FIRST REGULAR SESSION

[TRULY AGREED TO AND FINALLY PASSED**]**

SENATE BILL NO. 59

97TH GENERAL ASSEMBLY

2013

0181S.02T

AN ACT

To repeal sections 375.772, 375.775, 375.776, and 376.717, RSMo, and to enact in lieu thereof four new sections relating to the regulation of insurance guaranty associations.

Be it enacted by the General Assembly of the State of Missouri, as follows:

Section A. Sections 375.772, 375.775, 375.776, and 376.717, RSMo, are repealed and four new sections enacted in lieu thereof, to be known as sections 375.772, 375.775, 375.776, and 376.717, to read as follows:

375.772. 1. There is created a nonprofit unincorporated legal entity to be known as the "Missouri Property and Casualty Insurance Guaranty Association", hereinafter referred to as "association". All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation and through a board of directors established by section 375.776.

2. As used in sections 375.771 to 375.779, the following terms mean:

(1) "Account", any one of the four accounts established by section 375.773;

(2) "Affiliate", a person who directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with another person;

(3) "Affiliate of an insolvent insurer", a person who directly or indirectly through one or more intermediaries controls, is controlled by, or is under common control with an insolvent insurer on December thirty-first of the year immediately preceding the date the insurer becomes an insolvent insurer;

(4) "Association", the Missouri property and casualty insurance guaranty association;

EXPLANATION–Matter enclosed in bold-faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.

(5) "Claimant", any insured making a first-party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant;

(6) "Control", the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with the corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. Such presumption may be rebutted by a showing that control does not exist in fact;

(7) "Covered claim", an unpaid claim including those for unearned premiums, presented by a claimant within the time specified in accordance with subsection 1 and subdivision (2) of subsection 2 of section 375.775, and is for a loss arising out of and is within the coverage of an insurance policy to which sections 375.771 to 375.779 apply made by a person insured under such policy or by a person suffering injury or for which a person insured under such policy is legally liable, if:

(a) The policy is issued by a member insurer and such member insurer becomes an insolvent insurer after August 28, 2004; and

(b) The claimant or insured is a resident of this state at the time of the insured event, or the claim is a first-party claim by an insured for damage to property and the property from which the claim arises is permanently located in this state or in the case of an unearned premium, the policyholder is a resident of this state at the time the policy is issued. The residency of the claimant, insured, or policyholder, other than an individual, is the state in which its principal place of business is located at the time of the insured event;

(c) "Covered claim" shall not include:

a. Any amount awarded as punitive or exemplary damages, or which is a fine or penalty;

b. Any amount sought as a return of premium under any retrospective rating plan; or

c. Any amount due any reinsurer, insurer, insurance pool, or underwriting association, health maintenance organization, hospital plan corporation, health

services corporation, or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnity, or otherwise. To the extent of any amount due any reinsurer, insurer, insurance pool, or underwriting association, health maintenance organization, hospital plan corporation, health services corporation, or self-insurer as subrogation recoveries or otherwise there shall be no right of recovery by any person against a tort-feasor insured of an insolvent insurer, except that such limitation shall not apply with respect to those amounts that exceed the limits of the policy issued such tort-feasor by the insolvent insurer;

d. A claim by or against an insured of an insolvent insurer, if such insured has a net worth of more than twenty-five million dollars on the later of the end of the insured's most recent fiscal year or the December thirty-first of the year next preceding the date the insurer becomes an insolvent insurer; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its affiliates as calculated on a consolidated basis;

e. Any first-party claim by an insured which is an affiliate of the insolvent insurer;

f. Supplementary payment obligations incurred prior to the final order of liquidation, including but not limited to adjustment fees and expenses, fees for medical cost containment services, including but not limited to medical case management fees, attorney's fees and expenses, court costs, penalties, and bond premiums;

g. Any claims for interest;

h. Any amount that constitutes a portion of a covered claim that is within an insured's deductible or self-insured retention;

i. Any fee or other amount sought by or on behalf of an attorney or other provider of goods or services retained by an insured or claimant in connection with the assertion or prosecuting of any claim, covered or otherwise, against the association;

j. Any amount that constitutes a claim under a policy**, except in the case of a claim for benefits under workers' compensation coverage,** issued by an insolvent insurer with a deductible or self-insured retention of three hundred thousand dollars or more. However, such a claim shall be considered a covered claim, if, as of the deadline set forth for the filing of claims against the insolvent insurer or its liquidator, the insured is a debtor under 11 U.S.C. Section

701, et seq.;

k. Any amount to the extent that it is covered by any insurance that is available to the claimant or the insured, whether such other insurance is primary, pro rata, or excess. In all such instances, the association's obligations to the insured or claimant shall not be deemed to be other insurance;

(8) "Insolvent insurer", an insurer licensed to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against whom a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile or of this state under the provisions of sections 375.950 to 375.990 or sections 375.1150 to 375.1246, and which such order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order;

(9) "Insured", any named insured, additional insured, vendor, lessor, or any other party identified as an insured under the policy;

(10) "Member insurer", any person who writes any kind of insurance to which sections 375.771 to 375.779 apply, including the exchange of reciprocal or interinsurance contracts, and possesses a certificate of authority to transact the business of insurance in this state issued by the director of the department of insurance, financial institutions and professional registration. Whether or not approved by the director of the department of insurance, financial institutions and professional registration for the placing of lines of insurance by producers so authorized under the provisions of chapter 384, an insurance company not licensed to do business in this state shall not be a member insurer. Missouri mutual and extended Missouri mutual insurance companies doing business under chapter 380 shall be considered member insurers for the purposes of sections 375.771 to 375.779, and a special account shall be established applicable only to such companies;

(11) "Net direct written premiums", direct gross premiums written in this state on insurance policies to which sections 375.771 to 375.779 apply, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers;

(12) "Net worth", the total assets of a person less the total liabilities against those assets. Where the person is one who prepares an annual report to

shareholders such report for the fiscal year immediately preceding the date of insolvency of the insurance carrier shall be used to determine net worth. If the person is one who does not prepare such an annual report, but does prepare an annual financial report for management which reflects net worth, then such report for the fiscal year immediately preceding the date of insolvency of the insurance carrier shall be used to determine net worth;

(13) "Ocean marine insurance" includes marine insurance that insures against maritime perils or risks and other related perils or risks which are usually insured against by traditional marine insurance, such as hull and machinery, marine builders' risks, and marine protection and indemnity. Such perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured arising out of an incident related to ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waters for commercial purposes, including liability of the insured for personal injury, illness, or death for loss or damage to the property of the insured or another person;

(14) "Person", any individual, corporation, partnership, association or voluntary organization, municipality, or political subdivision;

(15) "Political subdivision", the same meaning as such term is defined in section 70.210;

(16) "Self-insurer", a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance. Self-insurer does not include the Missouri private sector individual self-insurers guaranty corporation created pursuant to section 287.860, et seq.

375.775. 1. The association shall be obligated to the extent of the covered claims existing prior to the date of a final order of liquidation or a judicial determination by a court of competent jurisdiction in the insurer's domiciliary state that an insolvent insurer exists and arising within thirty days from the date or at the time of the first such order or determination, or before the policy expiration date if less than thirty days after such date, or before or at the time the insured replaces the policy or causes its cancellation, if he does so within thirty days of such date. Such obligation shall be satisfied by paying to the claimant an amount as follows:

(1) The full amount of a covered claim for benefits under workers'

compensation insurance coverage;

(2) An amount not exceeding twenty-five thousand dollars per policy for a covered claim for the return of unearned premium;

(3) An amount not exceeding three hundred thousand dollars per claim for all other covered claims.

2. In no event shall the association be obligated to an insured or claimant in an amount in excess of the face amount or the limits of the policy from which a claim arises or be obligated for the payment of unearned premium in excess of the amount of twenty-five thousand dollars, or to an insured or claimant on any covered claim until it receives confirmation from the receiver or liquidator of an insolvent insurer that the claim is within the coverage of an applicable policy of the insolvent insurer, except that within the sole discretion of the association, if the association deems it has sufficient evidence from other sources, including any claim forms which may be propounded by the association, that the claim is within the coverage of an applicable policy of the insolvent insurer, it shall proceed to process the claim, pursuant to its statutory obligations, without such confirmation by the receiver or liquidator:

(1) All covered claims shall be filed with the association on the claim information form required by this subdivision no later than the final date first set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer, except that if the time first set by the court for filing claims is one year or less from the date of insolvency, and an extension of the time to file claims is granted by the court, claims may be filed with the association no later than the new date set by the court or within one year of the date of insolvency, whichever first occurs. In no event shall the association be obligated on a claim filed after such date or on one not filed on the required form. A claim information form shall consist of a statement verified under oath by the claimant which includes all of the following:

(a) The particulars of the claim;

(b) A statement that the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to said claim;

(c) The name and address of the claimant and the attorney who represents the claimant, if any; and

(d) If the claimant is an insured, that the insured's net worth did not exceed twenty-five million dollars on the date the insurer became an insolvent

insurer. The association may require that a prescribed form be used and may require that other information and documents be included. A covered claim shall not include any claim not described in a timely filed claim information form even though the existence of the claim was not known to the claimant at the time a claim information form was filed;

(2) In the case of claims arising from a member insurer subject to a final order of liquidation issued on or after September 1, 2000, the provisions of subdivision (1) of subsection 2 of this section shall not apply and in lieu thereof, such claims shall be governed by this subdivision. All covered claims shall be filed with the association, liquidator or receiver. Notwithstanding any other provisions of sections 375.771 to 375.779, a covered claim shall not include a claim filed after the earlier of eighteen months after the date of the order of liquidation, or the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. The association may require that other information and documents be included in confirming the existence of a covered claim or in determining eligibility of any claimant. Such information may include, but is not limited to:

(a) The particulars of the claim;

(b) A statement that the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to said claim;

(c) The name and address of the claimant and the attorney who represents the claimant, if any; and

(d) A verification under oath of such requested information. In no event shall the association be obligated on a claim filed with the association, liquidator or receiver for protection afforded under the insured's policy for incurred but not reported losses. A covered claim shall not include any claim that is not filed prior to the final date for filing claims, even though the existence of the claims was not known to the claimant prior to such final date.

3. In the case of claims arising from bodily injury, sickness or disease, the amount of any such award shall not exceed the claimant's reasonable expenses incurred for necessary medical, surgical, X-ray, dental services and comparable services for individuals who, in the exercise of their constitutional rights, rely on spiritual means alone for healing in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof, including prosthetic devices and necessary ambulance, hospital,

professional nursing, and any amounts lost or to be lost by reason of claimant's inability to work and earn wages or salary or their equivalent, except that the association shall pay the full amount of any covered claim arising out of a workers' compensation policy. Such award may also include payments in fact made to others, not members of claimant's household, which were reasonably incurred to obtain from such other persons ordinary and necessary services for the production of income in lieu of those services the claimant would have performed for himself had he not been injured. Verdicts as respect only those civil actions as may be brought to recover damages as provided in this section shall specifically set out the sums applicable to each item in this section for which an award may be made.

4. In the case of claims arising from a member insurer subject to a final order of liquidation dated on or after August 31, 2004, the provisions of subsection 3 of this section shall not apply.

5. Notwithstanding any other provision of sections 375.771 to 375.779, except in the case of a claim for benefits under workers' compensation coverage, any obligation of the association to or on behalf of the insured and its affiliates on covered claims shall cease when ten million dollars has been paid in the aggregate by the association and any one or more associations similar to the association in any other state or states to or on behalf of such insured, its affiliates, and additional insureds on covered claims or allowed claims arising under the policy or policies of any one insolvent insurer.

6. If the association determines that there may be more than one claimant having a covered claim or allowed claim against the association, or any associations similar to the association in other states, under the policy or policies of any one solvent insurer, the association may establish a plan to allocate amounts payable by the association in such manner as the association in its discretion deems equitable.

7. The association shall be deemed the insurer only to the extent of its obligations on the covered claims and to such extent, subject to the limitations provided in sections 375.771 to 375.779, shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations. The association shall not be deemed the insolvent insurer for any purpose relating to the issue of

whether the association is amenable to the personal jurisdiction of the courts of any states. However, any obligation to defend an insured shall cease upon:

(1) The association's payment by settlement releasing the insured or on a judgment of an amount equal to the lesser of the association's covered claim obligation limit or the applicable policy limit; or

(2) The association's tender of such amount.

8. The association shall allocate claims paid and expenses incurred among the four accounts separately, and assess member insurers separately for each account amounts necessary to pay the obligations of the association under subsection 1 of this section to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examinations under subdivision (3) of subsection 9 of this section, and other expenses authorized by sections 375.771 to 375.779. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the preceding calendar year of the kinds of insurance in the account. Each member insurer's assessment may be rounded to the nearest ten dollars. Each member insurer shall be notified of the assessment not later than thirty days before it is due. No member insurer may be assessed in any year on any account an amount greater than **[**one**]** **two** percent of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or, in the discretion of any such company, credited against future assessments. No dividends shall be paid

stockholders or policyholders of a member insurer so long as all or part of any assessment against such insurer remains deferred. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made. Assessments made under sections 375.771 to 375.779 and section 375.916 shall not be subject to subsection 1 of section 375.916;

9. The association shall:

(1) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the director, but such designation may be declined by a member insurer;

(2) Reimburse each servicing facility for obligations of the association paid by the facility and for actual expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this section;

(3) Be subject to examination and regulation by the director. The board of directors shall submit, not later than March thirtieth of each year, a financial report for the preceding calendar year in a form approved by the director; and

(4) Proceed to investigate, settle, and determine covered claims.

10. The association may:

(1) Appear in, defend and appeal any action on a claim brought against the association;

(2) Employ or retain such persons as are necessary to handle claims and perform other duties of the association;

(3) Act as a servicing facility for other similar entities created by similar laws in this state or other states;

(4) Borrow funds necessary to effect the purposes of sections 375.771 to 375.779 in accord with the plan of operation;

(5) Sue or be sued. Such power to sue includes the power and right to intervene as a party before any court that has jurisdiction over an insolvent insurer as defined in section 375.772;

(6) Negotiate and become a party to such contracts as are necessary to carry out the purpose of sections 375.771 to 375.779;

(7) Perform such other acts as are necessary or proper to effectuate the

purpose of sections 375.771 to 375.779;

(8) Refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if, at the end of any calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year; and

(9) Become a member of the National Conference on Insurance Guaranty Funds.

375.776. 1. The board of directors, subject to the supervision of the director, shall:

(1) Establish a plan of operation whereby the duties of the association under section 375.775 will be performed;

(2) Establish procedures for handling assets of the association;

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

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

(5) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the director within thirty days after the action or decision;

(6) Establish the procedures whereby selections for the board of directors will be submitted to the director; and

(7) Have and exercise such additional powers necessary or proper for the execution of the powers and duties of the association.

2. The plan of operation may provide that any or all powers and duties of the association, except those under subsection 8 and subdivision (4) of subsection 10 of section 375.775, are delegated to a corporation, association, or organization which performs or will perform functions similar to those of this association, or its equivalent, in two or more states. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the association. A delegation under this section shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association, or organization which extends protection not substantially less

favorable and effective than that provided by sections 375.771 to 375.779.

3. The board of directors of the association shall consist of **not less than** seven **nor more than nine** persons serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the director. Not less than four of the members shall represent domestic insurers. Vacancies on the board shall be filled for the remaining period of the term by **[**appointment**] a majority vote of the remaining board members subject to the approval** of the director. **[**If no members are selected within sixty days, the director shall appoint the initial members of the board of directors.**]**

4. Members of the board shall receive no remuneration.

5. To aid in the detection and prevention of insurer insolvencies:

(1) It shall be the duty of the board of directors, upon majority vote, to notify the director of any information indicating any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public;

(2) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents; and

(3) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association, and submit such report to the director.

376.717. 1. Sections 376.715 to 376.758 shall provide coverage for the policies and contracts specified in subsection 2 of this section:

(1) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees of the persons covered under subdivision (2) of this subsection; and

(2) To persons who are owners of or certificate holders under such policies or contracts, other than structured settlement annuities, who:

(a) Are residents of this state; or

(b) Are not residents, but only under all of the following conditions:

a. The insurers which issued such policies or contracts are domiciled in this state;

b. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in such state at the time specified in such state's guaranty association law; and

c. The states in which the persons reside have associations similar to the association created by sections 376.715 to 376.758;

(3) For structured settlement annuities specified in subsection 2 of this section, subdivisions (1) and (2) of subsection 1 of this section shall not apply, and sections 376.715 to 376.758 shall, except as provided in subdivisions (4) and (5) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

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

(b) Is not a resident, but only under both of the following conditions:

a. (i) The contract owner of the structured settlement annuity is a resident; or

(ii) The contract owner of the structure settlement annuity is not a resident, but:

i. The insurer that issued the structured settlement annuity is domiciled in this state; and

ii. The state in which the contract owner resides has an association similar to the association created under sections 376.715 to 376.758; and

b. Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

(4) Sections 376.715 to 376.758 shall not provide to a person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by such an association of another state;

(5) Sections 376.715 to 376.758 are intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under sections 376.715 to 376.758 is provided coverage under the laws of any other state, the person shall not be provided coverage under sections 376.715 to 376.758. In determining the application of the provisions of this subdivision in situations where a person could be covered by such an association of more than one state, whether as an owner, payee,

beneficiary, or assignee, sections 376.715 to 376.758 shall be construed in conjunction with the other state's laws to result in coverage by only one association.

2. Sections 376.715 to 376.758 shall provide coverage to the persons specified in subsection 1 of this section for direct, nongroup life, health, annuity policies or contracts, and supplemental contracts to any such policies or contracts, and for certificates under direct group policies and contracts, except as limited by the provisions of sections 376.715 to 376.758. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

3. Sections 376.715 to 376.758 shall not provide coverage for:

(1) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder;

(2) Any policy or contract of reinsurance, unless assumption certificates have been issued;

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

(a) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the association became obligated; and

(b) On and after the date on which the association becomes obligated with respect to such policy or contract exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) Any portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or other person under:

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

Section 1144, as amended;

(b) A minimum premium group insurance plan;

(c) A stop-loss group insurance plan; or

(d) An administrative services only contract;

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

(6) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;

(7) A portion of a policy or contract to the extent that the assessments required by section 376.735 with respect to the policy or contract are preempted by federal or state law;

(8) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(a) Claims based on marketing materials;

(b) Claims based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(c) Misrepresentations of or regarding policy benefits;

(d) Extra-contractual claims;

(e) A claim for penalties or consequential or incidental damages;

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

(10) An unallocated annuity contract;

(11) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an

impaired or insolvent insurer under sections 376.715 to 376.758, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, for purposes of determining the value that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(12) A policy or contract providing any hospital, medical, prescription drug or other health care benefit under Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, Medicare **[**Part**]** **Parts** C & D, or any regulations issued thereunder.

4. The benefits for which the association may become liable**, with regard to a member insurer that was first placed under an order of rehabilitation or under an order of liquidation if no order of rehabilitation was entered prior to August 28, 2013,** shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) With respect to any one life, regardless of the number of policies or contracts:

(a) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(b) One hundred thousand dollars in health insurance benefits, including any net cash surrender and net cash withdrawal values;

(c) One hundred thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. Provided, however, that in no event shall the association be liable to expend more than three hundred thousand dollars in the aggregate with respect to any one life under paragraphs (a), (b), and (c) of this subdivision.

5. **Except as otherwise provided in subdivision (2) of this subsection, the benefits for which the association may become liable with regard to a member insurer that was first placed under an order of rehabilitation or under an order of liquidation if no order of**

rehabilitation was entered on or after August 28, 2013, shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) (a) With respect to any one life, regardless of the number of policies or contracts:

a. Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

b. In health insurance benefits:

(i) One hundred thousand dollars of coverages other than disability insurance or basic hospital, medical, and surgical insurance or major medical insurance, or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(ii) Three hundred thousand dollars for disability insurance and three hundred thousand dollars for long-term care insurance;

(iii) Five hundred thousand dollars for basic hospital, medical, and surgical insurance or major medical insurance;

c. Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(b) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(c) Except that, in no event shall the association be obligated to cover more than:

a. An aggregate of three hundred thousand dollars in benefits with respect to any one life under paragraphs (a) and (b) of this subdivision, except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under item (iii) of subparagraph b. of paragraph (a) of this subdivision, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual; or

b. With respect to one owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the person insured are officers, managers, employees, or other persons, more than five million dollars in benefits, regardless of the number of policies and contracts held by the owner.

6. The limitations set forth in **[**subsection 4**] subsections 4 and 5** of this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which such benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under sections 376.715 to 376.758 may be met by the use of assets attributable to covered policies or reimbursed to the association under its subrogation and assignment rights.

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