Chapter 743 — Health and Life Insurance

2001 EDITION

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743.006 [Formerly 736.300; renumbered 742.003 in 1989]

743.009 [1967 c.359 §337; 1969 c.336 §11; 1973 c.608 §1; renumbered 742.005 in 1989]

GENERAL PROVISIONS

743.010 Rules regarding certain health insurance policy and health benefit plan forms. In addition to all other powers of the Director of the Department of Consumer and Business Services with respect thereto, the director may issue rules with respect to policy forms and health benefit plan forms described in ORS 742.005 (6)(a) and (b):

(1) Establishing minimum benefit standards;

(2) Requiring the ratio of benefits to premiums to be not less than a specified percentage in order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the insurer's compliance; and

(3) Establishing requirements intended to discourage duplication or overlapping of coverage and replacement, without regard to the advantage to policyholders, of existing policies by new policies. [1979 c.857 §2; 1997 c.96 §1; 1999 c.987 §4a]

743.011 [1985 c.827 §2; repealed by 1989 c.255 §15]

743.012 [1967 c.359 §338; 1989 c.700 §13; renumbered 742.007 in 1989]

743.013 Disclosure of differences in replacement health insurance policies; nonduplication for persons 65 and older; rules. (1) The Director of the Department of Consumer and Business Services shall adopt by rule requirements for disclosure by group and individual health insurers to individual and group health insurance policyholders the difference between coverage under the existing policy and coverage being offered to replace that coverage.

(2) The provisions of this section do not apply to disability income insurance.

(3) The director shall adopt by rule requirements for nonduplication and replacement of major medical, Medicare supplement, long term care and special illness policies for applicants 65 years of age and older. The agent shall offer to compare for any applicants 65 years of age and older the applicant's existing policy or policies and coverage being offered to replace or supplement the applicant's existing coverage. [1989 c.474 §2]

743.015 Filing and approval of credit life and credit health insurance forms; filing of rates. (1) All credit life and credit health insurance policies subject to ORS 743.371 to 743.380, and all certificates of insurance, notices of proposed insurance, applications for insurance, indorsements and riders used in connection with such kinds of policies, delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the Director of the Department of Consumer and Business Services. Such forms shall be subject to approval, disapproval or withdrawal of approval by the director as provided in ORS 742.003, 742.005 and 742.007. Policies issued pursuant to ORS 731.442 shall be subject to the same regulation as other credit insurance policies.

(2) An insurer may revise such schedules of premium rates from time to time, and shall file such revised schedules with the director. No insurer shall issue any such credit life or credit health insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the director.

(3) If such a group policy of credit life or credit health insurance has been or is delivered in another state the insurer shall be required to file only the group certificate, the individual application and notice of proposed insurance delivered or issued for delivery in this state as specified in ORS 743.377 (2) and (4), and such forms shall be approved

by the director if they conform with the requirements specified in such subsections and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates filed with the director. [Formerly 739.595; 1969 c.336 §12; 1971 c.231 §20]

743.018 Life and health insurance, filing rates. Except for group life and health insurance, and except as provided in ORS 743.015, every insurer shall file with the Director of the Department of Consumer and Business Services all schedules and tables of premium rates for life and health insurance to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables. [1967 c.359 §340]

743.021 [1967 c.359 §341; 1971 c.231 §21; 1973 c.525 §1; renumbered 742.009 in 1989]

743.024 Insurable interest and beneficiaries, personal insurance. (1) Any individual of competent legal capacity may procure or effect an insurance policy on the individual's own life or body for the benefit of any person. However, except as provided in ORS 743.030, no person shall procure or cause to be procured any insurance policy upon the life or body of another unless the benefits under such policy are payable to the individual insured or the personal representatives of the individual, or to a person having, at the time such policy was entered into, an insurable interest in the individual insured.

(2) If the beneficiary, assignee or other payee under any policy made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the individual insured, the individual insured or the individual's executor or administrator, as the case may be, may maintain an action to recover such benefits from the person so receiving them.

(3) An insurer shall be entitled to rely upon all statements, declarations and representations made by an applicant for insurance relative to the matter of insurable interest. No insurer shall incur legal liability, except as set forth in the policy, by virtue of any untrue statements, declarations or representations so relied upon in good faith by the insurer.

(4) This section does not apply to annuity policies. [1967 c.359 §342]

743.027 Consent of individual required for life and health insurance; exceptions. No life or health insurance policy upon an individual, except a policy of group life insurance or of group or blanket health insurance, shall be made or effectuated unless at the time of the making of the policy the individual insured, being of competent legal capacity to contract, applies therefor or has consented thereto in writing, except in the following cases:

(1) A spouse may effectuate such insurance upon the other spouse.

(2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of or pertaining to such minor.

(3) Family policies may be issued insuring any two or more members of a family on an application signed by either parent, a stepparent, or by a husband or wife.

(4) A person may effectuate insurance that provides for the final expenses of an adult who is dependent upon the person for support and maintenance. [1967 c.359 §342a; 1991 c.182 §2]

743.028 Authority to prescribe uniform health insurance claim forms. The Director of the Department of Consumer and Business Services shall prescribe uniform health insurance claim forms which shall be used by all insurers transacting health insurance in this state and by all state agencies that require health insurance claim forms for their records. [1973 c.109 §2]

743.030 Life insurance for benefit of charity. (1) Life insurance policies may be effected although the person paying the consideration has no insurable interest in the life of the person insured if a charitable, benevolent, educational or religious institution is designated irrevocably as the beneficiary.

(2) In making such policies the person paying the premium shall make and sign the application therefor as owner. The application also must be signed by the person whose life is to be insured. Such a policy shall be valid and binding between and among all of the parties thereto.

(3) The person paying the consideration for such insurance shall have all rights conferred by the policy to loan value at any time during the premium-paying period, but not at maturity, notwithstanding such person has no insurable interest in the life of the person insured. [Formerly 739.420]

743.033 [1967 c.359 §344; renumbered 742.011 in 1989]

743.036 [Formerly 736.330; 1973 c.823 §149; repealed by 1973 c.827 §83]

743.037 [1973 c.521 §2; renumbered 743.721 in 1989]

743.039 Alteration of application, life and health insurance. (1) An application for a life insurance policy may not provide for alterations by any person other than the applicant in either the application or the policy to be issued thereon with respect to the amount of insurance, classification of risk, plan of insurance or the benefits unless the application contains a statement that no such changes are effective until approved in writing by the applicant.

(2) No alteration of any written application for any health insurance policy shall be made by any person other than the applicant without the written consent of the applicant, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant. [1967 c.359 §346]

743.041 Payment discharges insurer. Whenever the proceeds of or payments under a life or health insurance policy become payable in accordance with the terms of such policy, or the exercise of any right or privilege under such policy, and the insurer makes payment in accordance with the terms of the policy or in accordance with any written assignment of the policy, the person so designated as being entitled to the proceeds or payments shall be entitled to receive them and to give full acquittance therefor, and such payments shall fully discharge the insurer from all claims under the policy unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such proceeds or payments or some interest in the policy. [Formerly 743.084]

743.042 [1967 c.359 §347; 1985 c.465 §1; renumbered 742.013 in 1989]

743.043 Assignment of policies. A policy may be assignable or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or health insurance policy, under the terms of which the beneficiary may be changed upon the sole request of the insured or owner, may be assigned either by pledge or transfer of title, by an assignment executed by the insured or owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment. [Formerly 743.087]

743.045 [Formerly 736.305; 1971 c.231 §22; 1985 c.465 §2; renumbered 742.016 in 1989]

743.046 Exemption of proceeds of individual life insurance other than annuities. (1) When a policy of insurance is effected by any person on any person's own life or on another life in favor of some person other than that person having an insurable interest in the life insured, the lawful beneficiary thereof, other than that person or that person's legal representative, is entitled to its proceeds against the creditors or representatives of the person effecting the policy.

(2) The person to whom a policy of life insurance is made payable may maintain an action thereon in the person's own name.

(3) A policy of life insurance payable to a beneficiary other than the estate of the insured, having by its terms a cash surrender value available to the insured, is exempt from execution issued from any court in this state and in the event of bankruptcy of such insured is exempt from all demands in legal proceeding under such bankruptcy.

(4) Subject to the statute of limitations, the amount of any premiums paid in fraud of creditors for such insurance, with interest thereon, shall inure to their benefit from the proceeds of the policy. The insurer issuing the policy shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms unless, before such payment, the insurer has received at its home office written notice by or in behalf of some creditor, with specifications of the amount claimed, claiming to recover for certain premiums paid in fraud of creditors.

(5) The insured under any policy within this section shall not be denied the right to change the beneficiary when such right is expressly reserved in the policy.

(6) This section does not apply to annuity policies. [Formerly 739.405 and then 743.099]

743.047 Exemption of proceeds of group life insurance. (1) A policy of group life insurance or the proceeds thereof payable to a person or persons other than the individual insured or the individual's estate shall be exempt from debts and claims of creditors or representatives of the individual insured and, in the event of bankruptcy of the individual insured, from all demands in legal proceedings under such bankruptcy.

(2) The provisions of subsection (1) of this section do not apply to group life insurance issued to a creditor covering the creditor's debtors to the extent that such proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued. [Formerly 743.102]

743.048 [Formerly 736.315; renumbered 742.010]

743.049 Exemption of proceeds of annuity policies; assignability of rights. (1) The benefits, rights, privileges and options which are due or prospectively due an annuitant under any annuity policy issued before, on or after June 8, 1967, shall not be subject to execution, nor shall the annuitant be compelled to exercise any such rights, powers or options, nor shall creditors be allowed to interfere with or terminate the policy, except:

(a) As to amounts paid for or as premium on any such annuity with intent to defraud creditors, with interest thereon, and of which the creditor has given the insurer written notice at its home office prior to the making of the payments to the annuitant out of which the creditor seeks to recover. Any such notice shall specify the amount claimed or such facts as will enable the insurer to ascertain such amount, and shall set forth such facts as will enable the insurer to ascertain the annuity policy, the annuitant and the payments sought to be avoided on the ground of fraud.

(b) The total exemption of benefits presently due and payable to any annuitant periodically or at stated times under all annuity policies under which the person is an annuitant shall not at any time exceed $500 per month for the length of time represented by such installments. Such periodic payments in excess of $500 per month shall be subject to garnishee execution to the same extent as are wages and salaries.

(c) If the total benefits presently due and payable to any annuitant under all annuity policies under which the person is an annuitant shall at any time exceed payment at the rate of $500 per month, the court may order such annuitant to pay to a judgment creditor or apply on the judgment, in installments, the portion of such excess benefits as to the court may appear just and proper, after due regard for the reasonable requirements of the judgment debtor and family, if dependent upon the judgment debtor, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

(2) If the policy so provides, the benefits, rights, privileges or options accruing under the policy to a beneficiary or assignee shall not be transferable nor subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained in this section for the annuitant shall apply with respect to such beneficiary or assignee. [Formerly 743.105; 1991 c.182 §3]

743.050 Exemption of proceeds of health insurance. Except as may otherwise be expressly provided by the policy, the proceeds or avails of all health insurance policies and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance policies, issued before, on or after June 8, 1967, shall be exempt from all liability for any debt of the insured, and from any debt of the beneficiary existing at the time the proceeds are made available for the use of the beneficiary. [Formerly 743.108]

743.051 [1967 c.359 §350; renumbered 742.021 in 1989]

743.052 [1971 c.372 §2; renumbered 743.719 in 1989]

743.053 Prohibition on requirement that death or dismemberment occur in less than 180 days after accident. A life insurance policy or health insurance policy, whether group or individual, that contains provisions providing benefits in case of death or dismemberment by accident shall not require that the death or dismemberment occur less than 180 days after the date of the accident in order for benefits to be paid under the policy. [1991 c.182 §8]

743.054 [1967 c.359 §351; renumbered 742.023 in 1989]

743.055 [1991 c.875 §2; repealed by 1995 c.506 §11]

743.057 [1967 c.359 §352; renumbered 742.026 in 1989]

743.060 [1967 c.359 §353; renumbered 742.028 in 1989]

743.063 [1967 c.359 §354; renumbered 742.033 in 1989]

743.066 [1967 c.359 §355; 1971 c.231 §23; renumbered 742.036 in 1989]

743.069 [1967 c.359 §356; renumbered 742.038 in 1989]

743.072 [Formerly 736.310; 1971 c.231 §24; 1973 c.149 §1; renumbered 742.041 in 1989]

743.075 [1967 c.359 §358; 1975 c.391 §1; 1977 c.742 §8; renumbered 742.043 in 1989]

743.078 [1967 c.359 §359; renumbered 742.046 in 1989]

743.080 [1971 c.231 §5; 1983 c.249 §1; renumbered 742.048 in 1989]

743.081 [1967 c.359 §360; renumbered 742.051 in 1989]

743.084 [1967 c.359 §361; renumbered 743.041 in 1989]

743.087 [1967 c.359 §362; renumbered 743.043 in 1989]

743.090 [Formerly 736.335; repealed by 1973 c.827 §83]

743.093 [1967 c.359 §364; renumbered 742.053 in 1989]

743.096 [1967 c.359 §365; renumbered 742.056 in 1989]

743.099 [Formerly 739.405; renumbered 743.046 in 1989]

POLICY LANGUAGE SIMPLIFICATION

743.100 Short title. ORS 743.100 to 743.109 may be cited as the Life and Health Insurance Policy Language Simplification Act. [Formerly 743.350]

743.101 Purpose. (1) The purpose of the Life and Health Insurance Policy Language Simplification Act is to establish minimum standards for language used in policies and certificates of life insurance and health insurance delivered or issued for delivery in this state in order to facilitate ease of reading.

(2) ORS 743.100 to 743.109 is not intended to increase the risk assumed by insurers or to supersede their obligation to comply with the substance of other Insurance Code provisions applicable to insurance policies. ORS 743.100 to 743.109 is not intended to impede flexibility and innovation in the development of policy forms or content or to lead to the standardization of policy forms or content. [Formerly 743.353]

743.102 [1967 c.359 §367; renumbered 743.047 in 1989]

743.103 Definitions for ORS 743.100 to 743.109. As used in ORS 743.100 to 743.109, “policy” has the meaning given in ORS 731.122 and, in addition, includes a certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state. [Formerly 743.357]

743.104 Scope of ORS 743.100 to 743.109. (1) ORS 743.100 to 743.109 applies to all policies delivered or issued for delivery in this state, except:

(a) Any policy that is a security subject to federal jurisdiction.

(b) Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit health insurance policy. However, this paragraph shall not exempt any certificate issued pursuant to a group policy.

(c) Any group annuity contract that serves as a funding vehicle for a pension, profit-sharing or deferred compensation plan.

(d) Any form used in connection with, as a conversion from, as an addition to, or, pursuant to a contractual provision, in exchange for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the date the form must be approved under section 9, chapter 708, Oregon Laws 1979.

(e) The renewal of a policy delivered or issued for delivery prior to the date the policy form must be approved under section 9, chapter 708, Oregon Laws 1979.

(f) Any certificate issued pursuant to a group policy not delivered or issued for delivery in this state.

(2) A non-English language policy will be deemed to comply with ORS 743.106 if the insurer certifies that the policy is translated from an English language policy that complies with ORS 743.106. [Formerly 743.362]

743.105 [1967 c.359 §368; renumbered 743.049 in 1989]

743.106 Reading ease standards for life and health insurance policies; procedures for determining ease; certificate of compliance to accompany policy filing. (1) No policy form shall be delivered or issued for delivery in this state unless:

(a) The policy text achieves a score of 40 or more on the Flesch reading ease test, or an equivalent score on any comparable test as provided in subsection (3) of this section;

(b) The policy, except for specification pages, schedules and tables is printed in not less than 10-point type, one point leaded;

(c) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, including the text of any indorsements or riders; and

(d) The policy contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words of text printed on three or less pages, or regardless of the number of words if the policy has more than three pages.

(2) For the purposes of this section, a Flesch reading ease test score shall be calculated as follows:

(a) For policy forms containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, two 200-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines.

(b) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1.015.

(c) The total number of syllables in the text shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84.6.

(d) The sum of the figures computed under paragraphs (b) and (c) of this subsection subtracted from 206.835 equals the Flesch reading ease test score for the policy form.

(e) For purposes of paragraphs (b) and (c) of this subsection, the following procedures shall be used:

(A) A contraction, hyphenated word or numbers and letters, when separated by spaces, shall be counted as one word.

(B) A unit of words ending with a period, semicolon or colon shall be counted as a sentence.

(C) A “syllable” means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(f) As used in this section, “text” includes all written matter except the following:

(A) The name and address of the insurer; the name, number or title of the policy; the table of contents or index; captions and subcaptions; specification pages; schedules or tables; and

(B) Policy language drafted to conform to the requirements of any state or federal law, regulation or agency interpretation; policy language required by any collectively bargained agreement; medical terminology; and words that are defined in the policy. However, the insurer shall identify the language or terminology excepted by this subparagraph and shall certify in writing that the language or terminology is entitled to be excepted by this subparagraph.

(3) Any other reading test may be approved by the Director of the Department of Consumer and Business Services

as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

(4) Each policy filing shall be accompanied by a certificate signed by an officer of the insurer stating that the policy meets the minimum required reading ease score on the test used, or stating that the score is lower than the minimum required but should be authorized in accordance with ORS 743.107. To confirm the accuracy of a certification, the director may require the submission of further information.

(5) At the option of the insurer, riders, indorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used. [Formerly 743.365]

743.107 When director may authorize lower standards. The Director of the Department of Consumer and Business Services may authorize a lower score than the Flesch reading ease test score required by ORS 743.106 when, in the director's sole discretion, the director finds that a lower required score:

(1) Will provide a more accurate reflection of the readability of a policy form;

(2) Is warranted by the nature of a particular policy form or type or class of policy forms; or

(3) Is caused by certain policy language drafted to conform to the requirements of any state law, regulation or agency interpretation. [Formerly 743.368]

743.108 [1967 c.359 §369; renumbered 743.050 in 1989]

743.109 Approval of certain policy forms containing specified provisions; conditions for approval. A policy form meeting the requirements of ORS 743.106 shall not be disapproved because of other provisions of the Insurance Code that specify the content of policies, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such provisions. [Formerly 743.370]

743.111 [Formerly 744.090; renumbered 742.058 in 1989]

743.114 [Formerly 736.325; 1971 c.123 §1; 1981 c.667 §1; renumbered 742.061 in 1989]

743.115 [1987 c.774 §46; 1989 c.376 §1; renumbered 742.063 in 1989]

743.116 [1971 c.603 §2; 1981 c.422 §1; 1981 c.891 §2; renumbered 743.701 in 1989]

743.117 [1967 c.271 §§2,3; renumbered 743.703 in 1989]

743.118 [1987 c.720 §2; renumbered 743.704 in 1989]

743.119 [1981 c.254 §2; renumbered 743.706 in 1989]

743.120 [1975 c.135 §2; renumbered 743.707 in 1989]

743.123 [1975 c.338 §2; renumbered 743.709 in 1989]

743.125 [1979 c.268 §6; renumbered 743.710 in 1989]

743.128 [1979 c.785 §20; renumbered 743.712 in 1989]

743.132 [1979 c.1 §15; renumbered 743.713 in 1989]

743.135 [1981 c.422 §5; 1989 c.721 §54; 1989 c.1080 §1; renumbered 743.714 in 1989]

743.138 [1987 c.739 §§2,4b; renumbered 743.715 in 1989]

743.140 [1985 c.536 §1; renumbered 743.716 in 1989]

743.143 [1985 c.312 §2; renumbered 743.717 in 1989]

743.145 [1985 c.747 §59; renumbered 743.700 in 1989]

743.147 [1987 c.530 §2; renumbered 743.718 in 1989]

INDIVIDUAL LIFE INSURANCE AND ANNUITIES

(Generally)

743.150 Scope of ORS 743.150, 743.153 and 743.156. This section and ORS 743.153 and 743.156 apply only to policies of life insurance, other than group life insurance. [1967 c.359 §372]

743.153 Statement of benefits. A life insurance policy shall contain a provision stating the amount of benefits payable or the method to be used or procedure to be followed in determining such amount, the manner of payment and the consideration therefor. [Formerly 739.310]

743.154 Acceleration of death benefits. (1) A life insurance policy or a rider to a life insurance policy may provide for the acceleration of death benefits as part of the life insurance coverage. For purposes of this section, accelerated death benefits are benefits that:

(a) Are payable to the policy owner or certificate holder during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions as defined by the policy or rider;

(b) Reduce the death benefit otherwise payable under the life insurance policy; and

(c) Are payable upon the occurrence of a single qualifying event that results in the payment of a benefit amount fixed at the time of acceleration.

(2) For purposes of this section, a qualifying event is one or more of the following:

(a) A medical condition that will result in a drastically limited life span, as specified in the policy or rider, not exceeding 24 months.

(b) A medical condition that has required or requires extraordinary medical intervention, such as a major organ transplant or continuous artificial life support, without which the insured would die.

(c) Any condition that usually requires continuous confinement in an eligible institution, as defined in the policy or rider, if the insured is expected to remain there for the rest of the insured's life.

(d) A medical condition that in the absence of extensive or extraordinary medical treatment will result in a drastically limited life span. Such conditions may include but are not limited to one or more of the following:

(A) Coronary artery disease resulting in an acute infarction or requiring surgery;

(B) Permanent neurological deficit resulting from cerebral vascular accident;

(C) End-stage renal failure; or

(D) Acquired Immune Deficiency Syndrome.

(e) Any other event determined by the Director of the Department of Consumer and Business Services to be life-threatening.

(3) A policy or rider that provides for the acceleration of death benefits:

(a) Must also provide for the continuation of the policy as to the amount of the death benefit that is not accelerated.

(b) Must allow the policy owner or the certificate holder to request payment at any time during the period that the qualifying event continues.

(4) A policy or rider that provides for the acceleration of death benefits under this section shall not be described or marketed by an insurer as long term care insurance or as providing long term care benefits.

(5) The director shall adopt rules establishing minimum benefits, criteria for the payment of accelerated benefits, disclosure requirements and actuarial standards. [1991 c.571 §2; 1993 c.17 §1]

743.156 Statement of premium. A life insurance policy shall contain a provision separately stating the premium for each benefit provision of the policy for which such separate statement is necessary, as determined by the Director of the Department of Consumer and Business Services, to give adequate disclosure of the terms of the policy. [1967 c.359 §374]

(Individual Life Insurance Policies)

743.159 Scope of ORS 743.162 to 743.243. ORS 743.162 to 743.243 apply only to policies of life insurance other than group life insurance, and do not apply to annuity or pure endowment policies. Such sections apply to such policies that are policies of variable life insurance, except to the extent the provisions of such sections are obviously inapplicable to variable life insurance or are in conflict with other provisions of such sections that are expressly applicable to variable life insurance. [1967 c.359 §375; 1973 c.435 §16]

743.162 Payment of premium. A life insurance policy shall contain a provision relating to the time and place of payment of premium. [1967 c.359 §376]

743.165 Grace period. A life insurance policy shall contain a provision that a grace period of 30 days, or, at the option of the insurer, of one month of not less than 30 days, or of four weeks in the case of industrial life insurance policies the premiums for which are payable more frequently than monthly, shall be allowed within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in full force. The insurer may impose an interest charge not in excess of six percent per annum for the number of days of grace elapsing before the payment of the premium. If a claim arises under the policy during such period of grace the amount of any premium due or overdue, together with interest and any deferred installment of the annual premium, may be deducted from the policy proceeds. [1967 c.359 §377]

743.168 Incontestability. (1) A life insurance policy shall contain a provision that the policy shall be incontestable after it has been in force for two years from its date of issue during the lifetime of the insured, except for nonpayment of premiums. At the option of the insurer the two-year limit within which the policy may be contested shall not apply to the provisions for benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident.

(2) A provision in a life insurance policy providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such provision. [1967 c.359 §378]

743.171 Incontestability and limitation of liability after reinstatement. (1) A reinstated policy of life insurance may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement, and with the same conditions and exceptions, as the policy provides with respect to contestability after original issuance.

(2) When any policy of life insurance is reinstated, such reinstated policy may exclude or restrict liability to the same extent that such liability could have been or was excluded or restricted when the policy was originally issued, and such exclusion or restriction shall be effective from the date of reinstatement. [1967 c.359 §379]

743.174 Entire contract. A life insurance policy shall contain a provision that the policy constitutes the entire contract between the parties. [1967 c.359 §380]

743.177 Statements of insured. A life insurance policy shall contain a provision that all statements made by or on behalf of the insured shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense of a claim under the policy unless contained in a written application and unless a copy of such application is indorsed upon or attached to the policy when issued. [1967 c.359 §381]

743.180 Misstatement of age. A life insurance policy shall contain a provision that if it is found at any time before final settlement under the policy that the age of the insured or of any other person whose age is considered in determining the premium or benefit accruing under the policy has been misstated, the amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages, or the premium may be adjusted and credit given to the insured or to the insurer, according to the insurer's published rate at date of issue. [1967 c.359 §382]

743.183 Dividends. (1) A life insurance policy other than a nonparticipating policy shall contain a provision that the policy shall participate in the divisible surplus of the insurer annually, beginning not later than the end of the third

policy year. Any policy containing provision for participation beginning at the end of the first or the second policy year may provide that dividends for either or both of such years shall be paid subject to the payment of the premium for the next ensuing year. The owner of the policy shall have the right each year to have the dividend arising from such participation paid in cash, and if the policy provides other dividend options, it shall further provide which dividend option is effective if the owner does not elect one of such options on or before the expiration of the period of grace allowed for the payment of the premium.

(2) In participating industrial life insurance policies, in lieu of the provision required in subsection (1) of this section, there shall be a provision that, beginning not later than the end of the fifth policy year, the policy shall participate annually in the divisible surplus in the manner set forth in the policy.

(3) This section does not apply to any form of paid-up insurance or temporary insurance or endowment insurance issued or granted in exchange for lapsed or surrendered policies. [1967 c.359 §383]

743.186 Policy loan. (1) A life insurance policy shall contain a provision that after three full years' premiums have been paid and after the policy has a cash surrender value and while no premium is in default beyond the grace period for payment, the insurer will advance, on proper assignment or pledge of the policy and on the sole security thereof, an amount equal to or, at the option of the party entitled thereto, less than the loan value of the policy, at a rate of interest not exceeding the maximum rate permitted by the policy loan provision. The interest rate provision shall comply with ORS 743.187. The loan value of the policy shall be equal to the cash surrender value at the end of the then current policy year, less any existing indebtedness not already deducted in determining such cash surrender value including any interest then accrued but not due, any unpaid balance of the premium for the current policy year, and interest on the loan to the end of the current policy year. The policy may also provide that:

(a) Interest on any indebtedness that is 90 or more days past due shall be added to the existing indebtedness and shall bear interest at the rate applicable to the existing indebtedness; and

(b) Except as provided in ORS 743.187, if the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value of the policy, the policy shall terminate and become void upon 30 days' notice by the insurer mailed to the last-known address of the insured or other policy owner and of any assignee of record at the home office of the insurer.

(2) The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six months after application therefor.

(3) The policy, at the insurer's option, may provide for automatic premium loan.

(4) This section does not apply to term insurance policies or term insurance benefits provided by rider or supplemental policy provisions, or to industrial life insurance policies. [1967 c.359 §384; 1975 c.575 §1; 1981 c.412 §18; 2001 c.318 §12]

743.187 Maximum interest rate on policy loan; adjustable interest rate. (1) Except as provided otherwise in this section, the maximum interest rate in the policy loan provision required by ORS 743.186 shall be eight percent per year. The insurer may include in the policy loan provision, in lieu of a fixed maximum interest rate, a provision for an adjustable interest rate. The adjustable interest rate provision must comply with this section. A limitation on interest rates under state law, other than a limitation contained in the Insurance Code, shall not apply to interest rates for life insurance policy loans unless the limitation specifically applies to life insurance policy loans.

(2) The adjustable interest rate provision:

(a) Shall state in substance that in accordance with the policy and the law of the jurisdiction in which the policy is delivered, the insurer will establish from time to time the interest rate for an existing or a new policy loan; and

(b) Shall set forth the dates on which the insurer will determine policy loan interest rates. These determination dates shall be at regular intervals no longer than one year and no shorter than three months.

(3) The maximum interest rate permitted for a policy loan under the adjustable interest rate provision shall be established by the provision as the higher of:

(a) The interest rate used to calculate cash surrender values under the policy during the same period, plus one percent; and

(b) The Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc., for the calendar month which precedes by two months the month in which the determination date for the policy loan interest rate falls. However, if the Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or if the National Association of Insurance Commissioners determines that the Moody's Corporate Bond Yield Average - Monthly Average Corporates is no

longer an appropriate rate for this purpose, the Director of the Department of Consumer and Business Services by rule may establish the method of determining the rate under this paragraph. The director's rule, to the maximum extent reasonable, shall be consistent with the pertinent actions of the National Association of Insurance Commissioners.

(4) On any date specified in the adjustable interest rate provision of the policy for determining the policy loan interest rate:

(a) The insurer may increase the existing rate if the maximum rate permitted by the provision exceeds the existing rate by at least one-half of one percent. The increase shall not be less than one-half of one percent or more than the amount by which the permitted maximum rate exceeds the existing rate; and

(b) The insurer shall decrease the existing rate if the existing rate exceeds the maximum rate permitted by the provision by at least one-half of one percent. The decrease shall not be less than the amount by which the existing rate exceeds the permitted maximum rate.

(5) The insurer under the adjustable interest rate provision shall give notice of the policy loan interest rate and related matters to the policy owner and all other persons entitled to notice by the policy, as follows:

(a) In the case of a loan other than for payment of a premium to the insurer, the insurer shall give notice of the initial interest rate on the loan when the loan is made.

(b) In the case of a loan for payment of a premium to the insurer, the insurer shall give notice of the initial interest rate on the loan as soon as reasonably practicable after the loan is made. However, the insurer need not give this notice when an additional premium loan is made at the same interest rate then applicable to an existing premium loan to the borrower.

(c) In the case of a policy with an outstanding loan, the insurer shall give notice of each increase in the loan interest rate reasonably in advance of the increase.

(d) Notices given under this subsection shall include in substance the information required by subsection (2) of this section.

(6) Notwithstanding ORS 743.186, a policy shall not terminate in a particular policy year solely because a change in the policy loan interest rate during that year caused the total indebtedness under the policy to reach the policy loan value. The policy shall remain in force during that year unless and until it would have terminated in the absence of any policy loan interest rate change during that year. [1981 c.412 §20]

743.189 Reinstatement. A life insurance policy shall contain a provision that if in the event of a default in premium payments the value of the policy has been applied to provide a paid-up nonforfeiture benefit, and if this benefit is currently in force and the original policy has not been surrendered to the insurer and canceled, and if a period of not more than three years has elapsed since the default (or two years in the case of an industrial life insurance policy), the policy may be reinstated upon furnishing evidence of insurability satisfactory to the insurer and payment of arrears of premiums and payment or reinstatement of any other indebtedness to the insurer under the policy, with interest at a rate not exceeding the maximum permitted by the policy loan provision. [1967 c.359 §385; 1981 c.412 §21]

743.192 Payment of claim; payment of interest upon failure to pay proceeds. (1) A life insurance policy shall contain a provision that when the policy becomes a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and of the interest of the claimant.

(2) If the insurer fails to pay the proceeds of or make payment under the policy within 30 days after receipt of due proof of death and of the interest of the claimant, and if the beneficiary elects to receive a lump sum settlement, the insurer shall pay interest on any money due and unpaid after expiration of the 30-day period. The insurer shall compute the interest from the date of the insured's death until the date of payment, at a rate not lower than that paid by the insurer on other withdrawable policy owner funds. At the end of the 30-day period, the insurer shall notify the named beneficiary or beneficiaries at their last-known address that interest at the applicable rate will be paid on the lump sum proceeds from the date of death of the insured.

(3) Nothing in this section shall be construed to allow an insurer to withhold payment of money payable under a life insurance policy to any named beneficiary for a period longer than reasonably necessary to transmit the payment. [1967 c.359 §386; 1983 c.754 §2]

743.195 Settlement option. A life insurance policy shall contain a table showing the amounts of installments, if any, by which its proceeds may be payable. [1967 c.359 §387]

743.198 Title. A life insurance policy shall contain a title briefly and correctly describing the policy. If an industrial life insurance policy, it shall have the words “industrial policy” imprinted on the face thereof as part of the descriptive matter. [1967 c.359 §388]

743.201 Beneficiary of industrial policies. An industrial life insurance policy shall have the name of the beneficiary designated thereon, or in the application or other form if attached to the policy, with a reservation of the right to designate or change the beneficiary after the issuance of the policy unless such beneficiary has been irrevocably designated. The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until indorsed on the policy by the insurer, and that the insurer may refuse to indorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. The policy may also provide that if the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than 30 days after the death of the insured, or if the beneficiary is the estate of the insured, or is a minor, or dies before the insured, or is not legally competent to give a valid release, then the insurer may make any payment thereunder to the executor or administrator of the insured, or to any relative of the insured by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary, or by reason of having incurred expense for the maintenance, medical attention or burial of the insured. The policy may also include a similar provision applicable to any other payment due under the policy. [1967 c.359 §389]

743.204 Standard Nonforfeiture Law for Life Insurance; applicability. (1) ORS 743.204 to 743.222 may be cited as the Standard Nonforfeiture Law for Life Insurance.

(2) The operative date of the Standard Nonforfeiture Law for Life Insurance as to any policy is the earlier of:

(a) January 1, 1948; or

(b) The date specified in a written notice, filed with the Director of the Department of Consumer and Business Services by the insurer, of election to comply with the Standard Nonforfeiture Law for Life Insurance as to such policy as of the specified date.

(3) The Standard Nonforfeiture Law for Life Insurance shall not apply to:

(a) Any reinsurance, group insurance, pure endowment, annuity or reversionary annuity policy.

(b) Any term policy or renewal thereof, of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy. For this purpose, the age at death for a joint term life insurance policy shall be the age at death of the oldest life.

(c) Any term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, if each adjusted premium, calculated as specified in ORS 743.215 and 743.216, is less than the adjusted premium so calculated on a term policy or renewal thereof of uniform amount, which provides no guaranteed nonforfeiture benefits or endowment benefits, which is issued at the same age, for the same initial amount of insurance and for a term of 20 years or less that expires before age 71 and for which uniform premiums are payable during the entire term of the policy. For this purpose, the age at death for a joint term life insurance policy shall be the age at death of the oldest life.

(d) Any policy which provides no guaranteed nonforfeiture or endowment benefits, and for which policy the cash surrender value or present value of paid-up nonforfeiture benefit calculated for the beginning of any policy year as specified in ORS 743.210, 743.213, 743.215 and 743.216 does not exceed two and one-half percent of the amount of insurance at the beginning of such year. [Formerly 739.340; 1977 c.320 §13; 1981 c.609 §12]

743.207 Required provisions relating to nonforfeiture. (1) A life insurance policy shall contain in substance the following provisions, or corresponding provisions which in the opinion of the Director of the Department of Consumer and Business Services are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this section, and which are essentially in compliance with ORS 743.221:

(a) That in the event of default in any premium payment the insurer will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of the amount required by ORS 743.213. In lieu of this stipulated benefit the insurer may substitute, upon proper request made not later than 60 days after the due date of the premium in default, another paid-up nonforfeiture benefit which is actuarially equivalent and provides a greater amount or longer period of death benefit

or, if applicable, a greater amount or earlier payment of endowment benefit.

(b) That upon surrender of the policy within 60 days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary life insurance or five full years in the case of industrial life insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of the amount required by ORS 743.210.

(c) That a specified paid-up nonforfeiture benefit will become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default.

(d) That, if the policy has become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary life insurance or the fifth policy anniversary in the case of industrial life insurance, the insurer will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of the amount required by ORS 743.210.

(e)(A) In the case of all policies other than those provided for in subparagraph (B) of this paragraph, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first 20 policy years or during the term of the policy, whichever is shorter. Such values and benefits shall be calculated on the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy. At the option of the insurer such table may also show such values and benefits for any year or years beyond the 20th policy year.

(B) In the case of policies which provide, on a basis guaranteed in the policy, for unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than by change to a new policy, a statement of the mortality table, interest rate and method used in calculating cash surrender values and paid-up nonforfeiture benefits available under the policy.

(f)(A) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered.

(B) An explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy.

(C) If a detailed statement of the method of computation of the cash surrender values and paid-up nonforfeiture benefits shown in the policy is not stated in the policy, a statement that the method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered.

(D) A statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are shown for consecutive years in the policy.

(2) Any of the provisions set forth in subsection (1) of this section, or portions of the provisions, not applicable by reason of the particular plan of insurance may, to the extent inapplicable, be omitted from the policy.

(3) The insurer shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy. [Formerly 739.345; 1981 c.609 §13]

743.210 Determination of cash surrender values; applicability to certain policies. (1) Except as otherwise provided in subsections (2) and (3) of this section, any cash surrender value available under a life insurance policy in the event of default in a premium payment due on any policy anniversary, whether or not required by ORS 743.207, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(a) The present value on such anniversary of the adjusted premiums, as defined in ORS 743.215 and 743.216, corresponding to premiums which would have fallen due on and after such anniversary; and

(b) The amount of any indebtedness to the insurer on the policy.

(2) This subsection applies to a life insurance policy issued on or after the operative date defined in ORS 743.215 which provides supplemental life insurance or annuity benefits by rider or supplemental policy provision at the option of the insured and for an identifiable additional premium. For such a policy, the cash surrender value shall be an amount not less than the cash surrender value required by subsection (1) of this section for a policy otherwise similar

to the subject policy but without such rider or supplemental policy provision, plus the cash surrender value required by subsection (1) of this section for a policy which provides only the benefits provided by such rider or supplemental policy provision in the subject policy.

(3) This subsection applies to a family life insurance policy issued on or after the operative date defined in ORS 743.215 which policy defines a primary insured and provides term insurance on the life of the spouse of the primary insured with a term that expires before age 71 of the spouse. For such a policy, the cash surrender value shall be an amount not less than the cash surrender value required by subsection (1) of this section for a policy otherwise similar to the subject policy but without such term insurance on the life of the spouse, plus the cash surrender value required by subsection (1) of this section for a policy which provides only the benefits provided by such term insurance on the life of the spouse in the subject policy.

(4) Any cash surrender value available within 30 days after any policy anniversary under any policy which has been paid up by completion of all premium payments or any policy which has been continued under any paid-up nonforfeiture benefit, whether or not required by ORS 743.207, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by the amount of any indebtedness to the insurer on the policy. [Formerly 739.350; 1981 c.609 §14]

743.213 Determination of paid-up nonforfeiture benefits. Any paid-up nonforfeiture benefit available under a life insurance policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by ORS 743.207 in the absence of the condition that premiums have been paid for at least a specified period. [Formerly 739.355; 1981 c.609 §15]

743.215 Calculation of adjusted premiums. (1) This section applies to all life insurance policies issued on or after the operative date defined in this subsection for the issuing insurer. After January 1, 1982, any insurer may file with the Director of the Department of Consumer and Business Services a written notice of its election to comply with the provisions of this section with regard to any number of plans of insurance after a specified date before January 1, 1989. The specified date shall be the operative date of this subsection for the plan or plans, but if an insurer elects to make this subsection operative before January 1, 1989, for fewer than all plans, the insurer must comply with rules adopted by the director. There is no limit to the number of times that an insurer may make the election. If an insurer makes no such election, the operative date of this section for the insurer shall be January 1, 1989.

(2) Except as provided in subsection (8) of this section, the adjusted premiums referred to in ORS 743.210 for any life insurance policy to which this section applies shall be calculated as provided in this subsection, on an annual basis, as a uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and excluding any uniform annual contract charge or policy fee specified in the policy statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits. This percentage shall be such that the present value, at the date of issue of the policy, of all such adjusted premiums shall equal the sum of:

(a) The present value at the policy issue date of the future guaranteed benefits provided for by the policy;

(b) One percent of either the amount of insurance, if the insurance is uniform in amount, or the average of the amounts of insurance at the beginning of each of the first 10 policy years; and

(c) One hundred twenty-five percent of the nonforfeiture net level premium as defined in subsection (3) of this section. For this purpose, any excess of the nonforfeiture net level premium over four percent of such uniform or average amount of insurance shall be disregarded.

(3) The nonforfeiture net level premium referred to in subsection (2) of this section shall equal the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue and on each anniversary of the policy on which a premium falls due.

(4) In the case of policies which provide, on a basis guaranteed in the policy, for unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than by change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated by the policy at the date of issue. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated as provided in subsection (5) of this section on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(5) Except as otherwise provided in subsection (8) of this section, the recalculated future adjusted premiums referred to in subsection (4) of this section shall be calculated as provided in this subsection, on an annual basis, as a uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards and excluding any uniform annual contract charge or policy fee specified in the policy statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits. This percentage shall be such that the present value, at the date of change to the newly defined benefits or premiums, of all such future adjusted premiums shall equal A plus B minus C, where these amounts are defined as follows:

(a) “A” equals the present value, as of the date of change, of the future guaranteed benefits provided for by the policy.

(b) “B” equals the additional expense allowance, if any, for the policy, as defined in subsection (6) of this section.

(c) “C” equals the cash surrender value under the policy, if any, or present value of any paid-up nonforfeiture benefit under the policy, as of the date of change.

(6) The additional expense allowance at the date of the change to the newly defined benefits or premiums, as referred to in subsection (5) of this section, shall equal the sum of:

(a) One percent of the excess, if positive, of the average of the amounts of insurance at the beginning of each of the first 10 policy years subsequent to the change, over the average of the amounts of insurance, as defined before the change, at the beginning of each of the first 10 policy years subsequent to the last previous change or the policy issue date if there has been no change.

(b) One hundred twenty-five percent of the change, if positive, in the amount of the nonforfeiture net level premium from the amount applicable prior to the change in policy benefits or premiums to the amount of the recalculated nonforfeiture net level premium determined from subsection (7) of this section as of the date of the change in policy benefits or premiums.

(7) The recalculated nonforfeiture net level premium referred to in subsection (6) of this section shall equal Y divided by Z, where these amounts are defined as follows:

(a) “Y” equals the sum of:

(A) The nonforfeiture net level premium applicable prior to the change times the present value at the date of change of an annuity of one per annum payable on each anniversary of the policy, on or subsequent to the date of the change, on which a premium would have fallen due had the change not occurred; and

(B) The present value at the date of change of the increase in future guaranteed benefits provided for by the policy.

(b) “Z” equals the present value at the date of change of an annuity of one per annum payable on each anniversary of the policy, on or subsequent to the date of change, on which a premium falls due.

(8) Notwithstanding any other provisions of this section, the provisions of this subsection shall apply in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance determined so that, in each policy year, the policy has the same tabular mortality cost as for an otherwise similar policy of a higher nongraded amount or amounts of insurance issued on the standard basis. Adjusted premiums and present values for a policy on such a substandard basis may be calculated as if the policy were issued to provide such a higher nongraded amount or amounts of insurance on the standard basis.

(9) Except as provided in subsection (10) of this section, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall, for all policies of life insurance to which this section applies, be calculated on the mortality and interest bases as follows:

(a) For ordinary life insurance mortality:

(A) The Commissioners 1980 Standard Ordinary Mortality Table shall be used; or

(B) At the option of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors may be used instead of such table without Ten-Year Select Mortality Factors.

(b) For industrial life insurance mortality, the Commissioners 1961 Standard Industrial Mortality Table shall be used.

(c) For all policies issued in a particular calendar year, an interest rate shall be used which does not exceed the nonforfeiture interest rate, as defined in subsection (11) of this section, for policies issued in that year.

(10) The following provisions shall also apply, for policies to which this section applies, to the calculation of premiums and values referred to in the Standard Nonforfeiture Law for Life Insurance:

(a) At the option of the insurer, such calculations for all policies issued in a particular calendar year may be made on the basis of an interest rate which does not exceed the nonforfeiture interest rate, as defined in subsection (11) of

this section, for policies issued in the last preceding calendar year.

(b) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by ORS 743.207, shall be calculated on the basis of the mortality table and interest rate used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions.

(c) An insurer shall calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions, on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(d) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary life insurance, and not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial life insurance.

(e) For insurance issued on a substandard basis, the calculation of premiums and values may be based on appropriate modifications of the mortality tables referred to in subsection (9) of this section and in this subsection.

(f) Any ordinary life mortality tables adopted after 1980 by the National Association of Insurance Commissioners that are approved under rules issued by the director for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors, or for the Commissioners 1980 Extended Term Insurance Table.

(g) Any industrial life mortality tables adopted after 1980 by the National Association of Insurance Commissioners that are approved under rules issued by the director for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table.

(11) The nonforfeiture interest rate for any policy issued in a particular calendar year shall equal 125 percent of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law, rounded to the nearer one-quarter of one percent.

(12) Notwithstanding any other provision in this chapter, for any previously approved policy form, any refiling of nonforfeiture values or their methods of computation which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not of itself require refiling of any other provisions of that policy form. [1981 c.609 §17; 1983 c.282 §1]

743.216 Adjusted premiums; applicability. This section applies only to life insurance policies issued before the operative date defined in ORS 743.215. For such policies:

(1) Except as provided in subsection (3) of this section, the adjusted premiums referred to in ORS 743.210 shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

(a) The present value at the policy issue date of the future guaranteed benefits provided for by the policy.

(b) Two percent of the amount of insurance if the insurance is uniform in amount, or of the equivalent uniform amount as defined in subsection (2) of this section if the amount of insurance varies with duration of the policy.

(c) Forty percent of the adjusted premium for the first policy year. For this purpose, any excess of the adjusted premium over four percent of the amount of insurance or equivalent uniform amount shall be disregarded.

(d) Twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy for the same uniform or the same equivalent uniform amount of insurance with uniform premiums for the whole of life issued at the same age, whichever is less. For this purpose, any excess of the adjusted premium over four percent of the amount of insurance or equivalent uniform amount shall be disregarded.

(2) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount of the subject policy for the purpose of this section shall be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the subject policy. However, in the case of a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the subject policy prior to the attainment of age 10 were the amount provided by the subject policy at age 10.

(3) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be calculated in accordance with this subsection. The amounts specified in paragraphs (a) and (b) of

this subsection shall be calculated separately. Each such amount shall be calculated as specified in subsections (1) and (2) of this section. However, for the purposes of subsection (1)(b), (c) and (d) of this section, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in paragraph (b) of this subsection shall be equal to the excess of the uniform or equivalent uniform amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in paragraph (a) of this subsection. The adjusted premiums for the entire policy shall equal the sum of:

(a) The adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits; and

(b) During the period for which premiums for such term insurance benefits are payable, the adjusted premiums for such term insurance benefits.

(4) Except as provided in paragraphs (a) and (b) of this subsection and subsection (5) of this section, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall for all policies of ordinary life insurance to which this section applies be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table. Such calculations for any category of ordinary life insurance issued on female lives may, however, be based on an age not more than six years younger than the actual age of the insured. Except as provided in paragraphs (a) and (b) of this subsection and subsection (7) of this section, such calculations of adjusted premiums and present values for all policies of industrial life insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. The following exceptions pertain:

(a) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than 130 percent of the rates of mortality according to the respective table.

(b) For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the Director of the Department of Consumer and Business Services.

(5) This subsection applies only to policies of ordinary life insurance to which this section applies and which are issued on or after the operative date of this subsection as defined in subsection (6) of this section. For such policies, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall, except as provided in paragraphs (a) and (b) of this subsection, be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Such calculations for any category of ordinary life insurance issued on female lives may, however, be based on an age not more than six years younger than the actual age of the insured. Such rate of interest shall not exceed three and one-half percent, except that a rate of interest not exceeding four percent may be used for policies issued from January 1, 1974, to December 31, 1977, and a rate of interest not exceeding five and one-half percent may be used for policies issued on or after January 1, 1978, and with the further exception that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent may be used. The following exceptions pertain:

(a) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table.

(b) For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the director.

(6) After August 9, 1961, any insurer may file with the director a written notice of its election to comply with the provisions of subsection (5) of this section after a specified date before January 1, 1966. After the filing of such notice, such specified date shall be the operative date of subsection (5) of this section for the insurer with respect to the ordinary life policies it thereafter issues. If an insurer makes no such election, such operative date for the insurer shall be January 1, 1966.

(7) This subsection applies only to policies of industrial life insurance to which this section applies and which are issued on or after the operative date of this subsection as defined in subsection (8) of this section. For such policies, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall, except as provided in paragraphs (a) and (b) of this subsection, be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Such rate of interest shall not exceed three and one-half percent, except that a rate of interest

not exceeding four percent may be used for policies issued from January 1, 1974, to December 31, 1977, and a rate of interest not exceeding five and one-half percent may be used for policies issued on or after January 1, 1978, and with the further exception that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent may be used. The following exceptions pertain:

(a) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table.

(b) For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the director.

(8) After September 2, 1963, any insurer may file with the director a written notice of its election to comply with the provisions of subsection (7) of this section after a specified date before January 1, 1968. After the filing of such notice, such specified date shall be the operative date of subsection (7) of this section for the insurer with respect to the industrial life insurance policies it thereafter issues. If an insurer makes no such election, such operative date for the insurer shall be January 1, 1968. [Formerly 739.360; 1973 c.636 §6; 1977 c.320 §14; 1981 c.609 §16]

743.218 Requirements for determination of future premium amounts or minimum values. In the case of policies of life insurance which provide for determination of future premium amounts by the insurer on the basis of current estimates of future experience, or policies of life insurance which are of such a nature that minimum values cannot in the judgment of the Director of the Department of Consumer and Business Services be determined by the methods otherwise described in the Standard Nonforfeiture Law for Life Insurance, the following requirements shall apply:

(1) The director must be satisfied that the policy benefits are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by the Standard Nonforfeiture Law for Life Insurance;

(2) The director must be satisfied that the benefits and the pattern of premiums of the policy are not misleading to prospective policyholders or insureds; and

(3) The cash surrender values and paid-up nonforfeiture benefits provided by the policy must not be less than the minimum values and benefits required for the policy as calculated by a method consistent with the principles of the Standard Nonforfeiture Law for Life Insurance, as determined under rules issued by the director. [1981 c.609 §18]

743.219 Supplemental rules for calculating nonforfeiture benefits. (1) Any cash surrender value and any paid-up nonforfeiture benefit available under a life insurance policy in the event of default in a premium payment due at any time other than on the policy anniversary date shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary.

(2) All values referred to in the Standard Nonforfeiture Law for Life Insurance may be calculated on the assumption that any death benefit is payable at the end of the policy year of death.

(3) The net value of any paid-up additions, other than paid-up term additions, shall not be less than the amounts used to provide the additions. [Formerly 739.365; 1981 c.609 §19]

743.221 Cash surrender values upon default in premium payment. (1) This section shall apply to all life insurance policies issued on or after January 1, 1986.

(2) Any cash surrender value available in the event of default in a premium payment due on any policy anniversary under a life insurance policy to which this section applies shall be in an amount which does not differ, by more than two-tenths of one percent of the amount of insurance, if uniform, or the average of the amounts of insurance at the beginning of each of the first 10 policy years, from A plus B minus C, where these amounts are defined as follows:

(a) “A” equals the basic cash value on such anniversary as defined in subsection (3) of this section.

(b) “B” equals the present value on such anniversary of any existing paid-up additions.

(c) “C” equals the amount of any indebtedness to the insurer under the policy on such anniversary.

(3)(a) The basic cash value referred to in subsection (2) of this section shall equal the present value, on a particular subject policy anniversary, of the future guaranteed benefits which would have been provided for by the policy if there had been no premium default, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, less the present value on such anniversary of the nonforfeiture factors, as defined in subsection (4) of this section, corresponding to premiums which would have fallen due on and after such anniversary. The basic cash value shall be taken as zero if this calculation produces a negative result.

(b) Supplemental life insurance or annuity benefits and family coverage, as described in ORS 743.210 or 743.216,

whichever is applicable to the policy, shall affect the basic cash value in the same manner as is provided in ORS 743.210 or 743.216 for their effect on the cash surrender values.

(4)(a) Except as provided in paragraph (b) of this subsection, the nonforfeiture factor referred to in subsection (3) of this section shall for each policy year equal a percentage of the adjusted premium for that policy year as defined in ORS 743.215 or 743.216, whichever is applicable to the policy. This percentage must:

(A) Be uniform for each policy year between the second policy anniversary and the later of:

(i) The fifth policy anniversary; and

(ii) The first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, at least equal to two-tenths of one percent of the amount of insurance, if uniform, or of the average of the amounts of insurance at the beginning of each of the first 10 policy years; and

(B) Be such that no percentage after the later policy anniversary defined in subparagraph (A) of this paragraph applies to fewer than five consecutive policy years.

(b) No basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy as defined in ORS 743.215 or 743.216, whichever is applicable to the policy, were substituted for the nonforfeiture factors defined in this subsection in the calculation of the basic cash value.

(5) All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the compliance of the policy with the Standard Nonforfeiture Law for Life Insurance. The cash surrender values referred to in this section shall include any endowment benefits provided for by the policy.

(6)(a) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment, shall be determined in a manner consistent with the manner specified for determining the analogous minimum amounts under the Standard Nonforfeiture Law for Life Insurance.

(b) The amounts of any cash surrender values and any paid-up nonforfeiture benefits granted in connection with additional benefits such as those described in ORS 743.222 shall conform with the principles of this section. [1981 c.609 §21]

743.222 Policy benefits and premiums that shall be disregarded in calculating cash surrender values and paid-up nonforfeiture benefits. (1) Notwithstanding ORS 743.210, in ascertaining minimum cash surrender values and paid-up nonforfeiture benefits required by the Standard Nonforfeiture Law for Life Insurance, benefits and their respective premiums provided for in a life insurance policy shall be disregarded where the benefits are payable:

(a) In the event of death or dismemberment by accident or accidental means;

(b) In the event of total and permanent disability;

(c) As reversionary annuity or deferred reversionary annuity benefits;

(d) As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, the Standard Nonforfeiture Law for Life Insurance would not apply;

(e) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is 26, is uniform in amount after the child's age is one, and has not become paid up by reason of the death of a parent of the child; or

(f) As other policy benefits additional to life insurance and endowment benefits.

(2) No benefits such as are described in subsection (1) of this section are required to be included in any paid-up nonforfeiture benefits. [Formerly 739.370; 1981 c.609 §20]

743.225 Prohibited provisions. No life insurance policy shall contain any of the following provisions:

(1) A provision limiting the time within which any action at law or suit in equity may be commenced to less than three years after the cause of action or suit accrues.

(2) A provision by which the policy purports to be issued or to take effect more than six months before the original application for the insurance was made.

(3) A provision for forfeiture of the policy for failure to repay any loan on the policy or any interest on such loan while the total indebtedness on the policy is less than the loan value thereof. [Formerly 739.315]

743.228 Acts of corporate insured or beneficiary with respect to policy. (1) Whenever a corporation organized under the laws of this state or qualified to do business in this state has caused to be insured the life of any director,

officer, agent or employee, or whenever such corporation is named as a beneficiary in or assignee of any life insurance policy, due authority to effect, assign, release, relinquish, convert, surrender, change the beneficiary or take any other or different action with reference to such insurance shall be sufficiently evidenced to the insurer by a written statement under oath showing that such action has been approved by a majority of the board of directors. Such a statement shall be signed by the president and secretary of the corporation and bear the corporate seal.

(2) Such a statement shall be binding upon the corporation and shall protect the insurer concerned in any act done or suffered by it upon the faith thereof without further inquiry into the validity of the corporate authority or the regularity of the corporate proceedings.

(3) No person shall be disqualified by reason of interest in the subject matter from acting as a director or as a member of the executive committee of such a corporation on any corporate act touching such insurance. [Formerly 739.415]

743.230 Variable life policy provisions. A variable life insurance policy shall contain in substance the following provisions:

(1) A provision that there will be a period of grace of 30 days within which payment of any premium after the first may be made, during which period of grace the policy will continue in full force. If a claim arises under the policy during such period of grace, the amount of any premiums due or overdue, together with interest not in excess of six percent per annum and any deferred installment of the annual premium, may be deducted from the policy proceeds. The policy may contain a statement of the basis for determining any variation in benefits that may occur as a result of the payment of premium during the period of grace.

(2) A provision that the policy will be reinstated at any time within three years from the date of a default in premium payments, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the production of evidence of insurability satisfactory to the insurer and the payment of an amount not exceeding the greater of:

(a) All overdue premiums and any other indebtedness to the insurer upon said policy with interest at a rate not exceeding six percent per annum; and

(b) One hundred ten percent of the increase in cash surrender value resulting from reinstatement.

(3) A provision for cash surrender values and paid-up insurance benefits available as nonforfeiture options in the event of default in a premium payment after premiums have been paid for a specified period. If the policy does not include a table of figures for the options so available, the policy shall provide that the insurer will furnish, at least once in each policy year, a statement showing the cash value as of a date no earlier than the next preceding policy anniversary.

(a) The method of computation of cash values and other nonforfeiture benefits shall be as described either in the policy or in a statement filed with the Director of the Department of Consumer and Business Services, and shall be actuarially appropriate to the variable nature of the policy.

(b) The method of computation must result, if the net investment return credited to the policy at all times from the date of issue equals the specified investment increment factor, with premiums and benefits determined accordingly under the terms of the policy, in cash values and other nonforfeiture benefits at least equal to the minimum values required by the Standard Nonforfeiture Law for a policy with such premiums and benefits. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, but are not limited to, a guarantee which provides that the amount payable at death or maturity shall be at least equal to the amount that would be payable if the net investment return credited to the policy at all times from the date of issue is equal to the specified investment increment factor.

(4) A provision specifying the investment increment factor to be used in computing the dollar amount of variable benefits or other variable payments or values under the policy, and guaranteeing that expense and mortality results will not adversely affect such dollar amounts. [1973 c.435 §18]

743.231 “Profit-sharing policy” defined. “Profit-sharing policy” means:

(1) A life insurance policy which by its terms expressly provides that the policyholder will participate in the distribution of earnings or surplus other than earnings or surplus attributable, by reasonable and nondiscriminatory standards, to the participating policies of the insurer and allocated to the policyholder on reasonable and nondiscriminatory standards; or

(2) A life insurance policy the provisions of which, through sales material or oral presentations, are interpreted by the insurer to prospective policyholders as entitling the policyholder to the benefits described in subsection (1) of this

section. [Formerly 739.705]

743.234 “Charter policy” or “founders policy” defined. “Charter policy” or “founders policy” means:

(1) A life insurance policy which by its terms expressly provides that the policyholder will receive some preferential or discriminatory advantage or benefit not available to persons who purchase insurance from the insurer at future dates or under other circumstances; or

(2) A life insurance policy the provisions of which, through sales material or oral presentations, are interpreted by the insurer to prospective policyholders as entitling the policyholder to the benefits described in subsection (1) of this section. [Formerly 739.710]

743.237 “Coupon policy” defined. “Coupon policy” means a life insurance policy which provides a series of pure endowments maturing periodically in amounts not exceeding the gross annual policy premiums. The term “pure endowment” or “endowment” is used in its accepted actuarial sense, meaning a benefit becoming payable at a specific future date if the insured person is then living. [Formerly 739.715]

743.240 Profit-sharing, charter or founders policies prohibited. No profit-sharing, charter or founders policy shall be issued or delivered in this state. [Formerly 739.720]

743.243 Restrictions on form of coupon policy. Coupon policies issued or delivered in this state shall be subject to the following provisions:

(1) No detachable coupons or certificates or passbooks may be used. No other device may be used which tends to emphasize the periodic endowment benefits or which tends to create the impression that the endowments represent interest earnings or anything other than benefits which have been purchased by part of the policyholder’s premium payments.

(2) Each endowment benefit must have a fixed maturity date and payment of the endowment benefit shall not be contingent upon the payment of any premium becoming due on or after such maturity date.

(3) The endowment benefits must be expressed in dollar amounts rather than as percentages of other quantities or in other ways, both in the policy itself and in the sale thereof.

(4) A separate premium for the periodic endowment benefits must be shown in the policy adjacent to the rest of the policy premium information and must be given the same emphasis in the policy and in the sale thereof as that given the rest of the policy premium information. This premium shall be calculated with mortality, interest and expense factors which are consistent with those for the basic policy premium. [1967 c.359 §403]

743.245 Variable life insurance policy provisions. A variable life insurance policy shall contain a provision stating the essential features of the procedures to be followed by the insurer in determining benefits thereunder. Such a policy, and any certificate evidencing such a policy, shall contain on its first page a clear and prominent statement to the effect that benefits thereunder are variable. [1973 c.435 §14]

743.247 Notice to variable life insurance policyholders. An insurer issuing individual variable life insurance policies shall mail to each policyholder at least once in each policy year after the first, at the last address of the policyholder known to the insurer:

(1) A statement reporting the investments held in the applicable separate account.

(2) A statement reporting as of a date not more than four months preceding the date of mailing:

(a) In the case of an annuity policy under which payments have not yet commenced, the number of accumulation units credited to such policy and the dollar value of a unit, or the value of the policyholder’s account; and

(b) In the case of a life insurance policy, the dollar amount of the death benefit. [1973 c.435 §15]

(Individual Annuity and Pure Endowment Policies)

743.252 Scope of ORS 743.255 to 743.273. ORS 743.255 to 743.273 apply only to annuity and pure endowment policies, other than reversionary annuity policies except as provided in ORS 743.273, and other than group annuity policies, and shall not apply to reversionary or deferred annuity benefits included in life insurance policies. Such sections apply to such policies that are variable annuity policies, except to the extent the provisions of such sections are obviously inapplicable to variable annuities or are in conflict with other provisions of such sections that are expressly

applicable to variable annuities. [1967 c.359 §404; 1973 c.435 §19]

743.255 Grace period for annuities. An annuity or pure endowment policy shall contain a provision that there shall be a period of grace of one month, but not less than 30 days, within which any stipulated payment to the insurer falling due after the first such payment may be made, subject at the option of the insurer to an interest charge thereon at the rate specified in the policy but not exceeding six percent per annum for the number of days of grace elapsing before such payment, during which period of grace the policy shall continue in full force. In case a claim arises under the policy on account of death prior to expiration of the period of grace before the overdue payment to the insurer or the deferred payments of the current policy year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the policy in settlement. [1967 c.359 §405]

743.258 Incontestability. If any statement other than those relating to age, sex and identity are required as a condition to issuing an annuity or pure endowment policy, the policy shall contain a provision that the policy shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of two years from its date of issue, except for nonpayment of stipulated payments to the insurer. At the option of the insurer the two year limit within which the policy may be contested shall not apply to any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means. [1967 c.359 §406]

743.261 Entire contract. An annuity or pure endowment policy shall contain a provision that the policy, including a copy of the application if indorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties. [1967 c.359 §407]

743.264 Misstatement of age or sex. An annuity or pure endowment policy shall contain a provision that if the age or sex of the person or persons upon whose life or lives the policy is made, or of any of them, has been misstated, the amount payable or benefits accruing under the policy shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex, and that if the insurer has made any overpayment or overpayments on account of any such misstatement, the amount thereof with interest at the rate specified in the policy but not exceeding six percent per annum may be charged against the current or next succeeding payment or payments to be made by the insurer under the policy. [1967 c.359 §408]

743.267 Dividends. If an annuity or pure endowment policy is participating, it shall contain a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy. [1967 c.359 §409]

743.269 Periodic payments for period certain. An annuity policy meeting the requirements of this section may provide that periodic payments shall be made under the policy for a period certain. Payments under such a policy shall begin on a date less than 13 months after the date on which the insurer issues the policy. The policy shall provide that payments will be made for a period of five years or more. The periodic payments may be fixed or variable in amount. If such policy offers commuted values on the annuity, such values must be based on an interest rate not more than one percent in excess of the interest rates that were used in determining the payments when the annuity was purchased. [1995 c.632 §2]

743.270 Reinstatement. An annuity or pure endowment policy shall contain a provision that the policy may be reinstated at any time within one year from a default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the policy shall be paid or reinstated with interest at the rate specified in the policy but not exceeding six percent per annum, and in cases where applicable the insurer may also include a requirement of evidence of insurability satisfactory to the insurer. [1967 c.359 §410]

743.271 Periodic stipulated payments on variable annuities. A variable annuity policy requiring periodic stipulated payments to the insurer shall contain in substance the following provisions:

(1) A provision that there will be a period of grace of 30 days within which any stipulated payment to the insurer after the first may be made, during which period of grace the policy will continue in full force. The policy may include a statement of the basis for determining the date as of which any such payment received during the period of grace

will be applied.

(2) A provision that, at any time within one year from the date of a default in making periodic stipulated payments to the insurer during the life of the annuitant, and unless the cash surrender value has been paid, the policy may be reinstated upon payment to the insurer of the overdue payments and all indebtedness to the insurer on the policy, with interest. The policy may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness will be applied.

(3) A provision specifying the options available in the event of a default in a periodic stipulated payment. Such options may include an option to surrender the policy for a cash value as determined by the policy, and shall include an option to receive a paid-up annuity if the policy is not surrendered for cash, the amount of the paid-up annuity being determined by applying the value of the policy at the annuity commencement date in accordance with the terms of the policy. [1973 c.435 §21]

743.272 Computing benefits. (1) A variable annuity policy shall specify the investment increment factors to be used in computing the dollar amount of variable benefits or other variable payments or values under the policy, and may guarantee that expense or mortality results or both will not adversely affect such dollar amounts. In the case of an individual variable annuity policy under which the expense or mortality results may adversely affect the dollar amount of benefits, the expense and mortality factors shall be correspondingly specified in the policy. “Expense” as used in this subsection may exclude some or all taxes, as specified in the policy.

(2) In computing the dollar amount of variable benefits or other policy payments or values:

(a) The annual net investment increment assumption shall not exceed five percent, except with the approval of the Director of the Department of Consumer and Business Services; and

(b) To the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a lower life expectancy at any age or, if approved by the director, from another table. [1973 c.435 §22]

743.273 Standard provisions of reversionary annuities. A policy of reversionary annuity shall contain in substance the following provisions:

(1) The provisions specified in ORS 743.255 to 743.267, except that under ORS 743.255 the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue payment in lieu of providing for deduction of the overdue payment from an amount payable upon settlement under the policy.

(2) A provision that the policy may be reinstated at any time within three years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon the condition that all overdue payments and any indebtedness to the insurer on account of the policy be paid or reinstated with interest at the rate specified in the policy but not exceeding six percent per annum. [1967 c.359 §411]

743.275 Standard Nonforfeiture Law for Individual Deferred Annuities; operative date; application. (1) ORS 743.275 to 743.295 may be cited as the Standard Nonforfeiture Law for Individual Deferred Annuities.

(2) The operative date of the Standard Nonforfeiture Law for Individual Deferred Annuities for an insurer is the earlier of:

(a) Two years after October 4, 1977; and

(b) The date specified in a written notice filed with the Director of the Department of Consumer and Business Services by the insurer of election to comply with the Standard Nonforfeiture Law for Individual Deferred Annuities as of the specified date.

(3) The Standard Nonforfeiture Law for Individual Deferred Annuities does not apply to:

(a) Annuity benefits purchased under a group annuity policy issued in conjunction with a retirement or deferred compensation plan established or maintained by an employer, an employee organization, or both. This exclusion does not apply, however, to a retirement or deferred compensation plan providing individual retirement accounts or individual retirement annuities governed by section 408 of the federal Internal Revenue Code.

(b) A premium deposit fund.

(c) A variable annuity policy.

(d) An investment annuity policy.

(e) An immediate annuity policy.

(f) A deferred annuity policy with respect to the period after annuity payments begin.

(g) A reversionary annuity.

(h) A policy issued before the operative date of the Standard Nonforfeiture Law for Individual Deferred Annuities for the insurer. [1977 c.320 §2]

743.278 Required provisions in annuity policies; exception. (1) An annuity policy shall contain in substance the following provisions, or corresponding provisions that in the opinion of the Director of the Department of Consumer and Business Services are at least as favorable to the policyholder:

(a) That upon the termination of consideration payments under the policy the insurer will grant a paid-up annuity benefit on a plan stipulated in the policy, of the value required by ORS 743.284.

(b) That, if the policy provides for a lump sum settlement at maturity or any other time, the insurer will pay upon surrender of the policy on or before the start of annuity payments, in lieu of a paid-up annuity benefit, a cash surrender benefit of the amount required by ORS 743.284. The insurer shall reserve the right to defer the payment of the cash surrender benefit for a period of six months after demand therefor with surrender of the policy.

(c) A statement of the mortality table, if any, and interest rates used in calculating minimum guaranteed paid-up annuity, cash surrender and death benefits under the policy, together with sufficient information to determine the amount of such benefits.

(d) A statement that paid-up annuity, cash surrender and death benefits available under the policy are not less than the minimums required by the statutes of the jurisdiction in which the policy is delivered, with an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the insurer to the policy, any indebtedness to the insurer on the policy or any prior withdrawals from or partial surrenders of the policy.

(2) Notwithstanding subsection (1) of this section, the policy may provide that if no consideration payments have been received for two full years and the paid-up annuity benefit at maturity on the plan stipulated in the policy, arising from the considerations paid before such two-year period, is less than $20 monthly, the insurer at its option may terminate the policy by payment in cash of the then present value of the paid-up annuity benefit. Such value shall be calculated on the basis of the mortality table, if any, and the interest rate specified in the policy for calculating the paid-up annuity benefit. By this payment the insurer will be relieved of further obligations under the policy. [1977 c.320 §3]

743.281 Calculation of "minimum nonforfeiture amount." "Minimum nonforfeiture amount" as referred to in the Standard Nonforfeiture Law for Individual Deferred Annuities shall be calculated as follows:

(1) For a policy providing for flexible consideration payments, the minimum nonforfeiture amount at a given time equals the then accumulated value at three percent interest of the percentages specified in paragraph (b) of this subsection of the net considerations previously paid, decreased by the then accumulated value at three percent interest of previous withdrawals from or partial surrenders of the policy and the amount of any indebtedness to the insurer on the policy, and increased by any existing additional amounts credited by the insurer to the policy.

(a) The net considerations used in calculating the minimum nonforfeiture amount equal, for a given policy year, the gross considerations credited to the policy during that year less a policy charge for the year of $30 and less a collection charge of $1.25 per consideration credited during that year, but the net considerations shall not be less than zero for any year.

(b) The percentages shall be 65 percent of the net considerations for the first policy year, and 87-1/2 percent of the net considerations for the years thereafter, except that the percentage for years after the first policy year shall be 65 percent for the portion of the total net consideration in any such year that exceeds the sum, but does not exceed twice the sum, of the portions of net considerations in previous years for which the percentage was 65 percent.

(2) For a policy providing for scheduled amounts of consideration payments, the minimum nonforfeiture amount shall be calculated using the assumption that considerations are paid annually in advance and the same calculation method as for a policy with flexible considerations, except that:

(a) The portion of the net considerations for the first policy year to be accumulated shall be 65 percent of such net considerations plus 22-1/2 percent of the excess of such net considerations over the lesser of the net considerations for the second and third policy years; and

(b) The policy charge for a given policy year shall be the lesser of $30 and 10 percent of the gross considerations for the year.

(3) For a policy providing for a single consideration, the minimum nonforfeiture amount shall be calculated using the same method as for a policy with flexible considerations, except that:

(a) The net consideration shall be the gross consideration less a policy charge of $75; and

(b) The percentage shall be 90 percent. [1977 c.320 §4]

743.284 Computation of benefits. (1) Any paid-up annuity benefit available under an annuity policy shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the policy for determining the minimum guaranteed paid-up annuity benefits.

(2) For annuity policies that provide cash surrender benefits, such benefits available prior to maturity shall be an amount not less than the present value on the date of surrender of the portion of the policy maturity value of its paid-up annuity benefits that arises from considerations paid before the surrender, reduced by appropriate amounts reflecting any previous withdrawals from or partial surrenders of the policy. Such present value shall be calculated using an interest rate not more than one percent higher than the interest rate specified in the policy for accumulating the net considerations to determine such policy maturity value, shall be decreased by the amount of any indebtedness to the insurer on the policy, and shall be increased by any existing additional amounts credited by the insurer to the policy. In no event shall the cash surrender benefit be less than the minimum nonforfeiture amount on the date of surrender. The death benefit under an annuity policy that provides cash surrender benefits shall be at least equal to the cash surrender benefit.

(3) For annuity policies that do not provide cash surrender benefits, the present value of the paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of the portion of the policy maturity value of its paid-up annuity benefits that arises from considerations paid before the policy is surrendered in exchange for, or changed to, a deferred paid-up annuity. Such present value shall be calculated for the period prior to the maturity date on the basis of the interest rate specified in the policy for accumulating the net considerations to determine the policy maturity value, and shall be increased by any existing additional amounts credited by the insurer to the policy. For such annuity policies that also do not provide any death benefits before annuity payments start, such present value shall be calculated on the basis of such interest rate and the mortality table specified in the policy for determining the policy maturity value of its paid-up annuity benefit. In no event, however, shall the present value of a paid-up annuity benefit be less at any time than the minimum nonforfeiture amount. [1977 c.320 §5]

743.287 Commencement of annuity payments at optional maturity dates; calculation of benefits. (1) For the purpose of ORS 743.284 (2) and (3) in the case of annuity policies under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be considered to be the latest date for which such election is permitted by the policy, but not later than the later of the policy anniversary next following the annuitant's 70th birthday and the 10th anniversary of the policy.

(2) Paid-up annuity, cash surrender and death benefits available at any time other than on a policy anniversary of a policy with scheduled amounts of consideration payments shall be calculated with allowance for the lapse of time and the payment of scheduled considerations beyond the start of the policy year in which termination of consideration payments occurs. [1977 c.320 §6]

743.290 Notice of nonpayment of certain benefits to be included in annuity policy. An annuity policy that does not provide cash surrender benefits, or that does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the start of annuity payments, shall include a prominent statement to that effect. [1977 c.320 §7]

743.295 Effect of certain life insurance and disability benefits on minimum nonforfeiture amounts. (1) For an annuity policy that includes, by rider or otherwise, life insurance benefits that exceed the greater of the cash surrender benefit and the return of the gross considerations with interest, the minimum nonforfeiture benefits shall equal the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion, computed as if each portion were a separate policy.

(2) Additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts and paid-up annuity, cash surrender and death benefits required by the Standard Nonforfeiture Law for Individual Deferred Annuities. The inclusion of such additional benefits shall not be required in any paid-up benefits unless the additional benefits would separately require minimum nonforfeiture amounts and paid-up annuity, cash surrender and death benefits. [1977 c.320 §8]

GROUP LIFE INSURANCE

743.303 Requirements for issuance of group life insurance policies. Policies of group life insurance are subject to the following requirements:

(1) The policy shall be issued upon the lives of persons who are associated in a common group formed for purposes other than the obtaining of insurance, except that either of the following kinds of policies may be issued to persons other than those in a common group:

(a) Group policies of credit life insurance; or

(b) Group policies of mortgage life insurance on first and second mortgages secured by real estate;

(2) Not less than 75 percent of the eligible members of the group or 10 lives, whichever is the greater, are insured at the date of issue of the policy;

(3) The amounts of insurance under the policy shall be based on some plan precluding individual selection, except that optional supplemental insurance may be available to persons insured under the policy, if the amounts of such supplemental insurance are based upon age, salary, rank or similar objective standards;

(4) The person contracting for the group coverage shall be responsible for the payment of premiums;

(5) For the purposes of this section, the term “mortgage” includes trust deeds; and

(6) As used in this section, “trust deed” has the meaning given in ORS 86.705. [1967 c.359 §412; 1971 c.231 §44; 1991 c.182 §4; 1993 c.426 §1]

743.306 Required provisions in group life insurance policies. (1) Except as provided in subsection (2) of this section a group life insurance policy shall contain in substance the provisions described in ORS 743.309 to 743.342.

(2) The provisions described in ORS 743.327 to 743.339 shall not apply to policies of group credit life insurance. [1967 c.359 §413]

743.309 Nonforfeiture provisions. If a group life insurance policy is on a plan of insurance other than the term plan, it shall contain nonforfeiture provision or provisions which in the opinion of the Director of the Department of Consumer and Business Services are equitable to the insured persons and to the policyholder, but nothing in this section shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies. [1967 c.359 §414]

743.312 Grace period. A group life insurance policy shall contain a provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period. [1967 c.359 §415]

743.315 Incontestability. A group life insurance policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any person insured under the policy relating to the insurability of the person shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person’s lifetime nor unless it is contained in a written instrument signed by the person. [1967 c.359 §416]

743.318 Application; representations by policyholders and insureds. A group life insurance policy shall contain a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the beneficiary of the person. [1967 c.359 §417]

743.321 Evidence of insurability. A group life insurance policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the coverage. [1967 c.359 §418]

743.324 Misstatement of age. A group life insurance policy shall contain a provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used. [1967 c.359 §419]

743.327 Payments under policy; payment of interest upon failure to pay proceeds. (1) A group life insurance policy shall contain a provision that any sum becoming due by reason of the death of a person insured shall be payable to the beneficiary designated by the person insured, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the person insured, and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding $500 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

(2) If the insurer fails to pay the proceeds of or make payment under the policy within 30 days after receipt of due proof of death and of the interest of the claimant, and if the beneficiary elects to receive a lump sum settlement, the insurer shall pay interest on any money due and unpaid after expiration of the 30-day period. The insurer shall compute the interest from the date of the insured's death until the date of payment, at a rate not lower than that paid by the insurer on other withdrawable policy owner funds. At the end of the 30-day period, the insurer shall notify the designated beneficiary or beneficiaries at their last-known address that interest at the applicable rate will be paid on the lump sum proceeds from the date of death of the insured.

(3) Nothing in this section shall be construed to allow an insurer to withhold payment of money payable under a group life insurance policy to any designated beneficiary for a period longer than reasonably necessary to transmit the payment. [1967 c.359 §420; 1983 c.754 §3]

743.330 Issuance of certificates. A group life insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, to whom the insurance benefits are payable, and the rights and conditions set forth in ORS 743.333, 743.336 and 743.339. [1967 c.359 §421]

743.333 Termination of individual coverage. A group life insurance policy shall contain a provision that if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within 31 days after such termination, and provided further that:

(1) The individual policy shall, at the option of such person, be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for;

(2) The individual policy shall be in an amount not in excess of the amount of life insurance which ceases because of such termination, less the amount of any life insurance for which such person is or becomes eligible under the same or any other group policy within 31 days after such termination, provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination; and

(3) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to the age attained on the effective date of the individual policy. [1967 c.359 §422]

743.336 Termination of policy or class of insured persons. A group life insurance policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates and who has been so insured for at least five years prior to such termination date shall be entitled to have issued by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by ORS 743.333, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of:

(1) The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which the person is or becomes eligible under any group policy

issued or reinstated by the same or another insurer within 31 days after such termination; and

(2) $10,000. [1967 c.359 §423; 1989 c.784 §16]

743.339 Death during period for conversion to individual policy. A group life insurance policy shall contain a provision that if a person insured under the group policy dies during the period within which the person would have been entitled to have an individual policy issued in accordance with ORS 743.333 or 743.336 and before such an individual policy shall have become effective, the amount of life insurance which the person would have been entitled to have issued under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made. [1967 c.359 §424]

743.342 Statement furnished to insured under credit life insurance policy. A group credit life insurance policy shall contain a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a form which will contain a statement that the life of the debtor is insured under the policy and that any death benefit paid thereunder by reason of death shall be applied to reduce or extinguish the indebtedness. [1967 c.359 §425]

743.345 Assignability of group life policies. Nothing in the Insurance Code or in any other law shall be construed to prohibit any person insured under a group life insurance policy from making an assignment of all or any part of the incidents of ownership under such policy, including but not limited to the privilege to have issued an individual policy of life insurance pursuant to the provisions of ORS 743.333 to 743.339 and the right to name a beneficiary. Subject to the terms of the policy or an agreement between the insured, the group policyholder and the insurer relating to assignment of incidents of ownership under the policy, such an assignment by an insured, made either before or after September 9, 1971, is valid for the purpose of vesting in the assignee, in accordance with any provisions included in the assignment as to the time at which it is to be effective, all of such incidents of ownership so assigned, but without prejudice to the insurer on account of any payment it may make, or individual policy it may issue in accordance with ORS 743.333 to 743.339, prior to receipt of notice of the assignment. [1971 c.231 §6]

743.348 Certain sales practices prohibited. (1) No person selling group life insurance is authorized to sell membership in a common group for the purpose of qualifying an applicant who is an individual for group life insurance.

(2) No person selling membership in a common group is authorized to offer group life insurance for the purpose of selling membership in the common group. [1989 c.784 §6]

743.350 [1979 c.708 §2; renumbered 743.100 in 1989]

743.351 Eligibility of association to be group life policyholder; rules. (1) An insurer shall not offer a policy of group life insurance in this state to an association as the policyholder or offer coverage under such a policy, whether the policy is issued in this or another state, unless the Director of the Department of Consumer and Business Services determines that the association satisfies the following requirements:

(a) The association must have had an active existence for at least one year;

(b) The association must insure under the policy the employees or members of the association, or employees of members of the association, for the benefit of persons other than the association or its officers or trustees; and

(c) The association must be maintained primarily for purposes other than the procurement of insurance.

(2) An insurer shall submit evidence to the director that the association satisfies the requirements of subsection (1) of this section. The director shall review the evidence and may request additional evidence as needed.

(3) An insurer shall submit to the director any changes in the evidence submitted under subsection (2) of this section.

(4) The director may order an insurer to cease offering group life insurance to an association if the director determines that the association does not meet the requirements under subsection (1) of this section.

(5) For purposes of this section:

(a) An association includes a labor union.

(b) “Employees” may include retired employees.

(6) The director may adopt rules to carry out this section. [1989 c.784 §7]

743.353 [1979 c.708 §3; renumbered 743.101 in 1989]

743.354 Requirements for certain group life policies issued to trustees of certain funds. (1) An insurer shall not offer in this state a policy of group life insurance that is described in this section and insures persons in this state, or shall not offer coverage under such a policy, whether the policy is to be issued in this or another state, unless the Director of the Department of Consumer and Business Services determines that the requirements of subsections (2) and (3) of this section are satisfied. This section applies to a policy to be issued to the trustees of a fund established for:

(a) Two or more employers in the same or related industry;

(b) One or more labor unions;

(c) One or more employers and one or more labor unions; or

(d) An association determined by the director to satisfy the requirements of ORS 743.351 (1).

(2) A policy of group life insurance shall provide coverage for the benefit of employees of the employers, members of the unions or members of the association. The policy may include as employees the officers and managers of the employer, and the individual proprietor or partners if the employer is an individual proprietor or a partnership. In addition to such employees, the policy may also insure retired employees and the trustees or their employees, or both, if their duties are principally connected with the trust.

(3) The director shall determine with respect to a policy whether the trustees are the policyholder. If the director determines that the trustees are the policyholder and if the policy is issued or proposed to be issued in this state, the policy is subject to the Insurance Code. If the director determines that the trustees are not the policyholder, the evidence of coverage that is issued or proposed to be issued in this state to a participating employer, labor union or association shall be deemed to be a group life insurance policy subject to the Insurance Code. For purposes of this section, the director may determine that the trustees are not the policyholder if:

(a) The evidence of coverage issued or proposed to be issued to a participating employer, labor union or association is in fact the primary statement of coverage for the employer, labor union or association; and

(b) The trust arrangement is under the actual control of the insurer.

(4) An insurer shall submit evidence to the director showing that the requirements of subsections (2) and (3) of this section are satisfied. The director shall review the evidence and may request additional evidence as needed.

(5) An insurer shall submit to the director any changes in the evidence submitted under subsection (4) of this section.

(6) The director may adopt rules to carry out this section. [1989 c.784 §8]

743.356 Continuing coverage upon replacement of group life policy. When coverage under a group life insurance policy is replaced by coverage under another group life insurance policy, the insurer offering the policy that is replaced shall continue to provide coverage for each certificate holder under the replaced policy whose premium payments are suspended because the certificate holder is disabled. [1989 c.784 §9]

Note: 743.356 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 743 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

743.357 [1979 c.708 §4; renumbered 743.103 in 1989]

743.358 Borrowing by certificate holders under group life policy. (1) An insurer of a group life insurance policy may authorize certificate holders under the policy to borrow upon the policy, subject to the following provisions:

(a) The insurer may require a certificate holder, in order to borrow on the policy, to have been a certificate holder under the policy for a minimum period specified by the insurer.

(b) The insurer may require that no premium on the policy be in default beyond the grace period for payment.

(2) An insurer authorizing a certificate holder under a group life insurance policy may establish a minimum loan amount, but the amount may not exceed $1,000.

(3) An insurer may charge a fixed interest rate not exceeding eight percent per year, or an adjustable interest rate. The policy provision establishing an adjustable interest rate must comply with ORS 743.187. The exemption from a limitation on interest rates under state law established in ORS 743.187 for individual life insurance policies also applies to interest rates established pursuant to this section.

(4) The loan value of a certificate shall be equal to 90 percent of the cash surrender value of the certificate at the time of the loan, less any existing indebtedness not already deducted, including any unpaid interest. This subsection

does not apply to certificates issued under a group policy for which the loan value is established by federal law. [1991 c.182 §9]

743.360 Alternative group life insurance coverage. (1) Group life insurance coverage offered to a resident in this state under a group life insurance policy issued to a group other than one described in ORS 743.351 or 743.354 may be delivered if:

(a) The Director of the Department of Consumer and Business Services finds that:

(A) The issuance of the policy is in the best interest of the public;

(B) The issuance of the policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged;

(b) The premium for the policy is paid either from funds of a policyholder, from funds contributed by a covered person or from both; and

(c) An insurer has the discretion to exclude or limit coverage for a voluntary plan on any person for whom evidence of individual insurability is not satisfactory to the insurer.

(2) The requirements of ORS 743.303 do not apply to a policy authorized under subsection (1) of this section. [2001 c.943 §3]

743.362 [1979 c.708 §5; renumbered 743.104 in 1989]

743.365 [1979 c.708 §6; renumbered 743.106 in 1989]

743.368 [1979 c.708 §7; renumbered 743.107 in 1989]

743.370 [1979 c.708 §8; renumbered 743.109 in 1989]

CREDIT LIFE AND CREDIT HEALTH INSURANCE

743.371 Definitions for credit life and credit health insurance provisions. (1) “Credit life insurance” means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

(2) “Credit health insurance” means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

(3) “Creditor” means the lender of money or vendor or lessor of goods, services, property, rights or privileges for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender, vendor or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them.

(4) “Debtor” means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

(5) “Indebtedness” means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction. [Formerly 739.565 and then 743.561]

743.372 Applicability of credit life and credit health insurance provisions. (1) All life or health insurance in connection with loans or other credit transactions shall be subject to ORS 743.371 to 743.380, except:

(a) Insurance in connection with a loan or other credit transaction of more than 10 years’ duration; or

(b) Insurance, the issuance of which is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

(2) Notwithstanding subsection (1) of this section, credit life and credit health insurance may be issued for up to 10 years in connection with a loan or other credit transaction of any duration. [Formerly 739.570 and then 743.564]

743.373 Forms of credit life and credit health insurance. Credit life and credit health insurance shall be issued only in the following forms:

(1) Individual policies of life insurance issued to debtors on the term plan.

(2) Individual policies of health insurance issued to debtors on a term plan, or disability benefit provisions in individual policies of credit life insurance.

(3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term

plan.

(4) Group policies of health insurance issued to creditors on a term plan insuring debtors, or disability benefit provisions in group credit life insurance policies. [Formerly 739.575 and then 743.567]

743.374 Limits on amount of credit life insurance. (1) The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness and, where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

(2) Notwithstanding the provisions of subsection (1) of this section, insurance on agricultural credit transaction commitments not exceeding 18 months in duration may be written up to the amount of the loan commitment, on a nondecreasing or level term plan.

(3) Notwithstanding the provisions of subsection (1) of this section, insurance on educational credit transaction commitments may include the portion of such commitment that has not been advanced by the creditor. [Formerly 743.570]

743.375 Limit on amount of credit health insurance. The total amount of periodic indemnity payable by credit health insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness; and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments. [Formerly 741.425 and then 743.573]

743.376 Duration of credit life and credit health insurance. (1) The term of any credit life or credit health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than 30 days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance.

(2) The term of the insurance shall not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor.

(3) If the indebtedness is discharged because of renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness.

(4) In all cases of termination of the insurance prior to the scheduled maturity date of the indebtedness, a refund shall be paid or credited as provided in ORS 743.378. [Formerly 739.585 and then 743.576]

743.377 Credit life and credit health insurance policy or group certificate; contents; delivery of policy, certificate or copy of application. (1) All credit life or credit health insurance shall be evidenced by an individual policy or, in the case of group insurance, by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(2) Each individual policy or group certificate of credit life or credit health insurance, or both shall, in addition to other requirements of law, set forth:

(a) The name and home-office address of the insurer;

(b) The name or names of the debtor, or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor;

(c) The premium or amount of payment by the debtor separately for credit life insurance and for credit health insurance;

(d) A description of the coverage including the amount and term thereof, and any exceptions, limitations and restrictions; and

(e) A statement that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to the estate of the debtor.

(3) Such individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as provided in subsection (4) of this section.

(4) If such individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for insurance or a notice of proposed insurance, signed by the debtor and setting forth the name and home-office address of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor separately for credit life insurance and for credit health insurance, and the amount, term and a brief description of the coverage provided, shall be delivered to the debtor at the time the indebtedness is incurred. The copy of the application for insurance or notice of proposed insurance shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within 30 days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application for insurance or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in ORS 743.376.

(5) If an insurer other than the named insurer accepts the risk, then the debtor shall receive a policy or certificate of insurance setting forth the name and home-office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made. [Formerly 739.590 and then 743.579]

743.378 Charges and refunds to debtor. (1) Each individual policy or group certificate of credit life or credit health insurance, or both, shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto. However, the Director of the Department of Consumer and Business Services shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the director.

(2) If a creditor requires a debtor to make any payment for credit life insurance or credit health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.

(3) The amount charged to a debtor for credit life insurance and for credit health insurance shall not exceed the respective premiums charged by the insurer, as computed at the time the charge to the debtor is determined. [Formerly 739.600 and then 743.582]

743.379 Status of remuneration to creditor. Notwithstanding the provisions of any other law of this state which may expressly or by construction provide otherwise, any commission or service fee or other benefit or return to any creditor arising out of the sale or provision of credit life and credit health insurance shall not be deemed interest or charges in connection with loans or credit transactions. [Formerly 739.603 and then 743.585]

743.380 Claim report and payment. (1) All claims under policies of credit life or credit health insurance, or both, shall be promptly reported to the insurer or its designated claim representative and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the policy.

(2) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment is due pursuant to the policy provisions or, upon direction of such claimant, to the one specified. [Formerly 739.610 and then 743.588]

HEALTH INSURANCE

(Individual)

743.402 Exceptions to individual health insurance policy requirements. Nothing in ORS 743.405 to 743.498 shall apply to or affect:

(1) Any workers' compensation insurance policy or any liability insurance policy with or without supplementary expense coverage therein;

(2) Any policy of reinsurance;

(3) Any blanket or group policy of insurance; or

(4) Any life insurance policy, or policy supplemental thereto which contains only such provisions relating to health insurance as:

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident; or

(b) Operate to safeguard such policy against lapse, or to give a special surrender value or special benefit or an annuity in the event the insured shall become totally and permanently disabled, as defined by the policy or supplemental policy.

(5) Coverage under ORS 735.600 to 735.650. [Formerly 741.022; 2001 c.356 §5]

743.405 General requirements for individual health insurance policies. An individual health insurance policy must meet the following requirements:

(1) The entire money and other considerations therefor shall be expressed therein.

(2) The time at which the insurance takes effect and terminates shall be expressed therein.

(3) It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder.

(4) The policy may not be issued individually to an individual in a group of persons as described in ORS 743.522 for the purpose of separating the individual from health insurance benefits offered or provided in connection with a group health benefit plan.

(5) Except as provided in ORS 743.498, the style, arrangement and overall appearance of the policy may not give undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point. Captions shall be printed in not less than 12-point type. As used in this subsection, “text” includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions.

(6) The exceptions and reductions of indemnity must be set forth in the policy. Except those required by ORS 743.411 to 743.480, exceptions and reductions shall be printed at the insurer’s option either included with the applicable benefit provision or under an appropriate caption such as EXCEPTIONS, or EXCEPTIONS AND REDUCTIONS. However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the applicable benefit provision.

(7) Each form constituting the policy, including riders and indorsements, must be identified by a form number in the lower left-hand corner of the first page of the policy.

(8) The policy may not contain provisions purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short rate table filed with the Director of the Department of Consumer and Business Services. [Formerly 741.120; 1999 c.987 §5]

743.408 Mandatory provisions, individual health insurance policies. Except as provided in ORS 742.021, a health insurance policy shall contain the provisions set forth in ORS 743.411 to 743.444. Such provisions shall be preceded individually by the caption appearing in such sections or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Director of the Department of Consumer and Business Services may approve. [1967 c.359 §428]

743.411 Entire contract; changes. A health insurance policy shall contain a provision as follows: “ENTIRE CONTRACT; CHANGES: This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.” [1967 c.359 §429]

743.412 Coverage for alcoholism treatment on request; notice; conditions; limits. A health insurance policy providing coverage for hospital or medical expenses not limited to expenses from accidents or specified sicknesses shall provide, at the request of the applicant, coverage for expenses arising from treatment for alcoholism. The following conditions apply to the requirement for such coverage:

(1) The applicant shall be informed of the applicant’s option to request this coverage.

(2) The inclusion of the coverage may be made subject to the insurer’s usual underwriting requirements.

(3) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance.

(4) The policy may limit hospital expense coverage to treatment provided by the following facilities:

(a) A health care facility licensed as required by ORS 441.015.

(b) A health care facility accredited by the Joint Commission on Accreditation of Hospitals.

(5) Except as permitted by subsection (3) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than $4,500 in any 24-consecutive month period and the policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the hospital and medical expenses for treatment for alcoholism. [1977 c.632 §2; 1981 c.319 §1; 2001 c.900 §230]

743.414 Time limit on certain defenses; incontestability. (1) A health insurance policy shall contain a provision as follows: "TIME LIMIT ON CERTAIN DEFENSES: After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of that period."

(2) The policy provision set forth in subsection (1) of this section shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, or to limit the application of ORS 743.450 to 743.462 in the event of misstatement with respect to age or occupation or other insurance.

(3) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the provision set forth in subsection (1) of this section the following provision, from which the clause in parentheses may be omitted at the insurer's option: "INCONTESTABLE: After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."

(4) The policy shall contain a provision as follows, which shall be a separate paragraph under the same caption as, and immediately following, the provision set forth in subsection (1) or (3) of this section: "No claim for loss incurred or disability, as defined in the policy, commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy." [1967 c.359 §430; 1969 c.159 §1]

743.417 Grace period. (1) An individual health insurance policy shall contain a provision as follows: "GRACE PERIOD: A minimum grace period of 10 days after the premium due date will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

(2) A policy that contains a cancellation provision may add the following clause at the end of the provision set forth in subsection (1) of this section: "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."

(3) A policy in which the insurer reserves the right to refuse renewal shall have the following clause at the beginning of the provision set forth in subsection (1) of this section: "Unless not less than 30 days prior to the premium due date the insurer has delivered to the insured or has mailed to the last address of the insured as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted. The insurer shall state in the notice the reason for its refusal to renew this policy." [1967 c.359 §431; 1989 c.784 §19; 2001 c.943 §9]

743.420 Reinstatement. (1) A health insurance policy shall contain a provision as follows: "REINSTATEMENT: If any renewal premium is not paid within the grace period, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other

respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

(2) The last sentence of the provision set forth in subsection (1) of this section may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. [1967 c.359 §432; 2001 c.943 §10]

743.423 Notice of claim. (1) A health insurance policy shall contain a provision as follows: "NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer."

(2) In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the provision set forth in subsection (1) of this section: "Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of such disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given." [1967 c.359 §433]

743.426 Claim forms. A health insurance policy shall contain a provision as follows: "CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made." [1967 c.359 §434]

743.429 Proofs of loss. A health insurance policy shall contain a provision as follows: "PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required." [1967 c.359 §435]

743.432 Time of payment of claims. A health insurance policy shall contain a provision as follows: "TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid _____ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof." [1967 c.359 §436]

743.435 Payment of claims. (1) A health insurance policy shall contain a provision as follows: "PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured."

(2) The following provisions, or either of them, may be included with the provision set forth in subsection (1) of this section at the option of the insurer:

(a) "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $____ (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment."

(b) "Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person." [1967 c.359 §437]

743.438 Physical examinations and autopsy. A health insurance policy shall contain a provision as follows: "PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law." [1967 c.359 §438]

743.441 Legal actions. A health insurance policy shall contain a provision as follows: "LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished." [1967 c.359 §439]

743.444 Change of beneficiary. (1) A health insurance policy shall contain a provision as follows: "CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries or to any other changes in this policy."

(2) The first clause of the provision set forth in subsection (1) of this section, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option. [1967 c.359 §440]

743.447 Optional provisions, individual health insurance. Except as provided in ORS 742.021, provisions in a health insurance policy respecting the matters set forth in ORS 743.450 to 743.480 shall be in the words which appear in such sections. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in such sections or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Director of the Department of Consumer and Business Services may approve. [1967 c.359 §441]

743.450 Change of occupation. A health insurance policy may contain a provision as follows: "CHANGE OF OCCUPATION: If the insured be injured or contract sickness after having changed occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation." [1967 c.359 §442]

743.453 Misstatement of age. A health insurance policy may contain a provision as follows: "MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the

premium paid would have purchased at the correct age." [1967 c.359 §443]

743.456 Other insurance in same insurer. (1) A health insurance policy may contain a provision as follows: "OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of $____ (insert maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the estate of the insured."

(2) In lieu of the provisions set forth in subsection (1) of this section, the policy may contain a provision as follows: "OTHER INSURANCE IN THIS INSURER: Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, the beneficiary or the estate of the insured, as the case may be, and the insurer will return all premiums paid for all other such policies." [1967 c.359 §444]

743.459 Insurance with other insurers, expense incurred benefits. (1) A health insurance policy may contain a provision as follows: "INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the 'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage."

(2) If the policy provision set forth in subsection (1) of this section is included in a policy which also contains the policy provision set forth in ORS 743.462, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Director of the Department of Consumer and Business Services, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the director. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage." [1967 c.359 §445]

743.462 Insurance with other insurers, other than expense incurred benefits. (1) A health insurance policy may contain a provision as follows: "INSURANCE WITH OTHER INSURERS: If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined."

(2) If the policy provision set forth in subsection (1) of this section is included in a policy which also contains the policy provision set forth in ORS 743.459, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the Director of the Department of Consumer and Business Services, which definition shall be limited in subject matter to coverage provided by organizations subject to

regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the director. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage." [1967 c.359 §446]

743.465 Relation of earnings to insurance. (1) A health insurance policy may contain a provision as follows: "RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the average monthly earnings of the insured for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time."

(2) The policy provision set forth in subsection (1) of this section may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the Director of the Department of Consumer and Business Services, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the director or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations. [1967 c.359 §447]

743.468 Unpaid premium. A health insurance policy may contain a provision as follows: "UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom." [1967 c.359 §448]

743.471 Cancellation provision. A health insurance policy may contain a provision as follows: "CANCELLATION: The insurer may cancel this policy by written notice delivered to the insured, or mailed to the last address of the insured as shown by the records of the insurer. The notice must state the reason for cancellation and the date on which the cancellation shall be effective. Except as provided under the 'GRACE PERIOD' provision of this policy for nonpayment of premium, cancellation shall not become effective earlier than the 30th day after the date of the notice. After the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation." [1967 c.359 §449; 1989 c.784 §20]

743.472 Permissible reasons for cancellation or refusal to renew. An insurer selling individual health insurance policies may cancel or refuse to renew an individual health insurance policy only if the insurer makes a determination to cancel or not to renew all policies of the same type and form as the individual policy, or if the ground for

cancellation or nonrenewal is any of the following and is stated as a provision of the policy:

(1) A fraudulent or material misstatement made by the applicant in an application for the health policy. A material misstatement is subject to any time limit, as specified by law and included in the policy, for voiding the policy on the basis of a misstatement. For purposes of this subsection, a misstatement may include an incorrect statement or a misrepresentation, omission or concealment of fact;

(2) Excess or other insurance in the same insurer, as described in ORS 743.456;

(3) Nonpayment of premium; or

(4) Any other reason specified by the Director of the Department of Consumer and Business Services by rule. [1989 c.784 §18; 1991 c.182 §5]

Note: 743.472 was added to and made a part of 743.405 to 743.498 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

743.474 Conformity with state statutes. A health insurance policy may contain a provision as follows: "CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date hereby is amended to conform to the minimum requirements of such statutes." [1967 c.359 §450]

743.477 Illegal occupation. A health insurance policy may contain a provision as follows: "ILLEGAL OCCUPATION: The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation." [1967 c.359 §451]

743.480 Intoxicants and controlled substances. A health insurance policy may contain a provision as follows: "INTOXICANTS AND CONTROLLED SUBSTANCES: The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician." [1967 c.359 §452; 1979 c.744 §64]

743.483 Arrangement of provisions. The provisions of a health insurance policy which are the subject of ORS 743.408 to 743.480, or any corresponding provisions which are used in lieu thereof in accordance with the Insurance Code, shall be printed in the consecutive order of such sections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued. [1967 c.359 §453]

743.486 Scope of term "insured" in statutory policy provisions. As used in ORS 743.402 to 743.498, the word "insured" shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein. [1967 c.359 §454]

743.489 Extension of coverage beyond policy period; effect of misstatement of age. If any health insurance policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy shall continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy. [Formerly 741.170]

743.492 Policy return and premium refund provision. Every health insurance policy except single premium nonrenewable policies shall have printed on its face or attached thereto a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to the purchaser and to have the premium paid refunded if, after examination of the policy, the purchaser is not satisfied with it for any reason.

If a policyholder or purchaser pursuant to such notice returns the policy to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. [Formerly 741.180]

743.495 Use of terms "noncancelable" or "guaranteed renewable"; synonymous terms. (1) No health insurance policy shall contain the following unqualified terms except as provided in this subsection:

(a) The unqualified terms "noncancelable" or "noncancelable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force for life by the timely payment of premiums set forth in the policy, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force.

(b) The unqualified term "guaranteed renewable," except as provided in paragraph (a) of this subsection, may be used only in a policy which the insured has the right to continue in force for life by the timely payment of premiums, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

(2) The limitations prescribed in subsection (1) of this section on the use of the term "noncancelable" shall also apply to any synonymous term such as "not cancelable" and such limitations on the use of the term "guaranteed renewable" shall also apply to any synonymous term such as "guaranteed continuable." [Formerly 741.190]

743.498 Statement in policy of cancelability or renewability. (1) A health insurance policy which is noncancelable or guaranteed renewable as those terms are used in ORS 743.495, except that the insured's right is for a limited period of more than one year rather than for life, shall contain the applicable one of the following statements, or such other statement which, in the opinion of the Director of the Department of Consumer and Business Services, is equally clear or more definite as to the subject matter:

(a) "THIS POLICY IS NONCANCELABLE _____" (designating the applicable period such as, for example, "to age ___ (specify)," or "for the period of ___ (specify) years from date of issuance") if the policy is noncancelable for such period.

(b) "THIS POLICY IS GUARANTEED RENEWABLE _____" (designating the applicable period such as, for example, "to age ___ (specify)," or "for the period of ___ (specify) years from date of issuance") if the policy is guaranteed renewable for such period.

(2) Except for policies meeting the conditions specified in ORS 743.495 or subsection (1) of this section, and except as provided in subsection (3) of this section, a health insurance policy shall contain the applicable one of the following statements, or such other statement which, in the opinion of the director, is equally clear or more definite as to the subject matter:

(a) "THIS POLICY MAY BE CANCELED BY THE INSURER ONLY FOR A REASON PERMITTED BY LAW" if the policy contains a provision for cancellation by the insurer.

(b) "THE INSURER MAY REFUSE TO RENEW THIS POLICY ONLY FOR A REASON PERMITTED BY LAW" if the policy is not guaranteed renewable.

(3) The limitations and requirements as to the use of terms contained in ORS 743.495 and this section shall not prohibit the use of other terms for policies having other guarantees of renewability, provided such terms, in the opinion of the director are accurate, clear and not likely to be confused with the terms contained in ORS 743.495 and this section, and are incorporated in a concise statement relating to the guarantees of renewability.

(4) The statement required by this section shall be printed in a type not smaller than the type used for captions. It shall appear prominently on the first page of the policy and shall be a part of the brief description if the policy has a brief description on its first page. [Formerly 741.200; 1989 c.784 §20a]

743.516 [1967 c.359 §459; repealed by 1999 c.987 §28]

743.519 [1967 c.359 §460; 1971 c.231 §25; repealed by 1999 c.987 §28]

743.520 [1971 c.231 §4; repealed by 1999 c.987 §28]

(Group and Blanket)

743.522 "Group health insurance" described. "Group health insurance" means that form of health insurance

covering groups of persons described in this section, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon one of the following bases:

(1)(a) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. As used in this paragraph, “employee” includes:

(A) The officers, managers, and employees of the employer;

(B) The individual proprietor or partners if the employer is an individual proprietor or partnership;

(C) The officers, managers, and employees of subsidiary or affiliated corporations;

(D) The individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise;

(E) The trustees or their employees, or both, if their duties are principally connected with such trusteeship; and

(F) The leased workers of a client employer.

(b) A policy issued to insure employees of a public body may provide that the term “employees” shall include elected or appointed officials.

(2) Under a policy issued to an association, including a labor union, that has an active existence for at least one year, that has a constitution and bylaws and that has been organized and is maintained in good faith primarily for purposes other than that of obtaining insurance, which shall be deemed the policyholder, insuring members, employees, or employees of members of the association for the benefit of persons other than the association or its officers or trustees.

(3) Under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in subsection (2) of this section, insuring employees of the employers or members of the unions or of such association, or employees of members of such association for the benefit of persons other than the employers or the unions or such association. The term “employees” as used in this subsection may include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term “employees” shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy.

(5) Group health insurance offered to a resident of this state under a group health insurance policy issued to a group other than one described in subsections (1) to (4) of this section may be delivered if:

(a) The Director of the Department of Consumer and Business Services finds that:

(A) The issuance of the policy is in the best interest of the public;

(B) The issuance of the policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged; and

(b) The premium for the policy is paid either from funds of a policyholder, from funds contributed by a covered person or from both.

(6) As used in this section and ORS 743.533:

(a) “Client employer” means an employer to whom workers are provided under contract and for a fee on a leased basis by a worker leasing company licensed under ORS 656.850.

(b) “Leased worker” means a worker provided by a worker leasing company licensed under ORS 656.850.

(c) “Employee” may include a retired employee. [1967 c.359 §461; 1975 c.229 §1; 1989 c.784 §13; 2001 c.943 §4]

743.523 Certain sales practices prohibited. (1) No person selling group health insurance is authorized to sell membership in an association, including a labor union, for the purpose of qualifying an applicant who is an individual for group health insurance.

(2) No person selling membership in an association, including a labor union, is authorized to offer group health insurance for the purpose of selling membership in the association. [1989 c.784 §10]

743.524 Eligibility of association to be group health policyholder; rules. (1) An insurer shall not offer a policy of group health insurance to an association as the policyholder or offer coverage under such a policy, whether issued in this or another state, unless the Director of the Department of Consumer and Business Services determines that the

association satisfies the requirements of an association under ORS 743.522 (2).

(2) An insurer shall submit evidence to the director that the association satisfies the requirements under ORS 743.522 (2). The director shall review the evidence and may request additional evidence as needed.

(3) An insurer shall submit to the director any changes in the evidence submitted under subsection (2) of this section.

(4) The director may order an insurer to cease offering health insurance to an association if the director determines that the association does not meet the standards under ORS 743.522 (2).

(5) The director may adopt rules to carry out this section. [1989 c.784 §11]

743.525 [1967 c.359 §462; repealed by 1981 c.752 §17]

743.526 Determination of whether trustees are policyholders; consequences. (1) An insurer shall not offer a policy of group health insurance described in ORS 743.522 (3) that insures persons in this state or offer coverage under such a policy, whether the policy is to be issued in this or another state, unless the Director of the Department of Consumer and Business Services determines that the requirements of this section and ORS 743.522 (3) are satisfied.

(2) The director shall determine with respect to a policy whether the trustees are the policyholder. If the director determines that the trustees are the policyholder and if the policy is issued or proposed to be issued in this state, the policy is subject to the Insurance Code. If the director determines that the trustees are not the policyholder, the evidence of coverage that is issued or proposed to be issued in this state to a participating employer, labor union or association shall be deemed to be a group health insurance policy subject to the provisions of the Insurance Code. The director may determine that the trustees are not the policyholder if:

(a) The evidence of coverage issued or proposed to be issued to a participating employer, labor union or association is in fact the primary statement of coverage for the employer, labor union or association; and

(b) The trust arrangement is under the actual control of the insurer.

(3) An insurer shall submit evidence to the director showing that the requirements of subsection (2) of this section and ORS 743.522 (3) are satisfied. The director shall review the evidence and may request additional evidence as needed.

(4) An insurer shall submit to the director any changes in the evidence submitted under subsection (3) of this section.

(5) The director may adopt rules to carry out this section. [1989 c.784 §12]

743.527 When group health insurance policies to continue in effect upon payment of premium by insured individual; conditions; required provisions; duration. (1) Every group health insurance policy delivered or issued for delivery in this state shall contain in substance the following provisions, applicable to the coverage for hospital or medical services or expenses provided under the policy:

(a) A provision that, when the premium for the policy or any part thereof is paid by an employer under the terms of a collective bargaining agreement, if there is a cessation of work by employees insured under the policy due to a strike or lockout, the policy, upon timely payment of the premium, will continue in effect with respect to those employees insured by the policy on the date of the cessation of work who continue to pay their individual contribution and who assume and pay the contribution due from the employer.

(b) A provision that, when an employee insured under the policy pays a contribution pursuant to paragraph (a) of this subsection, if the policyholder is not a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be:

(A) The rate in the policy, on the date cessation of work occurs, applicable to an individual in the class to which the employee belongs as set forth in the policy; or

(B) If the policy does not provide for a rate applicable to individuals, an amount equal to the amount determined by dividing the total monthly premium in effect under the policy at the date of cessation of work by the total number of persons insured under the policy on such date.

(c) A provision that, when an employee insured under the policy pays a contribution pursuant to paragraph (a) of this subsection, if the policyholder is a trustee of a fund established or maintained in whole or in part by an employer, the employee's individual contribution shall be the amount which the employee and employer would have been required to contribute if the cessation of work had not occurred.

(2) Every group health insurance policy delivered or issued for delivery in this state may contain in substance the following provisions applicable to the coverage for hospital or medical services or expenses provided under the policy:

(a) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, the continuation of insurance under the policy is contingent upon the collection of individual contributions by the union representing the employees when the policyholder is not a trustee and by the policyholder or the policyholder's agent when the policyholder is a trustee.

(b) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, the continuation of insurance under the policy on each employee is contingent upon timely payment of contributions by the employees and timely payment of the premium by the entity responsible for collecting the individual contributions.

(c) A provision that, when employees insured under the policy pay contributions pursuant to subsection (1)(a) of this section, each individual premium rate under the policy may be increased by not more than 20 percent, or by any higher percentage approved by the Director of the Department of Consumer and Business Services, during the period of cessation of work in order to provide sufficient compensation to the insurer for increased administrative costs and increased mortality and morbidity. If the policy contains the provision allowed under this paragraph, an employee's contribution paid under subsection (1)(a) of this section shall be increased by the same percentage.

(d) A provision that, when the policy is a policy insuring employees and which may continue in effect as provided in subsection (1)(a) of this section, if the premium is unpaid at the date of cessation of work and the premium became due prior to such cessation of work, the continuation of insurance is contingent upon payment of the premium prior to the date the next premium becomes due under the terms of the policy.

(e) Any provision with respect to the continuation of the policy as provided in subsection (1)(a) of this section that the director may approve.

(3) Nothing in this section shall be deemed to limit any right which the insurer may have in accordance with the terms of a policy to increase or decrease the premium rates before, during or after a cessation of work by employees insured under the policy when the insurer had the right to increase the premium rates even if the cessation of work did not occur. If such a premium rate change is made, it shall be effective on such date as the insurer shall determine in accordance with the terms of the policy.

(4) Nothing in this section shall be deemed to require continuation of any coverage in a group health insurance policy insuring employees and which may continue in effect as provided in subsection (1)(a) of this section for longer than:

(a) The time that 75 percent of insured employees continue such coverage;

(b) For an individual employee, the time at which the employee takes full-time employment with another employer; or

(c) Six months after cessation of work by the insured employees. [1979 c.797 §2; 1981 c.395 §1]

743.528 Required provisions in group health insurance policies. A group health insurance policy shall contain in substance the following provisions:

(1) A provision that, in the absence of fraud, all statements made by applicants, the policyholder or an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or the beneficiary of the person.

(2) A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member, to whom the insurance benefits are payable, and the applicable rights and conditions set forth in ORS 743.527, 743.529, 743.600 to 743.610 and 743.760. If dependents are included in the coverage, only one statement need be issued for each family unit.

(3) A provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy. [1967 c.359 §463; 1981 c.752 §13; 1997 c.716 §23]

743.529 Continuation of benefits after termination of group health insurance policy; rules. (1) Every group health insurance policy that provides coverage for hospital or medical services or expenses shall provide that the insurer shall continue its obligation for benefits under the policy for any person insured under the policy who is hospitalized on the date of termination if the policy is terminated and immediately replaced by a group health insurance policy issued by another insurer. Any payment required under this section is subject to all terms, limitations

and conditions of the policy except those relating to termination of benefits. Any obligation by an insurer under this section continues until the hospital confinement ends or hospital benefits under the policy are exhausted, whichever is earlier.

(2) The Director of the Department of Consumer and Business Services may adopt rules providing for uninterrupted coverage for individuals insured under a group health insurance policy providing coverage for hospital or medical expenses, when such a policy is replaced by a policy of similar benefits, whether issued by the same insurer or another. [1977 c.402 §5; 1991 c.182 §6]

743.530 Continuation of benefits after injury or illness covered by workers' compensation. Every policy of group health insurance delivered or issued for delivery in this state shall contain a provision applicable to the coverage for hospital or medical services or expenses provided under the policy that if an employee incurs an injury or illness for which a workers' compensation claim is filed, that policy will continue in effect with respect to that employee upon timely payment by the employee of the premium that includes the individual contribution and the contribution due from the employer under the applicable benefit plan. The employee may maintain such coverage until whichever of the following events first occurs:

(1) The employee takes full-time employment with another employer; or

(2) Six months from the date that the employee first makes payment under this section. [1985 c.634 §2]

743.531 Direct payment of hospital and medical services; rate limitations. (1) A group health insurance policy may on request by the group policyholder provide that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services. However, the amount of any such payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid. The amount of such payments pursuant to one or more assignments shall not exceed the amount of expenses incurred on account of such hospitalization or medical or surgical aid.

(2) Nothing in this section is intended to authorize an insurer to:

(a) Furnish or provide directly services of hospitals or physicians and surgeons; or

(b) Direct, participate in or control the selection of the specific hospital or physician and surgeon from whom the insured secures services or who exercises medical or dental professional judgment.

(3) Nothing in subsection (2) of this section prevents an insurer from negotiating and entering into contracts for alternative rates of payment with providers and offering the benefit of such alternative rates to insureds who select such providers. An insurer may utilize such contracts by offering a choice of plans at the time an insured enrolls, one of which provides benefits only for services by members of a particular provider organization with whom the insurer has an agreement. If an insured chooses such a plan, benefits are payable only for services rendered by a member of that provider organization, unless such services were requested by a member of such organization or are rendered as the result of an emergency.

(4) Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid.

(5) Insurers shall provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates under their group policy and shall also make such lists available for public inspection during regular business hours at the insurer's principal office within this state. [1967 c.359 §464; 1985 c.747 §71; 1989 c.784 §23]

743.532 [1987 c.782 §2; repealed by 1989 c.1044 §7]

743.533 Leased workers; offering group health insurance. (1) A leasing company may offer group health insurance to its leased workers. If the leasing company does not offer group health insurance to its leased workers, the client employer may offer group health insurance to the leased workers.

(2) If a leasing company offers group health insurance to its leased workers, the leasing company shall offer group health insurance to all its leased workers in the same manner. [2001 c.943 §5]

743.534 "Blanket health insurance" defined. "Blanket health insurance" means that form of a health insurance covering groups of persons defined in this section and issued on one of the following bases:

(1) Under a policy issued to a common carrier or to an operator, owner or lessee of a means of transportation, who shall be deemed the policyholder, insuring a group of persons who may become passengers and which group is defined

by reference to their travel status on such common carrier or means of transportation.

(2) Under a policy issued to an employer, who shall be deemed the policyholder, insuring any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder.

(3) Under a policy issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, insuring students, teachers or employees.

(4) Under a policy issued to a religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, insuring any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(5) Under a policy issued to a sports team, camp or sponsor thereof, who shall be deemed the policyholder, insuring members, campers, employees, officials or supervisors.

(6) Under a policy issued to a volunteer fire department, first aid, civil defense, or other such volunteer organization, which shall be deemed the policyholder, insuring any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(7) Under a policy issued to a newspaper or other publisher, which shall be deemed the policyholder, insuring its carriers.

(8) Under a policy issued to an association, including a labor union, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, insuring any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder.

(9) Under a policy issued to cover any other risk or class of risks which, in the discretion of the Director of the Department of Consumer and Business Services, may be properly eligible for blanket health insurance. The discretion of the director may be exercised on an individual risk basis or class of risks basis, or both. [1967 c.359 §465]

743.537 Required provisions, blanket health insurance policies. A blanket health insurance policy shall contain provisions which in the opinion of the Director of the Department of Consumer and Business Services are not less favorable to the policyholder and the individual insureds than the provisions described in ORS 743.411, 743.423, 743.426, 743.429, 743.432, 743.438 and 743.441. [1967 c.359 §466]

743.540 Application and certificates not required, blanket health insurance policies. An individual application need not be required from a person insured under a blanket health insurance policy, nor shall it be necessary for the insurer to furnish each person a certificate. [1967 c.359 §467]

743.543 Payment of benefits; blanket health insurance policies. All benefits under a blanket health insurance policy shall be payable to the person insured, or to the designated beneficiary or beneficiaries of the person, or to the estate of the person, except that if the person insured is a minor or otherwise not competent to give a valid release, such benefits may be made payable to the parent, guardian or other person actually supporting the person. However, the policy may provide that all or a portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid. [1967 c.359 §468]

743.546 Policy form approval, blanket health insurance. The Director of the Department of Consumer and Business Services may exempt from the policy form filing and approval requirements of ORS 742.003, for so long as the director deems proper, any blanket health insurance policy to which in the opinion of the director such requirements may not practicably be applied, or may dispense with such filing and approval whenever, in the opinion of the director, it is not desirable or necessary for the protection of the public. [1967 c.359 §469]

743.549 Restriction on reduction of benefits provisions in group and blanket health policies. No group or blanket health insurance policy providing hospital, medical or surgical expense benefits, and which contains a provision for the reduction of benefits otherwise payable thereunder on the basis of other existing coverages, shall

provide that such reduction operates to reduce total benefits payable below an amount equal to 100 percent of total allowable expenses, except as provided for in a collective bargaining agreement. [1973 c.143 §2; 1989 c.1080 §2]

743.550 Student health insurance; application of ORS 743.537, 743.540, 743.543, 743.546 and 743.549; coverage when other coverage available; policy provisions; alternative rates for providers. (1) Student health insurance is subject to ORS 743.537, 743.540, 743.543, 743.546 and 743.549, except as provided in this section.

(2) Coverage under a student health insurance policy may be mandatory for all students at the institution, voluntary for all students at the institution, or mandatory for defined classes of students and voluntary for other classes of students. As used in this subsection, "classes" refers to undergraduates, graduate students, domestic students, international students or other like classifications. Any differences based on a student's nationality may be established only for the purpose of complying with federal law in effect when the policy is issued.

(3) When coverage under a student health insurance policy is mandatory, the policyholder may allow any student subject to the policy to decline coverage if the student provides evidence acceptable to the policyholder that the student has similar health coverage.

(4) A student health insurance policy may provide for any student to purchase optional supplemental coverage.

(5) Student health insurance coverage for athletic injuries may:

(a) Exclude coverage for injuries of students who have not obtained medical release for a similar injury; and

(b) Be provided in excess of or in addition to any other coverage under any other health insurance policy, including a student health insurance policy.

(6) A student health insurance policy may provide that coverage under the policy is secondary to any other health insurance for purposes of guidelines established under ORS 743.552.

(7) A student health insurance policy may provide, on request by the policyholder, that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services. However, the amount of any such payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid. The amount of such payments pursuant to one or more assignments shall not exceed the amount of expenses incurred on account of such hospitalization or medical or surgical aid.

(8) An insurer providing student health insurance as primary coverage may negotiate and enter into contracts for alternative rates of payment with providers and offer the benefit of such alternative rates to insureds who select such providers. An insurer may utilize such contracts by offering a choice of plans at the time an insured enrolls, one of which provides benefits only for services by members of a particular provider organization with whom the insurer has an agreement. If an insured chooses such a plan, benefits are payable only for services rendered by a member of that provider organization, unless such services were requested by a member of such organization or are rendered as the result of an emergency.

(9) Payments made under subsection (8) of this section shall discharge the insurer's obligation with respect to the amount of insurance paid.

(10) An insurer shall provide each student health insurance policyholder with a current roster of institutional and professional providers under contract to provide services at alternative rates under the group policy and shall also make such lists available for public inspection during regular business hours at the insurer's principal office within this state.

(11) As used in this section, "student health insurance" means that form of health insurance under a policy issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or recognized student government at an institution of higher education within the Oregon University System, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, that is available exclusively to students at the college, school or other institution. [1995 c.623 §2]

743.552 Guidelines for application of ORS 743.549; rules. The Director of the Department of Consumer and Business Services shall by rule establish guidelines for the application of ORS 743.549, including:

(1) The procedures by which persons insured under such policies are to be made aware of the existence of such a provision;

(2) The benefits which may be subject to such a provision;

(3) The effect of such a provision on the benefits provided;

(4) Establishment of the order of benefit determination; and

(5) Reasonable claim administration procedures to expedite claim payments under such a provision which shall include a time limit of 14 days beyond which the insurer shall not delay payment of a claim by reason of the

application of coordination of benefits provision. [1973 c.143 §3]

743.555 Application of ORS 743.549 and 743.552. ORS 743.549 and 743.552 shall apply to any group or blanket health insurance policy containing a provision described in ORS 743.549 which is issued more than 90 days after June 26, 1973. Policies which are in existence 90 days after June 26, 1973, shall be brought into compliance on the next anniversary date, renewal date or the expiration date of the applicable collectively bargained contract, if any, whichever date is latest. [1973 c.143 §4]

743.556 Group health insurance coverage for treatment of chemical dependency, including alcoholism, and for mental or nervous conditions; rules. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcoholism and for mental or nervous conditions. The following conditions apply to the requirement for such coverage:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment provided in health care facilities, residential programs or facilities, day or partial hospitalization programs or outpatient services shall be considered eligible for reimbursement if it is provided by:

(a) Programs or providers described in ORS 430.010 or approved by the Department of Human Services under subsection (3) of this section.

(b) Programs accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities.

(c) Inpatient programs provided by health care facilities as defined in ORS 442.015. Residential, outpatient, or day or partial hospitalization programs offered by or through a health care facility must meet the requirements of either paragraph (a) or (b) of this subsection in order to be eligible for reimbursement.

(d) Residential programs or facilities described in subsection (3) of this section if the patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week.

(e) Programs in which staff are directly supervised or in which individual client treatment plans are approved by a person described in ORS 430.010 (4)(a) and which meet the standards established under subsection (3) of this section.

(3) Subject to ORS 430.065, the Department of Human Services shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient chemical dependency programs that are not related to the department or any county mental health program. The department shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient programs for mental or nervous conditions that are not related to the department or any county mental health program.

(4) A program that provides services for persons with both a chemical dependency diagnosis and a mental or nervous condition shall be considered to be a distinct and specialized type of program for both chemical dependency and mental or nervous conditions. The Department of Human Services shall develop specific standards related to such programs for program approval purposes and shall adopt rules relating to the approval, for insurance reimbursement purposes, of such noninpatient programs that are not related to the department and any county mental health program.

(5) As used in this section:

(a) “Chemical dependency” means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual’s social, psychological or physical adjustment to common problems on a recurring basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) “Child or adolescent” means a person who is 17 years of age or younger.

(c) “Facility” means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(d) “Program” means a particular type or level of service that is organizationally distinct within a facility.

(6) Notwithstanding the limits for particular types of services specified in this section, a policy shall not limit the total of payments for all treatment of any kind under this section for chemical dependency, together with payments for all treatment of any kind for mental or nervous conditions, to less than $13,125 for adults and $15,625 for children or adolescents. For persons requesting payments for treatment of any kind for chemical dependency, but not requesting payments for treatment of any kind of mental or nervous condition, a policy shall not limit the total of payments for all

treatment to less than $8,125 for adults and $13,125 for children and adolescents.

(7) The limits for mental or nervous conditions specified in this section shall apply to persons with diagnoses of both chemical dependency and mental or nervous conditions, who are being treated for both types of diagnosis, as well as persons with only a diagnosis of a mental or nervous condition.

(8) The higher benefit levels in this section for children or adolescents are in recognition of the longer period of treatment and the greater levels of staffing that may be required for children or adolescents and are intended to permit more services to meet the needs of children and adolescents.

(9) Payments shall not be made under this section for educational programs to which drivers are referred by the judicial system, nor for volunteer mutual support groups.

(10) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for inpatient treatment in hospitals and other health care facilities thereunder:

(a) For chemical dependency to an amount less than $5,625 for adults and $5,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $5,000 for adults and $7,500 for children or adolescents.

(11) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for treatment in residential programs or facilities or day or partial hospitalization programs:

(a) For chemical dependency to an amount less than $4,375 for adults and $3,750 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $1,250 for adults and $3,125 for children or adolescents.

(12) Notwithstanding the minimum benefits for particular types of services specified in subsections (10) and (11) of this section, and except as permitted by subsection (1) of this section, the policy shall not limit total payments for inpatient, residential and day or partial hospitalization program care or treatment:

(a) For chemical dependency to an amount less than $10,625 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $10,625 for adults and $13,125 for children or adolescents.

(13) Except as permitted by subsections (1) and (6) of this section, in the case of benefits for outpatient services, the policy shall not limit payments:

(a) For chemical dependency to an amount less than $1,875 for adults and $2,500 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than $2,500.

(14) If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health care facility, residential, day or partial hospitalization or outpatient services. The policy may limit coverage for in-home service to persons who have completed their initial health care facility, residential, day or partial hospitalization or outpatient treatment and did not terminate that initial treatment against advice. The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made.

(15) Under ORS 430.021 and 430.315, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(16) A group health insurance policy may provide, with respect to treatment for chemical dependency or mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state:

(a) Proportion of coinsurance required for treatment in residential programs or facilities, day or partial hospitalization programs or outpatient services less than the proportion of coinsurance required for treatment in health care facilities.

(b) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists and ORS 40.250 and 675.580 relating to licensed clinical social workers, review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either insurer staff or personnel under contract to the insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment:

(A) This review shall be made according to criteria made available to providers in advance upon request.

(B) To facilitate implementation of utilization review programs by insurers, the Director of Human Services shall

draft an advisory or model set of criteria for appropriate utilization of inpatient, residential, day or partial hospitalization, and outpatient facilities, programs and services by adults, children and adolescents, and persons with both a chemical dependency diagnosis and a mental or nervous condition. These criteria shall be consistent with this section and shall not be binding on any insurer or other party. However, at the time of contract negotiation or amendment, with the agreement of the parties to the contract, any insurer may adopt the criteria or similar criteria with or without modification. The director shall revise these criteria at least every two years. In developing and revising these criteria, the director shall organize a technical advisory panel including representatives of the Department of Consumer and Business Services, the Department of Human Services, the insurance industry, the business community and providers of each level of care. The director shall place substantial weight on the advice of this panel.

(C) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon; a psychologist licensed by the State Board of Psychologist Examiners; a nurse practitioner registered by the Oregon State Board of Nursing; or a clinical social worker licensed by the State Board of Clinical Social Workers, with physician consultation readily available. The reviewer shall have expertise in the evaluation of mental or nervous condition services or chemical dependency services.

(D) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, insurers shall permit treatment providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Insurers shall provide a timely response to such inquiries. Approval of a particular admission does not represent a guarantee of future payment.

(E) An appeals process shall be provided.

(F) An insurer may choose to review all providers on a sampling or audit basis only; or to review on a less frequent basis those providers who consistently supply full documentation, consistent with confidentiality statutes on each case in a timely fashion to the insurer.

(17) For purposes of subsection (16)(b) of this section, a utilization review contractor is a professional review organization or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(18) For purposes of subsection (16)(b) of this section, when implemented through an insurance contract, reimbursability of inpatient treatment requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in:

(a) The current living situation;

(b) An alternative, nontreatment living situation;

(c) An alternative residential program or facility; or

(d) A day or partial hospitalization program.

(19) For purposes of subsection (16)(b) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential, day or partial hospitalization level of treatment shall require demonstration that outpatient services, if appropriate and less costly than residential, day or partial hospitalization services:

(a) Are not presently appropriate and available;

(b) Cannot be readily and timely made available; and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situations; risks to self or others; and readiness to participate consistently in treatment.

(20) For purposes of subsection (16)(b) of this section, reimbursability of treatment at the level for outpatient facility, service or program shall require demonstration that treatment is justified, considering the individual’s history, and the current medical, occupational, social and psychological situation, and the overall prognosis.

(21) Discrete medical or neurologic diagnostic or treatment services including any professional component of that service, costing in excess of $300, occurring concurrently with but not directly related to treatment of mental or nervous conditions shall not be charged against the inpatient benefit level.

(22) The benefits described in this section shall renew in full either on the first day of the 25th month of coverage following the first use of services for the treatment of chemical dependency or mental or nervous conditions, or both, or on the first day following two consecutive contract years.

(23) Health maintenance organizations, as defined in ORS 750.005 (3), shall be subject to the following conditions and requirements in their provision of benefits for chemical dependency or mental or nervous conditions to enrollees:

(a) Notwithstanding the provisions of subsection (1) of this section, health maintenance organizations may establish reasonable provisions for enrollee cost-sharing, so long as the amount the enrollee is required to pay does not exceed the amount of coinsurance and deductible customarily required by other insurance policies which are subject to the provisions of this chapter for that type and level of service.

(b) Nothing in this section prevents health maintenance organizations from establishing durational limits which are actuarially equivalent to the benefits required by this section.

(c) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers associated with the health maintenance organization.

(d) The Department of Human Services shall make rules establishing objective and quantifiable criteria for determining when a health maintenance organization meets the conditions and requirements of this subsection.

(24) Nothing in this section shall prevent an insurer or health care service contractor other than a health maintenance organization, except as provided in subsection (23) of this section, from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) An insurer or health care service contractor may establish limits for contracted services which are actuarially equivalent to the benefits required by this section, so long as the same range of treatment settings is made available.

(b) An insurer or health care service contractor, other than a health maintenance organization, may negotiate with contracting providers as to the cost of actuarially equivalent benefits, and such actuarially equivalent benefits for services of contracting providers shall be deemed to equal the minimum benefit levels specified in this section.

(c) An insurer or health care service contractor is not required to contract with all eligible providers, and payment for covered services of contracting providers may be in alternative methods or amounts rather than as specified in this section.

(d) Insurers and health care service contractors other than health maintenance organizations shall pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions at the same level of deductible or coinsurance as would apply to covered charges of noncontracting providers of other health services under the same group policy or contract. The insured shall have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions. Policies described in this subsection shall be subject to the provisions of subsection (1) of this section, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(e) The department shall make rules establishing objective and quantifiable criteria for determining that a contract meets the conditions and requirements of this subsection and that actuarially equivalent services of contracting providers equal or exceed services obtainable with the minimum benefits specified in this section.

(25) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to assure continuing access to levels of care most appropriate for the insured's condition and progress.

(26) The director, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions. [1987 c.411 §2; 1989 c.721 §55; 1991 c.67 §198; 1991 c.470 §19; 1991 c.654 §2; 1999 c.1086 §1; 2001 c.900 §217]

Note: Section 6a, chapter 916, Oregon Laws 1991, provides:

Sec. 6a. Legislative Assembly to determine whether Health Services Commission priority list to replace mandated benefits. The Legislative Assembly shall determine whether the funded Health Services Commission priority list shall replace mandated benefits in ORS 743.556. [1991 c.916 §6a]

Note: Section 7, chapter 411, Oregon Laws 1987, provides:

Sec. 7. Application of ORS 743.700 to ORS 743.556 and 750.055. ORS 743.145 [renumbered 743.700] does not apply to section 2 of this Act [743.556] because section 2 of this Act constitutes a reenactment of ORS 743.557 and 743.558 or to ORS 750.055 because of its amendment by this Act. [1987 c.411 §7]

743.557 [1975 c.698 §2; 1977 c.632 §3; 1981 c.319 §2; 1983 c.601 §5; repealed by 1987 c.411 §9]

743.558 [1973 c.613 §2; 1983 c.601 §6; repealed by 1987 c.411 §9]

743.559 [1983 c.601 §12; repealed by 1991 c.182 §20]

743.560 Minimum grace period; notice upon termination of policy; effect of failure to notify. (1) A group health insurance policy shall contain a provision allowing a minimum grace period of 10 days after the premium due date for payment of premium.

(2) An insurer of a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, that seeks to terminate a policy for nonpayment of premium shall notify the policyholder as described in ORS 743.565.

(3) An insurer of a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall notify the group policyholder when the policy is terminated and the coverage is not replaced by the group policyholder. The notice required under this subsection:

(a) Must be given on a form prescribed by the Department of Consumer and Business Services;

(b) Must explain the rights of the certificate holders regarding continuation of coverage provided by federal and state law and portability coverage in accordance with ORS 743.760; and

(c) Must be given by mail and must be mailed not later than 10 working days after the date on which the group policy terminates according to the terms of the policy.

(4) A group health insurance policy to which subsection (3) of this section applies shall contain a provision requiring the insurer to notify the group policyholder when the policy is terminated and the coverage is not replaced by the group policyholder. Each certificate issued under the policy shall also contain a statement of the provision required under this subsection.

(5) If an insurer fails to give notice as required by this section, the insurer shall continue the group health insurance policy of the group policyholder in full force from the date notice should have been provided until the date that the notice is received by the policyholder and shall waive the premiums owing for the period for which the coverage is continued under this subsection. The time period within which the certificate holder may exercise any right to continuation or portability shall commence on the date that the policyholder receives the notice.

(6) The insurer shall supply the employer holding the terminated policy with the necessary information for the employer to be able to notify properly the employee of the employee's right to continuation of coverage under state and federal law and portability coverage in accordance with ORS 743.760. [1991 c.673 §§3,4; 1993 c.454 §1; 1997 c.716 §24; 2001 c.943 §11]

743.561 [Formerly 739.565; renumbered 743.371 in 1989]

743.562 Applicability of ORS 743.560. ORS 743.560 applies to multiple employer trusts when an employer ceases to participate therein. [1991 c.673 §5]

743.564 [Formerly 739.570; 1969 c.336 §13; 1989 c.1073 §1; renumbered 743.372 in 1989]

743.565 Separate notice to policyholder required before cancellation of individual or group health insurance policy for nonpayment of premium. Before a health insurer selling an individual policy or group health benefit plan, as defined in ORS 743.730, may cancel a policy for nonpayment of premium, the insurer must mail a separate notice to the policyholder at least 10 days prior to the end of the grace period informing the policyholder that the premium was not received and that the policy will be terminated as of the premium due date if the premium is not received by the end of the applicable grace period required by ORS 743.417 and 743.560. The notice shall be in writing and mailed by first class mail to the last-known address of the policyholder. [2001 c.943 §8]

743.566 Rules for certain notice requirements. The Director of the Department of Consumer and Business Services shall adopt rules necessary for the implementation and administration of ORS 743.565 and the amendments to ORS 743.417, 743.420, 743.560, 743.737, 743.754 and 743.766 by sections 9 to 14, chapter 943, Oregon Laws 2001. [2001 c.943 §16]

Note: 743.566 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 743 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

743.567 [Formerly 739.575; renumbered 743.373 in 1989]

743.570 [1967 c.359 §473; renumbered 743.374 in 1989]

743.573 [Formerly 741.425; renumbered 743.375 in 1989]

743.576 [Formerly 739.585; renumbered 743.376 in 1989]

743.579 [Formerly 739.590; renumbered 743.377 in 1989]

743.582 [Formerly 739.600; renumbered 743.378 in 1989]

743.585 [Formerly 739.603; renumbered 743.379 in 1989]

743.588 [Formerly 739.610; renumbered 743.380 in 1989]

(Continuation)

743.600 Availability of continued coverage under group policy for surviving, divorced or separated spouse 55 or older. (1) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision that:

(a) The surviving spouse of a certificate holder may continue coverage under the policy, at the death of the certificate holder, with respect to the spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death of the certificate holder if the surviving spouse is 55 years of age or older at the time of the death; and

(b) The divorced or legally separated spouse of a certificate holder may continue coverage under the policy, upon dissolution of marriage with, or legal separation from, the certificate holder, with respect to the divorced or legally separated spouse and any dependent children whose coverage under the policy otherwise would terminate because of the dissolution of marriage or legal separation, if the divorced or legally separated spouse is 55 years of age or older at the time of the dissolution or legal separation.

(2) Continued coverage for dental, vision care or prescription drug expenses shall be offered to legally separated, divorced or surviving spouses and any dependent children eligible under subsection (1) of this section if such coverage is or was available to the certificate holder. [Formerly 743.851]

743.601 Procedure for obtaining continuation of coverage under ORS 743.600. (1) As used in subsections (1) to (6) of this section, “plan administrator” means:

(a) The person designated as the plan administrator by the instrument under which the group health insurance plan is operated; or

(b) If no plan administrator is designated, the plan sponsor.

(2) Within 60 days of legal separation or the entry of a decree of dissolution of marriage, a legally separated or divorced spouse eligible for continued coverage under ORS 743.600 who seeks such coverage shall give the plan administrator written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse.

(3) Within 30 days of the death of a certificate holder whose surviving spouse is eligible for continued coverage under ORS 743.600, the group policyholder shall give the plan administrator written notice of the death and of the mailing address of the surviving spouse.

(4) Within 14 days of receipt of notice under subsection (2) or (3) of this section, the plan administrator shall notify the legally separated, divorced or surviving spouse that the policy may be continued. The notice shall be mailed to the mailing address provided to the plan administrator and shall include:

(a) A form for election to continue the coverage;

(b) A statement of the amount of periodic premiums to be charged for the continuation of coverage and of the method and place of payment; and

(c) Instructions for returning the election form by mail within 60 days after the date of mailing of the notice by the

plan administrator.

(5) Failure of the legally separated, divorced or surviving spouse to exercise the election in accordance with subsection (4) of this section shall terminate the right to continuation of benefits.

(6) If a plan administrator fails to notify the legally separated, divorced or surviving spouse as required by subsection (4) of this section, premiums shall be waived from the date the notice was required until the date notice is received by the legally separated, divorced or surviving spouse.

(7) The provisions of ORS 743.600 to 743.602 apply only to employers with 20 or more employees and group health insurance plans with 20 or more certificate holders. [Formerly 743.852]

743.602 Premium for continuation of coverage under ORS 743.600; termination of right to continuation. If a legally separated, divorced or surviving spouse elects continuation of coverage under ORS 743.601 (1) to (6):

(1) The monthly premium for the continuation shall not be greater than the amount that would be charged if the legally separated, divorced or surviving spouse were a current certificate holder of the group plan plus the amount that the group policyholder would contribute toward the premium if the legally separated, divorced or surviving spouse were a certificate holder of the group plan, plus an additional amount not to exceed two percent of the certificate holder and group plan holder contributions, for the costs of administration.

(2) The first premium shall be paid by the legally separated, divorced or surviving spouse within 45 days of the date of the election.

(3) The right to continuation of coverage shall terminate upon the earliest of any of the following:

(a) The failure to pay premiums when due, including any grace period allowed by the policy;

(b) The date that the group policy is terminated as to all group members except that if a different group policy is made available to group members, the legally separated, divorced or surviving spouse shall be eligible for continuation of coverage as if the original policy had not been terminated;

(c) The date on which the legally separated, divorced or surviving spouse becomes insured under any other group health plan;

(d) The date on which the legally separated, divorced or surviving spouse remarries and becomes covered under another group health plan; or

(e) The date on which the legally separated, divorced or surviving spouse becomes eligible for federal Medicare coverage. [Formerly 743.853]

743.603 [Formerly 744.070; renumbered 742.200 in 1989]

743.606 [1967 c.359 §481; 1967 c.453 §3; renumbered 742.202 in 1989]

743.607 [1967 c.453 §2; renumbered 742.204 in 1989]

743.609 [1967 c.359 §482; 1971 c.231 §26; renumbered 742.206 in 1989]

743.610 Continuation of coverage under group policy upon termination of employment or membership or dissolution of marriage; applicability of waiting period to rehired employee. (1) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision that certificate holders whose coverage under the policy otherwise would terminate because of termination of employment or membership may continue coverage under the policy for themselves and their eligible dependents as provided in this section.

(2) Continuation of coverage shall be available only to a certificate holder who has been insured continuously under the policy or similar predecessor policy during the three-month period ending on the date of the termination of employment or membership.

(3) Continuation of coverage shall not be available to a certificate holder who is eligible for:

(a) Federal Medicare coverage; or

(b) Coverage for hospital or medical expenses under any other program which was not covering the certificate holder immediately before the certificate holder’s termination of employment or membership.

(4) The continued coverage need not include benefits for dental, vision care or prescription drug expense, or any other benefits under the policy additional to hospital and medical expense benefits.

(5) A certificate holder who has terminated employment or membership and who wishes to continue coverage must

request continuation in writing not later than 10 days after the later of the date on which employment or membership terminated and the date on which the employer or group policyholder gave the certificate holder notice of the right to continue coverage. However, a certificate holder may not make a request for continuation more than 31 days after the date of termination of employment or membership.

(6) A certificate holder who requests continuation of coverage must pay the premium on a monthly basis and in advance, as provided in this subsection. The certificate holder shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment may not exceed the group premium rate, for the insurance being continued under the group policy, as of the date the premium payment is due. The certificate holder must pay the first premium not later than 31 days after the date on which the certificate holder's coverage under the policy otherwise would end.

(7) Continuation of coverage as provided under this section shall end upon the earliest of the following dates:

(a) Six months after the date on which the certificate holder's coverage under the policy otherwise would have ended because of termination of employment or membership.

(b) The end of the period for which the certificate holder last made timely premium payment, if the certificate holder fails to make timely payment of a required premium payment.

(c) The premium payment due date coinciding with or next following the date the certificate holder becomes eligible for federal Medicare coverage.

(d) The date on which the policy is terminated or the certificate holder's employer terminates participation under the policy. However, if the employer replaces the coverage which is terminating for the certificate holder with similar coverage under another group policy:

(A) The certificate holder may obtain coverage under the replacement group policy for the balance of the period that the certificate holder would have remained covered under the replaced group policy under this section;

(B) The minimum level of benefits to be provided the certificate holder by the replacement group policy shall be the applicable level of benefits of the replaced policy reduced by any benefits still payable under that policy; and

(C) The replaced policy shall continue to provide benefits to the certificate holder to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred.

(8) The group health insurance policy also shall contain a provision that:

(a) The surviving spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under the policy, at the death of the certificate holder, with respect to the spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death, in the same manner that a certificate holder may exercise the right under this section.

(b) The spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under the policy, upon dissolution of marriage with the certificate holder, with respect to the spouse and any children whose coverage under the policy otherwise would terminate because of the dissolution of marriage, in the same manner that a certificate holder may exercise the right under this section.

(c) A spouse who requests continuation of coverage under this subsection must pay the premium for the spouse and any dependent children, on a monthly basis and in advance, as provided in this paragraph. The spouse shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment under this subsection may not exceed the group premium rate, for the insurance being continued under the group policy, as of the date the premium payment is due.

(9) A certificate holder who has terminated employment by reason of layoff shall not be subject upon any rehire that occurs within six months of the time of the layoff to any waiting period prerequisite to coverage under the employer's group health insurance policy if the certificate holder was eligible for coverage at the time of the termination and regardless of whether the certificate holder continued coverage during the layoff.

(10) This section applies only to employers who are not required to make available continuation of health insurance benefits under Titles X and XXII of the Consolidated Omnibus Reconciliation Act of 1985, as amended, P.L. 99-272, April 7, 1986. [Formerly 743.850]

743.611 [Formerly 743.855; 1991 c.673 §6; repealed by 1995 c.603 §42]

743.612 [1967 c.359 §483; 1985 c.465 §3; renumbered 742.208 in 1989]

743.613 [Formerly 743.860; repealed by 1995 c.603 §42]

743.614 [Formerly 743.865; repealed by 1995 c.603 §42]

743.615 [1967 c.359 §484; renumbered 742.210 in 1989]

743.616 [Formerly 743.870; repealed by 1995 c.603 §42]

743.617 [Formerly 743.875; repealed by 1995 c.603 §42]

743.618 [1967 c.359 §485; renumbered 742.212 in 1989]

743.619 [Formerly 743.880; repealed by 1995 c.603 §42]

743.620 [Formerly 743.885; repealed by 1995 c.603 §42]

743.621 [1967 c.359 §486; renumbered 742.214 in 1989]

743.622 [Formerly 743.890; repealed by 1995 c.603 §42]

743.624 [1967 c.359 §487; renumbered 742.216 in 1989]

743.627 [1967 c.359 §488; renumbered 742.218 in 1989]

743.630 [1967 c.359 §489; renumbered 742.220 in 1989]

743.633 [1967 c.359 §490; renumbered 742.222 in 1989]

743.636 [1967 c.359 §491; 1989 c.426 §2; renumbered 742.224 in 1989]

743.639 [1967 c.359 §492; renumbered 742.226 in 1989]

743.642 [1967 c.359 §493; renumbered 742.228 in 1989]

743.645 [1967 c.359 §494; 1989 c.426 §1; renumbered 742.230 in 1989]

743.648 [1967 c.359 §495; renumbered 742.232 in 1989]

(Long Term Care)

743.650 Long Term Care Insurance Act; purpose; application. (1) ORS 743.650 to 743.656, 748.603 and 750.055 may be known and cited as the "Long Term Care Insurance Act."

(2) The purpose of ORS 743.650 to 743.656, 748.603 and 750.055 is to:

(a) Promote the public interest in long term care insurance;

(b) Promote the availability of long term care insurance policies;

(c) Protect applicants for long term care insurance from unfair or deceptive sales or enrollment practices;

(d) Establish standards for long term care insurance;

(e) Facilitate public understanding and comparison of long term care insurance policies;

(f) Facilitate flexibility and innovation in the development of long term care insurance coverage; and

(g) Assure that Oregon residents who purchase insurance for long term care shall have access to policies providing for a comprehensive range of benefits.

(3) The requirements of ORS 743.650 to 743.656, 748.603 and 750.055 apply to policies and certificates delivered or issued for delivery in this state on or after December 31, 1989. ORS 743.650 to 743.656, 748.603 and 750.055 are not intended to supersede the obligations of entities subject to ORS 743.650 to 743.656, 748.603 and 750.055 to comply with the substance of other applicable insurance laws insofar as such laws do not conflict with ORS 743.650 to 743.656, 748.603 and 750.055, except that laws and rules designed and intended to apply to Medicare supplement

insurance policies shall not be applied to long term care insurance. A policy that is not advertised, marketed or offered as long term care insurance or nursing home insurance is not required to meet the requirements of ORS 743.650 to 743.656, 748.603 and 750.055. [1989 c.1022 §§1,2,3]

743.651 [1967 c.359 §496; renumbered 742.234 in 1989]

743.652 Definitions for ORS 743.650 to 743.656. As used in ORS 743.650 to 743.656, 748.603 and 750.055, unless the context requires otherwise:

(1) "Applicant" means:

(a) In the case of an individual long term care insurance policy, the person who seeks to contract for benefits; and

(b) In the case of a group long term care insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group long term care insurance policy, if the policy has been delivered or issued for delivery in this state.

(3) "Director" means the Director of the Department of Consumer and Business Services.

(4) "Elimination period" means the period at the beginning of a disability during which no benefits are payable.

(5) "Functionally necessary" or "functionally impaired" means a need of a person who is not able to perform independently activities of daily living because of a physical or cognitive impairment.

(6) "Group long term care insurance" means a long term care insurance policy that is delivered or issued for delivery in this state and issued to:

(a) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations; or

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(A) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(B) Has been maintained in good faith for purposes other than obtaining insurance; or

(c)(A) An association or a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations shall file evidence with the director that the association or associations have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(i) The association or associations hold regular meetings not less than annually to further purposes of the members;

(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(iii) The members have voting privileges and representation on the governing board and committees; and

(B) Sixty days after such filing, the association or associations shall be considered to satisfy such organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements; and

(d) A group other than as described in paragraphs (a), (b) and (c) of this subsection, subject to a finding by the director that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

(B) The issuance of the group policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged.

(7) "Long term care insurance" means any insurance advertised, marketed, offered or designed to provide coverage for not less than 24 months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more functionally necessary or medically necessary services, including but not limited to nursing, diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. "Long term care insurance" includes group and individual policies or riders whether issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; or health maintenance organizations, health care service contractors or any similar organization. "Long term care insurance" shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, accident only coverage, specified disease or specified accident coverage.

(8) “Policy” means any policy, contract, subscriber agreement, rider or indorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital or medical service corporation; prepaid health plan; or health maintenance organization, health care service contractor or any similar organization. [1989 c.1022 §4; 1993 c.744 §30; 1995 c.79 §364]

743.653 Prohibition on certain policies. No group long term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in ORS 743.652 (6)(d), unless the other state has statutory and regulatory long term care insurance requirements substantially similar to those adopted in this state and the Director of the Department of Consumer and Business Services has made a determination that such requirements are substantially similar. [1989 c.1022 §5; 1991 c.67 §199]

743.654 [1967 c.359 §497; renumbered 742.236 in 1989]

743.655 Rules; disclosure; contents of policy. (1)(a) The Director of the Department of Consumer and Business Services shall adopt rules that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, program for public understanding, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, underwriting at time of application, requirements for replacement, recurrent conditions and definitions of terms. The director shall adopt rules establishing standards for loss ratios and reserves, provided that a specific reference to long term care insurance is contained in the rules.

(b) In adopting rules setting standards under this section, the director shall give timely notice to, and shall consider recommendations from the Director of Human Services.

(2) No long term care insurance policy shall:

(a) Be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care. This evaluation of the amount of coverage provided shall be based on aggregate days of care covered for lower levels of care, when compared to days of care covered for skilled care;

(d) Exclude coverage for Alzheimer’s disease and related dementias;

(e) Be nonrenewed or otherwise terminated for nonpayment of premiums until 31 days overdue and then only after notice of nonpayment is given the policyholder prior to expiration of the 31 days; or

(f) Be sold after December 31, 1989, to provide less than 24 months’ coverage.

(3)(a) No long term care insurance policy or certificate other than a policy or certificate issued to a group, as defined in ORS 743.652 (6)(a), (b) or (c), shall use a definition of “preexisting condition” which is more restrictive than the following: “Preexisting condition” means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(b) No long term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in ORS 743.652 (6)(a), (b) or (c) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(c) The director may extend the limitation periods set forth in paragraphs (a) and (b) of this subsection as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, over the 10 years immediately prior to the date of application, and, on the basis of the answers on the application, from underwriting in accordance with that insurer’s established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) of

this subsection expires. No long term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b) of this subsection, unless such waiver or rider has been specifically approved by the director.

(4) No long term care insurance policy shall be delivered or issued for delivery in this state if the policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement; or

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care.

(5)(a) Individual long term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(b) A person insured under a long term care insurance policy or certificate issued in this state or any other state to a group described in ORS 743.652 (6)(b), (c) or (d) shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long term care insurance policies shall have a notice prominently printed in 10 point type on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(6)(a) An outline of coverage shall be delivered to a prospective applicant for long term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(A) The director shall prescribe a standard format including style, arrangement and overall appearance and the content of an outline of coverage.

(B) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(C) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(b) The outline of coverage shall include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) A statement of the principal exclusions, reductions and limitations contained in the policy;

(C) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(D) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(E) A description of the terms under which the policy or certificate may be returned and premium refunded; and

(F) A brief description of the relationship of cost of care and benefits.

(7) A certificate issued pursuant to a group long term care insurance policy if the policy is delivered or issued for delivery in this state shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(c) A statement that the group master policy determines governing contractual provisions.

(8) No policy may be advertised, marketed or offered as long term care or nursing home insurance unless it complies with the provisions of ORS 743.650 to 743.656, 748.603 and 750.055.

(9) ORS 743.414 applies to long term care insurance regulated under ORS 743.650 to 743.656, 748.603 and 750.055.

(10) Rules adopted pursuant to ORS 743.650 to 743.656, 748.603 and 750.055 shall be in accordance with the provisions of ORS 183.310 to 183.550. [1989 c.1022 §§6,7; 1991 c.67 §200]

743.656 Eligibility for benefits; providers required to be covered. (1) No long term care insurance policy shall be delivered or issued for delivery in this state after January 1, 1992, unless such policy determines eligibility for benefits through a determination that is not more restrictive than requiring that:

(a) The policyholder be functionally impaired and needing assistance in any three or more activities of daily living as defined by the Director of the Department of Consumer and Business Services, by rule, after consultation with the Director of Human Services.

(b) Benefits must be payable when the beneficiary is receiving covered services from any of the following providers approved by the insurer:

(A) Nursing home;

(B) Assisted living;

(C) Home care; and

(D) Adult foster care.

(c) The insurer shall approve nursing home, assisted living, home care, adult foster home and any other providers of covered services by using standards that have been submitted to and approved by the director in consultation with the Director of Human Services.

(2) After January 1, 1992, no long term care policy shall be sold in this state that offers only nursing home benefits. [1989 c.1022 §§13,14]

743.657 [1967 c.359 §498; renumbered 742.238 in 1989]

743.660 [1967 c.359 §499; renumbered 742.240 in 1989]

743.663 [1967 c.359 §500; renumbered 742.242 in 1989]

743.666 [Formerly 744.125; renumbered 742.244 in 1989]

743.669 [Formerly 744.130; renumbered 742.246 in 1989]

743.672 [Formerly 744.430; renumbered 742.248 in 1989]

743.675 [Formerly 744.440; renumbered 742.250 in 1989]

743.678 [Formerly 744.450; renumbered 742.252 in 1989]

(Medicare Supplement)

743.680 Definitions for ORS 743.680 to 743.689. As used in ORS 743.680 to 743.689, unless the context requires otherwise:

(1) “Applicant” means:

(a) In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits.

(b) In the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder.

(2) “Certificate” means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

(3) “Medicare” means the “Health Insurance for the Aged Act,” Title XVIII of the Social Security Amendments of 1965.

(4) “Medicare supplement policy” means a group or individual policy of insurance or a subscriber contract which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. [1989 c.255 §1; 1993 c.113 §1]

743.681 [Formerly 744.460; renumbered 742.254 in 1989]

743.682 Application of ORS 743.680 to 743.689. (1) Except as otherwise specifically provided, ORS 743.680 to 743.689 apply to:

(a) All Medicare supplement policies and subscriber contracts delivered or issued for delivery in this state on or after May 31, 1989; and

(b) All certificates issued under group Medicare supplement policies or subscriber contracts, which certificates

have been delivered or issued for delivery in this state on or after May 31, 1989.

(2) ORS 743.680 to 743.689 do not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations. [1989 c.255 §2]

743.683 Policy contents; standards for benefit and claims payments; rules. (1) No Medicare supplement insurance policy, contract or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

(2) The Director of the Department of Consumer and Business Services shall adopt by rule specific standards for policy provisions of Medicare supplement policies and certificates. The standards shall be in addition to and in accordance with applicable laws of this state. No requirement of the Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in ORS 743.680 to 743.689, shall apply to Medicare supplement policies. The standards may cover, but not be limited to:

(a) Terms of renewability;

(b) Initial and subsequent conditions of eligibility;

(c) Nonduplication of coverage;

(d) Probationary periods;

(e) Benefit limitations, exceptions and reductions;

(f) Elimination periods;

(g) Requirements for replacement;

(h) Recurrent conditions; and

(i) Definitions of terms.

(3) Provisions established by the director governing eligibility for Medicare supplement insurance shall not be limited to persons qualifying for Medicare by reason of age.

(4) The director may adopt by rule standards that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the director, are unjust, unfair or unfairly discriminatory to any person insured or proposed for coverage under a Medicare supplement policy.

(5) Notwithstanding any other provision of law of this state, a Medicare supplement policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(6) The director shall adopt by rule standards for benefits and claims payment under Medicare supplement policies. [1989 c.255 §§3,4; 1993 c.113 §3]

743.684 Filing of policy; loss ratio standards; agent compensation. (1) Every insurer providing group Medicare supplement insurance benefits to a resident of this state pursuant to ORS 743.682 shall file a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state. However, no insurer shall be required to make a filing earlier than 30 days after insurance was provided to a resident of this state under a master policy issued for delivery outside this state.

(2) Medicare supplement policies shall return benefits which are reasonable in relation to the premium charged. The Director of the Department of Consumer and Business Services shall adopt by rule minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices. Every entity providing Medicare supplement policies or certificates in this state shall file annually its rates, rating schedule and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state. All filings of rates and rating schedules shall demonstrate that the actual and expected losses in relation to premiums comply with the requirements of ORS 743.680 to 743.689.

(3) No entity shall provide compensation to its agents or other producers which is greater than the renewal compensation which would have been paid on an existing policy if the existing policy is replaced by another policy with the same company where the new policy benefits are substantially similar to the benefits under the old policy and the old policy was issued by the same insurer or insurer group. [1989 c.255 §5]

743.685 Outline of coverage; information brochure; rules. (1) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(2) The Director of the Department of Consumer and Business Services shall prescribe the format and content of the outline of coverage required by subsection (1) of this section. The director shall consult with the Governor's Commission on Senior Services concerning the content and format of the outline of coverage, especially in reference to the ease with which senior citizens may understand the form and compare the coverage provided under the policy to which the outline of coverage refers. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The outline of coverage required by subsection (1) of this section shall include at least the following:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(c) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(3) Insurers shall fill out the standardized form and have the completed information included on the form approved by the director before selling supplemental Medicare coverage in this state.

(4) In the purchase or renewal of a Medicare supplement policy, a copy of the outline of coverage must be used in explaining policy coverage to a purchaser and shall be provided to the applicant at the time the sales presentation is made. The completed outline of coverage shall be considered part of the sales presentation materials for the purposes of ORS 742.009.

(5) The insurer shall obtain acknowledgment of receipt or certify delivery of the outline of coverage at the time of sale.

(6) The director may adopt by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the director may require by rule that the information brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the director may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(7) The director may adopt by rule captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all health insurance policies sold to persons eligible for Medicare, other than:

(a) Medicare supplement policies; or

(b) Disability income policies.

(8) The director may adopt rules governing the full and fair disclosure of the information in connection with the replacement of health insurance policies, subscriber contracts or certificates by persons eligible for Medicare. [1989 c.255 §6; 1993 c.113 §2; 1997 c.96 §2]

743.686 Right to return of policy; premium refund. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the insurer in a timely manner. [1989 c.255 §7]

743.687 Advertising. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Director of the Department of Consumer and Business Services of this state for review or approval by the director to the extent it may be required under state law. [1989 c.255 §8]

743.688 Rules. Rules adopted pursuant to ORS 743.680 to 743.689 shall be subject to the provisions of ORS 183.310 to 183.550. [1989 c.255 §9]

743.689 Director's authority upon violation of ORS 743.680 to 743.689. In addition to any other applicable penalties for violations of the Insurance Code, the Director of the Department of Consumer and Business Services may require insurers violating any provision of ORS 743.680 to 743.689 or rules adopted pursuant to ORS 743.680 to 743.689 to cease marketing any Medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require such insurer to take such actions as are necessary to comply with the provisions of ORS 743.680 to 743.689, or both. [1989 c.255 §10]

743.690 [1981 c.247 §17; renumbered 742.280 in 1989]

(Required Reimbursements)

743.693 Reimbursement for pregnancy and childbirth expenses. All health benefit plans as defined in ORS 743.730 must provide payment or reimbursement for expenses associated with pregnancy care, as defined by ORS 743.845, and childbirth. Benefits provided under this section shall be extended to all enrollees, enrolled spouses and enrolled dependents. [1999 c.428 §2; 2001 c.104 §289]

Note: See 743.700.

743.694 Reimbursement for diabetes self-management programs. (1) Subject to other terms, conditions and benefits in the plan, group health benefit plans as described in ORS 743.730 shall provide payment, coverage or reimbursement for supplies, equipment and diabetes self-management programs associated with the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes prescribed by a health care professional legally authorized to prescribe such items.

(2) As used in this section, "diabetes self-management program" means one program of assessment and training after diagnosis and no more than three hours per year of assessment and training upon a material change of condition, medication or treatment that is provided by:

(a) An education program credentialed or accredited by a state or national entity accrediting such programs; or

(b) A program provided by a physician licensed under ORS chapter 677, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes. [2001 c.742 §2]

Note: See 743.700.

743.695 Definition for ORS 743.697. As used in ORS 743.697, "peer-reviewed medical literature" means scientific studies printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity and reliability. "Peer-reviewed medical literature" does not include internal publications of pharmaceutical manufacturers. [1997 c.573 §2]

743.697 Coverage of particular drugs. (1) No insurance policy or contract providing coverage for a prescription drug to a resident of this state shall exclude coverage of that drug for a particular indication solely on the grounds that the indication has not been approved by the United States Food and Drug Administration if the Health Resources Commission determines that the drug is recognized as effective for the treatment of that indication:

(a) In publications that the commission determines to be equivalent to:

(A) The American Hospital Formulary Services drug information;

(B) "Drug Facts and Comparisons" (Lippincott-Raven Publishers);

(C) The United States Pharmacopoeia drug information; or

(D) Other publications that have been identified by the United States Secretary of Health and Human Services as authoritative;

(b) In the majority of relevant peer-reviewed medical literature; or

(c) By the United States Secretary of Health and Human Services.

(2) Required coverage of a prescription drug under this section shall include coverage for medically necessary services associated with the administration of that drug.

(3) Nothing in this section requires coverage for any prescription drug if the United States Food and Drug Administration has determined use of the drug to be contraindicated.

(4) Nothing in this section requires coverage for experimental drugs not approved for any indication by the United

States Food and Drug Administration.

(5) This section is exempt from ORS 743.700. [1997 c.573 §3]

743.699 Coverage of emergency services. (1) All insurers offering a health benefit plan shall provide coverage without prior authorization for:

(a) Emergency medical screening exams;

(b) Stabilization of an emergency medical condition; and

(c) Emergency services provided by a nonparticipating provider if a prudent layperson possessing an average knowledge of health and medicine would reasonably believe that the time required to go to a participating provider would place the health of the person, or a fetus in the case of a pregnant woman, in serious jeopardy.

(2) All insurers described in subsection (1) of this section shall provide information to enrollees in plain language regarding:

(a) What constitutes an emergency medical condition;

(b) The coverage provided for emergency services;

(c) How and where to obtain emergency services; and

(d) The appropriate use of 9-1-1.

(3) An insurer offering a health benefit plan may not discourage appropriate use of 9-1-1 and shall not deny coverage for emergency services solely because 9-1-1 was used. [1997 c.651 §2]

Note: See definitions in 743.801.

Note: See 743.700.

743.700 Automatic repeal of certain statutes on individual and group health insurance. (1) Any statute described in subsection (2) of this section that becomes effective on or after July 13, 1985, shall stand repealed on the sixth anniversary of the effective date of the statute, unless the Legislative Assembly specifically provides otherwise.

(2) This section governs any statute that applies to individual or group health insurance policies and does any of the following:

(a) Requires the insurer to include coverage for specific physical or mental conditions or specific hospital, medical, surgical or dental health services.

(b) Requires the insurer to include coverage for specified persons.

(c) Requires the insurer to provide payment or reimbursement to specified providers of services if the services are within the lawful scope of practice of the provider and the insurance policy provides payment or reimbursement for those services.

(d) Requires the insurer to provide any specific coverage on a nondiscriminatory basis.

(e) Forbids the insurer to exclude from payment or reimbursement any covered services.

(f) Forbids the insurer to exclude coverage of a person because of that person's medical history.

(3) A repeal of a statute under subsection (1) of this section shall not apply to any insurance policy in effect on the effective date of the repeal. However, the repeal of the statute shall apply to a renewal or extension of an existing insurance policy on or after the effective date of the repealer as well as to a new policy issued on or after the effective date of the repealer. [Formerly 743.145]

743.701 Reimbursement for services performed by state hospital or state approved program. No policy of health insurance shall exclude from payment or reimbursement losses incurred by an insured for any covered service because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program. [Formerly 743.116]

743.702 [Formerly 746.010; repealed by 1969 c.692 §11]

743.703 Reimbursement for services of optometrist. (1) Notwithstanding any provision of any policy of health insurance, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such policy shall be entitled to reimbursement for such service, whether such service is performed by a physician or duly licensed optometrist. Unless such policy shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or

appurtenances thereto.

(2) The provisions of this section shall not apply to any policy in effect upon September 13, 1967. [Formerly 743.117]

743.704 [Formerly 743.118; repealed by 2001 c.742 §3]

743.705 [Formerly 746.030; 1969 c.692 §9; 1973 c.179 §1; 1982 s.s.1 c.5 §1; 1987 c.846 §13; renumbered 742.282 in 1989]

743.706 Reimbursement for maxillofacial prosthetic services. (1) The Legislative Assembly declares that all group health insurance policies providing hospital, medical or surgical expense benefits include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment.

(2) As used in this section, "maxillofacial prosthetic services considered necessary for adjunctive treatment" means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

(a) Controlling or eliminating infection;

(b) Controlling or eliminating pain; or

(c) Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

(3) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions relating to deductibles and coinsurance.

(4) The services described in this section shall apply to individual health policies entered into or renewed on or after January 1, 1982. [Formerly 743.119]

743.707 Health insurance coverage for newly born and adopted children. (1) All individual and group health insurance policies providing hospital, medical or surgical expense benefits that include coverage for a family member of the insured shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to:

(a) A newly born child of the insured from the moment of birth; and

(b) An adopted child effective upon placement for adoption.

(2) The coverage of newly born and adopted children required by subsection (1) of this section shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of the birth of the child or of the placement for adoption of the child and payment of the premium be furnished the insurer within 31 days after the date of birth or date of placement in order to have the coverage extended beyond the 31-day period.

(4) The following requirements apply to coverage of an adopted child required by subsection (1)(b) of this section:

(a) In any case in which a policy provides coverage for dependent children of participants or beneficiaries, the policy shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, regardless of whether the adoption has become final.

(b) A policy may not restrict coverage of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(5) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligations.

(6) The provisions of ORS 743.700 do not apply to this section. [Formerly 743.120; 1991 c.674 §2; 1995 c.506 §10]

743.708 [Formerly 746.080; 1969 c.692 §10; 1973 c.823 §150; renumbered 742.284 in 1989]

743.709 Reimbursement for services provided by psychologist. Whenever any provision of any individual or group health insurance policy or contract provides for payment or reimbursement for any service which is within the lawful scope of a psychologist licensed under ORS 675.010 to 675.150:

(1) The insured under such policy or contract shall be free to select, and shall have direct access to, a psychologist licensed under ORS 675.010 to 675.150, without supervision or referral by a physician or another health practitioner, and wherever such psychologist is authorized to practice.

(2) The insured under such policy or contract shall be entitled to have payment or reimbursement made to the insured or on the insured's behalf for the services performed. Such payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be the same whether performed by a physician or a psychologist licensed under ORS 675.010 to 675.150. [Formerly 743.123]

743.710 Denial or cancellation of health insurance because of use by mother of diethylstilbestrol. No policy of health insurance may be denied or canceled by the insurer solely because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth. [Formerly 743.125]

743.711 [1987 c.846 §15; renumbered 742.286 in 1989]

743.712 Reimbursement for services of nurse practitioner. (1) Whenever any policy of health insurance provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed and certified nurse practitioner, including prescribing or dispensing drugs, the insured under the policy is entitled to reimbursement for such service whether it is performed by a physician licensed by the Board of Medical Examiners for the State of Oregon or by a duly licensed nurse practitioner.

(2) This section does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act. [Formerly 743.128]

743.713 Reimbursement for services of denturist. Notwithstanding any provisions of any policy of insurance covering dental health, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a denturist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a licensed denturist as defined in ORS 680.500. This section shall apply to any policy covering dental insurance which is issued after July 1, 1980. Policies which are in existence on July 1, 1980, shall be brought into compliance on the next anniversary date, renewal date, or the expiration date of the applicable collective bargaining contract, if any, whichever date is latest. [Formerly 743.132; 1993 c.142 §15]

Note: 743.713 was added to and made a part of the Insurance Code by the people in the exercise of their initiative power but was not added to or made a part of ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.714 Reimbursement for services of clinical social worker. Whenever any individual or group health insurance policy or blanket health insurance policy described in ORS 743.534 (3) provides for payment or reimbursement for any service which is within the lawful scope of service of a clinical social worker licensed under ORS 675.510 to 675.600:

(1) The insured under the policy shall be entitled to the services of a clinical social worker licensed under ORS 675.510 to 675.600, upon referral by a physician or psychologist.

(2) The insured under the policy shall be entitled to have payment or reimbursement made to the insured or on behalf of the insured for the services performed. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician, by a psychologist or by a clinical social worker, according to the customary and usual fee of clinical social workers in the area served. [Formerly 743.135]

743.715 [Formerly 743.138; repealed by 1991 c.182 §21]

743.716 [Formerly 743.140; repealed by 1995 c.506 §11]

743.717 Tourette Syndrome; reimbursement for treatment. For purpose of coverage by group health insurers, health care service contractors and health maintenance organizations, reimbursement for treatment of Tourette Syndrome shall be made on the basis of the diagnosis and treatment modality employed. [Formerly 743.143]

Note: See 743.700.

743.718 Method of payments for ambulance care and transportation. Any insurance policy issued or issued for delivery in this state that provides coverage for ambulance care and transportation shall provide that payments will be made jointly to the provider of the ambulance care and transportation and to the insured, unless the policy provides for direct payment to the provider. [Formerly 743.147]

743.719 Reimbursement for certain surgical services performed by dentists. Notwithstanding any provision of a policy of health insurance, whenever the policy provides for payment of a surgical service, the performance for the insured of such surgical service by any dentist acting within the scope of the dentist's license is compensable if performance of that service by a physician acting within the scope of the physician's license would be compensable. [Formerly 743.052]

743.720 [1979 c.866 §4; 1987 c.774 §56; renumbered 742.300 in 1989]

743.721 Nondiscriminatory health insurance coverage for women. Each policy of health insurance shall provide:

(1) The same payments for costs of maternity to unmarried women that it provides to married women, including the wives of insured persons choosing family coverage; and

(2) The same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives. [Formerly 743.037]

743.722 Reimbursement for acupuncturist. (1) Whenever any individual or group health insurance policy provides for payment or reimbursement for acupuncture services performed by a physician, the policy also shall pay or reimburse the insured for acupuncture services performed by an acupuncturist licensed under ORS 677.757 to 677.770. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician or an acupuncturist, according to the customary and usual fee of acupuncturists in the area served.

(2)(a) Subsection (1) of this section does not require the employment of acupuncturists licensed under ORS 677.757 to 677.770 by group practice health maintenance organizations that are federally qualified pursuant to Title XIII subchapter XI of the Public Health Service Act (42 U.S.C. 300e et seq.).

(b) When a group practice health maintenance organization reimburses its members for acupuncture services performed by physicians outside its employ, it shall also reimburse its members for acupuncture services performed by an acupuncturist. [1989 c.832 §2; 1991 c.314 §3; 1995 c.79 §365]

Note: See 743.700.

743.723 [1979 c.866 §5; 1981 c.525 §1; 1987 c.774 §57; renumbered 742.302 in 1989]

743.724 [Formerly 746.307; repealed by 1997 c.695 §2 (743.725 enacted in lieu of 743.724)]

743.725 Claim submitted by physician assistant. No insurer shall refuse a claim solely on the ground that the claim was submitted by a physician assistant practicing under the circumstances set forth in ORS 677.515 (4) rather than by the supervising physician for the physician assistant. [1997 c.695 §3 (enacted in lieu of 743.724)]

Note: See 743.700.

743.726 Reimbursement for inborn errors of metabolism. (1) All individual and group health insurance policies providing coverage for hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall include coverage for treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues. Coverage shall include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.

(2) As used in this section, "medical foods" means foods that are formulated to be consumed or administered enterally under the supervision of a physician, as defined in ORS 677.010, that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts, that are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation and that are essential to optimize growth, health and metabolic homeostasis. [1997 c.496 §2]

Note: See 743.700.

743.727 Reimbursement for mammo-grams; schedule of covered mammo-grams. (1) Every health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage of mammograms as follows:

(a) Mammograms for the purpose of diagnosis in symptomatic or high-risk women at any time upon referral of the woman's health care provider; and

(b) An annual mammogram for the purpose of early detection for a woman 40 years of age or older, with or without referral from the woman's health care provider.

(2) An insurance policy described in subsection (1) of this section must not limit coverage of mammograms to the schedule provided in subsection (1) of this section if the woman is determined by her health care provider to be at high risk for breast cancer. [1993 c.575 §2; 1999 c.429 §1]

Note: See 743.700.

743.728 Reimbursement for pelvic examinations and Pap smear examinations; schedule of covered examinations. All policies providing health insurance, except those policies whose coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this section, shall include coverage for pelvic examinations and Pap smear examinations as follows:

(1) Annually for women 18 to 64 years of age; and

(2) At any time upon referral of the woman's health care provider. [1993 c.576 §2; 1999 c.429 §2]

Note: See 743.700.

743.729 Reimbursement for nonprescription enteral formula for home use; conditions. (1) All policies providing health insurance, as defined in ORS 731.162, except those policies whose coverage is limited to expenses from accidents or specific diseases that are unrelated to the coverage required by this section, shall include coverage for a nonprescription elemental enteral formula for home use, if the formula is medically necessary for the treatment of severe intestinal malabsorption and a physician has issued a written order for the formula and the formula comprises the sole source, or an essential source, of nutrition.

(2) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions related to deductibles and coinsurance. Deductibles and coinsurance for elemental enteral formulas shall be no greater than those for any other treatment for the condition under the policy. [1993 c.407 §2]

Note: See 743.700.

(Small Employer, Group, Individual and Portability Health Insurance, Generally)

743.730 Definitions for ORS 743.730 to 743.773. As used in ORS 743.730 to 743.773:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Consumer and Business Services that a carrier is in compliance with the provisions of ORS 743.736, 743.760 or 743.761, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for small employer and portability health benefit plans.

(2) "Affiliate" of, or person "affiliated" with, a specified person means any carrier who, directly or indirectly through one or more intermediaries, controls or is controlled by or is under common control with a specified person. For purposes of this definition, "control" has the meaning given that term in ORS 732.548.

(3) "Affiliation period" means, under the terms of a group health benefit plan issued by a health care service contractor, a period:

(a) That is applied uniformly and without regard to any health status related factors to an enrollee or late enrollee in lieu of a preexisting conditions provision;

(b) That must expire before any coverage becomes effective under the plan for the enrollee or late enrollee;

(c) During which no premium shall be charged to the enrollee or late enrollee; and

(d) That begins on the enrollee's or late enrollee's first date of eligibility for coverage and runs concurrently with any eligibility waiting period under the plan.

(4) "Basic health benefit plan" means a health benefit plan for small employers that is required to be offered by all small employer carriers and approved by the Director of the Department of Consumer and Business Services in accordance with ORS 743.736.

(5) "Bona fide association" means an association that meets the requirements of 42 U.S.C. 300gg-11 as amended and in effect on July 1, 1997.

(6) "Carrier" means any person who provides health benefit plans in this state, including a licensed insurance company, a health care service contractor, a health maintenance organization, an association or group of employers that provides benefits by means of a multiple employer welfare arrangement or any other person or corporation responsible for the payment of benefits or provision of services.

(7) "Committee" means the Health Insurance Reform Advisory Committee created under ORS 743.745.

(8) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on July 1, 1997, and includes coverage remaining in force at the time the enrollee obtains new coverage.

(9) "Department" means the Department of Consumer and Business Services.

(10) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(11) "Director" means the Director of the Department of Consumer and Business Services.

(12) "Eligible employee" means an employee of a small employer who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The employer may determine hours worked for eligibility between 17.5 and 40 hours per week subject to rules of the carrier. "Eligible employee" includes sole proprietors, partners of a partnership, leased workers as defined in ORS 743.522 or independent contractors if they are included as employees under a health benefit plan of a small employer but does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the small employer for fewer than 90 days are not eligible employees unless the small employer so allows.

(13) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group, individual or portability health benefit plan who has enrolled for coverage under the terms of the plan.

(14) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(15) "Financially impaired" means a member that is not insolvent and is:

(a) Considered by the Director of the Department of Consumer and Business Services to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(16)(a) "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a carrier in a geographic area established by the director for the carrier's:

(A) Small employer group health benefit plans;

(B) Individual health benefit plans; or

(C) Portability health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design or

family composition.

(17) “Group eligibility waiting period” means, with respect to a group health benefit plan, the period of employment or membership with the group that a prospective enrollee must complete before plan coverage begins.

(18)(a) “Health benefit plan” means any hospital expense, medical expense or hospital or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

(b) “Health benefit plan” does not include coverage for accident only, specific disease or condition only, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance policies, coverage of CHAMPUS services pursuant to contracts with the federal government, benefits delivered through a flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan, long term care insurance, hospital indemnity only, short term health insurance policies (the duration of which does not exceed six months including renewals), student accident and health insurance policies, dental only, vision only, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(c) Nothing in this subsection shall be construed to regulate any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(19) “Health statement” means any information that is intended to inform the carrier or agent of the health status of an enrollee or prospective enrollee in a health benefit plan. “Health statement” includes the standard health statement developed by the Health Insurance Reform Advisory Committee.

(20) “Implementation of chapter 836, Oregon Laws 1989” means that the Health Services Commission has prepared a priority list, the Legislative Assembly has enacted funding of the list and all necessary federal approval, including waivers, has been obtained.

(21) “Individual coverage waiting period” means a period in an individual health benefit plan during which no premiums may be collected and health benefit plan coverage issued is not effective.

(22) “Initial enrollment period” means a period of at least 30 days following commencement of the first eligibility period for an individual.

(23) “Insurance Pool Governing Board” means the Insurance Pool Governing Board established by ORS 735.704.

(24) “Late enrollee” means an individual who enrolls in a group health benefit plan subsequent to the initial enrollment period during which the individual was eligible for coverage but declined to enroll. However, an eligible individual shall not be considered a late enrollee if:

(a) The individual qualifies for a special enrollment period in accordance with 42 U.S.C. 300gg as amended and in effect on July 1, 1997;

(b) The individual applies for coverage during an open enrollment period;

(c) A court has ordered that coverage be provided for a spouse or minor child under a covered employee’s health benefit plan and request for enrollment is made within 30 days after issuance of the court order;

(d) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(e) The individual’s coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days of applying for coverage in a group health benefit plan.

(25) “Multiple employer welfare arrangement” means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, that is subject to ORS 750.301 to 750.341.

(26) “Oregon Medical Insurance Pool” means the pool created under ORS 735.610.

(27) “Preexisting conditions provision” means a health benefit plan provision applicable to an enrollee or late enrollee that excludes coverage for services, charges or expenses incurred during a specified period immediately following enrollment for a condition for which medical advice, diagnosis, care or treatment was recommended or received during a specified period immediately preceding enrollment. For purposes of ORS 743.730 to 743.773:

(a) Pregnancy does not constitute a preexisting condition except as provided in ORS 743.766;

(b) Genetic information does not constitute a preexisting condition in the absence of a diagnosis of the condition

related to such information; and

(c) A preexisting conditions provision shall not be applied to a newborn child or adopted child who obtains coverage in accordance with ORS 743.707.

(28) “Premium” includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of enrollees covered by the plan.

(29) “Rating period” means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(30) “Small employer” means any person, firm, corporation, partnership or association actively engaged in business that, on at least 50 percent of its working days during the preceding year, employed no more than 25 eligible employees and no fewer than two eligible employees, the majority of whom are employed within this state, and in which a bona fide partnership, independent contractor or employer-employee relationship exists. “Small employer” includes companies that are eligible to file a consolidated tax return pursuant to ORS 317.715.

(31) “Small employer carrier” means any carrier that offers health benefit plans covering eligible employees of one or more small employers. A fully insured multiple employer welfare arrangement otherwise exempt under ORS 750.303 (4) may elect to be a small employer carrier governed by the provisions of ORS 743.733 to 743.737. [1991 c.916 §3; 1993 c.18 §157; 1993 c.615 §25; 1993 c.649 §8; 1993 c.744 §31; 1995 c.603 §§1,36; 1997 c.716 §§1,2; 1999 c.547 §8; 1999 c.987 §6; 2001 c.943 §6]

743.731 Purposes. The purposes of ORS 743.730 to 743.773 are:

(1) To promote the availability of health insurance coverage to groups regardless of their enrollees’ health status or claims experience;

(2) To prevent abusive rating practices;

(3) To require disclosure of rating practices to purchasers of small employer, portability and individual health benefit plans;

(4) To establish limitations on the use of preexisting conditions provisions;

(5) To make basic health benefit plans available to all small employers;

(6) To encourage the availability of portability and individual health benefit plans for individuals who are not enrolled in group health benefit plans;

(7) To improve renewability and continuity of coverage for employers and covered individuals;

(8) To improve the efficiency and fairness of the health insurance marketplace; and

(9) To ensure that health insurance coverage in Oregon satisfies the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and that enforcement authority for those requirements is retained by the Director of the Department of Consumer and Business Services. [1991 c.916 §2; 1993 c.18 §158; 1993 c.649 §11; 1995 c.603 §2; 1997 c.716 §4]

743.732 [Formerly 747.080; renumbered 742.350 in 1989]

743.733 Issuance of group health benefit plan to affiliated group of employers; determination of number of employees for purpose of determining eligibility; small employer carrier. (1) For purposes of this section, “qualified employees” means employees who work on a regularly scheduled basis, with a normal workweek of 17.5 or more hours, but does not include employees who work on a temporary, seasonal or substitute basis.

(2) If an affiliated group of employers that is eligible to file a consolidated tax return pursuant to ORS 317.715 includes one or more small employers, a carrier may issue a group health benefit plan to the affiliated group on the basis of the number of employees in the affiliated group if the group requests such coverage.

(3) Subsequent to the issuance of a health benefit plan to an employer pursuant to the provisions of ORS 743.733 to 743.737 and for the purposes of determining eligibility, the number of employees of an employer shall be determined annually by the small employer carrier. Except as otherwise provided, the provisions of ORS 743.733 to 743.737 that apply to an employer shall continue to apply until the plan anniversary date following the date the employer no longer meets the requirements of this section.

(4) A carrier that offers health benefit plans covering employees of an employer who employed an average of at least two but not more than 50 qualified employees on business days during the preceding calendar year and who employs at least two qualified employees on the first day of the plan year, in accordance with 42 U.S.C. 300gg as amended and in effect on July 1, 1997, shall be considered a small employer carrier for purposes of this section and ORS 743.736. A health benefit plan issued to an employer described in this section, provided the employer does not

otherwise qualify as a small employer in accordance with ORS 743.730, shall be considered a small employer health benefit plan for purposes of ORS 743.737, except that the plan or carrier shall not be required to comply with ORS 743.737 (7), (8), (10), (11) and (13). [1991 c.916 §4; 1993 c.18 §159; 1995 c.603 §3; 1999 c.987 §7]

743.734 Group health benefit plans subject to provisions of specified laws; exemptions. (1) Every group health benefit plan shall be subject to the provisions of ORS 743.733 to 743.737, if the plan provides health benefits covering one or more employees of a small employer and if any one of the following conditions is met:

(a) Any portion of the premium or benefits is paid by a small employer or any eligible employee is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the health benefit plan premium; or

(b) The health benefit plan is treated by the employer or any of the eligible employees as part of a plan or program for the purposes of section 106, section 125 or section 162 of the Internal Revenue Code of 1986, as amended.

(2) Except as provided in ORS 743.733 to 743.737, no law requiring the coverage or the offer of coverage of a health care service or benefit applies to the basic health benefit plans offered or delivered to a small employer.

(3) Except as otherwise provided by law or ORS 743.733 to 743.737, no health benefit plan offered to a small employer shall:

(a) Inhibit a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits; or

(b) Impose any restriction on the ability of a small employer carrier to negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(4) Except to determine the application of a preexisting conditions provision for a late enrollee, a small employer carrier shall not use health statements when offering small employer health benefit plans and shall not use any other method to determine the actual or expected health status of eligible enrollees. Nothing in this subsection shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(5) Except in the case of a late enrollee and as otherwise provided in this section, a small employer carrier shall not impose different terms or conditions on the coverage, premiums or contributions of any eligible employee in a small employer group that are based on the actual or expected health status of any eligible employee.

(6) A small employer carrier may provide different health benefit plans to different categories of employees of a small employer when the employer has chosen to establish different categories of employees in a manner that does not relate to the actual or expected health status of such employees or their dependents. Except as provided in ORS 743.736 (10):

(a) When a small employer carrier offers coverage to a small employer, the small employer carrier shall offer coverage to all eligible employees of the small employer, without regard to the actual or expected health status of any eligible employee.

(b) If the small employer elects to offer coverage to dependents of eligible employees, the small employer carrier shall offer coverage to all dependents of eligible employees, without regard to the actual or expected health status of any eligible dependent. [1991 c.916 §5; 1993 c.18 §160; 1995 c.603 §4; 1997 c.716 §5; 1999 c.987 §8]

743.735 [Formerly 747.100; 1973 c.823 §151; renumbered 742.352 in 1989]

743.736 Requirements for basic plans; approval of plans and forms; offering of plan by carriers. (1) In order to improve the availability and affordability of health benefit coverage for small employers, the Health Insurance Reform Advisory Committee created under ORS 743.745 shall submit to the Director of the Department of Consumer and Business Services two basic health benefit plans pursuant to ORS 743.745. One plan shall be in the form of insurance and the second plan shall be consistent with the requirements of the federal Health Maintenance Organization Act, 42 U.S.C. 300e et seq.

(2)(a) The director shall approve the basic health benefit plans following a determination that the plans provide for maximum accessibility and affordability of needed health care services and following a determination that the basic health benefit plans substantially meet the social values that underlie the ranking of benefits by the Health Services Commission and that the basic health benefit plans are substantially similar to the Medicaid reform program under chapter 836, Oregon Laws 1989, funded by the Legislative Assembly.

(b) The basic health benefit plans shall include benefits mandated under ORS 743.556 until mental health, alcohol and chemical dependency services are fully integrated into the Health Services Commission’s priority list, and as

funded by the Legislative Assembly, and chapter 836, Oregon Laws 1989, is implemented.

(c) The commission shall aid the director by reviewing the basic health benefit plans and commenting on the extent to which the plans meet these criteria.

(3) After the director's approval of the basic health benefit plans submitted by the committee pursuant to subsection (1) of this section, each small employer carrier shall submit to the director the policy form or forms containing its basic health benefit plan. Each policy form must be submitted as prescribed by the director and is subject to review and approval pursuant to ORS 742.003.

(4)(a) As a condition of transacting business in the small employer health insurance market in this state, every small employer carrier shall offer small employers an approved basic health benefit plan and any other plans that have been submitted by the small employer carrier for use in the small employer market and approved by the director.

(b) Nothing in this subsection shall require a small employer carrier to resubmit small employer health benefit plans that were approved by the director prior to October 1, 1996, nor shall small employer carriers be required to reinitiate new plan selection procedures for currently enrolled small employers prior to the small employer's next health benefit plan coverage anniversary date.

(c) A carrier that offers a health benefit plan in the small employer market only through one or more bona fide associations is not required to offer that health benefit plan to small employers that are not members of the bona fide association.

(5) A small employer carrier shall issue to a small employer any small employer health benefit plan offered by the carrier if the small employer applies for the plan and agrees to make the required premium payments and to satisfy the other provisions of the health benefit plan.

(6) A multiple employer welfare arrangement, professional or trade association or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement shall not include any requirements that relate to the actual or expected health status of the prospective enrollee.

(7) A small employer carrier shall, pursuant to subsections (4) and (5) of this section, offer coverage to or accept applications from a group covered under an existing small employer health benefit plan whether or not a prospective enrollee is excluded from coverage under the existing plan because of late enrollment. When a small employer carrier accepts an application for such a group, the carrier may continue to exclude the prospective enrollee excluded from coverage by the replaced plan until the prospective enrollee would have become eligible for coverage under that replaced plan.

(8) No small employer carrier shall be required to offer coverage or accept applications pursuant to subsections (4) and (5) of this section if the director finds that acceptance of an application or applications would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

(9) Every small employer carrier shall market fairly all small employer health benefit plans offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

(10)(a) No small employer carrier shall be required to offer coverage or accept applications pursuant to subsections (4) and (5) of this section in the case of any of the following:

(A) To a small employer if the small employer is not physically located in the carrier's approved service area;

(B) To an employee if the employee does not work or reside within the carrier's approved service areas; or

(C) Within an area where the carrier reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity in its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

(b) A carrier that does not offer coverage pursuant to paragraph (a)(C) of this subsection shall not offer coverage in the applicable service area to new employer groups other than small employers until the carrier resumes enrolling groups of new small employers in the applicable area.

(11) For purposes of ORS 743.733 to 743.737, except as provided in this subsection, carriers that are affiliated carriers or that are eligible to file a consolidated tax return pursuant to ORS 317.715 shall be treated as one carrier and any restrictions or limitations imposed by ORS 743.733 to 743.737 apply as if all health benefit plans delivered or issued for delivery to small employers in this state by the affiliated carriers were issued by one carrier. However, any insurance company or health maintenance organization that is an affiliate of a health care service contractor located in

this state, or any health maintenance organization located in this state that is an affiliate of an insurance company or health care service contractor, may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area in this state may be considered a separate carrier.

(12) A small employer carrier that, after September 29, 1991, elects to discontinue offering all of its small employer health benefit plans under ORS 743.737 (5)(e), elects to discontinue renewing all such plans or elects to discontinue offering and renewing all such plans is prohibited from offering health benefit plans in the small employer market in this state for a period of five years from one of the following dates:

(a) The date of notice to the director pursuant to ORS 743.737 (5)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering small employer health benefit plans in this state. [1991 c.916 §6; 1993 c.649 §12; 1995 c.603 §5; 1997 c.716 §6; 1999 c.987 §9]

743.737 Required provisions of small employer health benefit plans; renewability; notices required for discontinuation; premium rates; carrier disclosures; annual actuarial certification. Health benefit plans covering small employers shall be subject to the following provisions:

(1) A preexisting conditions provision in a small employer health benefit plan shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

(2) A preexisting conditions provision in a small employer health benefit plan shall terminate its effect as follows:

(a) For an enrollee, not later than the first of the following dates:

(A) Six months following the enrollee's effective date of coverage; or

(B) Ten months following the start of any required group eligibility waiting period.

(b) For a late enrollee, not later than 12 months following the late enrollee's effective date of coverage.

(3) In applying a preexisting conditions provision to an enrollee or late enrollee, except as provided in this subsection, all small employer health benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the enrollment date in the new small employer health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period. This subsection does not preclude, within a small employer health benefit plan, application of:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) An exclusion period for specified covered services, as established by the Health Insurance Reform Advisory Committee, applicable to all individuals enrolling for the first time in the small employer health benefit plan.

(4) Late enrollees may be excluded from coverage for up to 12 months or may be subjected to a preexisting conditions provision for up to 12 months. If both an exclusion from coverage period and a preexisting conditions provision are applicable to a late enrollee, the combined period shall not exceed 12 months.

(5) Each small employer health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder, small employer or contract holder except:

(a) For nonpayment of the required premiums by the policyholder, small employer or contract holder.

(b) For fraud or misrepresentation of the policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, the enrollees or their representatives.

(c) When the number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) For noncompliance with the small employer carrier's employer contribution requirements under the health benefit plan.

(e) When the carrier discontinues offering or renewing, or offering and renewing, all of its small employer health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph

(A) of this paragraph if coverage is discontinued in the entire state or, except as provided in subparagraph (C) of this paragraph, in a specified service area;

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area; and

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the small employer market in this state or in the specified service area.

(f) When the carrier discontinues offering and renewing a small employer health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice to the director and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each small employer covered by the plan, all other small employer health benefit plans that the carrier offers in the specified service area. The carrier shall issue any such plans pursuant to the provisions of ORS 743.733 to 743.737. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) When the carrier discontinues offering or renewing, or offering and renewing, a health benefit plan for all small employers in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each small employer covered by the plan, all health benefit plans that the carrier offers in the specified service area.

(B) Issue any such plans pursuant to the provisions of ORS 743.733 to 743.737.

(C) Offer the plans at least 90 days prior to discontinuation.

(D) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(h) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(i) When, in the case of a small employer health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(j) When, in the case of a health benefit plan that is offered in the small employer market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(L) A small employer carrier may modify a small employer health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under paragraphs (e) and (g) of this subsection.

(6) Notwithstanding any provision of subsection (5) of this section to the contrary, any small employer carrier health benefit plan subject to the provisions of ORS 743.733 to 743.737 may be rescinded by a small employer carrier for fraud, material misrepresentation or concealment by a small employer and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.

(7) A small employer carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage. However, participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing group health benefit plan, Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan.

(8) Premium rates for small employer health benefit plans subject to ORS 743.733 to 743.737 shall be subject to the following provisions:

(a) Each small employer carrier issuing health benefit plans to small employers must file its geographic average rate for a rating period with the director on or before March 15 of each year.

(b)(A) The premium rates charged during a rating period for health benefit plans issued to small employers shall not vary from the geographic average rate by more than the following:

(i) 50 percent on October 1, 1996; and

(ii) 33 percent on October 1, 1999.

(B) The variations in premium rates described in subparagraph (A) of this paragraph shall be based solely on differences in the ages of participating employees, except that the premium rate may be adjusted to reflect the provision of benefits not required to be covered by the basic health benefit plan and differences in family composition. In addition:

(i) A small employer carrier shall apply uniformly the carrier's schedule of age adjustments for small employer groups as approved by the director; and

(ii) Except as otherwise provided in this section, the premium rate established for a health benefit plan by a small employer carrier shall apply uniformly to all employees of the small employer enrolled in that plan.

(c) The variation in premium rates between different small employer health benefit plans offered by a small employer carrier must be based solely on objective differences in plan design or coverage and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A small employer carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases shall be effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment attributable to changes in age, except an additional adjustment may be made to reflect the provision of benefits not required to be covered by the basic health benefit plan and differences in family composition.

(e) Premium rates for health benefit plans shall comply with the requirements of this section.

(9) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(a) The full array of health benefit plans that are offered to small employers by the carrier;

(b) The authority of the carrier to adjust rates, and the extent to which the carrier will consider age, family composition and geographic factors in establishing and adjusting rates;

(c) Provisions relating to renewability of policies and contracts; and

(d) Provisions affecting any preexisting conditions provision.

(10)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director annually on or before March 15 an actuarial certification that the carrier is in compliance with ORS 743.733 to 743.737 and that the rating methods of the small employer carrier are actuarially sound. Each such certification shall be in a uniform form and manner and shall contain such information as specified by the director. A copy of such certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in paragraph (a) of this subsection available to the director upon request. Except in cases of violations of ORS 743.733 to 743.737, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside the Department of Consumer and Business Services except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(11) A small employer carrier shall not provide any financial or other incentive to any agent that would encourage such agent to market and sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

(12) For purposes of this section, the date a small employer health benefit plan is continued shall be the anniversary date of the first issuance of the health benefit plan.

(13) A small employer carrier must include a provision that offers coverage to all eligible employees and to all dependents to the extent the employer chooses to offer coverage to dependents.

(14) All small employer health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on July 1, 1997.

(15) All small employer health benefit plans must include the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998, P.L. 105-277. [1991 c.916 §7; 1993 c.18 §161; 1993 c.649 §10; 1995 c.603 §§6,37; 1997 c.716 §§7,8; 1999 c.987 §10; 2001 c.943 §12]

743.738 [Formerly 747.110; renumbered 742.354 in 1989]

743.739 [1991 c.916 §8; repealed by 1995 c.603 §32]

743.740 [1991 c.916 §9; 1993 c.18 §162; repealed by 1995 c.603 §32]

743.741 [Formerly 747.130; renumbered 742.356 in 1989]

743.742 [1991 c.916 §10; repealed by 1995 c.603 §32]

743.743 [1991 c.916 §11; 1993 c.18 §163; 1993 c.649 §13; repealed by 1995 c.603 §32]

743.744 [Formerly 747.140; renumbered 742.358 in 1989]

743.745 Health Insurance Reform Advisory Committee; appointment; duties. The Director of the Department of Consumer and Business Services shall appoint a Health Insurance Reform Advisory Committee. This committee shall consist of at least one insurance agent, one representative of a health maintenance organization, one representative of a health care service contractor, one representative of a domestic insurer, one representative of a labor organization and one representative of consumer interests and shall have representation from the broad range of interests involved in the small employer and individual market and shall include members with the technical expertise necessary to carry out the following duties:

(1)(a) Subject to approval by the director, the committee shall recommend the form and level of coverages under the basic health benefit plans pursuant to ORS 743.736 to be made available by small employer carriers and the portability health benefit plans to be made available pursuant to ORS 743.760 or 743.761. The committee shall take into consideration the levels of health benefit plans provided in Oregon and the appropriate medical and economic factors and shall establish benefit levels, cost sharing, exclusions and limitations. The health benefit plans described in this section may include cost containment features including, but not limited to:

(A) Preferred provider provisions;

(B) Utilization review of health care services including review of medical necessity of hospital and physician services;

(C) Case management benefit alternatives;

(D) Other managed care provisions;

(E) Selective contracting with hospitals, physicians and other health care providers; and

(F) Reasonable benefit differentials applicable to participating and nonparticipating providers.

(b) The committee shall submit the basic and portability health benefit plans and other recommendations to the director within the time period established by the director. The health benefit plans and other recommendations shall be deemed approved unless expressly disapproved by the director within 30 days after the date the director receives the plans.

(2) In order to ensure the broadest availability of small employer and individual health benefit plans, the committee shall recommend for approval by the director market conduct and other requirements for carriers and agents, including requirements developed as a result of a request by the director, relating to the following:

(a) Registration by each carrier with the Department of Consumer and Business Services of its intention to be a small employer carrier under ORS 743.733 to 743.737 or a carrier offering individual health benefit plans, or both.

(b) Publication by the Department of Consumer and Business Services or the committee of a list of all small employer carriers and carriers offering individual health benefit plans, including a potential requirement applicable to

agents and carriers that no health benefit plan be sold to a small employer or individual by a carrier not so identified as a small employer carrier or carrier offering individual health benefit plans.

(c) To the extent deemed necessary by the committee to ensure the fair distribution of high-risk individuals and groups among carriers, periodic reports by carriers and agents concerning small employer, portability and individual health benefit plans issued, provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued, or both, to small employers and individuals.

(d) Methods concerning periodic demonstration by small employer carriers, carriers offering individual health benefit plans and agents that the small employer and individual carriers are marketing or issuing, or both, health benefit plans to small employers or individuals in fulfillment of the purposes of ORS 743.730 to 743.773.

(3) Subject to the approval of the Director of the Department of Consumer and Business Services, the committee shall develop a standard health statement to be used for all late enrollees and by all carriers offering individual policies of health insurance.

(4) Subject to the approval of the director, the committee shall develop a list of the specified services for small employer and portability plans for which carriers may impose an exclusion period, the duration of the allowable exclusion period for each specified service and the manner in which credit will be given for exclusion periods imposed pursuant to prior health insurance coverage. [1991 c.916 §12; 1993 c.18 §164; 1995 c.603 §§10,38; 1999 c.987 §11]

743.746 [1997 c.716 §9c; repealed by 1999 c.987 §28]

743.747 [Formerly 747.150; renumbered 742.360 in 1989]

743.749 Certifications and disclosure of coverage. All carriers that offer individual or group health benefit plans shall provide certifications and disclosure of coverage in accordance with 42 U.S.C. 300gg(e) and 300gg-43 as amended and in effect on July 1, 1997. [1997 c.716 §20]

743.750 [1967 c.359 §516; renumbered 742.362 in 1989]

743.751 Use of health statements in group health benefit plans. (1) Except to determine the application of a preexisting conditions provision for a late enrollee, a carrier offering group health benefit plans shall not use health statements when offering such plans to a group of two or more prospective certificate holders and shall not use any other method to determine the actual or expected health status of eligible prospective enrollees. Nothing in this section shall prevent a carrier from using health statements or other information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan or from obtaining aggregate group information related to historical medical claims expenses and health behavior surveys for rating purposes.

(2) Subsection (1) of this section applies only to group health benefit plans that are not small employer health benefit plans. [1995 c.603 §15; 1997 c.716 §10]

743.752 Coverage in group health benefit plans; consideration of prospective enrollee health status restricted; effect of discontinuing offer of plans; exceptions; coverage by multiple employer welfare arrangements. (1) Except in the case of a late enrollee and as otherwise provided in this section, a carrier offering a group health benefit plan to a group of two or more prospective certificate holders shall not decline to offer coverage to any eligible prospective enrollee and shall not impose different terms or conditions on the coverage, premiums or contributions of any enrollee in the group that are based on the actual or expected health status of the enrollee.

(2) A carrier that elects to discontinue offering all of its group health benefit plans under ORS 743.754 (6)(e), elects to discontinue renewing all such plans or elects to discontinue offering and renewing all such plans is prohibited from offering health benefit plans in the group market in this state for a period of five years from one of the following dates:

(a) The date of notice to the Director of the Department of Consumer and Business Services pursuant to ORS 743.754 (6)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering group health benefit plans in this state.

(3) Subsection (1) of this section applies only to group health benefit plans that are not small employer health

benefit plans.

(4) Nothing in this section shall prohibit an employer from providing different group health benefit plans to various categories of employees as defined by the employer nor prohibit an employer from providing health benefit plans through different carriers so long as the employer's categories of employees are established in a manner that does not relate to the actual or expected health status of the employees or their dependents.

(5) A multiple employer welfare arrangement, professional or trade association, or other similar arrangement established or maintained to provide benefits to a particular trade, business, profession or industry or their subsidiaries, shall not issue coverage to a group or individual that is not in the same trade, business, profession or industry or their subsidiaries as that covered by the arrangement. The arrangement shall accept all groups and individuals in the same trade, business, profession or industry or their subsidiaries that apply for coverage under the arrangement and that meet the requirements for membership in the arrangement. For purposes of this subsection, the requirements for membership in an arrangement shall not include any requirements that relate to the actual or expected health status of the prospective enrollee. [1995 c.603 §16; 1997 c.716 §11; 1999 c.987 §12]

743.753 [Formerly 747.170; 1969 c.526 §2; renumbered 742.364 in 1989]

743.754 Requirements for group health benefit plans and for discontinuation of plans. The following requirements apply to all group health benefit plans covering two or more certificate holders:

(1) A preexisting conditions provision in a group health benefit plan shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the enrollment date of an enrollee or late enrollee. As used in this section, the enrollment date of an enrollee shall be the earlier of the effective date of coverage or the first day of any required group eligibility waiting period and the enrollment date of a late enrollee shall be the effective date of coverage.

(2) A preexisting conditions provision in a group health benefit plan shall terminate its effect as follows:

(a) For an enrollee not later than the first of the following dates:

(A) Six months following the enrollee's effective date of coverage; or

(B) Twelve months following the start of any required group eligibility waiting period.

(b) For a late enrollee, not later than 12 months following the late enrollee's effective date of coverage.

(3) In applying a preexisting conditions provision to an enrollee or late enrollee, except as provided in this subsection, all group benefit plans shall reduce the duration of the provision by an amount equal to the enrollee's or late enrollee's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the enrollment date in the new group health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period. This subsection does not preclude, within a group health benefit plan, application of:

(a) An affiliation period that does not exceed two months for an enrollee or three months for a late enrollee; or

(b) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the group health benefit plan.

(4) Late enrollees may be excluded from coverage for up to 12 months or may be subjected to a preexisting conditions provision for up to 12 months. If both an exclusion from coverage period and a preexisting conditions provision are applicable to a late enrollee, the combined period shall not exceed 12 months.

(5) All group health benefit plans shall contain special enrollment periods during which eligible employees and dependents may enroll for coverage, as provided in 42 U.S.C. 300gg as amended and in effect on July 1, 1997.

(6) Each group health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder except:

(a) For nonpayment of the required premiums by the policyholder.

(b) For fraud or misrepresentation of the policyholder or, with respect to coverage of individual enrollees, the enrollees or their representatives.

(c) When the number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan.

(d) For noncompliance with the carrier's employer contribution requirements under the health benefit plan.

(e) When the carrier discontinues offering or renewing, or offering and renewing, all of its group health benefit plans in this state or in a specified service area within this state. In order to discontinue plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Director of the Department of Consumer and Business Services and to

all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except as provided in subparagraph (C) of this paragraph, in a specified service area;

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area; and

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the group market in this state or in the specified service area.

(f) When the carrier discontinues offering and renewing a group health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice of the decision to the director and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other group health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(g) When the carrier discontinues offering or renewing, or offering and renewing, a health benefit plan for all groups in this state or in a specified service area within this state, other than a plan discontinued under paragraph (f) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans that the carrier offers in the specified service area.

(B) Offer the plans at least 90 days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(h) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet contractual obligations.

(i) When, in the case of a group health benefit plan that delivers covered services through a specified network of health care providers, there is no longer any enrollee who lives, resides or works in the service area of the provider network.

(j) When, in the case of a health benefit plan that is offered in the group market only through one or more bona fide associations, the membership of an employer in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(k) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide services to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(L) A carrier may modify a group health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under paragraphs (e) and (g) of this subsection.

(7) Notwithstanding any provision of subsection (6) of this section to the contrary, a group health benefit plan may be rescinded by a carrier for fraud, material misrepresentation or concealment by a policyholder and the coverage of an enrollee may be rescinded for fraud, material misrepresentation or concealment by the enrollee.

(8) A carrier that continues to offer coverage in the group market in this state is not required to offer coverage in all of the carrier's group health benefit plans. If a carrier, however, elects to continue a plan that is closed to new policyholders instead of offering alternative coverage in its other group health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (6) of this section.

(9) All group health benefit plans must include the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998, P.L. 105-277.

(10) This section applies only to group health benefit plans that are not small employer health benefit plans. [1995 c.603 §17; 1995 c.603 §40; 1997 c.716 §§12,13; 1999 c.987 §13; 2001 c.943 §13]

743.755 [1969 c.526 §1; renumbered 742.366 in 1989]

743.756 [Formerly 747.180; renumbered 742.368 in 1989]

743.758 Implementation of Health Insurance Portability and Accountability Act of 1996; rules. The Department of Consumer and Business Services may adopt rules incorporating, implementing and administering the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and federal regulations that are issued in conjunction with the Act, to the extent that such federal law and regulations are not inconsistent with any provision of Oregon law. [1997 c.716 §21]

743.759 [Formerly 747.190; renumbered 742.370 in 1989]

743.760 Approval of portability plans; offering of plans by carriers; required provisions; actuarial certification. (1) As used in this section:

(a) "Carrier" means an insurer authorized to issue a policy of health insurance in this state. "Carrier" does not include a multiple employer welfare arrangement.

(b)(A) "Eligible individual" means an individual who:

(i) Has left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans, has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident at the time of such application; or

(ii) On or after January 1, 1998, meets the eligibility requirements of 42 U.S.C. 300gg-41, as amended and in effect on January 1, 1998, has applied for portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and is an Oregon resident at the time of such application.

(B) Except as provided in subsection (12) of this section, "eligible individual" does not include an individual who remains eligible for the individual's prior group coverage or would remain eligible for prior group coverage in a plan under the federal Employee Retirement Income Security Act of 1974, as amended, were it not for action by the plan sponsor relating to the actual or expected health condition of the individual, or who is covered under another health benefit plan at the time that portability coverage would commence or is eligible for the federal Medicare program.

(c) "Portability health benefit plans" and "portability plans" mean health benefit plans for eligible individuals that are required to be offered by all carriers offering group health benefit plans and that have been approved by the Director of the Department of Consumer and Business Services in accordance with this section.

(2)(a) In order to improve the availability and affordability of health benefit plans for individuals leaving coverage under group health benefit plans, the Health Insurance Reform Advisory Committee created under ORS 743.745 shall submit to the director two portability health benefit plans pursuant to ORS 743.745. One plan shall be in the form of insurance and the second plan shall be consistent with the type of coverage provided by health maintenance organizations. For each type of portability plan, the committee shall design and submit to the director:

(A) A prevailing benefit plan, which shall reflect the benefit coverages that are prevalent in the group health insurance market; and

(B) A low cost benefit plan, which shall emphasize affordability for eligible individuals.

(b) Except as provided in ORS 743.730 to 743.773, no law requiring the coverage or the offer of coverage of a health care service or benefit shall apply to portability health benefit plans.

(3) The director shall approve the portability health benefit plans if the director determines that the plans provide for appropriate accessibility and affordability of needed health care services and comply with all other provisions of this section.

(4) After the director's approval of the portability plans submitted by the committee under this section, each carrier offering group health benefit plans shall submit to the director the policy form or forms containing at least one low cost benefit and one prevailing benefit portability plan offered by the carrier that meets the required standards. Each policy form must be submitted as prescribed by the director and is subject to review and approval pursuant to ORS 742.003.

(5) Within 180 days after approval by the director of the portability plans submitted by the committee, as a condition of transacting group health insurance in this state, each carrier offering group health benefit plans shall make available to eligible individuals the prevailing benefit and low cost benefit portability plans that have been submitted by the carrier and approved by the director under subsection (4) of this section.

(6) A carrier offering group health benefit plans shall issue to an eligible individual who is leaving or has left group coverage provided by that carrier any portability plan offered by the carrier if the eligible individual applies for the plan within 63 days of termination of prior coverage and agrees to make the required premium payments and to satisfy the other provisions of the portability plan.

(7) Premium rates for portability plans shall be subject to the following provisions:

(a) Each carrier must file the geographic average rate for each of its portability health benefit plans for a rating period with the director on or before March 15 of each year.

(b) The premium rates charged during the rating period for each portability health benefit plan shall not vary from the geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. Adjustments for age shall comply with the following:

(A) For each plan, the variation between the lowest premium rate and the highest premium rate shall not exceed 100 percent of the lowest premium rate.

(B) Premium variations shall be determined by applying uniformly the carrier's schedule of age adjustments for portability plans as approved by the director.

(c) Premium variations between the portability plans and the rest of the carrier's group plans must be based solely on objective differences in plan design or coverage and must not include differences based on the actual or expected health status of individuals who select portability health benefit plans. For purposes of determining the premium variations under this paragraph, a carrier may:

(A) Pool all portability plans with all group health benefit plans; or

(B) Pool all portability plans for eligible individuals leaving small employer group health benefit plan coverage with all plans offered to small employers and pool all portability plans for eligible individuals leaving other group health benefit plan coverage with all health benefit plans offered to such other groups.

(d) A carrier may not increase the rates of a portability plan issued to an enrollee more than once in any 12-month period. Annual rate increases shall be effective on the anniversary date of the plan issued to the enrollee. The percentage increase in the premium rate charged to an enrollee for a new rating period may not exceed the average increase in the rest of the carrier's applicable group health benefit plans plus an adjustment for age.

(8) No portability plans under this section may contain preexisting conditions provisions, exclusion periods, waiting periods or other similar limitations on coverage.

(9) Portability health benefit plans shall be renewable with respect to all enrollees at the option of the enrollee, except:

(a) For nonpayment of the required premiums by the policyholder;

(b) For fraud or misrepresentation by the policyholder;

(c) When the carrier elects to discontinue offering all of its group health benefit plans in accordance with ORS 743.737 and 743.754; or

(d) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollees; or

(B) Impair the carrier's ability to meet its contractual obligations.

(10)(a) Each carrier offering group health benefit plans shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices relating to its portability plans, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial practices and are in accordance with sound actuarial principles.

(b) Each such carrier shall file with the director annually on or before March 15 an actuarial certification that the carrier is in compliance with this section and that its rating methods are actuarially sound. Each such certification shall be in a form and manner and shall contain such information as specified by the director. A copy of such certification shall be retained by the carrier at its principal place of business.

(c) Each such carrier shall make the information and documentation described in paragraph (a) of this subsection available to the director upon request. Except in cases of violations of the Insurance Code, the information is proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside the Department of Consumer and Business Services except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(11) A carrier offering group health benefit plans shall not provide any financial or other incentive to any agent that would encourage the agent to market and sell portability plans of the carrier on the basis of an eligible individual's anticipated claims experience.

(12) An individual who is eligible to obtain a portability plan in accordance with this section may obtain such a plan regardless of whether the eligible individual qualifies for a period of continuation coverage under federal law or under ORS 743.600 or 743.610. However, an individual who has elected such continuation coverage is not eligible to obtain a portability plan until the continuation coverage has been discontinued by the individual or has been exhausted. [1995 c.603 §18; 1997 c.716 §25; 1999 c.987 §14]

743.761 Satisfaction of requirements of ORS 743.760 by carrier offering individual health benefit plans. (1) A carrier approved pursuant to subsection (4) of this section that offers individual health benefit plans may satisfy the requirements of ORS 743.760 by issuing any individual health benefit plan offered by the carrier to any eligible individual as defined in ORS 743.760 who:

(a) Is leaving or has left a group health benefit plan provided by that carrier;

(b) Applies for the policy; and

(c) Agrees to make the required premium payments and to satisfy the other provisions of the plan.

(2) All health benefit plans issued pursuant to subsection (1) of this section shall:

(a) Comply with ORS 743.767 and 743.769; and

(b) Contain no preexisting conditions provisions, exclusion periods, waiting periods or other similar limitations on coverage.

(3) A carrier offering plans pursuant to this section shall offer plans that meet the standards and requirements described in ORS 743.760 (2).

(4) The Director of the Department of Consumer and Business Services shall adopt standards for minimum participation in the individual market necessary for a carrier to offer policies under this section and shall develop a program for approval of carriers under this section. [1995 c.603 §19]

743.762 [Formerly 747.082; 1989 c.634 §1; renumbered 742.372 in 1989]

743.763 [1995 c.603 §20; 1997 c.716 §26; renumbered 735.616 in 1997]

743.765 [Formerly 747.084; 1989 c.634 §2; renumbered 742.374 in 1989]

743.766 Use of health statements in individual health benefit plans; exclusions or limitations on coverage; eligibility to apply for Oregon Medical Insurance Pool; renewal; discontinuation of coverage. (1) All carriers who offer individual health benefit plans and evaluate the health status of individuals for purposes of eligibility shall use the standard health statement established by the Health Insurance Reform Advisory Committee and may not use any other method to determine the health status of an individual. Nothing in this subsection shall prevent a carrier from using health information after enrollment for the purpose of providing services or arranging for the provision of services under a health benefit plan.

(2)(a) If an individual is accepted for coverage under an individual health benefit plan, the carrier shall not impose exclusions or limitations on coverage greater than:

(A) A preexisting conditions provision that complies with the following requirements:

(i) The provision shall apply only to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six-month period immediately preceding the individual's effective date of coverage; and

(ii) The provision shall terminate its effect no later than six months following the individual's effective date of coverage;

(B) An individual coverage waiting period of 90 days; or

(C) An exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(b) Pregnancy may constitute a preexisting condition for purposes of this section.

(3) If the carrier elects to restrict coverage through the application of a preexisting conditions provision or an individual coverage waiting period provision, the carrier shall reduce the duration of the provision by an amount equal to the individual's aggregate periods of creditable coverage if the most recent period of creditable coverage is ongoing or ended within 63 days of the effective date of coverage in the new individual health benefit plan. The crediting of prior coverage in accordance with this subsection shall be applied without regard to the specific benefits covered during the prior period.

(4) If an eligible prospective enrollee is rejected for coverage under an individual health benefit plan, the prospective enrollee shall be eligible to apply for coverage under the Oregon Medical Insurance Pool.

(5) If a carrier accepts an individual for coverage under an individual health benefit plan, the carrier shall renew the policy except:

(a) For nonpayment of the required premiums by the policyholder.

(b) For fraud or misrepresentation by the policyholder.

(c) When the carrier discontinues offering or renewing, or offering and renewing, all of its individual health benefit plans in this state or in a specified service area within this state. In order to discontinue the plans under this paragraph, the carrier:

(A) Must give notice of the decision to the Director of the Department of Consumer and Business Services and to all policyholders covered by the plans;

(B) May not cancel coverage under the plans for 180 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in the entire state or, except as provided in subparagraph (C) of this paragraph, in a specified service area;

(C) May not cancel coverage under the plans for 90 days after the date of the notice required under subparagraph (A) of this paragraph if coverage is discontinued in a specified service area because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plans within the service area; and

(D) Must discontinue offering or renewing, or offering and renewing, all health benefit plans issued by the carrier in the individual market in this state or in the specified service area.

(d) When the carrier discontinues offering and renewing an individual health benefit plan in a specified service area within this state because of an inability to reach an agreement with the health care providers or organization of health care providers to provide services under the plan within the service area. In order to discontinue a plan under this paragraph, the carrier:

(A) Must give notice of the decision to the director and to all policyholders covered by the plan;

(B) May not cancel coverage under the plan for 90 days after the date of the notice required under subparagraph (A) of this paragraph; and

(C) Must offer in writing to each policyholder covered by the plan, all other individual health benefit plans that the carrier offers in the specified service area. The carrier shall offer the plans at least 90 days prior to discontinuation.

(e) When the carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan for all individuals in this state or in a specified service area within this state, other than a plan discontinued under paragraph (d) of this subsection. With respect to plans that are being discontinued, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more individual health benefit plans that the carrier offers in the specified service area.

(B) Offer the plans at least 90 days prior to discontinuation.

(C) Act uniformly without regard to the claims experience of the affected policyholders or the health status of any current or prospective enrollee.

(f) When the director orders the carrier to discontinue coverage in accordance with procedures specified or approved by the director upon finding that the continuation of the coverage would:

(A) Not be in the best interests of the enrollee; or

(B) Impair the carrier's ability to meet its contractual obligations.

(g) When, in the case of an individual health benefit plan that delivers covered services through a specified network of health care providers, the enrollee no longer lives, resides or works in the service area of the provider network and the termination of coverage is not related to the health status of any enrollee.

(h) When, in the case of a health benefit plan that is offered in the individual market only through one or more bona fide associations, the membership of an individual in the association ceases and the termination of coverage is not related to the health status of any enrollee.

(i) For misuse of a provider network provision. As used in this paragraph, "misuse of a provider network provision" means a disruptive, unruly or abusive action taken by an enrollee that threatens the physical health or well-being of health care staff and seriously impairs the ability of the carrier or its participating providers to provide service to an enrollee. An enrollee under this paragraph retains the rights of an enrollee under ORS 743.804.

(j) A carrier may modify an individual health benefit plan at the time of coverage renewal. The modification is not a discontinuation of the plan under paragraphs (c) and (e) of this subsection.

(6) Notwithstanding any other provision of this section, a carrier may rescind an individual health benefit plan for

fraud, material misrepresentation or concealment by an enrollee.

(7) A carrier that withdraws from the market for individual health benefit plans must continue to renew its portability health benefit plans that have been approved pursuant to ORS 743.761.

(8) A carrier that continues to offer coverage in the individual market in this state is not required to offer coverage in all of the carrier's individual health benefit plans. However, if a carrier elects to continue a plan that is closed to new individual policyholders instead of offering alternative coverage in its other individual health benefit plans, the coverage for all existing policyholders in the closed plan is renewable in accordance with subsection (5) of this section.

(9) All individual health benefit plans must include the benefit provisions of the federal Women's Health and Cancer Rights Act of 1998, P.L. 105-277. [1995 c.603 §§22,41; 1997 c.716 §§15,16; 1999 c.987 §15; 2001 c.943 §14]

743.767 Premium rates for individual health benefit plans. Premium rates for individual health benefit plans shall be subject to the following provisions:

(1) Each carrier must file the geographic average rate for its individual health benefit plans for a rating period with the Director of the Department of Consumer and Business Services on or before March 15 of each year.

(2) The premium rates charged during a rating period for individual health benefit plans issued to individuals shall not vary from the individual geographic average rate, except that the premium rate may be adjusted to reflect differences in benefit design, family composition and age. For age adjustments to the individual plans, a carrier shall apply uniformly its schedule of age adjustments for individual health benefit plans as approved by the director.

(3) A carrier may not increase the rates of an individual health benefit plan more than once in a 12-month period except as approved by the director. Annual rate increases shall be effective on the anniversary date of the individual health benefit plan's issuance. The percentage increase in the premium rate charged for an individual health benefit plan for a new rating period may not exceed the sum of the following:

(a) The percentage change in the carrier's geographic average rate for its individual health benefit plan measured from the first day of the prior rating period to the first day of the new period; and

(b) Any adjustment attributable to changes in age and differences in benefit design and family composition.

(4) Notwithstanding any other provision of this section, a carrier that imposes an individual coverage waiting period pursuant to ORS 743.766 may impose a monthly premium rate surcharge for a period not to exceed six months and in an amount not to exceed the percentage by which the rates for coverage under the Oregon Medical Insurance Pool exceed the rates established by the Oregon Medical Insurance Pool Board as applicable for individual risks under ORS 735.625. The surcharge shall be approved by the Director of the Department of Consumer and Business Services and, in combination with the waiting period, shall not exceed the actuarial value of a six-month preexisting conditions provision. [1995 c.603 §23; 1999 c.987 §16]

743.768 [Formerly 747.086; 1983 c.338 §964; 1989 c.634 §3; renumbered 742.376 in 1989]

743.769 Carrier marketing of individual health benefit plans; duties of carrier regarding applications; effect of discontinuing offer of plans. (1) Each carrier shall actively market all individual health benefit plans sold by the carrier.

(2) Except as provided in subsection (3) of this section, no carrier or agent shall, directly or indirectly, discourage an individual from filing an application for coverage because of the health status, claims experience, occupation or geographic location of the individual.

(3) Subsection (2) of this section shall not apply with respect to information provided by a carrier to an individual regarding the established geographic service area or a restricted network provision of a carrier.

(4) Rejection by a carrier of an application for coverage shall be in writing and shall state the reason or reasons for the rejection.

(5) The Director of the Department of Consumer and Business Services may establish by rule additional standards to provide for the fair marketing and broad availability of individual health benefit plans.

(6) A carrier that elects to discontinue offering all of its individual health benefit plans under ORS 743.766 (5)(c) or to discontinue offering and renewing all such plans is prohibited from offering and renewing health benefit plans in the individual market in this state for a period of five years from the date of notice to the director pursuant to ORS 743.766 (5)(c) or, if such notice is not provided, from the date on which the director provides notice to the carrier that the director has determined that the carrier has effectively discontinued offering individual health benefit plans in this state. This subsection does not apply with respect to a health benefit plan discontinued in a specified service area by a carrier that covers services provided only by a particular organization of health care providers or only by health care

providers who are under contract with the carrier. [1995 c.603 §24; 1999 c.987 §17]

743.770 [Formerly 743.780; 1987 c.774 §60; renumbered 742.400 in 1989]

743.771 [1987 c.774 §151; renumbered 742.405 in 1989]

743.772 [Formerly 743.783; renumbered 742.031 in 1989]

743.773 Rules for ORS 743.766 to 743.769. The Director of the Department of Consumer and Business Services shall adopt all rules necessary for the implementation and administration of ORS 743.766 to 743.769. [1995 c.603 §25]

743.774 [Formerly 486.097; renumbered 806.190 in 1987]

743.776 [Formerly 486.541; renumbered 742.450 in 1989]

743.778 [Formerly 486.546; renumbered 742.454 in 1989]

743.779 [Formerly 486.551; 1989 c.700 §14; renumbered 742.456 in 1989]

743.780 [1975 c.796 §10; 1977 c.448 §12; 1985 c.103 §14; 1985 c.323 §10; 1985 c.624 §17a; renumbered 743.770; renumbered 742.400 in 1989]

743.781 [Formerly 486.556; 1989 c.700 §15; renumbered 742.458 in 1989]

743.782 [Formerly 486.561; 1989 c.700 §16; renumbered 742.460 in 1989]

743.783 [Formerly 736.320; renumbered 743.772; renumbered 742.031 in 1989]

743.784 [Formerly 486.564; 1989 c.700 §17; renumbered 742.462 in 1989]

743.785 [Formerly 486.566; renumbered 742.464 in 1989]

743.786 [1967 c.482 §1; 1971 c.523 §11; 1979 c.842 §7; 1983 c.338 §965; renumbered 742.500 in 1989]

743.787 Definitions for ORS 743.788. As used in ORS 743.788:
(1) “Carrier” has the meaning given that term in ORS 743.730.
(2) “Enrollee” has the meaning given that term in ORS 743.730.
(3) “Health benefit plan” has the meaning given that term in ORS 743.730. [2001 c.549 §2]

Note: 743.787 becomes operative July 1, 2003. See section 5, chapter 549, Oregon Laws 2001.

743.788 Prescription drug identification card. (1) A carrier that provides coverage for prescription drugs provided on an outpatient basis and issues a card or other technology for claims processing, or an administrator of a health benefit plan including, but not limited to, a third party administrator for a self-insured plan, a pharmacy benefits manager and an administrator of a state administered plan, shall issue to an enrollee a prescription drug identification card or other technology that contains all information required for proper claims adjudication.

(2) Upon renewal of a health benefit plan, a carrier or administrator shall issue a prescription drug identification card or other technology containing all current information required for proper claims adjudication.

(3) A carrier or administrator of a health benefit plan is not required to issue a prescription drug identification card or other technology separate from another identification card or technology issued to an enrollee under the health benefit plan if the identification card or technology contains all of the information required for proper claims adjudication. [2001 c.549 §3]

Note: 743.788 becomes operative July 1, 2003. See section 5, chapter 549, Oregon Laws 2001.

743.789 [1967 c.482 §2; 1975 c.390 §1; 1981 c.586 §1; 1983 c.338 §966; 1987 c.632 §1; renumbered 742.502 in 1989]

743.790 Rules for prescription drug identification cards. The Director of the Department of Consumer and Business Services may adopt rules to implement ORS 743.788 and may consider any relevant standards developed by a standards development organization accredited by the American National Standards Institute that represents organizations interested in electronic standardization with the pharmacy services sector of the health care industry and the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. [2001 c.549 §4]

743.792 [1967 c.482 §3; 1977 c.600 §3; 1979 c.842 §8; 1983 c.338 §967; renumbered 742.504 in 1989]

743.795 [1979 c.842 §10; renumbered 742.506 in 1989]

743.796 [1987 c.742 §3; renumbered 742.508 in 1989]

743.797 [1987 c.742 §2; renumbered 742.510 in 1989]

743.800 [1971 c.523 §2; 1973 c.551 §1; 1975 c.784 §1; 1979 c.871 §45; 1981 c.414 §1; 1983 c.338 §968; 1987 c.588 §1; renumbered 742.520 in 1989]

MISCELLANEOUS

743.801 Definitions for ORS 743.699, 743.801 to 743.839 and 743.854 to 743.868. As used in ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.809, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.866 and 743.868:

(1) “Emergency medical condition” means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

(2) “Emergency medical screening exam” means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(3) “Emergency services” means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of a patient.

(4) “Enrollee” has the meaning given that term in ORS 743.730.

(5) “Grievance” means a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(6) “Health benefit plan” has the meaning provided for that term in ORS 743.730.

(7) “Independent practice association” means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 743.522, to provide health care services to group members.

(8) “Insurer” has the meaning provided for that term in ORS 731.106. For purposes of ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.809, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.866, 743.868, 750.055 and 750.333, “insurer” also includes a health care service contractor as defined in ORS 750.005.

(9) “Managed health insurance” means any health benefit plan that:

(a) Requires an enrollee to use a specified network or networks of providers managed, owned, under contract with or employed by the insurer in order to receive benefits under the plan, except for emergency or other specified limited service; or

(b) In addition to the requirements of paragraph (a) of this subsection, offers a point-of-service provision that allows an enrollee to use providers outside of the specified network or networks at the option of the enrollee and receive a reduced level of benefits.

(10) “Medical services contract” means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. “Medical services contract” does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(11)(a) “Preferred provider organization insurance” means any health benefit plan that:

(A) Specifies a preferred network of providers managed, owned or under contract with or employed by an insurer;

(B) Does not require an enrollee to use the preferred network of providers in order to receive benefits under the plan; and

(C) Creates financial incentives for an enrollee to use the preferred network of providers by providing an increased level of benefits.

(b) “Preferred provider organization insurance” does not mean a health benefit plan that has as its sole financial incentive a hold harmless provision under which providers in the preferred network agree to accept as payment in full the maximum allowable amounts that are specified in the medical services contracts.

(12) “Prior authorization” means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. “Prior authorization” does not include referral approval for evaluation and management services between providers.

(13) “Provider” means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(14) “Stabilization” means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

(15) “Utilization review” means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. [1995 c.672 §1; 1997 c.343 §18; 2001 c.266 §1; 2001 c.747 §5]

Note: The amendments to 743.801 by section 1, chapter 266, Oregon Laws 2001, become operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001. The text that is operative until July 1, 2002, including amendments by section 5, chapter 747, Oregon Laws 2001, is set forth for the user’s convenience.

743.801. As used in ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.809, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.866 and 743.868:

(1) “Emergency medical condition” means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

(2) “Emergency medical screening exam” means the medical history, examination, ancillary tests and medical determinations required to ascertain the nature and extent of an emergency medical condition.

(3) “Emergency services” means those health care items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of a patient.

(4) “Enrollee” has the meaning given that term in ORS 743.730.

(5) “Grievance” means a written complaint submitted by or on behalf of an enrollee regarding the:

(a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(6) “Health benefit plan” has the meaning provided for that term in ORS 743.730.

(7) “Independent practice association” means a corporation wholly owned by providers, or whose membership consists entirely of providers, formed for the sole purpose of contracting with insurers for the provision of health care services to enrollees, or with employers for the provision of health care services to employees, or with a group, as described in ORS 743.522, to provide health care services to group members.

(8) “Insurer” has the meaning provided for that term in ORS 731.106. For purposes of ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.809, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839, 743.866, 743.868, 750.055 and 750.333, “insurer” also includes a health care service contractor as defined in ORS 750.005.

(9) “Managed health insurance” means any health benefit plan that:

(a) Requires an enrollee to use, or creates incentives for an enrollee to use, providers managed, owned, under contract with or employed by the insurer; and

(b) Reimburses any of the providers described in paragraph (a) of this subsection on a basis other than fee-for-service billing or discounts from fee-for-service billing.

(10) “Medical services contract” means a contract between an insurer and an independent practice association, between an insurer and a provider, between an independent practice association and a provider or organization of providers, between medical or mental health clinics, and between a medical or mental health clinic and a provider to provide medical or mental health services. “Medical services contract” does not include a contract of employment or a contract creating legal entities and ownership thereof that are authorized under ORS chapter 58, 60 or 70, or other similar professional organizations permitted by statute.

(11) “Prior authorization” means a determination by an insurer prior to provision of services that the insurer will provide reimbursement for the services. “Prior authorization” does not include referral approval for evaluation and management services between providers.

(12) “Provider” means a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession.

(13) “Stabilization” means that, within reasonable medical probability, no material deterioration of an emergency medical condition is likely to occur.

(14) “Utilization review” means a set of formal techniques used by an insurer or delegated by the insurer designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings.

743.802 [1987 c.588 §5; renumbered 742.522 in 1989]

743.803 Medical services contract provisions; nonprovider party prohibitions; future contracts. (1) A medical services contract may not require the provider, as an element of the contract or as a condition of compensation for services, to agree:

(a) In the event of alleged improper medical treatment of a patient, to indemnify the other party to the medical services contract for any damages, awards or liabilities including but not limited to judgments, settlements, attorney fees, court costs and any associated charges incurred for any reason other than the negligence or intentional act of the provider or the provider’s employees;

(b) To charge the other party to the medical services contract a rate for services rendered pursuant to the medical services contract that is no greater than the lowest rate that the provider charges for the same service to any other person;

(c) To deny care to a patient because of a determination made pursuant to the medical services contract that the care is not covered or is experimental, or to deny referral of a patient to another provider for the provision of such care, if the patient is informed that the patient will be responsible for the payment of such noncovered, experimental or referral care and the patient nonetheless desires to obtain such care or referral; or

(d) Upon the provider’s withdrawal from or termination or nonrenewal of the medical services contract, not to treat or solicit a patient even at that patient’s request and expense.

(2) A medical services contract shall:

(a) Grant to the provider adequate notice and hearing procedures, or such other procedures as are fair to the provider under the circumstances, prior to termination or nonrenewal of the medical services contract when such termination or nonrenewal is based upon issues relating to the quality of patient care rendered by the provider.

(b) Set forth generally the criteria used by the other party to the medical services contract for the termination or

nonrenewal of the medical services contract.

(c) Entitle the provider to an annual accounting accurately summarizing the financial transactions between the parties to the medical services contract for that year.

(d) Allow the provider to withdraw from the care of a patient when, in the professional judgment of the provider, it is in the best interest of the patient to do so.

(e) Provide that a doctor of medicine or osteopathy licensed under ORS chapter 677 shall be retained by the other party to the medical services contract and shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the medical services contract.

(f) Provide that a physician who is practicing in conformity with ORS 677.095 may advocate a decision, policy or practice without being subject to termination or penalty for the sole reason of such advocacy.

(g)(A) Entitle the party to the medical services contract who is being reimbursed for the provision of health care services on a basis that includes financial risk withholds, or the party's representative, to a full accounting of health benefits claims data and related financial information on no less than a quarterly basis by the party to a medical service contract who has made reimbursement, as follows:

(i) The data shall include all pertinent information relating to the health care services provided, including related provider and patient information, reimbursements made and amounts withheld under the financial risk withhold provisions of the medical services contract for the period of time under reconciliation and settlement between the parties.

(ii) Any reconciliation and settlement undertaken pursuant to a medical services contract shall be based directly and exclusively upon data provided to the party who is being reimbursed for the provision of health care services.

(iii) All data, including supplemental information or documentation, necessary to finalize the reconciliation and settlement provisions of a medical services contract relating to financial risk withholds shall be provided to the party who is being reimbursed for the provision of health care services no later than 30 days prior to finalizing the reconciliation and settlement.

(B) Nothing in this paragraph shall be construed to prevent parties to a medical services contract from mutually agreeing to alternative reconciliation and settlement policies and procedures.

(h) Provide that when continuity of care is required to be provided under a health benefit plan by ORS 743.854, the insurer and the individual provider shall provide continuity of care to enrollees as provided in ORS 743.854.

(3) The other party to a medical services contract shall not:

(a) Refer to other documents or instruments in a contract unless the nonprovider party agrees to make available to the provider for review a copy of the documents or instruments within 72 hours of request; or

(b) Provide as an element of a contract with a third party relating to the provision of medical services to a patient of the provider that the provider's patient may not sue or otherwise recover from the nonprovider party, or must hold the nonprovider party harmless for, any and all expenses, damages, awards or liabilities that arise from the management decisions, utilization review provisions or other policies or determinations of the nonprovider party that have an impact on the provider's treatment decisions and actions with regard to the patient.

(4) An insurer, independent practice association, medical or mental health clinic or other party to a medical services contract shall provide the criteria for selection of parties to future medical services contracts upon the request of current or prospective parties. [1995 c.672 §2; 1997 c.343 §19; 1997 c.759 §4; 1999 c.271 §1; 2001 c.266 §4]

Note: The amendments to 743.803 by section 4, chapter 266, Oregon Laws 2001, become operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001. The text that is operative until July 1, 2002, is set forth for the user's convenience.

743.803. (1) No medical services contract may require the provider, as an element of the contract or as a condition of compensation for services, to agree:

(a) In the event of alleged improper medical treatment of a patient, to indemnify the other party to the medical services contract for any damages, awards or liabilities including but not limited to judgments, settlements, attorney fees, court costs and any associated charges incurred for any reason other than the negligence or intentional act of the provider or the provider's employees;

(b) To charge the other party to the medical services contract a rate for services rendered pursuant to the medical services contract that is no greater than the lowest rate that the provider charges for the same service to any other person;

(c) To deny care to a patient because of a determination made pursuant to the medical services contract that the care is not covered or is experimental, or to deny referral of a patient to another provider for the provision of such

care, if the patient is informed that the patient will be responsible for the payment of such noncovered, experimental or referral care and the patient nonetheless desires to obtain such care or referral; or

(d) Upon the provider's withdrawal from or termination or nonrenewal of the medical services contract, not to treat or solicit a patient even at that patient's request and expense.

(2) All medical services contracts shall:

(a) Grant to the provider adequate notice and hearing procedures, or such other procedures as are fair to the provider under the circumstances, prior to termination or nonrenewal of the medical services contract when such termination or nonrenewal is based upon issues relating to the quality of patient care rendered by the provider.

(b) Set forth generally the criteria used by the other party to the medical services contract for the termination or nonrenewal of the medical services contract.

(c) Entitle the provider to an annual accounting accurately summarizing the financial transactions between the parties to the medical services contract for that year.

(d) Allow the provider to withdraw from the care of a patient when, in the professional judgment of the provider, it is in the best interest of the patient to do so.

(e) Provide that a doctor of medicine or osteopathy licensed under ORS chapter 677 shall be retained by the other party to the medical services contract and shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the medical services contract.

(f) Provide that a physician who is practicing in conformity with ORS 677.095 may advocate a decision, policy or practice without being subject to termination or penalty for the sole reason of such advocacy.

(g)(A) Entitle the party to the medical services contract who is being reimbursed for the provision of health care services on a basis that includes financial risk withholds, or the party's representative, to a full accounting of health benefits claims data and related financial information on no less than a quarterly basis by the party to a medical service contract who has made reimbursement, as follows:

(i) The data shall include all pertinent information relating to the health care services provided, including related provider and patient information, reimbursements made and amounts withheld under the financial risk withhold provisions of the medical services contract for the period of time under reconciliation and settlement between the parties.

(ii) Any reconciliation and settlement undertaken pursuant to a medical services contract shall be based directly and exclusively upon data provided to the party who is being reimbursed for the provision of health care services.

(iii) All data, including supplemental information or documentation, necessary to finalize the reconciliation and settlement provisions of a medical services contract relating to financial risk withholds shall be provided to the party who is being reimbursed for the provision of health care services no later than 30 days prior to finalizing the reconciliation and settlement.

(B) Nothing in this paragraph shall be construed to prevent parties to a medical services contract from mutually agreeing to alternative reconciliation and settlement policies and procedures.

(3) The other party to a medical services contract shall not:

(a) Refer to other documents or instruments in a contract unless the nonprovider party agrees to make available to the provider for review a copy of the documents or instruments within 72 hours of request; or

(b) Provide as an element of a contract with a third party relating to the provision of medical services to a patient of the provider that the provider's patient may not sue or otherwise recover from the nonprovider party, or must hold the nonprovider party harmless for, any and all expenses, damages, awards or liabilities that arise from the management decisions, utilization review provisions or other policies or determinations of the nonprovider party that have an impact on the provider's treatment decisions and actions with regard to the patient.

(4) An insurer, independent practice association, medical or mental health clinic or other party to a medical services contract shall provide the criteria for selection of parties to future medical services contracts upon the request of current or prospective parties.

Note: 743.803, 743.806 and 743.811 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 743. See Preface to Oregon Revised Statutes for further explanation.

743.804 Requirements for insurer offering health benefit plan. All insurers offering a health benefit plan in this state shall:

(1) Have a written policy that recognizes the rights of enrollees:

(a) To voice grievances about the organization or health care provided;

(b) To be provided with information about the organization, its services and the providers providing care;

(c) To participate in decision making regarding their health care; and

(d) To be treated with respect and recognition of their dignity and need for privacy.

(2) Provide a summary of policies on enrollees' rights and responsibilities to all participating providers upon request and to all enrollees either directly or, in the case of group coverage, to the employer or other policyholder for distribution to enrollees.

(3) Have a timely and organized system for resolving grievances and appeals. The system shall include:

(a) A systematic method for recording all grievances and appeals, including the nature of the grievances, and significant actions taken;

(b) Written procedures explaining the grievance and appeal process, including a procedure to assist enrollees in filing written grievances;

(c) Written decisions in plain language justifying grievance determinations, including appropriate references to relevant policies, procedures and contract terms;

(d) Standards for timeliness in responding to grievances or appeals that accommodate the clinical urgency of the situation;

(e) Notice in all written decisions prepared pursuant to this subsection that the enrollee may file a complaint with the Director of the Department of Consumer and Business Services; and

(f) An appeal process for grievances that includes at least the following:

(A) Three levels of review, the second of which shall be by persons not previously involved in the dispute and the third of which shall provide external review pursuant to an external review program meeting the requirements of ORS 743.857, 743.859 and 743.861;

(B) Opportunity for enrollees and any representatives of the enrollees to appear before a review panel at either the first or second level of review. Representatives may include health care providers or any other persons chosen by the enrollee. The enrollee and insurer shall each provide advance notification of the number of representatives who will appear before the panel and the relationship of the representatives to the enrollee or insurer; and

(C) Written decisions in plain language justifying appeal determinations, including specific references to relevant provisions of the health benefit plan and related written corporate practices.

(4) If the insurer has a prescription drug formulary, have:

(a) A written procedure by which a provider with authority to prescribe drugs and medications may prescribe drugs and medications not included in the formulary. The procedure shall include the circumstances when a drug or medication not included in the formulary will be considered a covered benefit; and

(b) A written procedure to provide full disclosure to enrollees of any cost sharing or other requirements to obtain drugs and medications not included in the formulary.

(5) Furnish to all enrollees either directly or, in the case of a group policy, to the employer or other policyholder for distribution to enrollees written general information informing enrollees about services provided, access to services, charges and scheduling applicable to each enrollee's coverage, including:

(a) Benefits and services included and how to obtain them, including any restrictions that apply to services obtained outside the insurer's network or outside the insurer's service area, and the availability of continuity of care as required by ORS 743.854;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) Provisions for after-hours and emergency care and how enrollees may obtain that care, including the insurer's policy, if any, on when enrollees should directly access emergency care and use 9-1-1 services;

(d) Charges to enrollees, if applicable, including any policy on cost sharing for which the enrollee is responsible;

(e) Procedures for notifying enrollees of:

(A) A change in or termination of any benefit;

(B) If applicable, termination of a primary care delivery office or site; and

(C) If applicable, assistance available to enrollees affected by the termination of a primary care delivery office or site in selecting a new primary care delivery office or site;

(f) Procedures for appealing decisions adversely affecting the enrollee's benefits or enrollment status;

(g) Procedures, if any, for changing providers;

(h) Procedures for voicing grievances, including the option of obtaining external review under the insurer's program established pursuant to ORS 743.857, 743.859 and 743.861;

(i) A description of the procedures, if any, by which enrollees and their representatives may participate in the

development of the insurer's corporate policies and practices;

(j) Summary information on how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization review requirements that affect coverage or payment;

(k) A summary of criteria used to determine if a service or drug is considered experimental or investigational;

(L) Information about provider, clinic and hospital networks, if any, including a list of network providers and information about how the enrollee may obtain current information about the availability of individual providers, the hours the providers are available and a description of any limitations on the ability of enrollees to select primary and specialty care providers;

(m) A general disclosure of any risk-sharing arrangements the insurer has with physicians and other providers;

(n) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information, including the provision required in ORS 743.809;

(o) A description of any assistance provided to non-English-speaking enrollees;

(p) A summary of the insurer's policies, if any, on drug prescriptions, including any drug formularies, cost sharing differentials or other restrictions that affect coverage of drug prescriptions;

(q) Notice of the enrollee's right to file a complaint or seek other assistance from the Director of the Department of Consumer and Business Services; and

(r) Notice of the information that is available upon request pursuant to subsection (6) of this section and information that is available from the Department of Consumer and Business Services pursuant to ORS 743.804, 743.807, 743.814 and 743.817.

(6) Provide the following information upon the request of an enrollee or prospective enrollee:

(a) Rules related to the insurer's drug formulary, if any, including information on whether a particular drug is included or excluded from the formulary;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) A copy of the insurer's annual report on grievances and appeals as submitted to the department under subsection (9) of this section;

(d) A description of the insurer's risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the federal Health Care Financing Administration pursuant to 42 C.F.R. 417.124 (3)(b) as in effect on June 18, 1997;

(e) A description of the insurer's efforts, if any, to monitor and improve the quality of health services;

(f) Information about any insurer procedures for credentialing network providers and how to obtain the names, qualifications and titles of the providers responsible for an enrollee's care; and

(g) A description of the insurer's external review program established pursuant to ORS 743.857, 743.859 and 743.861.

(7) Except as otherwise provided in this subsection, provide to enrollees, upon request, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease to the extent the insurer maintains such criteria. Nothing in this section shall require an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that is proprietary shall be subject to verbal disclosure only.

(8) Provide the following information to an enrollee when the enrollee has filed a grievance:

(a) Detailed information on the insurer's grievance and appeal procedures and how to use them;

(b) Information on how to access the complaint line of the Department of Consumer and Business Services; and

(c) Information explaining how an enrollee applies for external review of the insurer's actions under the external review program established by the insurer pursuant to ORS 743.857.

(9) Provide annual summaries to the Department of Consumer and Business Services of the insurer's aggregate data regarding grievances, appeals and applications for external review in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances, appeals and applications for external review.

(10) Ensure that the confidentiality of specified patient information and records is protected, and to that end:

(a) Adopt and implement written confidentiality policies and procedures;

(b) State the insurer's expectations about the confidentiality of enrollee information and records in medical service contracts; and

(c) Afford enrollees the opportunity to approve or deny the release of identifiable medical personal information by

the insurer, except as otherwise required by law.

(11) Notify an enrollee of the enrollee's rights under the health benefit plan at the time that the insurer notifies the enrollee of an adverse decision. The notification shall include:

(a) Notice of the right of the enrollee to apply for internal and external review of the adverse decision;

(b) A statement whether a decision by an independent review organization is binding on the insurer and enrollee;

(c) A statement that if the decision is not binding on the insurer and if the insurer does not comply with the decision, the enrollee may sue the insurer as provided in ORS 743.864; and

(d) Information on filing a complaint with the Director of the Department of Consumer and Business Services. [1997 c.343 §3; 2001 c.266 §15]

Note: The amendments to 743.804 by section 15, chapter 266, Oregon Laws 2001, become operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001. The text that is operative until July 1, 2002, is set forth for the user's convenience.

743.804. All insurers offering a health benefit plan in this state shall:

(1) Have a written policy that recognizes the rights of enrollees:

(a) To voice grievances about the organization or health care provided;

(b) To be provided with information about the organization, its services and the providers providing care;

(c) To participate in decision making regarding their health care; and

(d) To be treated with respect and recognition of their dignity and need for privacy.

(2) Provide a summary of policies on enrollees' rights and responsibilities to all participating providers upon request and to all enrollees either directly or, in the case of group coverage, to the employer or other policyholder for distribution to enrollees.

(3) Have a timely and organized system for resolving grievances and appeals. The system shall include:

(a) A systematic method for recording all grievances and appeals, including the nature of the grievances, and significant actions taken;

(b) Written procedures explaining the grievance and appeal process, including a procedure to assist enrollees in filing written grievances;

(c) Written decisions in plain language justifying grievance determinations, including appropriate references to relevant policies, procedures and contract terms;

(d) Standards for timeliness in responding to grievances or appeals that accommodate the clinical urgency of the situation;

(e) Notice in all written decisions prepared pursuant to this subsection that the enrollee may file a complaint with the Director of the Department of Consumer and Business Services; and

(f) An appeal process for grievances that includes at least the following:

(A) Two levels of review, the second of which shall be by persons not previously involved in the dispute;

(B) Opportunity for enrollees and any representatives of the enrollees to appear before a review panel at either the first or second level of review. Representatives may include health care providers or any other persons chosen by the enrollee. The enrollee and insurer shall each provide advance notification of the number of representatives who will appear before the panel and the relationship of the representatives to the enrollee or insurer; and

(C) Written decisions in plain language justifying appeal determinations, including specific references to relevant provisions of the health benefit plan and related written corporate practices.

(4) If the insurer has a prescription drug formulary, have:

(a) A written procedure by which a provider with authority to prescribe drugs and medications may prescribe drugs and medications not included in the formulary. The procedure shall include the circumstances when a drug or medication not included in the formulary will be considered a covered benefit; and

(b) A written procedure to provide full disclosure to enrollees of any cost sharing or other requirements to obtain drugs and medications not included in the formulary.

(5) Furnish to all enrollees either directly or, in the case of a group policy, to the employer or other policyholder for distribution to enrollees written general information informing enrollees about services provided, access to services, charges and scheduling applicable to each enrollee's coverage, including:

(a) Benefits and services included and how to obtain them, including any restrictions that apply to services obtained outside the insurer's network or outside the insurer's service area;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) Provisions for after-hours and emergency care and how enrollees may obtain that care, including the insurer's policy, if any, on when enrollees should directly access emergency care and use 9-1-1 services;

(d) Charges to enrollees, if applicable, including any policy on cost sharing for which the enrollee is responsible;

(e) Procedures for notifying enrollees of:

(A) A change in or termination of any benefit;

(B) If applicable, termination of a primary care delivery office or site; and

(C) If applicable, assistance available to enrollees affected by the termination of a primary care delivery office or site in selecting a new primary care delivery office or site;

(f) Procedures for appealing decisions adversely affecting the enrollee's benefits or enrollment status;

(g) Procedures, if any, for changing providers;

(h) Procedures for voicing grievances;

(i) A description of the procedures, if any, by which enrollees and their representatives may participate in the development of the insurer's corporate policies and practices;

(j) Summary information on how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization review requirements that affect coverage or payment;

(k) A summary of criteria used to determine if a service or drug is considered experimental or investigational;

(L) Information about provider, clinic and hospital networks, if any, including a list of network providers and information about how the enrollee may obtain current information about the availability of individual providers, the hours the providers are available and a description of any limitations on the ability of enrollees to select primary and specialty care providers;

(m) A general disclosure of any risk-sharing arrangements the insurer has with physicians and other providers;

(n) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information, including the provision required in ORS 743.809;

(o) A description of any assistance provided to non-English-speaking enrollees;

(p) A summary of the insurer's policies, if any, on drug prescriptions, including any drug formularies, cost sharing differentials or other restrictions that affect coverage of drug prescriptions;

(q) Notice of the enrollee's right to file a complaint or seek other assistance from the Director of the Department of Consumer and Business Services; and

(r) Notice of the information that is available upon request pursuant to subsection (6) of this section and information that is available from the Department of Consumer and Business Services pursuant to ORS 743.804, 743.807, 743.814 and 743.817.

(6) Provide the following information upon the request of an enrollee or prospective enrollee:

(a) Rules related to the insurer's drug formulary, if any, including information on whether a particular drug is included or excluded from the formulary;

(b) Provisions for referrals, if any, for specialty care, behavioral health services and hospital services and how enrollees may obtain the care or services;

(c) A copy of the insurer's annual report on grievances and appeals as submitted to the department under subsection (9) of this section;

(d) A description of the insurer's risk-sharing arrangements with physicians and other providers consistent with risk-sharing information required by the federal Health Care Financing Administration pursuant to 42 C.F.R. 417.124 (3)(b) as in effect on June 18, 1997;

(e) A description of the insurer's efforts, if any, to monitor and improve the quality of health services; and

(f) Information about any insurer procedures for credentialing network providers and how to obtain the names, qualifications and titles of the providers responsible for an enrollee's care.

(7) Except as otherwise provided in this subsection, provide to enrollees, upon request, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease to the extent the insurer maintains such criteria. Nothing in this section shall require an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that is proprietary shall be subject to verbal disclosure only.

(8) Provide the following information to an enrollee when the enrollee has filed a grievance:

(a) Detailed information on the insurer's grievance and appeal procedures and how to use them; and

(b) Information on how to access the complaint line of the Department of Consumer and Business Services.

(9) Provide annual summaries to the department of the insurer's aggregate data regarding grievances and appeals in

a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances and appeals.

(10) Ensure that the confidentiality of specified patient information and records is protected, and to that end:

(a) Adopt and implement written confidentiality policies and procedures;

(b) State the insurer's expectations about the confidentiality of enrollee information and records in medical service contracts; and

(c) Afford enrollees the opportunity to approve or deny the release of identifiable medical personal information by the insurer, except as otherwise required by law.

743.805 [1971 c.523 §3; 1973 c.551 §2; 1975 c.784 §2; 1981 c.414 §2; 1987 c.588 §2; 1989 c.775 §1; renumbered 742.524 in 1989]

743.806 Utilization review requirements for medical services contracts to which insurer not party. All utilization review performed pursuant to a medical services contract to which an insurer is not a party shall comply with the following:

(1) The criteria used in the review process and the method of development of the criteria shall be made available for review to a party to such medical services contract upon request.

(2) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

(3) Any patient or provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

(4) A provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay. [1995 c.672 §6; 1997 c.343 §20]

Note: See second note under 743.803.

743.807 Utilization review requirements for insurers offering health benefit plan. (1) All insurers offering a health benefit plan in this state that provide utilization review or have utilization review provided on their behalf shall file an annual summary with the Department of Consumer and Business Services that describes all utilization review policies, including delegated utilization review functions, and documents the insurer's procedures for monitoring of utilization review activities.

(2) All utilization review activities conducted pursuant to subsection (1) of this section shall comply with the following:

(a) The criteria used in the utilization review process and the method of development of the criteria shall be made available for review to contracting providers upon request.

(b) A doctor of medicine or osteopathy licensed under ORS chapter 677 shall be responsible for all final recommendations regarding the necessity or appropriateness of services or the site at which the services are provided and shall consult as appropriate with medical and mental health specialists in making such recommendations.

(c) Any patient or provider who has had a request for treatment or payment for services denied as not medically necessary or as experimental shall be provided an opportunity for a timely appeal before an appropriate medical consultant or peer review committee.

(d) A provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay. [1997 c.343 §4]

743.808 Requirements for insurers that require designation of participating primary care physician; exceptions. (1) All insurers offering a health benefit plan in this state that requires an enrollee to designate a participating primary care physician shall:

(a) Permit the enrollee to change participating primary care physicians at will, except that the enrollee may be restricted to making changes no more frequently than two times in any 12-month period and may be limited to designating only those participating primary care physicians accepting new patients.

(b) Have available for employer purchasers of group health plans a point-of-service benefit plan providing for payment for the services of a provider on a fee-for-service or discounted fee-for-service basis with reasonable access to a broad array of licensed providers in the insurer's geographic service area. Any higher premium for the point-of-service benefit plan may not exceed true actuarial cost, including administrative costs, to the insurer.

(2) A health maintenance organization that is exempt from federal income tax under Internal Revenue Code section 501(c)(3) or (4) shall not be required to offer a point-of-service benefit plan as required by subsection (1)(b) of this section if offering such a plan could result in loss of federal tax-exempt status. Until such time as the federal government establishes guidelines for health maintenance organizations exempt from federal income tax that offer point-of-service benefit plans, such a health maintenance organization shall not be required to offer a point-of-service benefit plan if:

(a) Enrollment in Internal Revenue Code section 501(m) coverages exceeds five percent of its business; or

(b) Revenue from Internal Revenue Code section 501(m) coverages exceeds five percent of its revenue.

(3) A health maintenance organization that is federally qualified under 42 U.S.C. 300e et seq. shall not be required to offer a point-of-service benefit plan in a manner or to an extent that is inconsistent with federal law and regulation. [1995 c.672 §4; 1997 c.343 §1; 1999 c.987 §19]

743.809 Consent to examination of medical records. All insurers offering a policy of health insurance in this state shall include a provision in the policy that all subscribers or enrollees, by acceptance of the benefits of the policy, shall be deemed to have consented to the examination of medical records for purposes of utilization review, quality assurance and peer review by the insurer or its designee. [1995 c.672 §5]

743.810 [1971 c.523 §4; 1973 c.551 §4; 1975 c.784 §3; renumbered 742.526 in 1989]

743.811 Applicability of ORS 743.801 to 743.809. The provisions of ORS 743.801, 743.803, 743.806, 743.808 and 743.809 do not apply to medical services contracts for services to be provided under ORS chapter 656. [1995 c.672 §7a; 2001 c.104 §290]

Note: See second note under 743.803.

743.812 [1987 c.588 §4; renumbered 742.528 in 1989]

743.813 [1995 c.669 §2; renumbered 743.845 in 1997]

743.814 Requirements for insurers offering managed health insurance; quality assessment. All insurers offering managed health insurance in this state shall:

(1) Have a quality assessment program that enables the insurer to evaluate, maintain and improve the quality of health services provided to enrollees. The program shall include data gathering that allows the plan to measure progress on specific quality improvement goals chosen by the insurer.

(2) File an annual summary with the Department of Consumer and Business Services that describes quality assessment activities, including any activities related to credentialing of providers, and reports any progress on the insurer's quality improvement goals.

(3) File annually with the department the following information:

(a) Results of all publicly available federal Health Care Financing Administration reports and accreditation surveys by national accreditation organizations.

(b) The insurer's health promotion and disease prevention activities, if any, including a summary of screening and preventive health care activities covered by the insurer. In addition to the summary required in this paragraph, the consortium established pursuant to ORS 743.831 shall develop recommendations for, and the department shall adopt rules requiring, reporting of an insurer's health promotion and disease prevention activities related to:

(A) Two specific preventive measures;

(B) One specific chronic condition; and

(C) One specific acute condition. [1997 c.343 §5]

743.815 [1971 c.523 §5; 1973 c.551 §3; 1975 c.784 §4; 1981 c.414 §3; renumbered 742.530 in 1989]

743.816 [1995 c.506 §2; renumbered 743.847 in 1997]

743.817 Requirements for insurers offering managed health or preferred provider organization insurance; rules; opportunity to participate. An insurer offering managed health insurance or preferred provider organization insurance in this state shall:

(1) File an annual summary with the Department of Consumer and Business Services that reports on the scope and adequacy of the insurer's network and the insurer's ongoing monitoring to ensure that all covered services are reasonably accessible to enrollees. The Director of the Department of Consumer and Business Services shall adopt rules establishing uniform indicators that insurers offering managed health insurance or preferred provider organization insurance must use for reporting under this subsection, including but not limited to reporting on the scope and adequacy of networks. For the purpose of developing the rules, the director shall consult with an advisory committee appointed by the director. The advisory committee must include representatives of persons likely to be affected by the rules, including consumers, purchasers of health insurance and insurers that offer managed health insurance or preferred provider organization insurance.

(2) Establish a means to provide to the insurer's managed care plan or preferred provider organization insurance enrollees, purchasers and providers a meaningful opportunity to participate in the development and implementation of insurer policy and operation through:

(a) The establishment of advisory panels;

(b) Consultation with advisory panels on major policy decisions; or

(c) Other means including but not limited to:

(A) Governing board meetings or special meetings at which enrollees, purchasers and providers are invited to express opinions; and

(B) Enrollee councils that are given a reasonable opportunity to meet with the governing board or its designee. [1997 c.343 §6; 2001 c.266 §6]

Note: The amendments to 743.817 by section 6, chapter 266, Oregon Laws 2001, become operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001. The text that is operative until July 1, 2002, is set forth for the user's convenience.

743.817. All insurers offering managed health insurance in this state shall:

(1) File an annual summary with the Department of Consumer and Business Services that documents the scope of the insurer's network and the insurer's ongoing monitoring to ensure that all covered services are reasonably accessible to enrollees.

(2) Establish a means to provide to the insurer's managed care plan enrollees, purchasers and providers a meaningful opportunity to participate in the development and implementation of insurer policy and operation through:

(a) The establishment of advisory panels;

(b) Consultation with advisory panels on major policy decisions; or

(c) Other means including but not limited to:

(A) Governing board meetings or special meetings at which enrollees, purchasers and providers are invited to express opinions; and

(B) Enrollee councils that are given a reasonable opportunity to meet with the governing board or its designee.

743.819 Rules for certain reporting requirements. The Department of Consumer and Business Services shall develop by rule reporting requirements as necessary for the consistent and efficient implementation of ORS 743.804, 743.807, 743.814 and 743.817. In order to minimize duplicative reporting requirements, the department shall accept copies of reports prepared for national accreditation organizations as sufficient to meet the reporting requirements developed pursuant to this section to the extent that the reports include the information required by the department pursuant to this section. [1997 c.343 §11]

743.820 [1971 c.523 §6; 1975 c.784 §5; 1981 c.414 §4; renumbered 742.532 in 1989]

743.821 Required managed health insurance contract provision; enrollee liability. All insurers offering managed health insurance in this state shall include in contracts with providers a provision requiring that in the event the insurer fails to pay for health care services covered by the health benefit plan, the provider shall not bill or otherwise attempt to collect from enrollees for amounts owed by insurers, and enrollees shall not be liable to the

provider for any sums owed by the insurer. Nothing in this section shall be construed to in any manner limit the applicability of ORS 750.095 (2). [1997 c.343 §7]

743.823 Enforcement of Newborns' and Mothers' Health Protection Act of 1996. The Department of Consumer and Business Services shall enforce insurer compliance with the federal Newborns' and Mothers' Health Protection Act of 1996. [1997 c.343 §8]

743.825 [1971 c.523 §7; 1975 c.784 §6; 1987 c.569 §4; 1987 c.632 §2; renumbered 742.534 in 1989]

743.827 Health Care Consumer Protection Advisory Committee. The Director of the Department of Consumer and Business Services shall appoint a Health Care Consumer Protection Advisory Committee with fair representation of health care consumers, providers and insurers. The committee shall advise the director regarding the implementation of ORS 743.699, 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.809, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837 and 743.839 and other issues related to health care consumer protection. [1997 c.343 §10]

743.828 [1975 c.784 §8; renumbered 742.536 in 1989]

743.829 Decisions regarding health care facility length of stay, level of care and follow-up care. (1) All clinical decisions regarding length of stay in a health care facility as defined in ORS 442.015, transfer between levels of care and follow-up care shall be the decision of the treating provider in consultation with the patient, as appropriate.

(2) An insurer may not terminate or restrict the practice privileges of any provider solely on the basis of one or more decisions made pursuant to subsection (1) of this section. [1997 c.343 §12]

743.830 [1971 c.523 §8; 1975 c.784 §9; renumbered 742.538 in 1989]

743.831 Consortium established; managed health care performance. (1) The Administrator of the Office for Oregon Health Policy and Research shall establish a consortium of interested parties that shall:

(a) Develop, on a voluntary basis, standardized, quantitative performance measurements of managed health insurance organizations for use by health care consumers, purchasers and providers to continuously assess the quality of clinical and service-related aspects of health care arranged for or provided by managed health insurance organizations;

(b) Encourage managed health insurance organizations to collect, on a voluntary basis, the performance measurements specified in paragraph (a) of this subsection and share that information with the consortium;

(c) Develop, test, refine and produce one or more managed health care performance scorecards to provide consumers and purchasers with accurate, reliable and timely comparisons of managed health insurance organizations with respect to:

(A) Organizational characteristics;

(B) Clinical quality measurements;

(C) Service-related quality measurements; and

(D) Member and patient satisfaction; and

(d) Carry out the activities specified in this subsection with the objective of:

(A) Utilizing, to the greatest extent feasible and desirable, nationally developed quality assessment tools; and

(B) Minimizing duplicative quality assessment activities and associated administrative costs.

(2) The consortium established pursuant to subsection (1) of this section shall be comprised of representatives of:

(a) Health care consumers;

(b) Private-sector and public-sector health care purchasers;

(c) Managed health insurance organizations;

(d) Health care providers, including but not limited to physicians, nurses and hospitals;

(e) State agencies, including but not limited to the Department of Consumer and Business Services and the Department of Human Services;

(f) Oregon institutions of higher education with relevant professional expertise; and

(g) Other groups or organizations as determined to be appropriate by the administrator to ensure broad representation of interests and expertise.

(3) The Office for Oregon Health Policy and Research shall:
(a) Provide staffing for the consortium; and
(b) Seek public and private funds to assist in the work of the consortium. [1997 c.343 §13]

743.833 [1975 c.784 §12; renumbered 742.540 in 1989]

743.834 Insurer prohibited practices; patient communication, referral. No insurer may terminate or otherwise financially penalize a provider for:
(1) Providing information to or communicating with a patient in a manner that is not slanderous, defamatory or intentionally inaccurate concerning:
(a) Any aspect of the patient's medical condition;
(b) Any proposed treatment or treatment alternatives, whether covered by the insurer's health benefit plan or not; or
(c) The provider's general financial arrangement with the insurer.
(2)(a) Referring a patient to another provider, whether or not that provider is under contract with the insurer. If a provider refers a patient to another provider, the referring provider shall:
(A) Comply with the insurer's written policies and procedures with respect to any such referrals; and
(B) Inform the patient that the referral services may not be covered by the insurer.
(b) Allocation of costs for referral services shall be a matter of contract between the provider and the insurer. Allocation of costs to the provider by contract shall not be considered a penalty under this section. [1997 c.343 §15]

743.835 [1971 c.523 §9; 1975 c.784 §10; 1987 c.632 §3; renumbered 742.542 in 1989]

743.837 Prior authorization requirements. Except in the case of misrepresentation, prior authorization determinations shall be subject to the following requirements:
(1) Prior authorization determinations relating to benefit coverage and medical necessity shall be binding on the insurer if obtained no more than 30 days prior to the date the service is provided.
(2) Prior authorization determinations relating to enrollee eligibility shall be binding on the insurer if obtained no more than five business days prior to the date the service is provided. [1997 c.343 §16]

743.839 Disclosure of information. Nothing in ORS 743.699, 743.804, 743.807 and 743.814 to 743.839 shall be construed to require disclosure of information that is otherwise privileged or confidential under any other provision of law. [1997 c.343 §17]

743.840 [1985 c.527 §2; renumbered 742.466 in 1989]

743.842 Emergency eye care services without referral from primary care provider. (1) As used in this section:
(a) "Eye care practitioner" means an optometrist or ophthalmologist licensed by the State of Oregon.
(b) "Eye care services" means health care services related to the care of the eye and related structures as specified by a health benefit plan.
(c) "Health benefit plan" has the meaning provided for that term in ORS 743.730.
(2) Any insurer that offers a health benefit plan that provides coverage of eye care services shall allow any enrollee to receive covered eye care services on an emergency basis without first receiving a referral or prior authorization from a primary care provider. However, an insurer may require the enrollee to receive a referral or prior authorization from a primary care provider for any subsequent surgical procedures. Nothing in this subsection shall be construed to require that covered eye care services rendered by an eye care practitioner on an emergency basis be furnished in a hospital or similar medical facility.
(3) An insurer described in subsection (2) of this section may not:
(a) Impose a deductible or coinsurance for eye care services that is greater than the deductible or coinsurance imposed for other medical services under the health benefit plan.
(b) Require an eye care practitioner to hold hospital privileges as a condition of participation as a provider in the health benefit plan.
(4) Nothing in this section:
(a) Requires an insurer to provide coverage or reimbursement of eye care services;
(b) Requires an insurer to provide coverage or reimbursement of refractive surgery, ophthalmic materials, lenses,

eyeglasses or other appurtenances; or

(c) Prevents an enrollee from receiving eye care or other covered services from the enrollee's primary care provider in accordance with the terms of the enrollee's health benefit plan.

(5) This section is exempt from ORS 743.700. [1999 c.749 §2]

743.845 Designation of women's health care provider as primary care provider; direct access to women's health care provider. (1) For purposes of this section:

(a) "Pregnancy care" means the care necessary to support a healthy pregnancy and care related to labor and delivery.

(b) "Women's health care provider" means an obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specialist in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice.

(2) Every health insurance policy that covers hospital, medical or surgical expenses and requires an enrollee to designate a participating primary care provider shall permit a female enrollee to designate a women's health care provider as the enrollee's primary care provider if:

(a) The women's health care provider meets the standards established by the insurer in collaboration with interested parties, including but not limited to the Oregon section of the American College of Obstetricians and Gynecologists; and

(b) The women's health care provider requests that the insurer make the provider available for designation as a primary care provider.

(3) If a female enrollee has designated a primary care provider who is not a women's health care provider, an insurance policy as described in subsection (2) of this section shall permit the enrollee to have direct access to a women's health care provider for the following services:

(a) At least one annual preventative women's health examination;

(b) Medically necessary follow-up visits resulting from a preventative women's health examination. A health plan may require the women's health care provider to notify and consult with the enrollee's primary care provider; and

(c) Pregnancy care.

(4) The standards established by the insurer under subsection (2) of this section shall not prohibit an insurer from establishing the maximum number of participating primary care providers and participating women's health care providers necessary to serve a defined population or geographic service area. [Formerly 743.813; 1999 c.607 §1; 2001 c.104 §291]

743.847 Medicaid not considered in coverage eligibility determination; state acquires right of individual to payment; prohibited ground for denial of enrollment of child; insurer duties. (1) For the purposes of this section:

(a) "Health insurer" or "insurer" means the issuer of any individual, franchise, group or blanket health policy or certificate or of any stop-loss or excess insurance issued in relation to a plan of a self-insured employer.

(b) "Medicaid" means medical assistance provided under 42 U.S.C. 1396a (section 1902 of the Social Security Act).

(2) A health insurer is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid, when considering eligibility for coverage or making payments under its group or individual plan for eligible enrollees, subscribers, policyholders or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual, in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) An insurer shall not deny enrollment of a child under the group or individual health plan of the child's parent on the ground that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the child's parent or in the insurer's service area.

(5) When a child has group or individual health coverage through an insurer of a noncustodial parent, the insurer shall:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the custodial parent or the provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and

(c) Make payments on claims submitted in accordance with subsection (6) of this section directly to the custodial parent, the provider or the state Medicaid agency.

(6) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651 to 669, the child support enforcement program; and

(c) Not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(7) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for health benefits from the insurer if the requirements are different from requirements applicable to an agent or assignee of any other individual so covered.

(8) The provisions of ORS 743.700 do not apply to this section. [Formerly 743.816]

743.850 [1981 c.752 §1; 1983 c.817 §1; 1987 c.505 §1; renumbered 743.610 in 1989]

743.851 [1987 c.505 §3; renumbered 743.600 in 1989]

743.852 [1987 c.505 §§3a,4; 1989 c.784 §22; renumbered 743.601 in 1989]

743.853 [1987 c.505 §5; renumbered 743.602 in 1989]

RIGHTS OF ENROLLEES

743.854 Continuity of care. (1) As used in this section, "continuity of care" means the feature of a health benefit plan under which an enrollee who is receiving care from an individual provider is entitled to continue with care with the individual provider for a limited period of time after the medical services contract terminates.

(2) An insurer offering managed health insurance or preferred provider organization insurance in this state shall provide continuity of care to an enrollee under a health benefit plan if:

(a) A medical services contract or other contract for an individual provider's services is terminated;

(b) The provider no longer participates in the provider network; and

(c) The insurer does not cover services when services are provided to enrollees by the individual provider or covers services at a benefit level below the benefit level specified in the plan for out-of-network providers.

(3) In order to obtain continuity of care, an enrollee must request continuity of care from the insurer.

(4) An enrollee of a health benefit plan is entitled to continuity of care when the following conditions are met:

(a) The enrollee is undergoing an active course of treatment that is medically necessary and, by agreement of the individual provider and the enrollee, it is desirable to maintain continuity of care; and

(b) The contractual relationship between the individual provider and the insurer described in subsection (2) of this section with respect to the plan covering the enrollee has ended, except as provided in subsection (5) of this section.

(5) A health benefit plan is not required to provide continuity of care when the contractual relationship between the individual provider and the insurer described in subsection (2) of this section ends under one of the following circumstances:

(a) The contractual relationship between the individual provider and the insurer has ended because the individual provider:

(A) Has retired;

(B) Has died;

(C) No longer holds an active license;

(D) Has relocated out of the service area;

(E) Has gone on sabbatical; or

(F) Is prevented from continuing to care for patients because of other circumstances; or

(b) The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the individual provider have been exhausted.

(6) A health benefit plan is not required to provide continuity of care if the enrollee leaves a health benefit plan or if the policyholder discontinues the plan in which the enrollee is enrolled.

(7) Except as provided for pregnancy in subsection (8) of this section, an enrollee who is entitled to continuity of care shall receive the care until the earlier of the following dates:

(a) The day following the date on which the active course of treatment entitling the enrollee to continuity of care is completed; or

(b) The 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider, as required by subsection (9) of this section.

(8) An enrollee who is undergoing care for a pregnancy and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy shall receive the care until the later of the following dates:

(a) The 45th day after the birth; or

(b) As long as the enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the enrollee of the termination of the contractual relationship with the individual provider as required by subsection (9) of this section.

(9) An insurer shall give written notice of the termination of the contractual relationship between the insurer and the individual provider and of the right to obtain continuity of care to those enrollees that the insurer knows or reasonably should know are under the care of the individual provider. The notice may be given prior to the date on which the termination of the contractual relationship with the individual provider takes effect only if the insurer gives notice in a good faith belief that the termination will take effect as stated in the notice. In any event, the notice shall be given to those enrollees not later than the 10th day after the date on which the termination of the contractual relationship with the individual provider takes effect. If the insurer first learns the identity of an affected enrollee after the date of termination of the contractual relationship with the individual provider or after the date on which the insurer gave notice to the other affected enrollees, then the insurer shall give a notice of termination to the affected enrollee not later than the 10th day after learning that enrollee's identity.

(10) For the purpose of notifying an enrollee under subsection (7)(b) or (8)(b) of this section:

(a) The date of notification by the insurer is the earlier of the date on which the enrollee receives the notice or the date on which the insurer receives or approves the request for continuity of care.

(b) If an individual provider belongs to a provider group, the provider group may deliver the notice if the insurer agrees that the provider group may do so and if the notice clearly provides the information that the plan is required to provide to the enrollee under subsection (9) of this section.

(11) A health benefit plan may condition continuity of care upon the requirement that the individual provider adhere to the medical services contract between the provider and the insurer and accept the contractual reimbursement rate applicable at the time of contract termination or, if the contractual reimbursement rate was not based on a fee for service, a rate equivalent to the contractual rate. [2001 c.266 §3]

Note: 743.854 becomes operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001.

743.855 [1981 c.752 §2; renumbered 743.611 in 1989]

743.856 Referrals to specialists. (1) If an insurer offers a health benefit plan that requires, as a condition of coverage for specialty care services, a referral by a physician who is authorized under the plan or under the medical services contract between the physician and the insurer to refer an enrollee to specialty care services, the insurer must include the requirements of this section in the plan. The requirements apply only to benefits for which the member is contractually eligible under the plan. The requirements are as follows:

(a) The plan must establish and implement a procedure for standing referrals, so that an enrollee is not required to obtain approval from the authorized physician for each appointment with a specialist after the initial appointment.

(b) The plan must allow a standing referral for an enrollee if the authorized physician determines that the enrollee needs continuing care from a specialist.

(c) The plan must allow an enrollee to request and obtain a second medical opinion or consultation from a second physician who is a network provider and who is authorized to make decisions regarding the need for a referral to a

specialist. If the plan does not have a network provider available to give a second medical opinion or consultation, the plan must allow the enrollee to obtain the opinion or consultation from a similarly qualified physician who is not a network provider. The plan may not impose a charge for the second medical opinion or consultation that is greater than the cost that the enrollee would otherwise pay for an initial medical opinion or consultation from the second physician.

(2) A specialist to whom an enrollee is referred must make regular reports to the authorized physician under subsection (1) of this section in accordance with best practices for coordinated care as established by the insurer. [2001 c.266 §5]

Note: 743.856 becomes operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001.

743.857 External review. (1) An insurer offering health benefit plans in this state shall have an external review program that meets the requirements of this section and ORS 743.859 and 743.861. Each insurer shall provide the external review through an independent review organization that is under contract with the Director of the Department of Consumer and Business Services to provide external review. Each health benefit plan must allow an enrollee, by applying to the insurer, to obtain review by an independent review organization of a dispute relating to an adverse decision by the insurer on one or more of the following:

(a) Whether a course or plan of treatment is medically necessary.

(b) Whether a course or plan of treatment is experimental or investigational.

(c) Whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743.854.

(2) An insurer shall incur all costs of its external review program. The insurer may not establish or charge a fee payable by enrollees for conducting external review.

(3) When an enrollee applies for external review, the insurer shall request the director to appoint an independent review organization. When an independent review organization is appointed, the insurer shall forward all medical records and other relevant materials to the independent review organization and shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the insurer. The insurer shall furnish all such records, materials and information in a timely manner in order to enable a timely decision by the independent review organization. The director may establish timelines for the purpose of this subsection.

(4) An insurer shall expedite an enrollee’s case if a provider with an established clinical relationship to the enrollee certifies in writing and provides supporting documentation that the ordinary time period for external review would seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function. [2001 c.266 §8]

Note: 743.857 becomes operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001.

743.858 Director to contract with independent review organizations to provide external review; rules. (1) The Director of the Department of Consumer and Business Services shall contract with independent review organizations as provided in this section for the purpose of providing external review under ORS 743.857. The director may have contracts with no more than five independent review organizations at any one time. Contracts shall be let with independent review organizations on a biennial basis. A contract may be renewed if both parties agree.

(2) The director shall seek public comment when the director proposes to enter into a contract with an independent review organization or proposes to renew or not renew a contract.

(3) When evaluating proposals to contract with independent review organizations, the director shall consider factors that include but are not limited to relative expertise, professionalism, quality of compliance with the rules established under subsection (4) of this section, cost and record of past performance.

(4) The director shall adopt rules governing independent review organizations, their composition and their conduct. The rules shall include but need not be limited to:

(a) Professional qualifications of health care providers, physicians or contract specialists making external review determinations;

(b) Criteria requiring independent review organizations to demonstrate protections against bias and conflicts of interest;

(c) Procedures for conducting external reviews;

(d) Procedures for complaint investigations;

(e) Procedures for ensuring the confidentiality of medical records transmitted to the independent review organizations for use in external reviews;

(f) Fairness of procedures used by independent review organizations;

(g) Fees for external reviews;

(h) Timelines for decision making and notice to the parties; and

(i) Quality assurance mechanisms to ensure timeliness and quality of review.

(5) The director shall develop procedures for assigning cases filed by enrollees to independent review organizations under contract with the director. The cases shall be assigned on a random basis. The procedures shall allow an insurer only one opportunity to reject the assignment of an independent review organization to a particular case. [2001 c.266 §9]

Note: 743.858 becomes operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001.

743.859 Inclusion of statements regarding external review in health benefit plans. (1) An insurer of a health benefit plan shall include in the plan the following statements, in boldfaced type or otherwise emphasized:

(a) A statement of the right of enrollees to apply for external review by an independent review organization; and

(b) A statement of whether the insurer agrees to be bound by decisions of independent review organizations.

(2) If an insurer states in the health benefit plan as provided in subsection (1) of this section that the insurer is not bound by the decisions of independent review organizations, the plan and the written information provided by the plan must prominently disclose that:

(a) The insurer is not bound by the decisions of independent review organizations;

(b) The insurer may follow nonetheless a decision by an independent review organization; and

(c) If the insurer does not follow a decision of an independent review organization, the enrollee has the right to sue the insurer.

(3) If an insurer states in the health benefit plan as provided in subsection (1) of this section that the insurer is bound by the decisions of independent review organizations, the plan must prominently disclose that fact. The plan must also state that the insurer agrees to act in accordance with the decision of the independent review organization notwithstanding the definition of medical necessity in the plan. [2001 c.266 §10]

Note: 743.859 becomes operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001.

743.860 [1981 c.752 §3; renumbered 743.613 in 1989]

743.861 Enrollee application for external review. (1) An enrollee shall apply in writing for external review of an adverse decision by the insurer of a health benefit plan not later than the 180th day after receipt of the insurer's final written decision following its internal review through its grievance and appeal process under ORS 743.804. An enrollee is eligible for external review only if the enrollee has satisfied the following requirements:

(a) The enrollee must have signed a waiver granting the independent review organization access to the medical records of the enrollee.

(b) The enrollee must have exhausted the plan's internal grievance procedures established pursuant to ORS 743.804. The insurer may waive the requirement of compliance with the internal grievance procedures and have a dispute referred directly to external review upon the enrollee's consent.

(2) An enrollee who applies for external review of an adverse decision shall provide complete and accurate information to the independent review organization in a timely manner. [2001 c.266 §11]

Note: 743.861 becomes operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001.

743.862 Duties of independent review organizations. (1) An independent review organization shall perform the following duties when appointed under ORS 743.857 to review a dispute under a health benefit plan between an insurer and an enrollee:

(a) Decide whether the dispute is covered by the conditions established in ORS 743.857 for external review and notify the enrollee and insurer in writing of the decision. If the decision is against the enrollee, the independent review organization shall notify the enrollee of the right to file a complaint with or seek other assistance from the Director of the Department of Consumer and Business Services and the availability of other assistance as specified by the director.

(b) Appoint a reviewer or reviewers as determined appropriate by the independent review organization.

(c) Notify the enrollee of information that the enrollee is required to provide and any additional information the enrollee may provide, and when the information must be submitted.

(d) Notify the insurer of additional information the independent review organization requires and when the information must be submitted.

(e) Decide the dispute relating to the adverse decision of the insurer under ORS 743.857 (1) and issue the decision in writing.

(2) A decision by an independent review organization shall be based on expert medical judgment after consideration of the enrollee's medical record, the recommendations of each of the enrollee's providers, relevant medical, scientific and cost-effectiveness evidence and standards of medical practice in the United States. An independent review organization must make its decision in accordance with the coverage described in the health benefit plan, except that the independent review organization may override the insurer's standards for medically necessary or experimental or investigational treatment if the independent review organization determines that the standards of the insurer are unreasonable or are inconsistent with sound medical practice.

(3) When review is expedited, the independent review organization shall issue a decision not later than the third day after the date on which the enrollee applies to the insurer for an expedited review.

(4) When a review is not expedited, the independent review organization shall issue a decision not later than the 30th day after the enrollee applies to the insurer for a review.

(5) An independent review organization shall file synopses of its decisions with the director according to the format and other requirements established by the director. The synopses shall exclude information that is confidential, that is otherwise exempt from disclosure under ORS 192.501 and 192.502 or that may otherwise allow identification of an enrollee. The director shall make the synopses public. [2001 c.266 §12]

Note: 743.862 becomes operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001.

743.863 Civil penalty for failure to comply by insurer that agreed to be bound by decision. (1) If an insurer has agreed under the provisions of a health benefit plan to be bound by the decision of an independent review organization and the insurer fails to comply with such a decision, the Director of the Department of Consumer and Business Services shall impose on the insurer a civil penalty of not less than $100,000 and not more than $1 million.

(2) A decision of an independent review organization is admissible in any legal proceeding involving the insurer or the enrollee and involving the disputed issues subject to external review.

(3) The sanctions under subsection (1) of this section and the remedies under subsection (2) of this section are in addition to and not in lieu of other sanctions, rights and remedies provided by law or contract. [2001 c.266 §13]

Note: 743.863 becomes operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001.

743.864 Private right of action. (1) An enrollee who is the subject of a decision of an independent review organization has a private right of action against the insurer for damages arising from an adverse decision by the insurer that is subject to external review if:

(a) The insurer states in the health benefit plan in which the enrollee is enrolled that the insurer is not bound by the decisions of an independent review organization; and

(b) The insurer fails to comply with the decision.

(2) The Legislative Assembly intends that there is no private right of action under subsection (1) of this section if a court finds either subsection (1)(a) or (b) of this section to be unconstitutional or otherwise void. [2001 c.266 §14]

Note: 743.864 becomes operative July 1, 2002. See section 18, chapter 266, Oregon Laws 2001.

743.865 [1981 c.752 §4; renumbered 743.614 in 1989]

PAYMENT OF CLAIMS

743.866 Payment or denial of health benefit plan claims. (1) Except as provided in this subsection, when a claim under a health benefit plan is submitted to an insurer by a provider on behalf of an enrollee, the insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the claim. If an

insurer requires additional information before payment of a claim, not later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional information needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the additional information.

(2) A contract between an insurer and a provider may not include a provision governing payment of claims that limits the rights and remedies available to a provider under this section and ORS 743.868 or has the effect of relieving either party of their obligations under this section and ORS 743.868.

(3) An insurer shall establish a method of communicating to providers the procedures and information necessary to complete claim forms. The procedures and information must be reasonably accessible to providers.

(4) This section does not create an assignment of payment to a provider.

(5) Each insurer shall report to the Director of the Department of Consumer and Business Services annually on its compliance under this section according to requirements established by the director.

(6) The director shall adopt by rule a definition of “clean claim” and shall consider the definition of “clean claim” used by the federal Department of Health and Human Services for the payment of Medicare claims. [2001 c.747 §2]

743.868 Interest on unpaid claims. (1) An insurer that fails to pay a claim to a provider within the timelines established in ORS 743.866 shall pay simple interest of 12 percent per annum on the unpaid amount of the claim that is due and owing, accruing from the date after the payment was due until the claim is paid. Interest on any overdue payment for a claim begins to accrue on the 31st day after:

(a) The date on which the insurer received the claim; or

(b) The date the insurer receives the requested additional information.

(2) The interest is payable with the payment of the claim. An insurer is not required to pay interest that is in the amount of $2 or less on any claim.

(3) The availability of interest under subsection (1) of this section is in addition to and not in lieu of administrative actions and penalties that may be imposed by the Director of the Department of Consumer and Business Services under the Insurance Code. [2001 c.747 §3]

Note: Section 4, chapter 747, Oregon Laws 2001, provides:

Sec. 4. The Director of the Department of Consumer and Business Services shall report to the Seventy-third Legislative Assembly on the implementation of and compliance with sections 2 and 3 of this 2001 Act [743.866 and 743.868]. [2001 c.747 §4]

743.870 [1981 c.752 §5; renumbered 743.616 in 1989]

743.875 [1981 c.752 §6; renumbered 743.617 in 1989]

743.880 [1981 c.752 §7; renumbered 743.619 in 1989]

743.885 [1981 c.752 §8; renumbered 743.620 in 1989]

743.890 [1981 c.752 §9; renumbered 743.622 in 1989]

743.900 [1971 c.476 §2; 1975 c.570 §1; renumbered 742.560 in 1989]

743.905 [1971 c.476 §3; renumbered 742.562 in 1989]

743.910 [1971 c.476 §4; 1977 c.600 §7; 1989 c.426 §3; renumbered 742.564 in 1989]

743.915 [1971 c.476 §5; repealed by 1975 c.570 §2 (743.916 enacted in lieu of 743.915)]

743.916 [1975 c.570 §3 (enacted in lieu of 743.915); 1977 c.600 §8; 1989 c.426 §4; renumbered 742.566 in 1989]

743.920 [1971 c.476 §6; renumbered 742.568 in 1989]

743.925 [1971 c.476 §7; renumbered 742.570 in 1989]

743.930 [1971 c.476 §8; 1977 c.600 §4; renumbered 742.572 in 1989]

743.940 [1987 c.774 §36; renumbered 742.700 in 1989]

743.942 [1987 c.774 §37; renumbered 742.702 in 1989]

743.944 [1987 c.774 §38; renumbered 742.704 in 1989]

743.946 [1987 c.774 §§39,40; 1989 c.700 §18; renumbered 742.706 in 1989]

743.948 [1987 c.774 §41; renumbered 742.708 in 1989]

743.950 [1987 c.774 §42; 1989 c.181 §1; renumbered 742.710 in 1989]