoting, or intending to devote, fifty per cent of the

person's time to the solicitation or procurement of insurance contracts for such society. [L 1987, c 347, pt of §2; am L 1999, c 246, §4; am L 2001, c 216, §27; am L 2002, c 155, §104; am L 2003, c 212, §123; am L 2006, c 154, §43]

" **§432:2-610 Unfair methods of competition and unfair and deceptive acts and practices.** Every society authorized to do business in this State shall be subject to the provisions of article 13 of the insurance code relating to unfair practices; provided, however, that nothing in such provisions shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members [or] persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society. [L 1987, c 347, pt of §2]

" **[§432:2-611] Federal law compliance.** A fraternal benefit society shall comply with applicable federal law. The commissioner shall enforce the consumer protections and market reforms relating to insurance as set forth in the federal Patient Protection and Affordable Care Act, Public Law 111-148. [L 2011, c 15, §3]

"**PART VII. MISCELLANEOUS**

§432:2-701 Service of process. (a) Every society authorized to do business in this State shall appoint in writing the commissioner and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in such writing that any lawful process against it which is served on said attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this State. Copies of such appointment, certified by the commissioner, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the force and effect as the original thereof might be admitted.

(b) Service shall only be made upon the commissioner, or if absent, upon the person in charge of the commissioner's office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the commissioner, the commissioner shall immediately forward one of the duplicate copies by certified mail, prepaid, directed to the secretary or

corresponding officer. No such service shall require a society to file its answer, pleading or defense in less than thirty days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided. At the time of serving any process upon the commissioner, the plaintiff or complainant in the action shall pay to the commissioner a fee of $25. [L 1987, c 347, pt of §2; am L 2015, c 63, §16]

" **§432:2-702 Review.** All decisions and findings of the commissioner made under the provisions of this article shall be subject to review by proper proceedings in any court of competent jurisdiction in this State. [L 1987, c 347, pt of §2]

" **§432:2-703 Penalties.** (a) Any person who wilfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society, shall upon conviction be fined not less than $100 nor more than $500 or imprisoned for not less than thirty days nor more than one year, or both.

(b) Any person who wilfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this article, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

(c) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this State shall upon conviction be fined not less than $50 nor more than $200.

(d) Any person guilty of a wilful violation of, or neglect or refusal to comply with, the provisions of this article for which a penalty is not otherwise prescribed, shall upon conviction, be subject to a fine not exceeding $200.

(e) All penalties collected pursuant to this section and section 432:2-108 shall be deposited to the credit of the compliance resolution fund. [L 1987, c 347, pt of §2; am L 2015, c 63, §17]

" **§432:2-704 Exemption of certain societies.** (a) Nothing contained in this article shall be so construed as to affect or apply to:

(1) Grand or subordinate lodges of societies, orders, or associations now doing business in this State that provide benefits exclusively through local or subordinate lodges;

(2) Orders, societies, or associations that admit to membership only persons engaged in one or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies, or associations;

(3) Domestic societies that limit their membership to employees of a particular city or town, designated firm, business house or corporation that provide for a death benefit of not more than $400 or disability benefits of not more than $350 to any person in any one year, or both;

(4) Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than $400 or for disability benefits of not more than $350 to any one person in any one year, or both; or

(5) Any association, whether a fraternal benefit society or not; provided that:

(A) The association was organized before 1880;

(B) The association's membership consists of active, retired, or honorably discharged members of the armed forces or sea services of the United States, including officers or enlisted members and regular or reserve members; and

(C) A principal purpose of the association is to provide insurance and other benefits to its members and their dependents or beneficiaries.

(b) Any such society or association described in subsections (a)(3) or (4) which provides for death or disability benefits for which benefit certificates are issued, and any such society or association included in subsection (a)(4) which has more than one thousand members, shall not be exempted from the provisions of this article but shall comply with all requirements thereof.

(c) No society which, by the provisions of this section, is exempt from the requirements of this article, except any society described in subsection (a)(2), shall give or allow, or promise to give or allow to any person any compensation for procuring new members.

(d) Every society which provides for benefits in case of death or disability resulting solely from accident, and which

does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this article except that the provisions thereof relating to medical examination, valuations of benefit certificates, and incontestability, shall not apply to such society.

(e) The commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether such society or association is exempt from the provisions of this article.

(f) Societies, exempted under the provisions of this section, shall also be exempt from all other provisions of the insurance laws of this State. [L 1987, c 347, pt of §2; am L 2011, c 21, §1]

" **§432:2-705 Severability.** If any provision of this article or the application of such provision to any circumstance is held invalid, the remainder of the article or the application of the provision to other circumstances, shall not be affected thereby. [L 1987, c 347, pt of §2]