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**OKLAHOMA LIFE AND HEALTH INSURANCE  
GUARANTY ASSOCIATION**

**PLAN OF OPERATION**

**ARTICLE 1  
PLAN OF OPERATION**

- A. Effective Date:** This Plan of Operation ("the Plan") shall become effective upon written approval of the Commissioner as provided in Section 2027 of the Oklahoma Life and Health Insurance Guaranty Association Act, Title 36, the Insurance Code ("the Code").
- B. Amendments:** Amendments to this Plan of Operation, as necessary or suitable to assure the fair, reasonable and equitable administration of the Association, shall be adopted by the Board of Directors and submitted to the Commissioner for approval. Any such amendments so submitted shall be effective upon written approval of the Commissioner or thirty (30) days after submission if the Commissioner has not disapproved them.
- C. Availability of Copies:** A copy of this Plan of Operation shall be available for inspection by any member insurer at the office of the Association during normal business hours, and a copy shall be provided to any member insurer upon request.
- D. Notices:** Unless otherwise specified in this Plan, actions and communications including notices, approvals, consents and signatures will be deemed to be written and acceptable if they are written and provided by the United States Postal Service mail, courier service, or by e-mail, facsimile, or other electronic means. Contemporaneous documentation of such actions and communication should be maintained in the Association's records in a hard copy or an electronic file for future reference.

**ARTICLE 2  
ANNUAL MEETINGS OF THE MEMBER INSURERS**

- A. Location:** An annual meeting of the member insurers of the Association shall be held for the election of directors at the office of the Association immediately preceding the annual meeting of the Board of Directors, unless the Chairman of the Board of Directors, upon proper notice, shall designate some other time, day and place.
- B. Notice:** Member insurers and the Commissioner shall be notified of the time, day and place of the annual meeting of the member insurers, and the nominees to succeed each director whose term expires or otherwise terminates at the annual meeting of the Association, at least ninety (90) days prior to such annual meeting.

- C. Voting Rights:** At annual meetings of the member insurers if there are more nominees than vacancies, Directors shall be elected by member insurers whose votes may be cast on some type of weighted basis using the net Oklahoma direct premiums received as provided by the Commissioner for the last available year on covered policies. The use of such a weighted basis and the form it shall take shall be within the sole discretion of the Board of Directors. Each member insurer shall have at least one vote in person or by proxy for each member of the Board of Directors to be elected.
- D. Election Procedure:** At all annual meetings of the member insurers:
1. Proxy voting shall be permitted. The presence of not fewer than five member insurers shall be required to constitute a quorum and such presence shall within itself constitute a quorum.
  2. The member insurers receiving the greatest number of votes, on a non-cumulative basis, shall be elected.
  3. In the event that there is not more than one (1) nominee for each position to be filled, the Secretary shall cast one (1) vote for each nominee.

**ARTICLE 3  
BOARD OF DIRECTORS**

- A. Composition of Board:** There shall be a Board of Directors in accordance with the provisions of Section 2026 of the Code.
- 1. Terms of Office:**
- a. The Board of Directors shall consist of no less than seven (7) nor more than eleven (11) member insurers to be elected for staggered terms of three (3) years so that the terms of all Directors shall not expire in the same year.
  - b. The Board of Directors shall be elected by the member insurers as provided in Article 2 hereof. No two members of the Board shall be from the same affiliated insurers.
  - c. Each elected member of the Board shall designate its representative and any alternate from the same member insurer.
  - d. The previously elected Board members shall serve until their successors have been duly elected and qualified to serve.

- e. In the event of a change in a Board member's corporate or licensing status, the Executive Committee, if there is such a Committee, or the Board, will review whether such change is consistent with the conditions and requirements for Board membership. Based on its review, the Executive Committee, if there is one, will recommend action to the full Board, or the Board may take action. Such action may include requesting the company to resign from the Board if it is determined that the company's new status is no longer consistent with the basis for inviting it to be a nominee or to fill a vacancy. The Board member shall be replaced in accordance with the provisions of paragraph (a).

**2. Approval by Insurance Commissioner:** Upon the election of members of the Board, the Association shall notify the Commissioner and request written approval of the members of the Board as elected. In the event the Commissioner shall disapprove the election of any Director elected at an annual meeting, the existing Board of Directors shall call another election. The Board of Directors shall have the option of seeking approval of the nominees by the Commissioner in writing prior to holding the election or annual meeting elected.

**3. Officers:** The Board of Directors shall:

- a. Elect a Chairman, Vice Chairman, Secretary and Treasurer from among its members, and such other officers as it deems necessary. The posts of Secretary and Treasurer may be held by the same member. Each officer shall serve a term of one (1) year or until a successor is elected.
- b. Have its Chairman, with the advice and consent of the Board, appoint an Executive Committee from among its members. Such Committee shall have as its members the Chairman, the Vice Chairman, Secretary and Treasurer, and such other Directors, if any, as appointed by the Board. The Executive Committee shall have such powers as may be delegated by the Board, provided it shall not have the authority to act on matters requiring a majority vote of the full Board as provided in B (3) below.
- c. Have its Chairman, with the advice and consent of the Board, appoint an audit committee which shall consist of three (3) member insurers. The audit committee shall recommend selection of the independent outside auditor and facilitate the annual audit of the Association by an independent outside auditor; it shall also review and provide recommendations regarding any financial or operational review of the Association by independent outside auditors or the Insurance Department.

- d. Appoint, from among its members, a nominating committee. Such committee, or the Board as a whole, shall select a nominee to succeed each Board member whose term expires at the annual meeting of the member insurers. Such nominees shall be made known to the member insurers at least ninety (90) days prior to such annual meeting. Other nominees may be submitted to the Board, but not less than sixty (60) days prior to such annual meeting, upon the petition of ten (10) member Insurers.
- e. In the event there is more than one (1) nominee for each position to be filled, the Board shall make the names of said nominees known to member insurers at least thirty (30) days prior to the annual meeting of the member insurers.

**4. Vacancies:** Vacancies occurring on the Board of Directors between annual meetings of the member insurers shall be filled by a majority vote of the remaining members of the Board with the approval of the Commissioner. Vacancies occurring in elective offices between annual meetings shall be filled by majority vote of the Board. Such officers shall serve for the unexpired terms.

**B. Voting Procedures:** All Directors shall receive notice of all meetings of the Board and committees appointed by the Board, and be afforded the opportunity to participate. Meetings of the Board and committees appointed by the Board may be held in person, by telephone, or by other electronic means:

- 1. Voting Rights:** At any meeting of the Board of Directors, each member of the Board shall have one (1) vote.
- 2. Quorum:** A majority of the Board shall constitute a quorum for the transaction of business and the acts of the majority of the Board members present at a meeting at which a quorum is present shall be the acts of the Board, except as provided in paragraph 3 below.
- 3. Actions Requiring Majority Approval:** An affirmative vote of a majority of the full Board is required to:
  - a. approve a contract with a servicing facility for overall administration of the Association, except that administrations of specific functions with regard to specific insolvencies shall not require an affirmative vote of a majority of the full Board;
  - b. levy an assessment or provide for a refund;
  - c. borrow money, establish, authorize or change a line of credit;
  - d. approve reinsurance contracts, assumption agreements or guaranty plans;  
or
  - e. adopt amendments to the Plan of Operation.

- C. Annual Meeting Of Board:** An annual meeting of the Board shall be held at the office of the Insurance Commissioner or another venue at 10:00 a.m. on the First Tuesday in the month of October, immediately following the annual meeting of the member insurers, unless the Chairman of the Board, upon proper notice, shall designate some other time, day or place. At each annual meeting the Board shall:
1. Review the Plan and submit proposed amendments, if any, to the Commissioner for approval.
  2. Review each outstanding contract or agreement, if any, and make necessary or desirable corrections, improvements or additions.
  3. Review operating expenses and outstanding contractual obligations and determine whether an assessment, or a refund of a prior assessment, is necessary for the proper administration of the Association and if so, the amount of either. The Board may establish an amount below which assessments or refunds shall not be made.
  4. Review, consider and act on any other matters deemed by it to be necessary and proper for the administration of the Association.
- D. Other Meetings:** The Board may hold other regular or special meetings at such times and with such frequency as it deems appropriate to conduct the business of the Association. Such meetings may be held telephonically. Any Board member not present may consent in writing to any specific action taken by the Board, but this shall not permit Board members to act through other Board members by proxy. Any action approved by the required number of Board members at such meeting, including those consenting in writing, shall be as valid a Board action as though authorized at an annual or regular meeting of the Board or at a meeting held in person.
- E. Special Meetings:** Special meetings of the Board of Directors may be called by the Chairman and shall be called upon the request of any two (2) Board members. At such special meeting the Board may consider and decide any matter deemed necessary for the proper administration of the Association. Not less than five (5) days notice shall be given to each Board member of the time, place and purpose of any such special meeting.
- F. Meetings Regarding Insolvency of Member:** At meetings at which the impairment or insolvency of a member insurer is considered, the Board may:
1. Consider and determine the legal obligations of the Association with regard to any reported impairment or insolvency.
  2. Consider and decide what methods or facilities, as permitted under Section 2028 of the Code, shall be adopted or utilized to assure fulfillment of the covered

obligations of the impaired or insolvent member insurer for each of the categories of covered policies.

3. Assure that timely action is taken to gain access to and effect proper retention of records of the impaired or insolvent member insurer which are deemed necessary to the prompt and economical handling of its legally imposed duties.
  4. Consider and decide to what extent and in what manner the Board shall exercise the powers authorized by Section 2029 of the Code to bring legal actions or provide for the defense thereof in order to avoid payment of improper claims.
  5. Consider and decide or defer the decision as to what assessment, if any, should be levied, and consider and decide whether any assessment shall be deferred or abated. If such assessment, deferral or abatement shall be determined to be appropriate, such action or actions shall be in accordance with the requirements specified in the appropriate item or items of Section 2030 of the Code. Notices of assessments to member insurers shall be in sufficient detail as to form a basis for the payment of such assessment by the member insurer. The Board shall promptly inform the Commissioner of the failure of any member to pay an assessment made pursuant to this paragraph when due.
  6. Take all steps permitted by law, and deemed necessary, to protect the Association's rights as pertaining to the impaired or insolvent member insurer and its policyholders. In addition to the foregoing powers, the Board shall have and exercise such other powers as may be reasonably necessary to implement its powers and responsibilities under the Code.
  7. Issue to each member insurer a "certificate of contribution" for each Class of assessment paid for which certificates are to be provided under section 2030 of the Code. The certificate shall show the amount paid by each insurer, date of assessment, name of the particular insolvent or impaired insurer for which the assessment was made, the value, if any, of such certificate as determined by the Commissioner, and such other information as the Board shall find relevant.
  8. In addition to the foregoing powers, the Board shall have and exercise such other powers as may be reasonably necessary to implement the provisions of the Code.
- G. Reimbursement:** Members of the Board may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board of Directors upon approval of such expenses by the Board, but members of the Board shall not be compensated by the Association for their services as members of the Board of Directors.

## ARTICLE 4 OPERATIONS

- A. **Address:** The official address of the Association shall be the address of the office of the Commissioner unless otherwise designated by the Board of Directors.
- B. **Employment of Third Parties:** The Board of Directors may employ or retain such persons, firms or corporations to perform such administrative functions as are necessary for the Board's performance of the duties imposed upon the Association. The Board may use the mailing address of such person, firm or corporation as the official address of the Association. Such persons may include an Executive Vice President with such authority as may be delegated by the Board to implement and carry out broad directives of the Board made pursuant to its statutory authority and duties. Such person shall be knowledgeable about insurance matters, conversant with the law as it relates to covered policies of insurance and administratively capable of implementing the Board's directives. Such persons may also include attorneys at law, actuaries, accountants, claims personnel and such other specialists or persons whose advice or assistance is deemed by the Board to be necessary to the discharge of its duties imposed by law. The Executive Vice President may function in a dual capacity for the Association if he is appropriately qualified for employment as a professional or specialist as herein authorized. The Board may agree to compensate such persons so as to best serve the interests of the Association and the public. Such persons, firms or corporations shall keep and maintain such records of their activities as may be required by the Board and the Code.
- C. **Bank Accounts:** The Board may open such bank accounts as it deems necessary for the proper administration of Association business. Reasonable delegation and withdrawal authority to such accounts for Association business will be made consistent with prudent fiscal policy. Check signature limits and wire authority limits and procedures shall be determined by the Treasurer and approved by the Board. Investment policy shall be recommended by the Treasurer and approved by the Board, and shall be reviewed at the annual meeting of the Board of Directors.
- D. **Maximum Assessment Insufficiency:** In the event of the judgment of the Board of Directors the maximum assessment under Section 2025 of the Code, in combination with the Association's borrowing authority, will be insufficient over any given year to cover the outstanding and anticipated covered claims against the Association relating to one or more impaired or insolvent member insurers under any account or accounts, the Board of Directors may provide that the Association shall make partial and periodic payments on such claims in accordance with a schedule to be adopted by the Board of Directors. Such schedule may give preference to health claims, periodic annuity benefit payments, death benefits, supplemental benefits and cash withdrawals under emergency or hardship standards proposed by the Board of Directors. Such schedule may be adjusted from time to time as changes in the volume and type of such covered claims may warrant and may be structured so as not to give preference to claims in the order in which they were

incurred or made in the order of which member insurers first became impaired or insolvent, or to require retroactive adjustments.

- E. Procedures For Detecting Insolvencies:** In order to effectuate the purposes set forth in Section 2032 of the Code concerning the prevention of impairments, the Board of Directors may develop procedures for discovering and reporting any member insurer that may be insolvent or in an impaired financial condition which is hazardous to the interest of the policyholders of such insurer or to the public interest. No such reports shall be considered public documents. The Board of Directors may review the Insurance Code and appropriate regulations with a view toward making recommendations to the Commissioner for the improved and more certain detection and prevention of member insurer insolvencies or impairments.
- F. Allocation of Class B Assessments:** The purpose of this paragraph is to provide the framework for allocating Class B assessments attributable to the Association's obligations for any covered long-term care policies between the "Health Account" and the "Life and Annuity Account" defined below. The allocation method outlined below is intended to implement the requirements of Section 2030C of the Code. The instructions are intended to result in a net allocation of any Class B assessments for the Association's long-term care policy obligations in equal 50% shares to "Accident and Health Member Insurers" and "Life and Annuity Member Insurers" as those two categories of member insurers are defined below.

In accordance with Section 2030C of the Code if a Class B assessment is authorized due to covered long-term care policies, a portion of the Association's Class B assessment authorized to meet its obligations for the covered long-term care policies (the "LTC Assessment") shall be allocated to the Life and Annuity Account, without dividing it between the subaccounts thereof, with the remaining portion of the LTC Assessment allocated to the Health Account.

The following definitions shall apply only for the purposes of allocating any such Class B assessment for covered long-term care policies to the Life and Annuity Account and the Health Account in accordance with the below formula:

"Accident and Health Member Insurer" means any member insurer that does not qualify as a Life and Annuity Member Insurer.

"Health Account" shall mean the health insurance account established under Section 2023B of the Code.

"LAMIHA" shall mean the quotient of (a) the Life and Annuity Member Insurers' aggregate assessable premium in the Health Account divided by (b) the total assessable premium in the Health Account;

“LAMILAA” shall mean the quotient of (a) the Life and Annuity Member Insurers’ aggregate assessable premium in the Life and Annuity Account divided by (b) the total assessable premium in the Life and Annuity Account.

“Life and Annuity Account” shall mean the aggregate life insurance and annuity account established under Section 2023B of the Code without dividing such account into subaccounts.

“Life and Annuity Member Insurers” shall mean each and every member insurer having (i) total assessable premium in the Life and Annuity Account greater than or equal to (ii) its total assessable premium in the Health Account, where assessable premium in the Health Account includes, but is not limited to, the member insurer’s assessable health maintenance organization premiums but shall exclude the member insurer’s assessable premiums for disability income and long-term care insurance. Note: The exclusion of a member insurer’s assessable premiums for disability income and long-term care insurance shall be applied only for the purpose of the definition of “Life and Annuity Member Insurers,” and such exclusion shall not apply for any other purposes.

The amount of the LTC Assessment allocated to the Life and Annuity Account shall be determined in accordance with the following formula:

$$\begin{array}{l} \text{Life and Annuity} \\ \text{Account LTC} \\ \text{Assessment} \\ \text{Share} \end{array} = \text{LTC Assessment} * \frac{(.50 - \text{LAMIHA})}{(\text{LAMILAA} - \text{LAMIHA})}$$

The amount of the LTC Assessment not allocated to the Life and Annuity Account as provided above shall be allocated to the Health Account.

The amount of any LTC Assessment allocated to the Life and Annuity Account or to the Health Account shall be allocated among member insurers in accordance with Section 2030 of the Code, except that the total assessable premium in the entire Life and Annuity Account shall be used in the aggregate without dividing it between the subaccounts.

**G. Policy Forms and Rates:** Pursuant to the Association's authority under section 2028 of the Code, the Board of Directors may adopt for future issuance without regard to any particular impairment or insolvency, and submit to the Commissioner for approval, policy forms of various types, containing at least the minimum statutory provisions required in this state, and associated tables of premium rates. Policy forms and rates so adopted and approved may be used to provide substitute benefits or alternative continued coverages with respect to the covered policies or contracts of an impaired or insolvent member insurer.

**G. Excess Funds:** The Board of Directors shall determine at least annually if an excess of funds in any account exists such that the funds are not reasonably needed to fund future obligations of current or future insolvencies for the payment of the obligations of the Association. The Board's review for this purpose shall include, but not be limited to, a review of assets accruing from assignment, subrogation, net realized gains on distributions and income from investments. If the Board determines an excess exists, it can in its sole discretion, and in proportion to the contribution of each insurer to that account:

- (1) refund in cash; or,
- (2) refund in the form of a credit against any future assessments with respect to that account; to the extent a credit is granted to an insurer, it shall be reflected in the next subsequent assessment of the insurer for that account; or,
- (3) reallocate excess funds to any other impairment or insolvency within the same account, or place the excess funds in a composite account to be held for this purpose.

In order to avoid disproportionate clerical expense, the Board may establish an amount below which refunds shall not be made.

**H. Amending Assessable Premium:** The Board may establish a general policy whereby the Board or the Board's designee may accept amended assessable premium reports filed with the NAIC which correct reports filed for prior years which contain inadvertent errors made by a member insurer. Under such a policy, correction of the error would be prospective only. The corrected assessable premium would be used for future assessments, but could not be used to re-calculate prior assessments.

## **ARTICLE 5 RECORDS AND REPORTS**

**A. Minutes and Records of Meetings:** Minutes of the proceedings of each Board meeting shall be written. The original of these minutes shall be retained by the Secretary of the Board of Directors or by such other person as the Board may designate. Records of negotiations or meetings shall be made public only upon the termination of the impairment

or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the Association to render a report of its activities under Section C. The Board of Directors may, upon majority vote, make reports and recommendations to the Commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

- B. Copies of Minutes and Records:** Copies of minutes, reports, recommendations, records and documents shall be furnished to each Board member, and to the Commissioner or to any member insurer upon request; provided, however, that such minutes, reports, recommendations or other records and documents relating to the portions of such proceeding which were closed, because of the confidential nature of the matters addressed, shall also be confidential, and distribution of such minutes, reports, recommendations, records and documents shall be limited to the members of the Board of Directors and the Association's attorneys, employees or agents, considered by the Board of Directors to be necessary or pertinent to the discussion of the matters addressed or performance of the actions taken during such confidential proceedings.
- C. Annual Report by Board:** The Board of Directors shall make an annual report as required by Section 2039 of the Code not later than May 1 of each year to the Commissioner. Such report shall include a financial report for the preceding calendar year in a form approved by the Commissioner and a review of the activities of the Association during the preceding calendar year.
- D. Annual Audit:** The Board shall, once each calendar year, either appoint certain of the member insurers as an audit committee, or engage a certified public accountant to review or audit the financial affairs of the Association. An audit committee shall consist of three (3) member insurers, at least two (2) of which shall not be members of the Board of Directors. Such committee or accountant shall report its findings to the Board of Directors.

## **ARTICLE 6 MEMBERSHIP**

- A. Members:** Pursuant to Section 2024 of the Code, insurers which were admitted as of October 1, 1981, to transact the kinds of insurance covered by the Oklahoma Life and Health Insurance Guaranty Association Act in the State of Oklahoma shall be member insurers of this Association. Each insurer admitted after said date to transact the kinds of insurance covered by said Act shall automatically become, effective on the date of its admission, a member insurer of this Association.
- B. Members no Longer Doing Business in Oklahoma:** A member insurer which ceases to be admitted after said date shall automatically cease to be a member effective on the day following the termination or expiration of its license to transact the kinds of insurance covered by the Oklahoma Life and Health Insurance Guaranty Association Act. However, such insurer shall remain liable for any assessments based on impairments

occurring prior to the termination of its license. Such insurer shall also be entitled to a refund of all or part of any assessments which were made prior to termination of its license which later proves to be excessive.

- C. Impaired or Insolvent Members:** A member insurer which becomes an impaired or insolvent insurer after its license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn shall remain a member insurer for purposes of the liability of the Association with respect to the covered policies or contracts of such member insurer.

## **ARTICLE 7 APPEALS**

Any member insurer aggrieved by an act of the Board of Directors or Association shall appeal to the Board of Directors before appealing to the Commissioner. Such appeal shall be taken within sixty (60) days of the date on which such member insurer knew, or should have known, of such act. If such member insurer is aggrieved by the final action or decision of the Board on the appeal, or if the Board declines or fails to act on such appeal within sixty (60) days, the member insurer may appeal to the Commissioner within sixty (60) days after the action or decision of the Board or the expiration of the sixty (60) day period within which the Board failed to act on such appeal. Any member insurer which makes an appeal to the Commissioner pursuant to this Article must provide the Association with notice of the appeal by mailing a copy of the appeal to the Association by certified mail on the same day on which the appeal is submitted to the Commissioner. Failure to take an appeal within the time and in the manner set forth in this plan shall bar any claim that a member might otherwise have with respect to any act taken by the Association or its Board. If the appeal pertains to a protest of all or part of an assessment, the member shall pay when due the full amount of the assessment as set forth in the notice provided by the Association. The payment shall be available to meet Association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

## **ARTICLE 8 INDEMNIFICATION**

- A. Extent Of Indemnification:** All persons, except the Commissioner and his representatives, described in Section 2041 of the Code, including but not limited to the individual representatives of the member insurers serving on the Board of Directors, shall be indemnified by the Association for all reasonable expenses incurred on account of any action taken or not taken by them in the performance of their powers and duties under the Oklahoma Life and Health Insurance Guaranty Association Act, unless such persons shall be finally adjudged to have committed a breach of duty involving gross negligence, bad faith, dishonesty, willful misfeasance or reckless disregard of the responsibilities of their office or position. Such expenses shall include, but not be limited to, attorneys fees, judgments, decrees, fines, penalties

and amounts paid in settlement actually and necessarily incurred in the defense of any action, suit or proceeding, whether civil, criminal, administrative or investigative, including all appeals brought against such persons, their testators or intestates. In the event of settlement before final adjudication, with or without court approval, such indemnity shall be provided only if the Association is advised by independent legal counsel that such persons did not, in counsel's opinion, commit such a breach of duty.

- B. Supplement to Statutory Indemnification:** This Article is intended to operate as a supplement and additional safeguard to, and not in place of, the immunity granted by Section 2041 of the Code.

**ARTICLE 9  
CONFORMITY TO STATUTE**

Title 36 of the Oklahoma Statutes, Sections 2021 through 2043, of the Oklahoma Life and Health Insurance Guaranty Association Act as written, and as may be hereafter amended, is incorporated as a part of this Plan and as such is attached hereto.

\*\*\*\*\* Amended Plan Adopted this \_\_\_\_\_ day of November, 2019

