Chapter 743

2013 EDITION

Health and Life Insurance

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743.003 [1967 c.359 §335; renumbered 742.001 in 1989]

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 Health insurance policy and health benefit plan forms; rules. 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743.011 [1985 c.827 §2; repealed by 1989 c.255 §15]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 insurance producer 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; 2003 c.364 §106]

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 are subject to approval, disapproval or withdrawal of approval by the director as provided in ORS 742.003, 742.005 and 742.007.

(2) An insurer may revise the schedules of premium rates from time to time and shall file the revised schedules with the director. An insurer may not issue any credit life or credit health insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as then on file with the director.

(3) If a group policy of credit life or credit health insurance has been or is delivered in another state, the insurer shall file only the group certificate, the individual application and the notice of proposed insurance delivered or issued for delivery in this state as specified in ORS 743.377 (2) and (4). The director shall approve the group certificate, the individual application and the notice of proposed insurance if the forms conform with the requirements specified in ORS 743.377 (2) and (4) and the schedules of premium rates applicable to the insurance evidenced by the 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; 2005 c.185 §3]

743.018 Filing of rates for life and health insurance; rules. (1) 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. Premium rates are subject to approval, disapproval or withdrawal of approval by the director as provided in ORS 742.003, 742.005 and 742.007.

(2) Except as provided in ORS 743.737 and subsection (3) of this section, a rate filing by a carrier for any of the following health benefit plans subject to ORS 743.730 to 743.773 shall be available for public inspection immediately upon submission of the filing to the director:

(a) Health benefit plans for small employers.

(b) Individual health benefit plans.

(3) The director may by rule:

(a) Specify all information a carrier must submit as part of a rate filing under this section; and

(b) Identify the information submitted that will be exempt from disclosure under this section because the information constitutes a trade secret and would, if disclosed, harm competition.

(4) The director, after conducting an actuarial review of the rate filing, may approve a proposed premium rate for a health benefit plan for small employers or for an individual health benefit plan if, in the director's discretion, the proposed rates are:

(a) Actuarially sound;

(b) Reasonable and not excessive, inadequate or unfairly discriminatory; and

(c) Based upon reasonable administrative expenses.

(5) In order to determine whether the proposed premium rates for a health benefit plan for small employers or for an individual health benefit plan are reasonable and not excessive, inadequate or unfairly discriminatory, the director may consider:

(a) The insurer's financial position, including but not limited to profitability, surplus, reserves and investment savings.

(b) Historical and projected administrative costs and medical and hospital expenses.

(c) Historical and projected loss ratio between the amounts spent on medical services and earned premiums.

(d) Any anticipated change in the number of enrollees if the proposed premium rate is approved.

(e) Changes to covered benefits or health benefit plan design.

(f) Changes in the insurer's health care cost containment and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan.

(g) Whether the proposed change in the premium rate is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the future.

(h) Any public comments received under ORS 743.019 pertaining to the standards set forth in subsection (4) of this section and this subsection.

(6) With the written consent of the insurer, the director may modify a schedule or table of premium rates filed in accordance with subsection (1) of this section.

(7) The requirements of this section do not supersede other provisions of law that require insurers, health care service contractors or multiple employer welfare arrangements providing health insurance to file schedules or tables of premium rates or proposed premium rates with the director or to seek the director's approval of rates or changes to rates. [1967 c.359 §340; 2007 c.391 §1; 2009 c.595 §31; 2013 c.681 §11]

Note: Section 6, chapter 681, Oregon Laws 2013, provides:

Sec. 6. (1) Notwithstanding ORS 743.737 (8)(d) and 743.767 (3), at one time during the 2014 calendar year, insurers may increase their rates by an amount that reflects:

(a) The health insurance providers fee imposed under section 9010 of the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by section 10905 of the Patient Protection and Affordable Care Act, and as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); and

(b) A federal fee, tax or assessment imposed to pay for the costs of a federal reinsurance program.

(2) To the extent the existing rate was approved by the Department of Consumer and Business Services, the resulting rate, including the additional amount reflecting the health insurance providers fee and a federal fee, tax or assessment, shall be considered an approved rate. [2013 c.681 §6]

Note: Section 6, chapter 681, Oregon Laws 2013, was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.019 Public comment on proposed rates for health insurance. (1) When an insurer files a schedule or table of premium rates for individual or small employer health insurance under ORS 743.018, the Director of the Department of Consumer and Business Services shall open a 30-day public comment period on the rate filing that begins on the date the insurer files the schedule or table of premium rates. The director shall post all comments to the website of the Department of Consumer and Business Services without delay.

(2) The director shall give written notice to an insurer approving or disapproving a rate filing or, with the written consent of the insurer, modifying a rate filing submitted under ORS 743.018 no later than 10 business days after the close of the public comment period. The notice shall comply with the requirements of ORS 183.415. [2009 c.595 §28; 2013 c.681 §36]

Note: 743.019 and 743.020 were added to and made a part of ORS chapter 743 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

743.020 Rate filing to include statement of administrative expenses; rules. An insurer licensed by the Department of Consumer and Business Services shall include in any rate filing under ORS 743.018 with respect to individual and small employer health insurance policies a statement of administrative expenses in the form and manner prescribed by the department by

rule. The statement must include, but is not limited to:

(1) A statement of administrative expenses on a per member per month basis; and

(2) An explanation of the basis for any proposed premium rate increases or decreases. [2009 c.595 §29]

Note: See note under 743.019.

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

743.024 Personal insurance, insurable interest and beneficiaries. (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. A life or health insurance policy upon an individual, except a policy of group life insurance or of group or blanket health insurance, may not 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 funeral expenses of an adult who is dependent upon the person for support and maintenance.

(5) A person may effectuate insurance that provides for the funeral expenses of an adult if the person:

(a) Is closely related to the adult by blood or by law or has a substantial interest in the adult engendered by love and affection; and

(b) Has a lawful and substantial interest in having the life, health and bodily safety of the adult continue. [1967 c.359 §342a; 1991 c.182 §2; 2009 c.331 §1]

743.028 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 for life or 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 742.018]

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]

743.056 Insurer may not refuse to defend or pay claim based on provider's disclosure of adverse event or provider's participation in mediation. (1) As used in this section:

(a) "Adverse event" means a negative consequence of patient care that is unanticipated, is usually preventable and results in or presents a significant risk of patient injury.

(b) "Claim" means a written demand for restitution for an injury alleged to have been caused by the medical negligence of a health practitioner or licensed health care facility.

(c) "Health practitioner" means a person described in ORS 31.740 (1).

(d) "Patient's family" includes:

(A) A parent, sibling or child by marriage, blood, adoption or domestic partnership.

(B) A foster parent or foster child.

(2) An insurer may not decline or refuse to defend or indemnify a health practitioner or a health care facility with respect to a claim, for any reason that is based on:

(a) The disclosure to the patient or the patient's family by the health practitioner or facility of an adverse event or information relating to the cause of an adverse event;

(b) A notice of adverse health care incident filed under section 2, chapter 5, Oregon Laws 2013; or

(c) Participation in a discussion or mediation under section 3 or 5, chapter 5, Oregon Laws 2013.

(3) A policy or contract of insurance or indemnity may not include a provision or term excluding or limiting coverage based on:

(a) The disclosure to a patient or the patient's family by a health practitioner or

facility of an adverse event or information relating to the cause of an adverse event;

(b) A notice of adverse health care incident filed under section 2, chapter 5, Oregon Laws 2013; or

(c) Participation in a discussion or mediation under section 3 or 5, chapter 5, Oregon Laws 2013.

(4) An insurer may establish requirements and policy provisions for coverage of payments of compensation made under section 3, chapter 5, Oregon Laws 2013, or as a result of a mediation under section 5, chapter 5, Oregon Laws 2013. Requirements and policy provisions established under this subsection may not be intended to or have the effect of preventing meaningful participation in discussions and mediations under sections 3 and 5, chapter 5, Oregon Laws 2013.

(5) An insurer may not provide or be required to provide information related to an adverse health care incident as defined in section 1, chapter 5, Oregon Laws 2013, for credentialing purposes. [2011 c.30 §2; 2013 c.5 §15]

Note 1: The amendments to 743.056 by section 15, chapter 5, Oregon Laws 2013, become operative July 1, 2014, and apply to adverse health care incidents that occur on or after July 1, 2014. See sections 21 and 23, chapter 5, Oregon Laws 2013. The text that is operative until July 1, 2014, is set forth for the user's convenience.

743.056. (1) As used in this section:

(a) "Adverse event" means a negative consequence of patient care that is unanticipated, is usually preventable and results in or presents a significant risk of patient injury.

(b) "Claim" means a written demand for restitution for an injury alleged to have been caused by the medical negligence of a health practitioner or licensed health care facility.

(c) "Health practitioner" means a person described in ORS 31.740 (1).

(d) "Patient's family" includes:

(A) A parent, sibling or child by marriage, blood, adoption or domestic partnership.

(B) A foster parent or foster child.

(2) An insurer may not decline or refuse to defend or indemnify a health practitioner or a health care facility with respect to a claim, for any reason that is based on the disclosure to the patient or the patient's family by the health practitioner or facility of an adverse event or information relating to the cause of an adverse event.

(3) A policy or contract of insurance or indemnity may not include a provision or term excluding or limiting coverage based on the disclosure to a patient or the patient's family by a health practitioner or facility of an adverse event or information relating to the cause of an adverse event.

Note 2: The amendments to 743.056 by section 16, chapter 5, Oregon Laws 2013, become operative December 31, 2023. See section 22, chapter 5, Oregon Laws 2013. The text that is operative on and after December 31, 2023, is set forth for the user's convenience.

743.056. (1) As used in this section:

(a) "Adverse event" means a negative consequence of patient care that is unanticipated, is usually preventable and results in or presents a significant risk of patient injury.

(b) "Claim" means a written demand for restitution for an injury alleged to have been caused by the medical negligence of a health practitioner or licensed health care facility.

(c) "Health practitioner" means a person described in ORS 31.740 (1).

(d) "Patient's family" includes:

(A) A parent, sibling or child by marriage, blood, adoption or domestic partnership.

(B) A foster parent or foster child.

(2) An insurer may not decline or refuse to defend or indemnify a health practitioner or a health care facility with respect to a claim, for any reason that is based on the disclosure to the patient or the patient's family by the health practitioner or facility of an adverse event or information relating to the cause of an adverse event.

(3) A policy or contract of insurance or indemnity may not include a provision or term excluding or limiting coverage based on the disclosure to a patient or the patient's family by a health practitioner or facility of an adverse event or information relating to the cause of an adverse event.

Note 3: 743.056 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

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

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

743.061 Uniform standards for health care financial and administrative transactions; rules. (1) The Department of Consumer and Business Services may adopt by rule uniform standards applicable to persons listed in subsection (2) of this section for health care financial and administrative transactions, including uniform standards for:

(a) Eligibility inquiry and response;

(b) Claim submission;

(c) Payment remittance advice;

(d) Claims payment or electronic funds transfer;

(e) Claims status inquiry and response;

(f) Claims attachments;

(g) Prior authorization;

(h) Provider credentialing; or

(i) Health care financial and administrative transactions identified by the stakeholder work group described in ORS 743.062.

(2) Any uniform standards adopted under subsection (1) of this section apply to:

(a) Health insurers.

(b) Prepaid managed care health services organizations as defined in ORS 414.736.

(c) Third party administrators.

(d) Any person or public body that either individually or jointly establishes a self-insurance plan, program or contract, includ-

ing but not limited to persons and public bodies that are otherwise exempt from the Insurance Code under ORS 731.036.

(e) Health care clearinghouses or other entities that process or facilitate the processing of health care financial and administrative transactions from a nonstandard format to a standard format.

(f) Any other person identified by the department that processes health care financial and administrative transactions between a health care provider and an entity described in this subsection.

(3) In developing or updating any uniform standards adopted under subsection (1) of this section, the department shall consider recommendations from the Oregon Health Authority under ORS 743.062. [2011 c.130 §2]

Note: 743.061 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.062 Stakeholder work group to recommend uniform standards. (1) The Oregon Health Authority shall convene a stakeholder work group to recommend uniform standards for health care financial and administrative transactions, including, to the extent allowed by law, standards applicable to commercial health insurance plans, self-funded plans and state governmental health plans and programs.

(2) The authority shall report uniform standards recommended under subsection (1) of this section to the Department of Consumer and Business Services for consideration in the adoption of uniform standards by the department under ORS 743.061.

(3) The stakeholder work group, in recommending uniform standards under subsection (1) of this section, shall consider or incorporate any applicable national standards for administrative simplification and timelines for implementation of national standards for administrative simplification that are established pursuant to federal law. [2011 c.130 §3]

Note: 743.062 and 743.064 were enacted into law by the Legislative Assembly but were 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.

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

743.064 Coordination with Oregon Health Authority concerning uniform standards; Department of Human Services to be subject to standards. (1) The Department of Consumer and Business Services and the Oregon Health Authority shall confer before the department finalizes rules implementing uniform standards under ORS 743.061, for the purpose of reconciling any differences between the department's and the authority's requirements for health care financial and administrative transactions described in ORS 743.061. If the Department of Consumer and Business Services proposes to amend any rule concerning uniform standards for health care financial and administrative transactions under ORS 743.061 or the authority proposes to amend any rule in a manner that would be inconsistent with the uniform standards, the agency proposing to amend the rules shall notify the other agency. The agencies shall confer before a final rule is adopted to ensure that the standards remain uniform and consistent to the extent practicable.

(2) The Department of Human Services shall be subject to the uniform standards adopted by the Department of Consumer and Business Services and the authority under ORS 743.061 that are applicable to the operations of the Department of Human Services. [2011 c.130 §5]

Note: See note under 743.062.

743.065 Uniform prior authorization form for prescription drug benefits; consultation with Oregon Health Authority; rules. (1) The Department of Consumer and Business Services, in consultation with the Oregon Health Authority, shall develop by rule a form that providers in this state shall use to request prior authorization for prescription drug benefits. The form must:

(a) Be uniform for all providers;

(b) Not exceed two pages;

(c) Be electronically available and transmissible; and

(d) Include a provision under which additional information may be requested and provided.

(2) If a person described in ORS 743.061 (2) requires prior authorization for prescription drug benefits, the person must allow the use of the form developed under subsection (1) of this section.

(3) An insurer meets the requirement set forth in ORS 743.807 (2)(d) if the insurer answers a provider's request for prior authorization within two business days of having received a completed form developed under subsection (1) of this section and all supporting documentation needed to process the request.

(4) The department may adopt rules to implement this section. [2013 c.596 §2]

Note: 743.065 becomes operative July 1, 2015. See section 4, chapter 596, Oregon Laws 2013.

Note: 743.065 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

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]

743.082 Selling and leasing of provider panels by contracting entity; definitions. As used in this section and ORS 743.083 to 743.086:

(1)(a) "Contracting entity" means any person that contracts directly with a provider for the delivery of health care services or contracts with a third party for the purpose of selling or making available to the third party the provider's health care services or discounted rates or the services or rates of a provider panel under a provider network contract.

(b) "Contracting entity" includes a person under common ownership and control of a contracting entity.

(c) "Contracting entity" does not include:

(A) A managed care organization that is certified under ORS 656.260;

(B) A discount medical plan organization as defined in ORS 742.420;

(C) The state medical assistance program;

(D) An independent practice association; or

(E) A self-funded, employer-sponsored health insurance plan regulated under the Employee Retirement Income Security Act of 1974, as codified and amended at 29 U.S.C. 1001, et seq., or any person that provides only administrative services to the self-funded employer-sponsored health insurance plan.

(2) "Health care services" means the treatment of humans for bodily injury, disablement or death by accidental means or as a result of sickness or childbirth, or in prevention of sickness, but does not include treatment for bodily injury, disablement or occupational diseases incurred as a result of employment.

(3) "Independent practice association" has the meaning given that term in ORS 743.801.

(4) "Person" has the meaning given that term in ORS 731.116.

(5)(a) "Provider" includes:

(A) A physician as defined in ORS 677.010.

(B) A physician group, independent practice association, physician-controlled organization, hospital organization or other provider organization that contracts with a provider for the purpose of facilitating the provider's participation in a provider network contract.

(C) A person licensed, certified or otherwise authorized or permitted by the laws of this state to administer medical services or mental health services in the ordinary course of business or practice of a profession.

(b) "Provider" does not include a contracting entity.

(6) "Provider network contract" means a contract between a provider and a contracting entity for the provision of health care services to patients other than Medicare enrollees or medical assistance recipients.

(7)(a) "Third party" means a person that enters into a contract with a contracting entity or with another party, other than a provider, for the right to exercise the rights of the contracting entity under a provider network contract.

(b) "Third party" includes any of the following:

(A) A payer that directly reimburses the cost of the delivery of health care services;

(B) A third party administrator or other entity that administers or processes claims on behalf of a payer;

(C) A preferred provider organization or network;

(D) A physician-controlled organization or a hospital organization; or

(E) An entity that is engaged in the electronic transmission of claims between a contracting entity and a payer and does not provide to another party access to the health care services and discounted rates of a provider.

(c) "Third party" does not include:

(A) Entities offering health care services under the same brand pursuant to a brand licensing agreement with the same licenser; or

(B) A self-funded, employer-sponsored health insurance plan regulated under the Employee Retirement Income Security Act of 1974, as codified and amended at 29 U.S.C. 1001, et seq., or any person that provides only administrative services to the self-funded employer-sponsored health insurance plan. [2011 c.561 §1]

Note: 743.082, 743.085 and 743.086 were enacted into law by the Legislative Assembly but were 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.

743.083 Registration of contracting entity. (1) A contracting entity that does not have a certificate of authority shall register with the Department of Consumer and Busi-

ness Services as a contracting entity by submitting the following information to the department in written or electronic form as prescribed by the department along with any fee prescribed by the department:

(a) The official name of the entity and any secondary, alternative or substitute designations.

(b) The mailing address and telephone number of the headquarters of the entity.

(c) The name and telephone number of a representative of the entity who shall serve as the primary contact for the department.

(2) The requirements of this section do not apply to a contracting entity that is under common ownership and control of a contracting entity that is licensed by or has a certificate of authority from the department. [2011 c.561 §3]

Note: 743.083 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

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

743.085 Third party contracts for leasing of provider panels; requirements. (1) A contracting entity or a third party may not contract with another third party to provide access to the health care services and discounted rates of a provider under a provider network contract unless:

(a) The third party contract is specifically authorized by the provider network contract; and

(b) The third party contract obligates the third party to comply with all applicable terms, limitations and conditions of the provider network contract.

(2) A contracting entity that provides access to the health care services and discounted rates of a provider under a provider network contract shall:

(a) Give to the provider in writing or electronically, at the time a provider network contract is entered into, a list of all third parties known by the contracting entity at the time to which the contracting entity has or will provide access to the health care services and discounted rates of a provider under the provider network contract;

(b) Maintain an Internet website, toll-free telephone number or other readily available mechanism through which a provider may obtain a list, updated at least every 90 days, of all third parties that have access to the provider's health care services and discounted rates under the provider network contract;

(c) Provide each third party listed under paragraph (a) or (b) of this subsection with information necessary to enable the third party to comply with all relevant terms, limitations and conditions of the provider network contract;

(d) Require a third party to identify on each remittance or explanation of payment sent to a provider the source of any contractual discount in rates taken by the third party under the provider network contract; and

(e)(A) Notify each third party listed under paragraph (a) or (b) of this subsection of the termination of the provider network contract no later than 30 days prior to the effective date of the termination; and

(B) Require third parties to cease claiming entitlement to discounted rates or other rights under a provider network contract after the termination of the contract.

(3) The notice required under subsection (2)(e)(A) of this section can be provided by any reasonable means, including but not limited to written notice, electronic communication or an update to an electronic database.

(4) Subject to any applicable continuity of care requirements, agreements or contractual provisions:

(a) A third party's right to access a provider's health care services and discounted rates under a provider network contract shall terminate on the date the provider network contract is terminated;

(b) Claims for health care services performed after the termination date of the provider network contract are not eligible for processing and payment in accordance with the provider network contract; and

(c) Claims for health care services performed before the termination date of the provider network contract, but processed after the termination date, are eligible for processing and payment in accordance with the provider network contract.

(5)(a) All information made available to a provider in accordance with the requirements of this section and ORS 743.086 shall be confidential and may not be disclosed to any person not involved in the provider's practice or the administration thereof without the prior written consent of the contracting entity.

(b) This section and ORS 743.086 may not be construed to prohibit a contracting entity from requiring a provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the provider's direct practice management or billing activities. [2011 c.561 §4]

Note: See note under 743.082.

743.086 Additional requirements for third party contracts. (1) A contract between a third party and a contracting entity or between two third parties with respect to a provider network contract must comply with this section and ORS 743.085.

(2)(a) A third party shall inform the contracting entity and providers under a contracting entity's provider network contract of a website, toll-free number or other readily available mechanism to identify the names of all third parties to which the third party provides access to the health care services and discounted rates of a provider under the provider network contract.

(b) The third party shall update the website described in paragraph (a) of this subsection at least every 90 days to reflect all third parties currently provided access. Upon request, the third party shall make the information available to a provider via telephone or through direct notification.

(3) A provider may refuse to accept as payment in full a discounted payment made by a third party under the terms of a provider network contract if there is no valid contractual basis for the discount or the discount is taken in violation of this section or ORS 743.085. [2011 c.561 §5]

Note: See note under 743.082.

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 apply 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. (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; rules. (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 divis-

ible 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 Installment payments. 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 non-

forfeiture 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 respec-

tive 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 or ORS chapter 743A, 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]

743.268 Advancement of policy loans. (1) An insurer may advance a policy loan equal to or less than the loan value of an annuity policy or a pure endowment policy if:

(a) The policy premium is not in default beyond the grace period for payment;

(b) The insured has properly assigned or pledged the policy on the sole security thereof; and

(c) The interest rate provision complies with ORS 743.187 and does not exceed the maximum interest rate permitted by the policy loan provision.

(2) An insurer may establish a minimum loan amount that may not exceed $1,000.

(3) Except as provided in subsection (4) of this section, the loan value of the policy shall be equal to the cash surrender value of the policy, less any existing indebtedness and interest due that is not already deducted in determining the cash surrender value, plus any interest then accrued but not credited.

(4) Subsection (3) of this section does not apply to a policy for which the loan value is established by federal law. When the loan value is established by federal law, the policy shall indicate the loan value as a dollar amount, a percentage of the cash surrender value or a combination of both.

(5) 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. However, if there is any remaining cash surrender value under the policy after deducting the total indebtedness on the policy, an insurer may not terminate the policy.

(6) A insurer may provide for automatic premium loans in an annuity policy or a pure endowment policy.

(7) An annuity policy or a pure endowment policy may reserve to the insurer the right to defer the granting of a loan, other than for payment of any premium to the insurer, for six months after application for the loan if the insurer makes a written request to and receives written approval from the chief insurance regulator of the state of domicile of the insurer prior to exercising a deferral. [2005 c.185 §5]

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

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

(a) Reinsurance.

(b) A group annuity policy purchased under a retirement or deferred compensation plan established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both. This exclusion does not apply, however, to a plan providing individual retirement accounts or individual retirement annuities under section 408 of the federal Internal Revenue Code.

(c) A premium deposit fund.

(d) A variable annuity policy.

(e) An investment annuity policy.

(f) An immediate annuity policy.

(g) A deferred annuity policy after annuity payments have commenced.

(h) A reversionary annuity.

(i) A policy delivered outside this state through an agent or other representative of the insurer issuing the policy. [1977 c.320 §2; 2003 c.370 §1]

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 considerations under the policy, or upon the written request of the policyholder, the insurer shall grant a paid-up annuity benefit on a plan stipulated in the policy, of the value specified in ORS 743.284 and 743.287.

(b) That, if the policy provides for a lump sum settlement at maturity or any other time, the insurer shall 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 specified in ORS 743.284 and 743.287. The insurer may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six months after demand therefor with surrender of the policy, if the insurer makes a written request and receives written approval from the director. The request shall address the necessity and equitability to all policyholders of the deferral.

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

(d) A statement that any paid-up annuity, cash surrender or death benefits available under the policy are not less than the minimum benefits required by any statute of the state in which the policy is delivered and an explanation of the manner in which the 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, a deferred annuity policy may provide that if no considerations have been received for two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the policy arising from prior considerations paid would be less than $20 monthly, the insurer at its option may terminate the policy by payment in cash of the then present value of the portion of the paid-up annuity benefit. The value shall be calculated on the basis of the mortality table, if any, and the interest rate specified in the policy for determining the paid-up annuity benefit. By this payment the insurer shall be relieved of further obligations under the policy. [1977 c.320 §3; 2003 c.370 §2]

743.281 [1977 c.320 §4; repealed by 2003 c.370 §9]

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. The present value shall be computed using the mortality table, if any, and the interest rate specified in the policy for determining the minimum paid-up annuity benefits guaranteed in the policy.

(2) For annuity policies that provide cash surrender benefits, the cash surrender benefits available prior to maturity shall not be less than the present value as of the date of surrender of the portion of the policy maturity value of the paid-up annuity benefit that would be provided under the policy at maturity arising from considerations paid prior to the time of cash surrender, reduced by appropriate amounts reflecting any previous withdrawals from or partial surrenders of the policy. The 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 maturity value, shall be decreased by the amount of any indebtedness to the insurer on the policy, including interest due and accrued, 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 may not be less than the present value of the portion of the maturity value of the paid-up annuity benefits provided under the policy arising from considerations paid before the policy is surrendered in exchange for, or changed to, a deferred paid-up annuity. The 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 value, and shall be increased by any additional amounts credited by the insurer to the policy. For annuity policies that do not provide any death benefits before annuity payments start, present values shall be calculated on the basis of such interest rate and the mortality table specified in the policy for determining the maturity value of paid-up annuity benefit. In no event, however, shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time. [1977 c.320 §5; 2003 c.370 §5]

743.287 Commencement of annuity payments at optional maturity dates; calculation of benefits. (1) For the purpose of determining the benefits calculated under 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 policy anniversary next following the annuitant's 70th birthday or the 10th anniversary of the policy, whichever is later.

(2) Any paid-up annuity, cash surrender or death benefits available at any time, other than on the policy anniversary of a policy with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the start of the policy year in which termination of considerations occurs. [1977 c.320 §6; 2003 c.370 §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 does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the start of annuity payments shall include a statement in a prominent place in the policy that the benefits are not provided. [1977 c.320 §7; 2003 c.370 §7]

743.293 Minimum forfeiture amounts for annuity policies; rules. (1) The minimum values as specified in ORS 743.284 and 743.287 of any paid-up annuity, cash surrender or death benefits available under an annuity policy shall be based on minimum nonforfeiture amounts as described in this section.

(2) The minimum nonforfeiture amount at or prior to the commencement of any annuity payments shall be equal to an accumulation up to that time at rates of interest as indicated in subsection (4) of this section of the net considerations previously paid, decreased by the sum of the following:

(a) Any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in subsection (4) of this section;

(b) An annual contract charge of $50, accumulated at rates of interest as indicated in subsection (4) of this section;

(c) Any premium tax paid by the insurer for the policy, accumulated at rates of interest as indicated in subsection (4) of this section; and

(d) The amount of any indebtedness to the insurer on the policy, including interest due and accrued.

(3) For purposes of subsection (2) of this section, the net considerations for a given policy year used to define the minimum nonforfeiture amount shall be an amount equal to 87.5 percent of the gross considerations credited to the policy during that policy year.

(4)(a) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of three percent per annum and the rate established under paragraph (b) of this subsection. The rates established shall be specified in the policy if the interest rate is reset.

(b) The following provisions apply to the rate:

(A) The rate shall be the five-year constant maturity treasury rate reported by the Federal Reserve as of a date certain or an average over a period, rounded to the nearest one-twentieth of one percent, that is specified in the policy and that is no longer than 15 months prior to the policy issue date or redetermination date under paragraph (c) of this subsection, reduced by 125 basis points.

(B) The resulting interest rate under subparagraph (A) of this paragraph may not be less than one percent.

(c) The interest rate shall apply to an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the policy. The basis is the date certain or an average over a specified period that produces the value of the five-year constant maturity treasury rate to be used at each redetermination date.

(5) During the period or term that a policy provides substantive participation in an equity indexed benefit, it may increase the reduction described in subsection (4)(b) of this section by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value on the policy issue date and at each redetermination date thereafter, may not exceed the market value of the benefit. The Director of the Department of Consumer and Business Services may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. If a demonstration is not acceptable to the director, the director may disallow or limit the additional reduction.

(6) The director may adopt rules to implement subsection (5) of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for policies that provide substantive participation in an equity index benefit and for other policies that the director determines justify an adjustment. [2003 c.370 §4]

743.295 Effect of certain life insurance and disability benefits on minimum nonforfeiture amounts. (1) For an annuity policy that includes, by rider or supplemental contract provision, both annuity benefits and life insurance benefits that exceed the greater of cash surrender benefits or a 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) Notwithstanding ORS 743.284 and 743.287, 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 benefits may 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; 2003 c.370 §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) No fewer than two lives 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 premium for the policy must be paid from the funds of the group policyholder or from funds contributed by persons insured under the policy, or from both sources.

(5) For the purposes of this section, the term "mortgage" includes trust deeds.

(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; 2007 c.560 §2]

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 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; 2005 c.22 §491]

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; rules. (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, 743A.160 and 743A.164 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. [Formerly 741.022; 2001 c.356 §5; 2013 c.698 §19]

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

(1) The policy must include a statement of the entire money and other considerations due.

(2) The policy must state the time at which the insurance takes effect and terminates.

(3) The policy may purport to insure only one person, unless an adult member of a family applies for coverage of family members or other dependents.

(4) The policy may not be issued individually to an individual in a group of persons described in ORS 731.098 for the purpose of separating the individual from health insurance benefits offered or provided in connection with a group health benefit plan.

(5)(a) 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 12-point type.

(b) 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 policy must state the exceptions and reductions of indemnity. Except those required by ORS 743.411 to 743.477, 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; 2009 c.11 §94; 2011 c.9 §91; 2011 c.500 §6; 2013 c.681 §12]

743.408 Mandatory provisions. Except as provided in ORS 742.021, a health insurance policy shall contain the provisions set forth in ORS 743.411 to 743.444. The provisions shall be preceded individually by the caption appearing in the sections or, at the option of the insurer, by the appropriate individual or group captions or subcaptions as the Director of the Department of Consumer and Business Services may approve. [1967 c.359 §428; 2011 c.9 §92]

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 insurance producer has authority to change this policy or to waive any of its provisions." [1967 c.359 §429; 2003 c.364 §107]

743.412 [1977 c.632 §2; 1981 c.319 §1; 2001 c.900 §230; renumbered 743A.160 in 2007]

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 specify a minimum grace period of at least 10 days after the premium due date 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 described 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 described 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; 2013 c.681 §13]

743.420 Reinstatement. (1) A health insurance policy, other than a health benefit plan as defined in ORS 743.730, 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 insurance producer 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 insurance producer 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; 2003 c.364 §108; 2013 c.681 §13a]

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. Except as provided in ORS 742.021, provisions in a health insurance policy respecting the matters set forth in ORS 743.450 to 743.477 shall be in the words that 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; 2011 c.9 §93]

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. 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 [1967 c.359 §452; 1979 c.744 §64; 2007 c.128 §1; renumbered 743A.164 in 2007]

743.483 Arrangement of provisions. The provisions of a health insurance policy that are the subject of ORS 743.408 to 743.477, or any corresponding provisions that 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; 2009 c.11 §95; 2011 c.9 §94]

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; 2011 c.9 §95]

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 insurance producer 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; 2003 c.364 §109]

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]

743.499 Notice to policyholder required for cancellation or nonrenewal of health benefit plan; effect of failure to give notice. (1) As used in this section, "health benefit plan" has the meaning given that term in ORS 743.730.

(2) An insurer shall notify a policyholder in writing if the insurer cancels or does not renew the policyholder's individual health benefit plan. The notice shall be sent to the policyholder's last-known mailing address by first class mail in a specially marked envelope or, if the policyholder has elected to receive communications from the insurer electronically, to the policyholder's last-known electronic mail address using a mechanism that will confirm delivery to the address.

(3) If the cancellation or nonrenewal results in a refund to the policyholder of all or part of a premium, the insurer must mail with the refund a written explanation that includes:

(a) The effective date of the cancellation;

(b) The reason for the cancellation; and

(c) The time period to which the refund is applicable.

(4) For any cancellation or nonrenewal due to a reported death of the policyholder, the insurer must:

(a) Confirm the accuracy of the reported death.

(b) If the death is confirmed:

(A) Provide any dependents covered by the plan with information about how to continue coverage or obtain alternative coverage; and

(B) Issue any refund that is due to the estate of the deceased in accordance with subsection (3) of this section.

(5) If an insurer cancels or does not renew an individual health benefit plan and fails to comply with the requirements of this section, the insurer shall continue the coverage under the plan for the policyholder and any dependents covered by the plan until the date that the insurer has complied with the requirements of this section. The insurer shall waive any premiums owed for the period during which the coverage was continued under this subsection and shall process

all claims incurred by the policyholder or any covered dependents according to the terms of the plan.

(6) This section does not apply:

(a) To a cancellation requested by the policyholder if the insurer documents the request and confirms the request with the policyholder;

(b) To a cancellation or nonrenewal that results from a policyholder making a change in coverage with the same insurer; or

(c) To a cancellation due to nonpayment of premium. [2011 c.500 §4a; 2012 c.24 §1]

Note: 743.499 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

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 Additional groups designated by director. (1) 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) "Employee" may include a retired employee.

(c) "Leased worker" means a worker provided by a worker leasing company licensed under ORS 656.850.

(2) Group health insurance may be offered to a resident of this state under a group health insurance policy issued to a group other than one of the groups described in ORS 731.098 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. [1967 c.359 §461; 1975 c.229 §1; 1989 c.784 §13; 2001 c.943 §4; 2005 c.22 §492; 2013 c.681 §14]

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 may 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 731.098 (2).

(2) An insurer shall submit evidence to the director that the association satisfies the requirements under ORS 731.098 (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 731.098 (2).

(5) The director may adopt rules to carry out this section. [1989 c.784 §11; 2005 c.22 §493; 2013 c.681 §14a]

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

743.526 Determination of whether trustees are policyholders; consequences; rules. (1) An insurer may not offer a policy of group health insurance described in ORS 731.098 (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 731.098 (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 731.098 (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; 2005 c.22 §494; 2013 c.681 §56]

743.527 When group health insurance policies to continue in effect upon payment of premium by insured individual. (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 and 743.600 to 743.610. 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; 2013 c.681 §57]

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 for 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 for 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 under 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 Exemption of policy form approval for blanket health insurance policies. 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 [1973 c.143 §2; 1989 c.1080 §2; repealed by 2013 c.681 §65 and 2013 c.640 §21]

743.550 Student health insurance. (1) Student health insurance is subject to ORS 743.537, 743.540, 743.543, 743.546 and 743.552, 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 mem-

bers 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":

(a) 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 a public university listed in ORS 352.002, 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.

(b) Does not include a student health benefit plan as defined in ORS 743.551. [1995 c.623 §2; 2011 c.637 §289; 2013 c.681 §15]

743.551 Student health benefit plans; rules. (1) As used in this section, "student health benefit plan" means a plan that is subject to rules adopted by the United States Department of Health and Human Services under 42 U.S.C. 18118(c).

(2) Notwithstanding any other provision of law, the Department of Consumer and Business Services shall by rule and in a manner consistent with federal law, adopt requirements for student health benefit plans. [2013 c.681 §4]

Note: 743.551 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.552 Guidelines for coordination of benefits; rules. The Director of the Department of Consumer and Business Services shall by rule establish guidelines for the coordination of benefits for individual and small group health insurance, including:

(1) The procedures by which persons insured under the policies are to be made aware of the existence of a coordination of benefits 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. [1973 c.143 §3; 2013 c.681 §15a]

743.555 [1973 c.143 §4; repealed by 2005 c.22 §495]

743.556 [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; 2003 c.33 §5; 2005 c.705 §1; 2007 c.71 §240; renumbered 743A.168 in 2007]

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

(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 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. [1991 c.673 §§3,4; 1993 c.454 §1; 1997 c.716 §24; 2001 c.943 §11; 2013 c.681 §58]

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 judgment 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 covered person 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 this section and ORS 743.600 and 743.602 apply only to employers with 20 or more employees and group health insurance plans with 20 or more certificate holders on a typical business day during the preceding calendar year. [Formerly 743.852; 2003 c.576 §557; 2011 c.500 §6a; 2012 c.24 §2]

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 membership in group health insurance policy; applicability of waiting period to rehired employee. (1) As used in this section:

(a) "Covered person" means an individual who was a certificate holder under a group health insurance policy:

(A) On the day before a qualifying event; and

(B) During the three-month period ending on the date of the qualifying event.

(b) "Qualified beneficiary" means:

(A) A spouse or dependent child of a covered person who, on the day before a qualifying event, was insured under the covered person's group health insurance policy; or

(B) A child born to or adopted by a covered person during the period of the continuation of coverage under this section who would have been insured under the covered person's policy if the child had been born or adopted on the day before the qualifying event.

(c) "Qualifying event" means the loss of membership in a group health insurance policy caused by:

(A) Voluntary or involuntary termination of the employment of a covered person;

(B) A reduction in hours worked by a covered person;

(C) A covered person becoming eligible for Medicare;

(D) A qualified beneficiary losing dependent child status under a covered person's group health insurance policy;

(E) Termination of membership in the group covered by the group health insurance policy; or

(F) The death of a covered person.

(2)(a) A grandfathered health plan, as defined in ORS 743.730, providing coverage under a group health insurance policy for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, must contain a provision that a covered person and any qualified beneficiary may continue coverage under the policy as provided in this section.

(b) A group health insurance policy that provides coverage for one or more of the essential health benefits, other than a grandfathered health plan, must contain a provision that a covered person and any qualified beneficiary may continue coverage under the policy as provided in this section.

(3) Continuation of coverage is not available to a covered person or qualified beneficiary who is eligible for:

(a) Medicare; or

(b) The same coverage under any other program that was not covering the covered person or qualified beneficiary on the day before a qualifying event.

(4) The continued coverage must be offered in the same manner as it is provided to other certificate holders under the group health insurance policy.

(5) A covered person or qualified beneficiary must submit a written request for continuation of coverage to the insurer within the time prescribed by the insurer, except that an insurer may not require a request to be submitted less than 10 days after the later of:

(a) The date of a qualifying event; or

(b) The date the insurer provides the notice required by subsection (10) of this section.

(6) A covered person or qualified beneficiary who requests continuation of coverage shall pay the premium on a monthly basis and in advance 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.

(7) Continuation of coverage as provided under this section ends on the earliest of the following dates:

(a) Nine months after the date of the qualifying event that was the basis for the continuation of coverage.

(b) The end of the period for which the last timely premium payment for the coverage is received by the insurer.

(c) The premium payment due date coinciding with or next following the date that continuation of coverage ceases to be available in accordance with subsection (3) of this section.

(d) The date that the policy is terminated. However, if the policyholder replaces the terminated policy with similar coverage under another group health insurance policy:

(A) The covered person and qualified beneficiaries may obtain coverage under the replacement policy for the balance of the period that the covered person or qualified beneficiary would have remained covered under the terminated policy in accordance with this section; and

(B) The terminated policy must continue to provide benefits to the covered person and qualified beneficiaries to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred.

(8) A qualified beneficiary who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under this section upon the dissolution of marriage with or the death of the covered person in the same manner that a covered person may exercise the right to continue coverage under this section.

(9) A covered person rehired by an employer no later than nine months after the layoff of the covered person by the employer

may not be subjected to a waiting period for coverage under the employer's group health insurance policy if the covered person was eligible for coverage at the time of the layoff, regardless of whether the covered person continued coverage during the layoff.

(10) If an insurer terminates the group health insurance coverage of a covered person or qualified beneficiary without providing replacement coverage that meets the criteria in subsection (7)(d) of this section, the insurer shall provide written notice to the covered person and any qualified beneficiary no later than 10 days after the insurer is notified of the qualifying event under subsection (5) of this section. The notice shall include information prescribed by the Director of the Department of Consumer and Business Services.

(11) 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 Budget Reconciliation Act of 1985, as amended, P.L. 99-272, April 7, 1986. [Formerly 743.850; 2009 c.73 §§3,4; 2011 c.500 §§6b,6c; 2012 c.24 §3; 2013 c.681 §16]

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 743.665 may be known and cited as the "Long Term Care Insurance Act."

(2) The purpose of ORS 743.650 to 743.665 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) Ensure 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 743.665, 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 743.665, 748.603 and 750.055 are not intended to supersede the obligations of entities subject to ORS 743.650 to 743.665, 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 743.665, 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 743.665, 748.603 and 750.055. [1989 c.1022 §§1,2,3; 2007 c.486 §1]

743.651 [1967 c.359 §496; renumbered 742.234 in 1989]

743.652 Definitions for ORS 743.650 to 743.665. As used in ORS 743.650 to 743.665, 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) "Benefit trigger" means a contractual provision in a long term care insurance pol-

icy that conditions the payment of benefits on an insured's inability to perform activities of daily living or on an insured's cognitive impairment. For qualified long term care insurance, the "benefit trigger" is the determination that an insured is a chronically ill individual, as defined in section 7702B(c) of the Internal Revenue Code.

(3) "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.

(4) "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;

(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;

(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 the 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 the filing, the association or associations shall be considered to satisfy the organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements; or

(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.

(5) "Long term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than 24 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more 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 annuities and life insurance policies or riders that provide directly or supplement long term care insurance. "Long term care insurance" also includes a policy or rider that provides for payment of benefits based upon cognitive impairment or the loss of functional capacity, and qualified long term care insurance contracts. Long term care insurance may be 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 to the extent they are otherwise authorized to issue life or health insurance. "Long term care insurance" does not include any insurance policy that 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 or related asset protection coverage, catastrophic coverage, accident only coverage, specified disease or specified accident coverage or limited benefit health coverage. With regard to life insurance, "long term care insurance" does not include life insurance policies that accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention or permanent institutional confinement, and that provide the option of a lump-sum payment for those benefits and when neither the benefits nor the eligibility for the benefits is

conditioned upon the receipt of long term care. Notwithstanding any other provision of ORS 743.650 to 743.665, any product advertised, marketed or offered as long term care insurance is subject to ORS 743.650 to 743.665.

(6) "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.

(7) "Qualified long term care insurance" means:

(a) The portion of a life insurance contract that provides long term care insurance coverage by rider or as part of the contract and that satisfies the requirements of section 7702B(b) and (e) of the Internal Revenue Code; or

(b) Individual or group long term care insurance as defined in this section that meets all of the following requirements of section 7702B(b) of the Internal Revenue Code:

(A) The only insurance protection provided under the contract is coverage of qualified long term care services. A contract shall not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(B) The contract does not pay or reimburse expenses incurred for services or items to the extent that the expenses are reimbursable under Title XVIII of the Social Security Act, or would be reimbursable but for the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to expenses that are reimbursable under Title XVIII of the Social Security Act only as a secondary payer. A contract does not fail to satisfy the requirements of this subparagraph by reason of payments being made on a per diem or other periodic basis without regard to the expenses incurred during the period to which the payments relate.

(C) The contract is guaranteed renewable within the meaning of section 7702B(b)(1)(C) of the Internal Revenue Code.

(D) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan, or borrowed except as provided in subparagraph (E) of this paragraph.

(E) All refunds of premiums, and all policyholder dividends or similar amounts, under the contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund on the event of death of the insured or a complete surrender or cancellation of the contract cannot exceed the aggregate premiums paid under the contract.

(F) The contract meets the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code. [1989 c.1022 §4; 1993 c.744 §30; 1995 c.79 §364; 2007 c.486 §2; 2011 c.69 §3]

743.653 Prohibition on certain policies. Group long term care insurance coverage may not be offered to a resident of this state under a group policy issued in another state to a group described in ORS 743.652 (4)(d), unless this state or another state having statutory and regulatory long term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met. [1989 c.1022 §5; 1991 c.67 §199; 2007 c.486 §3; 2011 c.69 §4]

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 and that include required procedures for internal and external review of whether the conditions of a benefit trigger have been met.

(b) In adopting rules under this section, the Director of the Department of Consumer and Business Services must give timely notice to, and shall consider recommendations from the Director of Human Services.

(2) A long term care insurance policy may not:

(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;

(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, except as otherwise provided by rule; or

(f) Be sold to provide less than 24 months' coverage.

(3)(a) A long term care insurance policy or certificate other than a policy or certificate issued to a group described in ORS 743.652 (4)(a), (b) or (c) may not use a definition of "preexisting condition" that is more restrictive than the following: "Preexisting condition" means 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) A long term care insurance policy or certificate other than a policy or certificate thereunder issued to a group described in ORS 743.652 (4)(a), (b) or (c) may not exclude coverage for a loss or confinement that is the result of a preexisting condition unless the loss or confinement begins within six months following the effective date of coverage of an insured person.

(c) The Director of the Department of Consumer and Business Services 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. A long term care insurance policy or certificate may not 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.

(4) A long term care insurance policy may not be delivered or issued for delivery in this state if the policy:

(a) Conditions eligibility for any benefits on a prior hospitalization requirement;

(b) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(c) Conditions eligibility for any benefits other than waiver of premium or post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(5)(a) A long term care insurance policy containing post-confinement, post-acute care or recuperative benefits must clearly label in a separate paragraph of the policy or certificate titled "Limitations or Conditions of Eligibility for Benefits" all such limitations or conditions, including any required number of days of confinement.

(b) A long term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

(6) Individual long term care insurance applicants 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. Long term care insurance policies and certificates must have a notice prominently printed on the first page or attached thereto stating in substance that the applicant has 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, other than a certificate issued pursuant to a policy issued to a group described in ORS 743.652 (4)(a), the applicant is not satisfied for any reason. This subsection also applies to denials of applications. Any refund must be made within 30 days of the return or denial.

(7)(a)(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 that prominently direct the attention of the recipient to the document and its purpose.

(B) The Director of the Department of Consumer and Business Services by rule must prescribe a standard format, including style, arrangement and overall appearance, and the content of an outline of coverage.

(C) In the case of solicitations by an insurance producer, the insurance producer must deliver the outline of coverage prior to the presentation of an application or enrollment form.

(D) In the case of direct response solicitations, the outline of coverage must be presented in conjunction with any application or enrollment form.

(E) In the case of a policy issued to a group described in ORS 743.652 (4)(a), an outline of coverage is not required to be delivered as long as the information described in paragraph (b) of this subsection is contained in other materials related to the enrollment. Upon request, these other materials must be made available to the Director of the Department of Consumer and Business Services.

(b) The outline of coverage must 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;

(F) A brief description of the relationship of cost of care and benefits; and

(G) A statement that discloses to the policyholder or certificate holder whether the policy is intended to be qualified long term care insurance as defined in ORS 743.652.

(8) 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.

(9) If an application for a long term care insurance policy or certificate is approved, the insurer must deliver the policy or certificate to the applicant no later than 30 days after the date of approval.

(10) At the time of policy delivery, a policy summary must be delivered for an individual life insurance policy that provides long term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer must deliver the policy summary upon the applicant's request, but regardless of request must make delivery not later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary must also include the provisions required in this subsection. The required provision may be incorporated into a basic illustration or into the life insurance policy summary if required by rule. The following provisions must be included in the summary:

(a) An explanation of how the long term care benefit interacts with other components of the policy, including deductions from death benefits;

(b) An illustration of the amount of benefits, the length of benefits and the guaranteed lifetime benefits, if any, for each covered person;

(c) Any exclusions, reductions and limitations on benefits of long term care;

(d) A statement that any long term care inflation protection option required by rule is not available under the policy; and

(e) If applicable to the policy type, the following:

(A) A disclosure of the effects of exercising other rights under the policy;

(B) A disclosure of guarantees related to long term care costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

(11) When a long term care benefit that is funded through a life insurance policy by an acceleration of the death benefit is in benefit payment status, the insurer must provide a monthly report to the policyholder. The report must include:

(a) Any long term care benefits paid out during the month;

(b) An explanation of any changes in the policy, such as death benefits or cash values, owing to payment of long term care benefits; and

(c) The amount of long term care benefits existing or remaining.

(12) If a claim under a long term care insurance policy is denied, then not later

than the 60th day after the date of a written request by the policyholder or certificate holder, or a personal or authorized representative of either, the insurer must:

(a) Provide a written explanation of the reasons for the denial; and

(b) Make available all information directly related to the denial.

(13) Long term care insurance policies shall include a clear description of the process for appealing and resolving disputes regarding whether the conditions of a benefit trigger have been met.

(14) A policy may not be advertised, marketed or offered as long term care or nursing home insurance unless it complies with the provisions of ORS 743.650 to 743.665.

(15) Rules adopted pursuant to ORS 743.650 to 743.665 shall be in accordance with the provisions of ORS chapter 183.

(16) This section is exempt from ORS 743A.001. [1989 c.1022 §§6,7; 1991 c.67 §200; 2003 c.364 §110; 2007 c.486 §4; 2011 c.69 §5]

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 unless the 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) No long term care policy that offers only nursing home benefits shall be sold in this state. [1989 c.1022 §§13,14; 2003 c.14 §449]

743.657 [1967 c.359 §498; renumbered 742.238 in 1989]

743.660 [1967 c.359 §499; renumbered 742.240 in 1989]

743.662 Rescission of policy and denial of claims. (1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long term care insurance policy or certificate or deny an otherwise valid long term care insurance claim upon a showing of a misrepresentation that is material to the acceptance for coverage.

(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long term care insurance policy or certificate or deny an otherwise valid long term care insurance claim upon a showing of a misrepresentation that is material to the acceptance for coverage and also pertains to the condition for which benefits are sought.

(3) After a policy or certificate has been in force for two years, the policy or certificate is not contestable upon the ground of misrepresentation alone. The policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(4) A long term care insurance policy or certificate may not be field issued based on medical or health status. A policy or certificate is field issued for the purposes of this subsection if the policy or certificate is issued by an insurance producer or a third party administrator pursuant to underwriting authority granted to the insurance producer or third party administrator by an insurer.

(5) If an insurer has paid benefits under the long term care insurance policy or certificate, the insurer may not recover the benefit payments in the event that the policy or certificate is rescinded.

(6) This section does not apply to the remaining death benefit of a life insurance policy in the event of the death of the insured if the policy accelerates benefits for long term care, but this section otherwise applies to a life insurance policy that accelerates benefits for long term care. In the event of the death of an insured, the remaining death benefits under the life insurance policy are governed by ORS 743.168.

(7) This section is exempt from ORS 743A.001. [2007 c.486 §6]

743.663 [1967 c.359 §500; renumbered 742.242 in 1989]

743.664 Offer of nonforfeiture benefit; rules. (1) Except as provided in subsection (2) of this section, a long term care insurance policy may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit. The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy.

If the policyholder or certificate holder declines the nonforfeiture benefit, the insurer must provide a contingent benefit upon lapse that is available for a specified period of time following a substantial increase in premium rates.

(2) When a group long term care insurance policy is issued, the offer required in subsection (1) of this section must be made to the group policyholder. However, if the policy is issued as group long term care insurance as described in ORS 743.652 (4)(d), other than to a continuing care retirement community or similar entity, the offering shall be made to each proposed certificate holder.

(3) The Director of the Department of Consumer and Business Services by rule shall specify:

(a) The type or types of nonforfeiture benefits to be offered as part of long term care insurance policies and certificates;

(b) The standards for nonforfeiture benefits; and

(c) The standards governing contingent benefits upon lapse, including a determination of the specified period of time during which a contingent benefit upon lapse will be available and the substantial premium increase that triggers a contingent benefit upon lapse as described in subsection (1) of this section.

(4) This section is exempt from ORS 743A.001. [2007 c.486 §7; 2011 c.69 §6]

743.665 Prompt pay requirements; rules. The Director of the Department of Consumer and Business Services shall adopt by rule prompt payment requirements for long term care insurance. The rules shall include a definition of "claim" and a definition of "clean claim." In adopting the rules, the director shall consider the prompt payment requirements in long term care insurance model acts developed by the National Association of Insurance Commissioners. [2011 c.69 §2]

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; insurance producer 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 insurance 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; 2003 c.364 §111]

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 chapter 183. [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]

743.691 [2003 c.748 §2; renumbered 743A.110 in 2007]

743.693 [1999 c.428 §2; 2001 c.104 §289; renumbered 743A.080 in 2007]

743.694 [2001 c.742 §2; renumbered 743A.184 in 2007]

743.695 [1997 c.573 §2; renumbered 743A.060 in 2007]

743.697 [1997 c.573 §3; renumbered 743A.062 in 2007]

743.699 [1997 c.651 §2; 2003 c.137 §1; renumbered 743A.012 in 2007]

743.700 [Formerly 743.145; 2005 c.69 §1; 2005 c.482 §3; 2007 c.313 §4; renumbered 743A.001 in 2007]

743.701 [Formerly 743.116; renumbered 743A.010 in 2007]

743.702 [Formerly 746.010; repealed by 1969 c.692 §11]

743.703 [Formerly 743.117; 2005 c.442 §4; renumbered 743A.040 in 2007]

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 [Formerly 743.119; renumbered 743A.148 in 2007]

743.707 [Formerly 743.120; 1991 c.674 §2; 1995 c.506 §10; renumbered 743A.090 in 2007]

743.708 [Formerly 746.080; 1969 c.692 §10; 1973 c.823 §150; renumbered 742.284 in 1989]

743.709 [Formerly 743.123; renumbered 743A.048 in 2007]

743.710 [Formerly 743.125; renumbered 743A.088 in 2007]

743.711 [1987 c.846 §15; renumbered 742.286 in 1989]

743.712 [Formerly 743.128; renumbered 743A.036 in 2007]

743.713 [Formerly 743.132; 1993 c.142 §15; 2005 c.22 §496; renumbered 743A.028 in 2007]

743.714 [Formerly 743.135; renumbered 743A.024 in 2007]

743.715 [Formerly 743.138; repealed by 1991 c.182 §21]

743.716 [Formerly 743.140; repealed by 1995 c.506 §11]

743.717 [Formerly 743.143; renumbered 743A.180 in 2007]

743.718 [Formerly 743.147; renumbered 743A.014 in 2007]

743.719 [Formerly 743.052; renumbered 743A.032 in 2007]

743.720 [1979 c.866 §4; 1987 c.774 §56; renumbered 742.300 in 1989]

743.721 [Formerly 743.037; renumbered 743A.084 in 2007]

743.722 [1989 c.832 §2; 1991 c.314 §3; 1995 c.79 §365; repealed by 2007 c.313 §3]

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 [1997 c.695 §3 (enacted in lieu of 743.724); 2003 c.446 §1; 2007 c.346 §1; renumbered 743A.044 in 2007]

743.726 [1997 c.496 §2; 2003 c.263 §1; renumbered 743A.188 in 2007]

743.727 [1993 c.575 §2; 1999 c.429 §1; renumbered 743A.100 in 2007]

743.728 [1993 c.576 §2; 1999 c.429 §2; renumbered 743A.104 in 2007]

743.729 [1993 c.407 §2; renumbered 743A.070 in 2007]

(Small Employer, Group, Individual and Portability Health Insurance, Generally)

743.730 Definitions for ORS 743.730 to 743.773. For purposes of 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 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 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;

(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) "Bona fide association" means an association that:

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

(5) "Carrier" means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(6) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon health insurance exchange.

(7) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

(8) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(9) "Eligible employee" means an employee 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" does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

(10) "Employee" means any individual employed by an employer.

(11) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

(12) "Exchange" means the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310.

(13) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(14) "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director 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.

(15)(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) Group health benefit plans offered to small employers; or

(B) Individual health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.

(16) "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

(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:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Health care service contractor or health maintenance organization subscriber contract; or

(C) 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, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) 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;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) 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; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

(19) "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.

(20) "Individual health benefit plan" means a health benefit plan:

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

(21) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

(22) "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 or as prescribed by rule by the Department of Consumer and Business Services;

(b) The individual applies for coverage during an open enrollment period;

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored 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 that 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, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

(23) "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

(24) "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.

(25) "Preexisting condition exclusion" means:

(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

(b) With respect to a grandfathered health plan, a 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 this paragraph pregnancy and genetic information do not constitute preexisting conditions.

(26) "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.

(27) "Rating period" means the 12-month calendar period for which premium rates es-

tablished by a carrier are in effect, as determined by the carrier.

(28) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(29)(a) "Small employer" means an employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.

(b) Any person that is treated as a single employer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. [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; 2003 c.364 §112; 2005 c.744 §38; 2007 c.389 §1; 2009 c.595 §1135; 2011 c.500 §§7,49; 2012 c.38 §20; 2013 c.681 §17; 2013 c.698 §20]

Note: The amendments to 743.730 by section 59, chapter 681, Oregon Laws 2013, become operative January 2, 2016. See section 66, chapter 681, Oregon Laws 2013. The text that is operative on and after January 2, 2016, is set forth for the user's convenience.

743.730. For purposes of 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 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 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;

(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) "Bona fide association" means an association that:

(a) Has been in active existence for at least five years;

(b) Has been formed and maintained in good faith for purposes other than obtaining insurance;

(c) Does not condition membership in the association on any factor relating to the health status of an individual or the individual's dependent or employee;

(d) Makes health insurance coverage that is offered through the association available to all members of the association regardless of the health status of the member or individuals who are eligible for coverage through the member;

(e) Does not make health insurance coverage that is offered through the association available other than in connection with a member of the association;

(f) Has a constitution and bylaws; and

(g) Is not owned or controlled by a carrier, producer or affiliate of a carrier or producer.

(5) "Carrier" means any person who provides health benefit plans in this state, including:

(a) A licensed insurance company;

(b) A health care service contractor;

(c) A health maintenance organization;

(d) An association or group of employers that provides benefits by means of a multiple employer welfare arrangement and that:

(A) Is subject to ORS 750.301 to 750.341; or

(B) Is fully insured and otherwise exempt under ORS 750.303 (4) but elects to be governed by ORS 743.733 to 743.737; or

(e) Any other person or corporation responsible for the payment of benefits or provision of services.

(6) "Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. 18022(e) and that is offered through the Oregon health insurance exchange.

(7) "Creditable coverage" means prior health care coverage as defined in 42 U.S.C. 300gg as amended and in effect on February 17, 2009, and includes coverage remaining in force at the time the enrollee obtains new coverage.

(8) "Dependent" means the spouse or child of an eligible employee, subject to applicable terms of the health benefit plan covering the employee.

(9) "Eligible employee" means an employee 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" does not include employees who work on a temporary, seasonal or substitute basis. Employees who have been employed by the employer for fewer than 90 days are not eligible employees unless the employer so allows.

(10) "Employee" means any individual employed by an employer.

(11) "Enrollee" means an employee, dependent of the employee or an individual otherwise eligible for a group or individual health benefit plan who has enrolled for coverage under the terms of the plan.

(12) "Exchange" means the health insurance exchange administered by the Oregon Health Insurance Exchange Corporation in accordance with ORS 741.310.

(13) "Exclusion period" means a period during which specified treatments or services are excluded from coverage.

(14) "Financial impairment" means that a carrier is not insolvent and is:

(a) Considered by the director 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.

(15)(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) Group health benefit plans offered to small employers; or

(B) Individual health benefit plans.

(b) "Geographic average rate" does not include premium differences that are due to differences in benefit design, age, tobacco use or family composition.

(16) "Grandfathered health plan" has the meaning prescribed by the United States Secretaries of Labor, Health and Human Services and the Treasury pursuant to 42 U.S.C. 18011(e).

(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:

(A) Hospital expense, medical expense or hospital or medical expense policy or certificate;

(B) Health care service contractor or health maintenance organization subscriber contract; or

(C) 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, to the extent that the plan is subject to state regulation.

(b) "Health benefit plan" does not include:

(A) Coverage for accident only, specific disease or condition only, credit or disability income;

(B) Coverage of Medicare services pursuant to contracts with the federal government;

(C) Medicare supplement insurance policies;

(D) Coverage of TRICARE services pursuant to contracts with the federal government;

(E) 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;

(F) Separately offered long term care insurance, including, but not limited to, coverage of nursing home care, home health care and community-based care;

(G) Independent, noncoordinated, hospital-only indemnity insurance or other fixed indemnity insurance;

(H) Short term health insurance policies that are in effect for periods of 12 months or less, including the term of a renewal of the policy;

(I) Dental only coverage;

(J) Vision only coverage;

(K) Stop-loss coverage that meets the requirements of ORS 742.065;

(L) Coverage issued as a supplement to liability insurance;

(M) Insurance arising out of a workers' compensation or similar law;

(N) 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; or

(O) Any employee welfare benefit plan that is exempt from state regulation because of the federal Employee Retirement Income Security Act of 1974, as amended.

(c) For purposes of this subsection, renewal of a short term health insurance policy includes the issuance of a new short term health insurance policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued by the insurer to the policyholder.

(19) "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.

(20) "Individual health benefit plan" means a health benefit plan:

(a) That is issued to an individual policyholder; or

(b) That provides individual coverage through a trust, association or similar group, regardless of the situs of the policy or contract.

(21) "Initial enrollment period" means a period of at least 30 days following commencement of the first eligibility period for an individual.

(22) "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 or as prescribed by rule by the Department of Consumer and Business Services;

(b) The individual applies for coverage during an open enrollment period;

(c) A court issues an order that coverage be provided for a spouse or minor child under an employee's employer sponsored 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 that 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, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including, but not limited to, the medical assistance program under ORS chapter 414, has been involuntarily terminated within 63 days after applying for coverage in a group health benefit plan.

(23) "Minimal essential coverage" has the meaning given that term in section 5000A(f) of the Internal Revenue Code.

(24) "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.

(25) "Preexisting condition exclusion" means:

(a) Except for a grandfathered health plan, a limitation or exclusion of benefits or a denial of coverage based on a medical condition being present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

(b) With respect to a grandfathered health plan, a 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 this paragraph pregnancy and genetic information do not constitute preexisting conditions.

(26) "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.

(27) "Rating period" means the 12-month calendar period for which premium rates established by a carrier are in effect, as determined by the carrier.

(28) "Representative" does not include an insurance producer or an employee or authorized representative of an insurance producer or carrier.

(29)(a) "Small employer" means an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, the majority of whom are employed within this state, and that employs at least one eligible employee on the first day of the plan year.

(b) Any person that is treated as a single employer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of 1986 shall be treated as one employer for purposes of this subsection.

(c) The determination of whether an employer that was not in existence throughout the preceding calendar year is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

743.731 Purposes. The purposes of ORS 743.730 to 743.773 and 743.923 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 and individual health benefit plans;

(4) To prohibit the use of preexisting condition exclusions except in grandfathered health plans;

(5) To encourage the availability of individual health benefit plans for individuals who are not enrolled in group health benefit plans;

(6) To improve renewability and continuity of coverage for employers and covered individuals;

(7) To improve the efficiency and fairness of the health insurance marketplace; and

(8) 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 the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152), 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; 2011 c.500 §8; 2013 c.681 §18]

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 as small employer. (1) If an affiliated group of employers is treated as a single employer under section 414 (b), (c), (m) or (o) of the Internal Revenue Code of 1986, a carrier may issue a single 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.

(2) Subsequent to the issuance of a health benefit plan to a small employer, other than a plan issued through the Oregon health insurance exchange, a carrier shall determine annually the number of employees of the employer for purposes of determining the employer's ongoing eligibility as a small employer.

(3)(a) ORS 743.733 to 743.737 shall continue to apply to a health benefit plan issued outside of the exchange to a small employer until the plan anniversary date following the date the employer no longer meets the definition of a small employer.

(b) ORS 743.733 to 743.737 shall continue to apply to an employer that receives coverage through the exchange until the employer no longer receives coverage through the exchange and is no longer a small employer. [1991 c.916 §4; 1993 c.18 §159; 1995 c.603 §3; 1999 c.987 §7; 2007 c.389 §4; subsection (3) of 2007 Edition enacted as 2007 c.389 §3; 2011 c.500 §9; 2013 c.681 §19]

743.734 Group health benefit plans subject to provisions of specified laws; exemptions. (1) Every 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 otherwise provided by ORS 743.733 to 743.737 or other law, no health benefit plan offered to a small employer shall:

(a) Inhibit a 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 carrier to negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans.

(3)(a) A 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. The categories must be based on bona fide employment-based classifications that are consistent with the employer's usual business practice.

(b) Except as provided in ORS 743.736 (8), a carrier that offers coverage to a small employer shall offer coverage to all eligible employees of the small employer.

(c) If a small employer elects to offer coverage to dependents of eligible employees, the carrier shall offer coverage to all dependents of eligible employees.

(4) Notwithstanding any other provision of law, an insurer may not deny, delay or terminate participation of an individual in a group health benefit plan or exclude coverage otherwise provided to an individual under a group health benefit plan based on a preexisting condition of the individual. [1991 c.916 §5; 1993 c.18 §160; 1995 c.603 §4; 1997 c.716 §5; 1999 c.987 §8; 2007 c.389 §5; 2007 c.752 §§4,9; 2010 c.81 §§1,2,3; 2011 c.500 §§12,13; 2013 c.681 §20]

743.735 [Formerly 747.100; 1973 c.823 §151; renumbered 742.352 in 1989]

743.736 Requirement to offer all health benefit plans to small employers; offering of plan by carriers; exceptions. (1) As a condition of transacting business in the small employer health insurance market in this state, a carrier shall offer small employers all of the carrier's health benefit plans, approved by the Department of Consumer and Business Services for use in the small employer market, for which the small employer is eligible.

(2) A carrier that offers a health benefit plan in the small employer market only to 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.

(3) A carrier shall issue to a small employer any health benefit plan that is 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.

(4) 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 may 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 may not include any requirements that relate to the actual or expected health status of the prospective enrollee.

(5) A carrier shall, pursuant to subsection (3) of this section, accept applications from and offer coverage to a small employer group covered under an existing health benefit plan regardless of whether a prospective enrollee is excluded from coverage under the existing plan because of late enrollment. When a carrier accepts an application for a small employer 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.

(6) A carrier is not required to accept applications from and offer coverage pursuant to subsection (3) of this section if the department 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.

(7) A carrier shall market fairly all health benefit plans that are offered by the carrier to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

(8)(a) Subsection (3) of this section does not require a carrier to offer coverage to or accept applications from:

(A) A small employer if the small employer is not physically located in the carrier's approved service area;

(B) An employee of a small employer if the employee does not work or reside within the carrier's approved service areas; or

(C) Small employers located within an area where the carrier reasonably anticipates, and demonstrates to the department, that it will not have the capacity in its network of providers to deliver services ade-

quately to the enrollees of those small employer groups because of its obligations to existing small employer group contract holders and enrollees.

(b) A carrier that does not offer coverage pursuant to paragraph (a)(C) of this subsection may 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.

(9) 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.

(10) A carrier that elects to discontinue offering all of its health benefit plans to small employers under ORS 743.737 (3)(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 to small employers in this state for a period of five years from one of the following dates:

(a) The date of notice to the department pursuant to ORS 743.737 (3)(e); or

(b) If notice is not provided under paragraph (a) of this subsection, from the date on which the department provides notice to the carrier that the department has determined that the carrier has effectively discontinued offering health benefit plans to small employers in this state.

(11) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a small employer not eligible for coverage under such a plan as provided by the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152). [1991 c.916 §6; 1993 c.649 §12; 1995 c.603 §5; 1997 c.716 §6; 1999 c.987 §9; 2011 c.500 §14; 2013 c.681 §21]

743.737 Requirements for small employer health benefit plans. (1) A health benefit plan issued to a small employer:

(a) Must cover essential health benefits consistent with 42 U.S.C. 300gg-11.

(b) May:

(A) Require an affiliation period that does not exceed two months for an enrollee or 90 days for a late enrollee;

(B) Impose an exclusion period for specified covered services, as established under ORS 743.745, applicable to all individuals enrolling for the first time in the small employer health benefit plan; or

(C) Not apply a preexisting condition exclusion to any enrollee.

(2) Late enrollees in a small employer health benefit plan may be subjected to a group eligibility waiting period that does not exceed 90 days.

(3) 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 unless:

(a) The policyholder, small employer or contract holder fails to pay the required premiums.

(b) The policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) 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) The small employer fails to comply with the contribution requirements under the health benefit plan.

(e) 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 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) 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 department 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 to small employers 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) The carrier discontinues offering or renewing, or offering and renewing, a health benefit plan, other than a grandfathered health 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.

(h) The carrier discontinues renewing or offering and renewing a grandfathered health 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.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

(A) Offer in writing to each small employer covered by the plan, all other health benefit plans that the carrier offers to small employers 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.

(j) The Director of the Department of Consumer and Business Services 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.

(k) 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.

(L) In the case of a health benefit plan that is offered in the small employer market only to 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.

(4) A 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 subsection (3)(e), (g) and (h) of this section.

(5) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind the coverage of an enrollee in a small employer health benefit plan unless:

(a) The enrollee or a person seeking coverage on behalf of the enrollee:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(6) Notwithstanding any provision of subsection (3) of this section to the contrary, a carrier may not rescind a small employer health benefit plan unless:

(a) The small employer or a representative of the small employer:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(7)(a) A carrier may continue to enforce reasonable employer participation and contribution requirements on small employers. 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 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, TRICARE, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the medical assistance program under ORS chapter 414.

(b) A carrier may not deny a small employer's application for coverage under a health benefit plan based on participation or contribution requirements but may require small employers that do not meet participation or contribution requirements to enroll during the open enrollment period beginning November 15 and ending December 15.

(8) Premium rates for small employer health benefit plans shall be subject to the following provisions:

(a) Each carrier must file with the department the initial geographic average rate and any changes in the geographic average rate with respect to each health benefit plan issued by the carrier to small employers.

(b)(A) The variations in premium rates charged during a rating period for health benefit plans issued to small employers shall be based solely on the factors specified in subparagraph (B) of this paragraph. A carrier may elect which of the factors specified in subparagraph (B) of this paragraph apply to premium rates for health benefit plans for small employers. All other factors must be applied in the same actuarially sound way to all small employer health benefit plans.

(B) The variations in premium rates described in subparagraph (A) of this paragraph may be based only on one or more of the following factors as prescribed by the department by rule:

(i) The ages of enrolled employees and their dependents, except that the rate for adults may not vary by more than three to one;

(ii) The level at which enrolled employees and their dependents 18 years of age and older engage in tobacco use, except that the rate may not vary by more than 1.5 to one; and

(iii) Adjustments to reflect differences in family composition.

(C) A carrier shall apply the carrier's schedule of premium rate variations as approved by the department and in accordance with this paragraph. Except as otherwise provided in this section, the premium rate established by a carrier for a small employer health benefit plan shall apply uniformly to all employees of the small employer enrolled in that plan.

(c) Except as provided in paragraph (b) of this subsection, the variation in premium rates between different health benefit plans offered by a carrier to small employers must be based solely on objective differences in plan design or coverage, age, tobacco use and family composition and must not include differences based on the risk characteristics of groups assumed to select a particular health benefit plan.

(d) A 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 and differences in family composition.

(e) Premium rates for small employer 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 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 premiums, and the extent to which the carrier will consider age, tobacco use, family composition and geographic factors in establishing and adjusting rates and premiums; and

(c) The benefits and premiums for all health insurance coverage for which the employer is qualified.

(10)(a) Each carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices relating to its small employer health benefit 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) A carrier offering a small employer health benefit plan shall file with the department at least once every 12 months an actuarial certification that the carrier is in compliance with ORS 743.733 to 743.737 and that the rating methods of the carrier are actuarially sound. Each certification shall be in a uniform form and manner and shall contain such information as specified by the department. A copy of each certification shall be retained by the carrier at its principal place of business. A carrier is not required to file the actuarial certification under this paragraph if the department has approved the carrier's rate filing within the preceding 12-month period.

(c) A carrier shall make the information and documentation described in paragraph (a) of this subsection available to the department upon request. Except as provided in ORS 743.018 and 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 to persons outside the department except as agreed to by the carrier or as ordered by a court of competent jurisdiction.

(11) A carrier shall not provide any financial or other incentive to any insurance producer that would encourage the insurance producer 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 carrier must include a provision that offers coverage to all eligible employees of a small employer and to all dependents of the eligible employees 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 by federal law and rules adopted by the department.

(15) A small employer health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

(16) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a small employer not eligible for coverage under such a plan. [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; 2003 c.364 §113; 2003 c.599 §§4,6; 2003 c.748 §5; 2007 c.389 §§6,7; 2007 c.391 §2; 2009 c.595 §1136; 2011 c.500 §15; 2013 c.681 §22]

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 Requirements for health benefit plans; director's authority to regulate small group and individual plans; allowable preexisting condition exclusions. (1) In order to ensure the broadest availability of small employer and individual health benefit plans, the Department of Consumer and Business Services may approve market conduct and other requirements for carriers and insurance producers, including:

(a) Registration by each carrier with the department of the carrier's intention to offer group health benefit plans under ORS 743.733 to 743.737 or individual health benefit plans, or both.

(b) To the extent deemed necessary by the department to ensure the fair distribution of high-risk individuals and groups among carriers, periodic reports by carriers and insurance producers concerning small employer 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 to small employers and individuals.

(c) Methods concerning periodic demonstration by carriers offering health benefit plans to individuals or small employers and insurance producers that the carriers and

insurance producers are marketing or issuing health benefit plans in fulfillment of the purposes of ORS 743.730 to 743.773.

(2) The department may require carriers and insurance producers offering health benefit plans to individuals or small employers to use the open and special enrollment periods prescribed by the department by rule.

(3) For small employer plans, the department may specify services 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; 2003 c.364 §114; 2011 c.500 §16; 2013 c.681 §23]

743.746 [1997 c.716 §9c; repealed by 1999 c.987 §28]

743.747 [Formerly 747.150; renumbered 742.360 in 1989]

743.748 Submission of information by carriers offering health benefit plans. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses and the assessment against the carrier for the Oregon Reinsurance Program;

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule.

(3) The department shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733; and

(d) Health benefit plans for employers that are not small employers.

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet. [2005 c.765 §2; 2007 c.752 §§5,10; 2011 c.500 §§17,18; 2013 c.681 §24; 2013 c.698 §21]

Note 1: The amendments to 743.748 by section 21, chapter 698, Oregon Laws 2013, become operative April 2, 2014. See section 41, chapter 698, Oregon Laws 2013. The text that is operative until April 2, 2014, including amendments by section 24, chapter 681, Oregon Laws 2013, is set forth for the user's convenience.

743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses and the assessment against the carrier for the Oregon Medical Insurance Pool;

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule.

(3) The department shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733; and

(d) Health benefit plans for employers that are not small employers.

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.

Note 2: The amendments to 743.748 by section 38, chapter 698, Oregon Laws 2013, become operative July 1, 2017. See section 41, chapter 698, Oregon Laws 2013. The text that is operative on and after July 1, 2017, is set forth for the user's convenience.

743.748. (1) Each carrier offering a health benefit plan shall submit to the Director of the Department of Consumer and Business Services on or before April 1 of each year a report that contains:

(a) The following information for the preceding year that is derived from the exhibit of premiums, enrollment and utilization included in the carrier's annual report:

(A) The total number of members;

(B) The total amount of premiums;

(C) The total amount of costs for claims;

(D) The medical loss ratio;

(E) The average amount of premiums per member per month; and

(F) The percentage change in the average premium per member per month, measured from the previous year.

(b) The following aggregate financial information for the preceding year that is derived from the carrier's annual report:

(A) The total amount of general administrative expenses, including identification of the five largest nonmedical administrative expenses;

(B) The total amount of the surplus maintained;

(C) The total amount of the reserves maintained for unpaid claims;

(D) The total net underwriting gain or loss; and

(E) The carrier's net income after taxes.

(2) A carrier shall electronically submit the information described in subsection (1) of this section in a format and according to instructions prescribed by the Department of Consumer and Business Services by rule.

(3) The department shall evaluate the reporting requirements under subsection (1)(a) of this section by the following market segments:

(a) Individual health benefit plans;

(b) Health benefit plans for small employers;

(c) Health benefit plans for employers described in ORS 743.733; and

(d) Health benefit plans for employers that are not small employers.

(4) The department shall make the information reported under this section available to the public through a searchable public website on the Internet.

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-related information in group health benefit plans. (1) Except for an individual grandfathered health plan, a carrier may require an applicant for individual or small group health benefit plan coverage to provide health-related information only for the purpose of health care management and may not use the information to deny coverage.

(2) Except for an individual grandfathered health plan, if a carrier requires an applicant to provide health-related information, the carrier must also notify the applicant, in the form and manner prescribed by the Department of Consumer and Business Services, that the information may not be used to deny coverage. [1995 c.603 §15; 1997 c.716 §10; 2011 c.500 §19; 2013 c.681 §25]

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 (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 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 (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 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; 2013 c.681 §26]

743.753 [Formerly 747.170; 1969 c.526 §2; renumbered 742.364 in 1989]

743.754 Requirements for group health benefit plans other than small employer plans. The following requirements apply to all group health benefit plans other than small employer health benefit plans covering two or more certificate holders:

(1) Except in the case of a late enrollee and except as otherwise provided in this section, a carrier offering a group health benefit plan may not decline to offer coverage to any eligible prospective enrollee and may 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 group health benefit plan may not apply a preexisting condition exclusion to any enrollee but may impose:

(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 plan.

(3) Late enrollees may be subjected to a group eligibility waiting period that does not exceed 90 days.

(4) Each group health benefit plan shall contain a special enrollment period during which eligible employees and dependents may enroll for coverage, as provided by federal law and rules adopted by the Department of Consumer and Business Services.

(5) Each group health benefit plan shall be renewable with respect to all eligible enrollees at the option of the policyholder unless:

(a) The policyholder fails to pay the required premiums.

(b) The policyholder or, with respect to coverage of individual enrollees, an enrollee or a representative of an enrollee engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan.

(c) 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) The policyholder fails to comply with the contribution requirements under the plan.

(e) 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 department 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) 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 department 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) The carrier discontinues offering or renewing, or offering and renewing, a group health benefit plan, other than a grandfathered health 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.

(h) The carrier discontinues renewing or offering and renewing a grandfathered health plan for all groups in this state or in a specified service are within this state, other than a plan discontinued under paragraph (f) of this subsection.

(i) With respect to plans that are being discontinued under paragraph (g) or (h) of this subsection, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, one or more health benefit plans that the carrier offers to groups 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.

(j) The Director of the Department of Consumer and Business Services 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.

(k) 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.

(L) In the case of a health benefit plan that is offered in the group market only to 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.

(6) 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 subsection (5)(e), (g) and (h) of this section.

(7) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind the coverage of an enrollee under a group health benefit plan unless:

(a) The enrollee:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to the enrollee; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(8) Notwithstanding any provision of subsection (5) of this section to the contrary, a carrier may not rescind a group health benefit plan unless:

(a) The plan sponsor or a representative of the plan sponsor:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan;

(b) The carrier provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee who would be affected by the rescission of coverage; and

(c) The carrier provides notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(9) 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 (5) of this section.

(10) A group health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

(11) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from a group not eligible for coverage under such a plan. [1995 c.603 §17; 1995 c.603 §40; 1997

c.716 §§12,13; 1999 c.987 §13; 2001 c.943 §13; 2003 c.748 §6; 2011 c.500 §20; 2013 c.681 §27]

743.755 [1969 c.526 §1; renumbered 742.366 in 1989]

743.756 [Formerly 747.180; renumbered 742.368 in 1989]

743.757 Health benefit coverage for guaranteed association. (1) As used in this section, "guaranteed association" means an association that:

(a) The Director of the Department of Consumer and Business Services has determined under ORS 743.524 meets the requirements described in ORS 731.098 (2); and

(b) Is a statewide nonprofit organization representing the interests of individuals licensed under ORS chapter 696.

(2) A carrier may offer a health benefit plan to a guaranteed association if the plan provides health benefits covering 500 or more members or dependents of members of the association.

(3) When a carrier offers coverage to a guaranteed association under subsection (2) of this section, the carrier shall offer coverage to all members of the association and all dependents of the members of the association without regard to the actual or expected health status of any member or any dependent of a member of the association.

(4) A carrier offering a health benefit plan under subsection (2) of this section shall establish premium rates as follows:

(a) For the initial 12-month period of coverage, the carrier shall submit to the director a certified statement that the premium rates charged to the guaranteed association are actuarially sound. The statement must be signed by an actuary certifying the accuracy of the rating methodology as established by the American Academy of Actuaries.

(b) For any subsequent 12-month period of coverage, according to a rating methodology as established by the American Academy of Actuaries.

(5) A member of a guaranteed association may apply for coverage offered by a carrier under subsection (2) of this section only:

(a) If the member has been an active member of the association for no less than 30 days;

(b) During an annual open enrollment period offered by the association; and

(c) After meeting any additional eligibility requirements agreed upon by the association and the carrier.

(6) Notwithstanding subsection (5) of this section, if a member or a dependent of a member of a guaranteed association terminates coverage under the health benefit plan, the member or dependent shall be excluded from coverage for 12 months from the date of termination of coverage. The member may enroll for coverage of the member or the dependent during an annual open enrollment period following the expiration of the exclusion period. [2005 c.571 §2; 2013 c.681 §60]

743.758 Implementation of federal laws; 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), the Patient Protection and Affordable Care Act (P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152) and federal regulations that are issued in conjunction with the Acts. [1997 c.716 §21; 2011 c.500 §21]

743.759 [Formerly 747.190; renumbered 742.370 in 1989]

743.760 [1995 c.603 §18; 1997 c.716 §25; 1999 c.987 §14; 2003 c.364 §115; 2007 c.391 §3; 2011 c.500 §22; repealed by 2013 c.681 §65 and 2013 c.640 §21]

743.761 [1995 c.603 §19; 2011 c.500 §23; repealed by 2013 c.681 §65 and 2013 c.640 §21]

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]

743.764 Preventive health services; coverage; cost sharing. Notwithstanding any other provision of law, a health benefit plan that is not a grandfathered health plan:

(1) Must provide coverage of preventive health services as prescribed by the United States Department of Health and Human Services pursuant to 42 U.S.C. 300gg-13; and

(2) May not impose cost-sharing requirements on an enrollee for preventive health services, except as allowed by federal law. [2011 c.500 §2]

Note: 743.764 was added to and made a part of 743.730 to 743.773 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

743.765 [Formerly 747.084; 1989 c.634 §2; renumbered 742.374 in 1989]

743.766 Individual health benefit plans; waiting or exclusion periods; preexisting condition exclusions; essential health benefits. (1) With respect to coverage under an individual health benefit plan, a carrier:

(a) May not impose an individual coverage waiting period that exceeds 90 days.

(b) May impose an exclusion period for specified covered services applicable to all individuals enrolling for the first time in the individual health benefit plan.

(c) With respect to individual coverage under a grandfathered health plan, a carrier may not impose a preexisting condition exclusion unless the exclusion complies with the following requirements:

(A) The exclusion applies 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.

(B) The exclusion expires no later than six months after the individual's effective date of coverage.

(2) If the carrier elects to restrict coverage as described in subsection (1) of this section, the carrier shall reduce the duration of the period during which the restriction is imposed 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 after 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.

(3) An individual health benefit plan other than a grandfathered health plan must cover, at a minimum, all essential health benefits.

(4) A carrier shall renew an individual health benefit plan, including a health benefit plan issued through a bona fide association, unless:

(a) The policyholder fails to pay the required premiums.

(b) The policyholder or a representative of the policyholder engages in fraud or makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

(c) 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 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) 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 department 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) The carrier discontinues offering or renewing, or offering and renewing, an individual health benefit plan, other than a grandfathered health 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.

(f) The carrier discontinues renewing or offering and renewing a grandfathered health 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.

(g) With respect to plans that are being discontinued under paragraph (e) or (f) of this subsection, the carrier must:

(A) Offer in writing to each policyholder covered by the plan, all health benefit plans that the carrier offers to individuals 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) The Director of the Department of Consumer and Business Services 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.

(i) 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.

(j) 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.

(5) 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 subsection (4)(c), (e) and (f) of this section.

(6) Notwithstanding any other provision of this section, and subject to the provisions of ORS 743.894 (2) and (4), a carrier may rescind an individual health benefit plan if the policyholder or a representative of the policyholder:

(a) Performs an act, practice or omission that constitutes fraud; or

(b) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the policy.

(7) 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 (4) of this section.

(8) An individual health benefit plan may not impose annual or lifetime limits on the dollar amount of essential health benefits.

(9) This section does not require a carrier to actively market, offer, issue or accept applications for a grandfathered health plan or from an individual not eligible for coverage under such a plan. [1995 c.603 §§22,41; 1997 c.716 §§15,16; 1999 c.987 §15; 2001 c.943 §14; 2003 c.748 §7; 2011 c.500 §24; 2012 c.24 §4; 2013 c.681 §28; 2013 c.698 §22]

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 carrier's initial geographic average rate and any changes to the geographic average rate for its individual health benefit plans with the Director of the Department of Consumer and Business Services.

(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, age, tobacco use and family composition. 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 differences in benefit design, age, tobacco use and family composition.

(4) A carrier offering an individual health benefit plan in this state shall include:

(a) In one risk pool, all of the insureds residing in this state who are covered in the carrier's individual health benefit plans that are not grandfathered health plans or student health plans; and

(b) In a separate risk pool, all of the insureds residing in this state who are covered in the carrier's individual grandfathered health plans. [1995 c.603 §23; 1999 c.987 §16; 2011 c.500 §25; 2013 c.681 §29; 2013 c.698 §23]

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; rules; 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 that are not grandfathered health plans.

(2) Except as provided in subsection (3) of this section, no carrier or insurance producer 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 does 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 (4)(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 (4)(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; 2003 c.364 §116; 2003 c.590 §§1,3; 2013 c.681 §61; 2013 c.698 §39]

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]

743.775 Submission of information by carriers offering individual health benefit plans. Each carrier that offers individual health benefit plans shall submit to the Director of the Department of Consumer and Business Services any information requested by the director for the purpose of assessing the impact of the amendments to ORS 743.769 and 746.600 by sections 1 and 2, chapter 590, Oregon Laws 2003. [2003 c.590 §8]

743.776 [Formerly 486.541; renumbered 742.450 in 1989]

743.777 Electronic administration; discounted rates; requirements. (1) As used in this section:

(a) "Explanation of benefits" means claim processing advice or notification of action on claims.

(b) "Payment, remittance and reconciliation information" means all information required for premium billing or invoicing, facilitating timely electronic payment of premiums due, delinquency notification, final billing notification or termination of coverage.

(c) "Plan renewal information" means all correspondence and materials related to an offer to renew insurance provided by an insurer to a health insurance purchaser.

(d) "Quote information" means all correspondence and materials related to an offer to insure or a rate quotation provided by an insurer to a health insurance purchaser.

(e) "Sale and enrollment information" means all information documenting the sale of a policy or certificate of health insurance, the renewal of a policy or certificate of health insurance, the enrollment of members in a group health insurance plan or the enrollment of an individual in an individual health insurance plan, including but not limited to:

(A) The application for insurance;

(B) Initial and ongoing documentation required by the insurer to be provided by an insured to establish eligibility and enrollment, adjudicate and process claims and prove prior creditable coverage or duplicate coverage;

(C) Premium information;

(D) Documentation of the payment of a premium; and

(E) Membership identification cards.

(2) Notwithstanding any other provision of law, in the administration of small employer group health insurance or individual health insurance, an insurer may elect to communicate one or more of the following by electronic means:

(a) Quote information.

(b) Sale and enrollment information.

(c) Payment, remittance and reconciliation information except notices required by ORS 743.499 and 743.565.

(d) Explanation of benefits.

(e) Plan renewal information.

(f) Notifications required by law.

(g) Other communications, documentation, revisions or materials otherwise provided on paper.

(3) An insurer that elects to communicate by electronic means shall offer a small employer group member or individual applying for coverage and coverage renewal the option to receive by regular mail one or more of the types of communications described in subsection (2) of this section.

(4) Electronic administration of small employer group or individual health insurance plans shall be transacted using secure systems specifically designed by the insurer for the purpose of electronic health insurance administration.

(5) An insurer who elects to offer discounted rates for a health insurance plan utilizing electronic administration shall include the schedule of discounts for utilization of electronic administration as part of a small employer group health insurance or individual health insurance rate filing. The rate discounts may be graduated and must be proportionate to the amount of administrative cost savings the insurer anticipates as a result of the use of electronic transactions described in subsections (2) to (4) of this section.

(6) Discounted rates allowed under subsection (5) of this section shall be applied uniformly to all similarly situated small employer group or individual health insurance purchasers of an insurer.

(7) Discounts in premium rates under subsections (5) and (6) of this section are not premium rate variations for purposes of ORS 743.737 (8) or 743.767.

(8) This section does not require an insurer to offer discounted rates for a health insurance plan utilizing electronic administration or require a small employer group or an individual health insurance purchaser to use electronic administration. [2010 c.75 §§2 to 5; 2011 c.500 §45; 2013 c.1 §93; 2013 c.160 §1; 2013 c.681 §30]

Note: 743.777 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

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]

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]

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]

743.791 [2005 c.482 §2; renumbered 743A.108 in 2007]

743.792 [1967 c.482 §3; 1977 c.600 §3; 1979 c.842 §8; 1983 c.338 §967; renumbered 742.504 in 1989]

743.793 [2003 c.91 §4; renumbered 743A.064 in 2007]

743.794 [2005 c.477 §2; renumbered 743A.120 in 2007]

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]

743.798 [2005 c.628 §2; renumbered 743A.050 in 2007]

743.799 [2005 c.765 §6; renumbered 743A.124 in 2007]

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. As used in this section and ORS 743.803, 743.804, 743.806, 743.807, 743.808, 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, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918:

(1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

(b) Rescission or cancellation of a policy or certificate;

(c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or

(e) Determination that 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) "Authorized representative" means an individual who by law or by the consent of a person may act on behalf of the person.

(3) "Enrollee" has the meaning given that term in ORS 743.730.

(4) "Grievance" means:

(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

(A) In writing, for an internal appeal or an external review; or

(B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited external review; or

(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

(A) Availability, delivery or quality of a health care service;

(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

(C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(5) "Health benefit plan" has the meaning given that term in ORS 743.730.

(6) "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 731.098, to provide health care services to group members.

(7) "Insurer" includes a health care service contractor as defined in ORS 750.005.

(8) "Internal appeal" means a review by an insurer of an adverse benefit determination made by the insurer.

(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) "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; 2003 c.87 §21; 2003 c.137 §§3,4; 2005 c.418 §2; 2009 c.806 §3; 2009 c.807 §4; 2011 c.500 §26; 2012 c.24 §5; 2013 c.681 §61a]

Note: The amendments to 743.801 by section 3, chapter 596, Oregon Laws 2013, become operative July 1, 2015. See section 4, chapter 596, Oregon Laws 2013. The text that is operative on and after July 1, 2015, is set forth for the user's convenience.

743.801. As used in this section and ORS 743.065, 743.803, 743.804, 743.806, 743.807, 743.808, 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, 743.894, 743.911, 743.912, 743.913, 743.917 and 743.918:

(1) "Adverse benefit determination" means an insurer's denial, reduction or termination of a health care item or service, or an insurer's failure or refusal to provide or to make a payment in whole or in part for a health care item or service, that is based on the insurer's:

(a) Denial of eligibility for or termination of enrollment in a health benefit plan;

(b) Rescission or cancellation of a policy or certificate;

(c) Imposition of a preexisting condition exclusion as defined in ORS 743.730, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered items or services;

(d) Determination that a health care item or service is experimental, investigational or not medically necessary, effective or appropriate; or

(e) Determination that 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) "Authorized representative" means an individual who by law or by the consent of a person may act on behalf of the person.

(3) "Enrollee" has the meaning given that term in ORS 743.730.

(4) "Grievance" means:

(a) A communication from an enrollee or an authorized representative of an enrollee expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:

(A) In writing, for an internal appeal or an external review; or

(B) In writing or orally, for an expedited response described in ORS 743.804 (2)(d) or an expedited external review; or

(b) A written complaint submitted by an enrollee or an authorized representative of an enrollee regarding the:

(A) Availability, delivery or quality of a health care service;

(B) Claims payment, handling or reimbursement for health care services and, unless the enrollee has not submitted a request for an internal appeal, the complaint is not disputing an adverse benefit determination; or

(C) Matters pertaining to the contractual relationship between an enrollee and an insurer.

(5) "Health benefit plan" has the meaning given that term in ORS 743.730.

(6) "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 731.098, to provide health care services to group members.

(7) "Insurer" includes a health care service contractor as defined in ORS 750.005.

(8) "Internal appeal" means a review by an insurer of an adverse benefit determination made by the insurer.

(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) "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 doctor of 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, as defined in ORS 677.010, 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 ser-

vices 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; 2013 c.129 §19]

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 Required notices to applicants and enrollees; grievances, internal appeals and external reviews. All insurers offering a health benefit plan in this state shall:

(1) Provide to all enrollees directly or in the case of a group policy to the employer or other policyholder for distribution to enrollees, to all applicants, and to prospective applicants upon request, the following information:

(a) The insurer's written policy on the rights of enrollees, including the right:

(A) To participate in decision making regarding the enrollee's health care.

(B) To be treated with respect and with recognition of the enrollee's dignity and need for privacy.

(C) To have grievances handled in accordance with this section.

(D) To be provided with the information described in this section.

(b) An explanation of the procedures described in subsection (2) of this section for making coverage determinations and resolving grievances. The explanation must be culturally and linguistically appropriate, as prescribed by the department by rule, and must include:

(A) The procedures for requesting an expedited response to an internal appeal under subsection (2)(d) of this section or for requesting an expedited external review of an adverse benefit determination;

(B) A statement that if an insurer does not comply with the decision of an independent review organization under ORS 743.862, the enrollee may sue the insurer under ORS 743.864;

(C) The procedure to obtain assistance available from the insurer, if any, and from the Department of Consumer and Business Services in filing grievances; and

(D) A description of the process for filing a complaint with the department.

(c) A summary of benefits and an explanation of coverage in a form and manner prescribed by the department by rule.

(d) A summary of the insurer's policies on prescription drugs, including:

(A) Cost-sharing differentials;

(B) Restrictions on coverage;

(C) Prescription drug formularies;

(D) Procedures by which a provider with prescribing authority may prescribe drugs not included on the formulary;

(E) Procedures for the coverage of prescription drugs not included on the formulary; and

(F) A summary of the criteria for determining whether a drug is experimental or investigational.

(e) A list of network providers and how the enrollee can obtain current information about the availability of providers and how to access and schedule services with providers, including clinic and hospital networks.

(f) Notice of the enrollee's right to select a primary care provider and specialty care providers.

(g) How to obtain referrals for specialty care in accordance with ORS 743.856.

(h) Restrictions on services obtained outside of the insurer's network or service area.

(i) The availability of continuity of care as required by ORS 743.854.

(j) Procedures for accessing after-hours care and emergency services as required by ORS 743A.012.

(k) Cost-sharing requirements and other charges to enrollees.

(L) Procedures, if any, for changing providers.

(m) Procedures, if any, by which enrollees may participate in the development of the insurer's corporate policies.

(n) A summary of how the insurer makes decisions regarding coverage and payment for treatment or services, including a general description of any prior authorization and utilization control requirements that affect coverage or payment.

(o) Disclosure of any risk-sharing arrangement the insurer has with physicians or other providers.

(p) A summary of the insurer's procedures for protecting the confidentiality of medical records and other enrollee information.

(q) An explanation of assistance provided to non-English-speaking enrollees.

(r) Notice of the information available from the department that is filed by insurers as required under ORS 743.807, 743.814 and 743.817.

(2) Establish procedures for making coverage determinations and resolving grievances that provide for all of the following:

(a) Timely notice of adverse benefit determinations in a form and manner approved by the department or prescribed by the department by rule.

(b) A method for recording all grievances, including the nature of the grievance and significant action taken.

(c) Written decisions meeting criteria established by the Director of the Department of Consumer and Business Services by rule.

(d) An expedited response to a request for an internal appeal that accommodates the clinical urgency of the situation.

(e) At least one but not more than two levels of internal appeal for group health benefit plans and one level of internal appeal for individual health benefit plans. If an insurer provides:

(A) Two levels of internal appeal, a person who was involved in the consideration of the initial denial or the first level of internal appeal may not be involved in the second level of internal appeal; and

(B) No more than one level of internal appeal, a person who was involved in the consideration of the initial denial may not be involved in the internal appeal.

(f)(A) An external review that meets the requirements of ORS 743.857, 743.859 and 743.861 and is conducted in a manner approved by the department or prescribed by the department by rule, after the enrollee has exhausted internal appeals or after the enrollee has been deemed to have exhausted internal appeals.

(B) An enrollee shall be deemed to have exhausted internal appeals if an insurer fails to strictly comply with this section and federal requirements for internal appeals.

(g) The opportunity for the enrollee to receive continued coverage of an approved and ongoing course of treatment under the health benefit plan pending the conclusion of the internal appeal process.

(h) The opportunity for the enrollee or any authorized representative chosen by the enrollee to:

(A) Submit for consideration by the insurer any written comments, documents, records and other materials relating to the adverse benefit determination; and

(B) Receive from the insurer, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the adverse benefit determination.

(3) Establish procedures for notifying affected enrollees of:

(a) A change in or termination of any benefit; and

(b)(A) The termination of a primary care delivery office or site; and

(B) Assistance available to enrollees in selecting a new primary care delivery office or site.

(4) Provide the information described in subsection (2) of this section and ORS

743.859 at each level of internal appeal to an enrollee who is notified of an adverse benefit determination or to an enrollee who files a grievance.

(5) Upon the request of an enrollee, applicant or prospective applicant, provide:

(a) The insurer's annual report on grievances and internal appeals submitted to the department under subsection (8) of this section.

(b) A description of the insurer's efforts, if any, to monitor and improve the quality of health services.

(c) Information about the insurer's procedures for credentialing network providers.

(6) Provide, upon the request of an enrollee, 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 subsection requires an insurer to advise an enrollee how the insurer would cover or treat that particular enrollee's disease or condition. Utilization review criteria that are proprietary shall be subject to oral disclosure only.

(7) Maintain for a period of at least six years written records that document all grievances described in ORS 743.801 (4)(a) and make the written records available for examination by the department or by an enrollee or authorized representative of an enrollee with respect to a grievance made by the enrollee. The written records must include but are not limited to the following:

(a) Notices and claims associated with each grievance.

(b) A general description of the reason for the grievance.

(c) The date the grievance was received by the insurer.

(d) The date of the internal appeal or the date of any internal appeal meeting held concerning the appeal.

(e) The result of the internal appeal at each level of appeal.

(f) The name of the covered person for whom the grievance was submitted.

(8) Provide an annual summary to the department of the insurer's aggregate data regarding grievances, internal appeals and requests for external review in a format prescribed by the department to ensure consistent reporting on the number, nature and disposition of grievances, internal appeals and requests for external review.

(9) Allow the exercise of any rights described in this section by an authorized representative. [1997 c.343 §3; 2001 c.266 §15; 2003 c.87 §22; 2011 c.500 §27; 2012 c.24 §6; 2013 c.681 §37]

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; right to appeal. 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; 2011 c.500 §28; 2012 c.24 §7]

Note: See 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 re-

garding 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 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; 2011 c.500 §29]

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 [1995 c.672 §5; repealed by 2003 c.87 §26]

743.810 [1971 c.523 §4; 1973 c.551 §4; 1975 c.784 §3; renumbered 742.526 in 1989]

743.811 Applicability. The provisions of ORS 743.801, 743.803, 743.806 and 743.808 do not apply to medical services contracts for services to be provided under ORS chapter 656. [1995 c.672 §7a; 2001 c.104 §290; 2003 c.87 §23]

Note: See 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; rules. 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 Centers for Medicare and Medicaid Services 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; 2003 c.14 §450]

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]

743.818 Data reporting. (1) A carrier offering a health benefit plan as defined in ORS 743.730 and a third party administrator licensed under ORS 744.702 shall annually submit to the Department of Consumer and Business Services, in a form and manner prescribed by the department, data concerning the number of covered lives of the carrier or third party administrator, reported by line of business and by zip code.

(2) The department shall aggregate the data collected under subsection (1) of this section and may publish reports on the number of covered lives in Oregon, by line of business and by region. [2009 c.595 §1195]

Note: 743.818 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.819 Reporting requirements; rules. 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]

743.822 Requirement to offer bronze and silver plans; rules. (1) In each individual or small group market, in which a carrier offers a health benefit plan through or outside of the Oregon health insurance exchange, the carrier must offer to residents of this state a bronze and a silver plan approved by the Department of Consumer and Business Services as meeting the requirements of subsection (2) of this section.

(2) The department shall prescribe by rule the form, level of coverage and benefit design for the bronze and silver plans that must be offered under subsection (1) of this section.

(3) As used in this section, "health benefit plan" has the meaning given that term in ORS 743.730. [2011 c.322 §§2,3; 2012 c.24 §8; 2012 c.38 §21; 2013 c.681 §31]

Note: 743.822, 743.824 and 743.826 were added to and made a part of the Insurance Code by legislative action but were not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

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]

743.824 Cash dividends for healthy behaviors. (1) As used in this section, "healthy behaviors" means participating in constructive behaviors that encourage fitness, healthy eating and other activities that are beneficial to good health.

(2) An insurer offering a health benefit plan, as defined in ORS 743.730, may pay cash dividends to enrollees in the plan who participate in a program approved by the insurer that promotes healthy behaviors.

(3) Dividends paid pursuant to this section are not premium variations for the purposes of ORS 743.767. [2009 c.461 §2]

Note: See note under 743.822.

Note: Section 2, chapter 484, Oregon Laws 2013, provides:

Sec. 2. (1) The Department of Consumer and Business Services, in consultation with the Oregon Health Authority, shall apply to the United States Secretary of Health and Human Services to participate in a wellness program demonstration project under 42 U.S.C. 300gg-4(l).

(2) The department shall adopt rules establishing requirements for an insurer's implementation of a wellness program as part of the demonstration project.

(3) ORS 743.824 applies to any wellness program implemented as part of the demonstration project. [2013 c.484 §2]

Note: Section 2, chapter 484, Oregon Laws 2013, was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.825 [1971 c.523 §7; 1975 c.784 §6; 1987 c.569 §4; 1987 c.632 §2; renumbered 742.534 in 1989]

743.826 Requirements for catastrophic plans. A carrier may offer a catastrophic plan only through the exchange and only to an individual who:

(1) Is under 30 years of age at the beginning of the plan year; or

(2) Is exempt from any state or federal penalties imposed for failing to maintain minimal essential coverage during the plan year. [2011 c.322 §4; 2012 c.38 §22]

Note: See note under 743.822.

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 743.801, 743.803, 743.804, 743.806, 743.807, 743.808, 743.811, 743.814, 743.817, 743.819, 743.821, 743.823, 743.827, 743.829, 743.831, 743.834, 743.837, 743.839 and 743A.012 and other issues related to health care consumer protection. [1997 c.343 §10; 2003 c.87 §24; 2003 c.137 §5; 2005 c.418 §3]

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 Oregon Health Authority;

(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; 2009 c.595 §1137]

743.833 [1975 c.784 §12; renumbered 742.540 in 1989]

743.834 Insurer prohibited practices; patient communication and 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 743.804, 743.807, 743.814 to 743.839 and 743A.012 shall be construed to require disclosure of information that is otherwise privileged or confidential under any other provision of law. [1997 c.343 §17; 2003 c.137 §6; 2005 c.418 §4]

743.840 [1985 c.527 §2; renumbered 742.466 in 1989]

743.842 [1999 c.749 §2; renumbered 743A.250 in 2013]

RIGHTS OF ENROLLEES

743.845 Designation of women's health care provider as primary care provider; direct access to women's health care provider. (1) As used in this section, "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, without a referral or prior authorization, for obstetrical or gynecological care by a participating health care professional who specializes in obstetrics or gynecology.

(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; 2011 c.500 §30]

743.847 Medicaid not considered in coverage eligibility determination; claims for services paid for by medical assistance; prohibited ground for denial of enrollment of child; insurer duties. (1) For the purposes of this section:

(a) "Health insurer" or "insurer" means an employee benefit plan, self-insured plan, managed care organization or group health plan, a third party administrator, fiscal intermediary or pharmacy benefit manager of the plan or organization, or other party that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service.

(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 may not deny a claim submitted by the state Medicaid agency, a prepaid managed care health services organization or a coordinated care organization described in ORS 414.651 under subsection (3) of this section based on the date of submission of the claim, the type or format of the claim form or a failure to present proper documentation at the point of sale that is the basis of the claim if:

(a) The claim is submitted by the agency, the prepaid managed care health services organization or the coordinated care organization within the three-year period beginning on the date on which the health care item or service was furnished; and

(b) Any action by the agency, the prepaid managed care health services organization or the coordinated care organization to enforce its rights with respect to the claim is commenced within six years of the agency's or organization's submission of the claim.

(5) An insurer must provide to the state Medicaid agency, a prepaid managed care health services organization or a coordinated care organization, upon request, the following information:

(a) The period during which a Medicaid recipient, the spouse or dependents may be or may have been covered by the plan;

(b) The nature of coverage that is or was provided by the plan; and

(c) The name, address and identifying numbers of the plan.

(6) An insurer may 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.

(7) When a child has group or individual health coverage through an insurer of a noncustodial parent, the insurer must:

(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 paragraph (b) of this subsection directly to the custodial parent, the provider or, if a claim is filed by the state Medicaid agency, a prepaid managed care health services organization or a coordinated care organization, directly to the agency or the organization.

(8) 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 must:

(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.

(9) 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.

(10) The provisions of ORS 743A.001 do not apply to this section. [Formerly 743.816; 2007 c.484 §2; 2011 c.602 §58]

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]

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]

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]

743.857 External review; rules. (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 743.861 and rules adopted by the Director of the Department of Consumer and Business Services to carry out the provisions of this section and ORS 743.861. Each insurer shall provide the external review through an independent review organization that is under contract with the director to provide external review. Each health benefit

plan must allow an enrollee, by applying to the insurer or the director, to obtain review by an independent review organization of a dispute relating to an adverse benefit determination 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.

(d) Whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

(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 director shall 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 no later than five business days after the appointment. The insurer shall produce additional information as requested by the independent review organization to the extent that the information is reasonably available to the insurer. An independent review organization may reverse the adverse benefit determination if the insurer fails to furnish records, information and materials to the independent review organization in a timely manner.

(4) An enrollee may submit additional information to the independent review organization no later than five business days after the enrollee's receipt of notification of the appointment of the independent review organization and the organization must consider the information in its review.

(5) The insurer and the director shall expedite the external review:

(a) If the adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care service for a medical condition for which the enrollee received emergency services, as defined in ORS 743A.012, and has not been discharged from a health care facility; or

(b) 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; 2011 c.500 §31]

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]

743.859 Notice to enrollee of right to sue if insurer does not follow decision of independent review organization. An insurer of a health benefit plan shall include in the plan the following statements, in boldfaced type or otherwise emphasized:

(1) A statement of the right of enrollees to apply for external review by an independent review organization; and

(2) A statement that if the insurer does not follow a decision of an independent review organization, the enrollee has the right to sue the insurer. [2001 c.266 §10; 2011 c.500 §32]

743.860 [1981 c.752 §3; renumbered 743.613 in 1989]

743.861 Enrollee application for external review; when enrollee deemed to have exhausted internal appeal. (1) An enrollee shall apply in writing for external review of an adverse benefit determination 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 grievance and internal 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 appeal procedures established pursuant to ORS 743.804 or be deemed to have exhausted the plan's internal appeal procedures. The insurer may waive the requirement of compliance with the internal appeal procedures and have a dispute referred directly to external review upon the enrollee's consent. An enrollee is deemed to have exhausted the internal appeal procedures if the insurer fails to strictly comply with ORS 743.804 and federal requirements for internal appeals.

(2) An enrollee who applies for external review of an adverse benefit determination shall provide complete and accurate information to the independent review organization as provided in ORS 743.857. [2001 c.266 §11; 2011 c.500 §33]

743.862 Duties of independent review organizations; expedited reviews. (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 pertains to an adverse benefit determination 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 Department of Consumer and Business Services and the availability of other assistance as specified by the department.

(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 as provided in ORS 743.857.

(d) Notify the insurer of additional information the independent review organization requires and when the information must be submitted as provided in ORS 743.857.

(e) Decide the dispute relating to the adverse benefit determination of the insurer 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 or the Director of the Department of Consumer and Business Services orders 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 or the director orders 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; 2011 c.500 §34]

743.863 Civil penalty for failure to comply by insurer that agreed to be bound by decision. (1) An insurer shall comply in a timely manner with a decision of an independent review organization under ORS 743.862 that reverses, in whole or in part, an adverse benefit determination. If an insurer fails to comply with the decision, the Director of the Department of Consumer and Business Services may impose on the insurer a civil penalty of 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; 2011 c.500 §35]

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 benefit determination by the insurer that is subject to external review if 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 subsection (1) of this section to be unconstitutional or otherwise void. [2001 c.266 §14; 2011 c.500 §36]

743.865 [1981 c.752 §4; renumbered 743.614 in 1989]

743.866 [2001 c.747 §2; renumbered 743.911 in 2007]

743.868 [2001 c.747 §3; renumbered 743.913 in 2007]

743.870 [1981 c.752 §5; renumbered 743.616 in 1989]

743.871 Definitions for ORS 743.871 to 743.893. As used in ORS 743.871 to 743.893:

(1) "In-network" means performed by a provider or provider group that has directly contracted with the insurer.

(2) "Out-of-network" means performed by a provider or provider group that has not contracted or has indirectly contracted with the insurer. [2007 c.390 §1]

Note: 743.871 to 743.893 were enacted into law by the Legislative Assembly but were 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.

743.874 Estimate of costs for in-network procedure or service. (1) An insurer offering a health benefit plan as defined in ORS 743.730 must establish a procedure for providing to an enrollee in the plan a reasonable estimate of an enrollee's costs for an in-network procedure or service covered by the enrollee's health benefit plan, in advance of the procedure or service, when an enrollee or an enrollee's authorized representative provides the following information to the insurer:

(a) The type of procedure or service;

(b) The name of the provider;

(c) The enrollee's member number or policy number; and

(d) If requested by the insurer, the site where the procedure or service will be performed.

(2) The estimate of costs described in subsection (1) of this section must include an itemization of:

(a) The enrollee's deductible;

(b) The amount of the deductible that has been met by processed claims;

(c) Coinsurance, copayment or other cost share to be paid by the enrollee for the procedure or service; and

(d) Any applicable benefit maximum.

(3) Subsections (1) and (2) of this section apply to the insurer's five most common procedures or services within each of the following categories:

(a) Office visits;

(b) Diagnostic radiology and imaging;

(c) Diagnostic pathology and laboratory procedures;

(d) Normal vaginal delivery;

(e) Immunizations;

(f) Orthopedic-musculoskeletal surgery; and

(g) Digestive system endoscopy.

(4) In addition to the information specified in subsections (1) and (2) of this section, the insurer's estimate must include the following disclosures:

(a) That other services may be provided to the enrollee that are medically necessary and appropriate as part of the common procedures, of which the insurer or enrollee may not be aware at the time of the inquiry and for which the enrollee may have additional financial responsibility;

(b) That the enrollee may be responsible for costs of procedures or services not covered by the plan;

(c) How an enrollee may contact the insurer for an explanation, if the estimate differs from the actual cost or if the enrollee has other questions; and

(d) The toll-free telephone number of the consumer advocacy unit of the Department of Consumer and Business Services and the

address for the department's consumer information and complaints website.

(5) An insurer must make the information required by this section available to enrollees and in-network providers through an interactive website and by toll-free telephone.

(6) This section does not prohibit an insurer from providing information in addition to or in more detail than the information required by this section. [2007 c.390 §2]

Note: See note under 743.871.

743.875 [1981 c.752 §6; renumbered 743.617 in 1989]

743.876 Estimate of costs for out-of-network procedure or service. (1) An insurer offering a health benefit plan as defined in ORS 743.730 must establish a procedure for providing to an enrollee in the plan a reasonable estimate of the enrollee's costs for an out-of-network procedure or service covered by the enrollee's health benefit plan, including the difference between the insurer's allowable charge and the billed charge for the procedure or service, in advance of the procedure or service, when an enrollee or an enrollee's authorized representative provides the following information to the insurer:

(a) The type of procedure or service;

(b) The name of the provider;

(c) The enrollee's member number or policy number;

(d) If requested by the insurer, the site where the procedure or service will be performed; and

(e) The provider's billed charge amount.

(2) The estimate of costs described in subsection (1) of this section must include an itemization of:

(a) The enrollee's deductible;

(b) The amount of the deductible that has been met by processed claims;

(c) Coinsurance, copayment or other cost share to be paid by the enrollee for the procedure or service;

(d) Any applicable benefit maximum;

(e) The difference between the insurer's allowable charge and the billed charge for the procedure or service; and

(f) The insurer's average payment or allowable charge for the procedure or service if performed in-network.

(3) Subsections (1) and (2) of this section apply to the insurer's five most common procedures or services within each of the following categories:

(a) Office visits;

(b) Diagnostic radiology and imaging;

(c) Diagnostic pathology and laboratory procedures;

(d) Normal vaginal delivery;

(e) Immunizations;

(f) Orthopedic-musculoskeletal surgery; and

(g) Digestive system endoscopy.

(4) In addition to the information specified in subsections (1) and (2) of this section, the insurer's estimate must include the following disclosures:

(a) That other services may be provided to the enrollee that are medically necessary and appropriate as part of the common procedures, of which the insurer or enrollee may not be aware at the time of the inquiry and for which the enrollee may have additional financial responsibility;

(b) That the enrollee may be responsible for costs of procedures or services not covered by the plan;

(c) How an enrollee may contact the insurer for an explanation, if the estimate differs from the actual cost or if the enrollee has other questions; and

(d) The toll-free telephone number of the consumer advocacy unit of the Department of Consumer and Business Services and the address for the department's consumer information and complaints website.

(5) An insurer must make the information required by this section available to enrollees and out-of-network providers through an interactive website and by toll-free telephone.

(6) This section does not prohibit an insurer from providing information in addition to or in more detail than the information required by this section. [2007 c.390 §3]

Note: See note under 743.871.

743.878 Submission of methodology used to determine insurer's allowable charges. An insurer offering a health benefit plan as defined in ORS 743.730 must submit to the Director of the Department of Consumer and Business Services:

(1) Upon request by the director, the methodology used to determine the insurer's allowable charges for out-of-network procedures and services or, if the insurer uses a third party to determine the charges, the methodology used by the third party to determine allowable charges;

(2) For approval, a written explanation of the method used by the insurer to determine the allowable charge, that is in plain language and that must be provided upon request to enrollees directly, or, in the case of group coverage, to the employer or other policyholder for distribution to enrollees; and

(3) Information prescribed by the director as necessary to assess the effect of the disclosure requirements in ORS 743.874 and 743.876 on the individual and group health insurance markets. [2007 c.390 §4; 2011 c.500 §37]

Note: See note under 743.871.

743.880 [1981 c.752 §7; renumbered 743.619 in 1989]

743.883 Alternative mechanism for disclosure of costs and charges. The Director of the Department of Consumer and Business Services may waive the requirements of ORS 743.874 or 743.876 to allow an insurer to use an alternative disclosure mechanism, provided that the mechanism enables enrollees to access information substantially similar to or more extensive than the information disclosed in ORS 743.874 or 743.876. [2007 c.390 §5]

Note: See note under 743.871.

743.885 [1981 c.752 §8; renumbered 743.620 in 1989]

743.890 [1981 c.752 §9; renumbered 743.622 in 1989]

743.893 Rules. The Director of the Department of Consumer and Business Services shall adopt rules necessary to carry out the purposes of ORS 743.871 to 743.893. [2007 c.390 §6]

Note: See note under 743.871.

743.894 Rescinding coverage; permissible bases; notice; rules. (1) As used in this section, "rescind" means to retroactively cancel or discontinue coverage under a health benefit plan or group or individual health insurance policy for reasons other than failure to timely pay required premiums or required contributions toward the cost of coverage.

(2) An insurer may not rescind coverage of an individual under a health benefit plan or group or individual health insurance policy unless:

(a) The individual or a person seeking coverage on behalf of the individual:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan or policy; and

(b) The insurer provides at least 30 days' advance written notice, in the form and manner prescribed by the Department of Consumer and Business Services, to the individual.

(3) An insurer may not rescind coverage of a group under a health benefit plan unless:

(a) The plan sponsor:

(A) Performs an act, practice or omission that constitutes fraud; or

(B) Makes an intentional misrepresentation of a material fact as prohibited by the terms of the plan; and

(b) The insurer provides at least 30 days' advance written notice, in the form and manner prescribed by the department, to each plan enrollee or policy holder who would be affected by the rescission of coverage.

(4) An insurer that rescinds a plan or policy must provide notice of the rescission to the department in the form, manner and time frame prescribed by the department by rule.

(5) This section does not apply to long term care insurance that is subject to ORS 743.650 to 743.665. [2011 c.500 §4; 2013 c.681 §32]

Note: 743.894 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

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]

PAYMENT OF CLAIMS

743.911 Payment or denial of health benefit plan claims; rules. (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 743.913 or has the effect of relieving either party of their obligations under this section and ORS 743.913.

(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. [Formerly 743.866]

743.912 Refund of paid claims. (1) As used in this section, "refund" means the return, either directly or through an offset to a future claim, of some or all of a payment already received by a health care provider.

(2) Except in the case of fraud or abuse of billing, and except as provided in subsections (3) and (5) of this section, a health insurer may not:

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing on or before the last day of the period specified by the contract with the health care provider or 18 months after the date the payment was made, whichever is earlier; and

(B) Specifies in the written request why the health insurer believes the provider owes the refund.

(b) Request that a contested refund be paid earlier than six months after the health care provider receives the request.

(3) A health insurer may not do the following for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim:

(a) Request from a health care provider a refund of a payment previously made to satisfy a claim unless the health insurer:

(A) Requests the refund in writing within 30 months after the date the payment was made;

(B) Specifies in the written request why the health insurer believes the provider owes the refund; and

(C) Includes in the written request the name and mailing address of the other health insurer or entity that has primary responsibility for payment of the claim.

(b) Request that a contested refund be paid earlier than six months after the provider receives the request.

(4) If a health care provider fails to contest a refund request in writing to the health insurer within 30 days after receiving the request, the request is deemed accepted and the provider must pay the refund within 30 days after the request is deemed accepted. If the provider has not paid the refund within 30 days after the request is deemed accepted, the health insurer may recover the amount through an offset to a future claim.

(5) A health insurer may at any time request from a health care provider a refund of a payment previously made to satisfy a claim if:

(a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law; and

(b) The health insurer is unable to recover directly from the third party because the third party has already paid or will pay the provider for the health care services covered by the claim.

(6) If a contract between a health insurer and a health care provider conflicts with this section, the provisions of this section prevail. However, nothing in this section prohibits a health care provider from choosing at any time to refund to a health insurer any payment previously made to satisfy a claim.

(7) This section neither permits nor precludes a health insurer from recovering from a subscriber, enrollee or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy or other benefit agreement.

(8) This section applies to health benefit plans. [2009 c.807 §2; 2011 c.660 §21]

Note: 743.912 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.913 Interest on unpaid claims. (1) An insurer that fails to pay a claim to a provider within the timelines established in ORS 743.911 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. [Formerly 743.868]

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]

743.917 Underpayment of claims. (1) Except in the case of fraud and except as provided in subsection (3) of this section, a health care provider may not:

(a) Request additional payment from a health insurer to satisfy a claim unless the provider:

(A) Requests the additional payment in writing on or before the last day of the period specified by the contract or 18 months after the date the claim was denied or payment intended to satisfy the claim was made, whichever is earlier; and

(B) Specifies in the written request why the provider believes the health insurer owes the additional payment.

(b) Request that an additional payment be paid earlier than six months after the health insurer receives the request.

(2) A health insurer may not consider a health care provider's claim untimely if the claim is made no later than 12 months after a different insurer:

(a) Denied the claim in whole or in part; or

(b) Requested a refund of an erroneous payment made on the claim.

(3) A health care provider may not do the following for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim:

(a) Request additional payment from a health insurer to satisfy a claim unless the provider:

(A) Requests the additional payment in writing within 30 months after the date the claim was denied or payment intended to satisfy the claim was made;

(B) Specifies in the written request why the provider believes the health insurer owes the additional payment; and

(C) Includes in the written request the name and mailing address of the other health insurer or entity that has disclaimed responsibility for payment of the claim.

(b) Request that the additional payment be paid earlier than six months after the health insurer receives the request.

(4) If a contract between a health insurer and a health care provider conflicts with this section, the provisions of this section prevail. However, nothing in this section prohibits a health insurer from choosing at any time to make additional payments to a health care provider to satisfy a claim.

(5) This section applies to health benefit plans. [2009 c.807 §3; 2011 c.660 §22]

Note: 743.917 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.918 Claims submitted during credentialing period. (1) As used in this section:

(a) "Complete application" means a provider's application to a health insurer to become a credentialed provider that includes:

(A) Information required by the health insurer;

(B) Proof that the provider is licensed by a health professional regulatory board as defined in ORS 676.160;

(C) Proof of current registration with the Drug Enforcement Administration of the United States Department of Justice, if applicable to the provider's practice; and

(D) Proof that the provider is covered by a professional liability insurance policy or certification meeting the health insurer's requirements.

(b) "Credentialing period" means the period beginning on the date a health insurer receives a complete application and ending on the date the health insurer approves or rejects the complete application or 90 days after the health insurer receives the complete application, whichever is earlier.

(c) "Health insurer" means an insurer that offers managed health insurance or preferred provider organization insurance, other than a health maintenance organization as defined in ORS 750.005.

(2) A health insurer shall approve or reject a complete application within 90 days of receiving the application.

(3)(a) A health insurer shall pay all claims for medical services covered by the health insurer that are provided by a provider during the credentialing period.

(b) A provider may submit claims for medical services provided during the credentialing period during or after the credentialing period.

(c) A health insurer may pay claims for medical services provided during the credentialing period:

(A) During or after the credentialing period.

(B) At the rate paid to nonparticipating providers.

(d) If a provider submits a claim for medical services provided during the credentialing period within six months after the end of the credentialing period, the health insurer may not deny payment of the claim

on the basis of the health insurer's rules relating to timely claims submission.

(4) Subsection (3) of this section does not require a health insurer to pay claims for medical services provided during the credentialing period if:

(a) The provider was previously rejected or terminated as a participating provider in any health benefit plan underwritten or administered by the health insurer;

(b) The rejection or termination was due to the objectively verifiable failure of the provider to provide medical services within the recognized standards of the provider's profession; and

(c) The provider was given the opportunity to contest the rejection or termination before a panel of peers in a proceeding conducted in conformity with the Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101 et seq. [2009 c.806 §2]

Note: 743.918 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.920 [1971 c.476 §6; renumbered 742.568 in 1989]

743.921 Payment of ambulatory surgical center claims. (1) As used in this section, "ambulatory surgical center" has the meaning given that term in ORS 442.015.

(2) An insurer or a third party administrator for a self-insured plan shall reimburse an out-of-network ambulatory surgical center for a service covered under a policy or certificate of health insurance by:

(a) Paying the center directly; or

(b) Issuing a check made payable to both the center and to the insured or beneficiary who received the service or, if the insured or beneficiary who received the service is a dependent, to the policyholder or certificate holder.

(3) The insurer or administrator shall pay the center the reimbursement amount allowed under the terms of the policy or certificate. [2013 c.534 §6]

Note: 743.921 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

RISK ADJUSTMENT PROCEDURES

743.923 Risk adjustment procedures; rules. (1) As used in this section, "health benefit plan" means a health benefit plan, as defined in ORS 743.730, that is offered in the individual or small group market.

(2) The Department of Consumer and Business Services may establish by rule a procedure for adjusting risk between insurers. If a procedure is established, the procedure may include:

(a) An assessment imposed on an insurer if the actuarial risk of the enrollees in the insurer's health benefit plans is less than the average actuarial risk of all enrollees in all health benefit plans in this state; and

(b) Payments to insurers if the actuarial risk of the enrollees in the insurer's health benefit plans is greater than the average actuarial risk of all enrollees in all health benefit plans in this state.

(3) A procedure established under this section must be consistent with 42 U.S.C. 18063 and regulations adopted by the Secretary of the United States Department of Health and Human Services to carry out 42 U.S.C. 18063. [2013 c.681 §3]

Note: 743.923 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

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]

ASSESSMENT ON PREMIUMS OR CLAIMS

743.951 Payment procedures; right to hearing. (1) As used in this section:

(a) "Insured" means an eligible employee or family member, as defined in ORS 243.105, who is covered by a self-insured health benefit plan under ORS 243.105 to 243.285.

(b) "Medical claim" means a request to a self-insured health benefit plan for payment for a health care item or service provided to an insured, other than a dental or vision care item or service.

(2) No later than 45 days following the end of a calendar quarter, the Public Employees' Benefit Board shall pay an assessment at the rate of one percent of all medical claims received and the administrative costs associated with the claims received during the calendar quarter.

(3) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified report, on a form prescribed by the department, together with any information required by the department.

(4) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on the board.

(5) If the department determines that the assessment paid by the board under this section is incorrect, the department shall charge or credit to the board the difference between the correct amount of the assessment and the amount paid by the board.

(6) The board is entitled to notice and an opportunity for a contested case hearing under ORS chapter 183 to contest an action of the department taken pursuant to subsection (5) of this section.

(7) The assessment paid by the board under this section shall be considered part of the board's administrative expenses. [2009 c.867 §3]

Note: Section 3a, chapter 867, Oregon Laws 2009, provides:

Sec. 3a. Section 3 of this 2009 Act [743.951] applies to medical claims received by the Public Employees' Benefit Board, or a person that contracts with the board to pay medical claims under a self-insured health benefit plan, during the period from October 1, 2009, through September 30, 2013. [2009 c.867 §3a]

Note: 743.951 to 743.965 and 743.990 were added to and made a part of the Insurance Code by legislative action but were not added to ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.960 Definitions for ORS 743.960 and 743.961. As used in this section and ORS 743.961:

(1) "Gross amount of premiums" has the meaning given that term in ORS 731.808.

(2) "Health plan" means health insurance and insurance provided by a health care service contractor as defined in ORS 750.005, excluding:

(a) Insurance policies covering vision only or dental only benefits;

(b) Medicare advantage plans;

(c) Medicare Part D plans;

(d) Long term care insurance;

(e) Health insurance issued to federal employees that is exempt from state taxes under federal law;

(f) A policy of stop-loss coverage that meets the requirements of ORS 742.065;

(g) Insurance policies issued to supplement liability insurance coverage;

(h) Automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is required by law to be contained in a liability insurance policy or equivalent self-insurance;

(i) Reinsurance as defined in ORS 731.126;

(j) Workers compensation insurance;

(k) Disability insurance; and

(L) Accident only, specified disease and hospital indemnity policies, if the policies pay benefits on an indemnity basis. [2009 c.867 §4; 2012 c.15 §1]

Note: See second note under 743.951.

743.961 Payment procedures. (1) No later than 45 days following the end of a calendar quarter, an insurer shall pay an assessment at the rate of one percent of the gross amount of premiums earned by the insurer during that calendar quarter that were derived from health plan policies delivered or issued for delivery in Oregon.

(2) The assessment shall be paid to the Department of Consumer and Business Services and shall be accompanied by a verified form prescribed by the department together with any information required by the department, that reports:

(a) All health plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid; and

(b) The gross amount of premiums by line of insurance, derived by the insurer from all health plans issued or renewed by the insurer during the calendar quarter for which the assessment is paid.

(3) The assessment imposed under this section is in addition to and not in lieu of any tax, surcharge or other assessment imposed on an insurer.

(4) Any rate filed for the department's approval may include amounts paid by the insurer under this section as a valid element of administrative expense or retention. [2009 c.867 §5; 2010 c.34 §1]

Note: See second note under 743.951.

Note: Section 8, chapter 867, Oregon Laws 2009, provides:

Sec. 8. (1) Sections 5 [743.961] and 6 [743.990] of this 2009 Act apply to premiums earned by an insurer during the period from October 1, 2009, through September 30, 2013.

(2) Notwithstanding any provision of contract or statute, including ORS 743.737 and 743.767, beginning October 1, 2009, insurers may include in their rates an additional one percent of the existing rate. To the extent the existing rate was approved by the Department of Consumer and Business Services, the resulting rate, including the additional one percent, shall be considered an approved rate. If an insurer increases its rates under this subsection, the insurer shall include in all consumer billings a notice explaining the increase in a form prescribed by the department. This subsection applies to any rate approved by or filed for the department's approval prior to the effective date of this 2009 Act [September 28, 2009] and to any contract of insurance not subject to the department's rate approval authority. [2009 c.867 §8]

743.965 Incorrect payments; right to hearing. (1) If the Department of Consumer and Business Services determines that the assessment paid by the insurer under ORS

743.961 is incorrect, the department shall charge or credit to the insurer the difference between the correct amount of the assessment and the amount paid by the insurer.

(2) An insurer that is aggrieved by an action of the department taken pursuant to subsection (1) of this section shall be entitled to notice and an opportunity for a contested case hearing under ORS chapter 183. [2009 c.867 §7]

Note: See second note under 743.951.

743.990 Penalties. (1) If the Public Employees' Benefit Board or an insurer fails to timely file a verified form or to pay an assessment required under ORS 743.951 or 743.961, the insurer or the board shall be subject to a penalty of up to $500 per day of delinquency. The total amount of penalties imposed under this section for a calendar quarter may not exceed five percent of the assessment due for that calendar quarter.

(2) Any penalty imposed under this section is in addition to and not in lieu of the assessment imposed under ORS 743.951 and 743.961. [2009 c.867 §6]

Note: See second note under 743.951.

Note: See second note under 743.961.