Chapter 750

2003 EDITION

Health Care Service Contractors; Multiple Employer Welfare Arrangements; Legal Expense Organizations

HEALTH CARE SERVICE CONTRACTORS

750.003 Purpose
750.005 Definitions
750.015 Management to include representatives of public
750.025 Restricting distribution of income and representation as health maintenance organization
750.035 Regulation of hospital care associations under prior law; exceptions
750.045 Required capitalization; bond, security or letter of credit; exemptions
750.047 Permitted investments
750.055 Other provisions applicable to health care service contractors
750.059 Application of reimbursement requirement to group practice maintenance organizations for services by state hospital or state-approved program
750.065 Reimbursement for services within scope of practice of optometrists

INSOLVENCY OF HEALTH CARE SERVICE CONTRACTOR

750.085 Offer of replacement coverage upon order of liquidation; procedure
750.095 Requirements of contract between provider and subscriber; content

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

750.301 Definitions for ORS 750.301 to 750.341
750.303 Conditions for use of multiple employer welfare arrangement; permitted coverage
750.305 Application for certificate
750.307 Requirements for association or group
750.309 Requirements for trust
750.311 Multiple employer welfare arrangements established in another state
750.313 Issuance or refusal of certificate of multiple employer welfare arrangement
750.315 Maintenance of reserves; actuarial opinion; rules
750.317 Board of trustees
750.318 Officers and persons appointed to act on behalf of board; bond
750.319 Salaries; other compensation
750.321 Assessment; maintenance of capital and surplus
750.323 Notice of coverage under plan
750.325 Filings by trust
750.327 Examinations
750.329 Taxation
750.331 Prohibited activities for trustee or officer
750.333 Applicable provisions of Insurance Code
750.335 Delinquency proceedings
750.337 Exclusion from membership in guaranty funds, joint underwriting associations and other pools
750.339 Liability of excess loss insurer
750.341 Requirement for multiple employer welfare arrangement to become traditional insurer

LEGAL EXPENSE ORGANIZATIONS

750.505 Definitions for ORS 750.505 to 750.715
750.515 Certificate of registration required
750.525 Inapplicability of ORS 750.505 to 750.715 to certain legal services
750.535 Registration requirements
750.545 Application; fee
750.555 Issuance of certificate of registration
750.565 Duration of certificate; renewal; fee
750.575 Grounds for suspension or revocation of certificate or refusal to issue or renew certificate
750.585 Written provider agreement with providing attorney
750.595 Membership agreement
750.605 Unfair, discriminatory or misleading provisions in agreements prohibited; record of transactions
750.615 Deposit to reimburse members for unearned premiums required
750.625 Paying providing attorney contingent on claims experience prohibited
750.635 Registered agent and registered office in state required
750.645 Annual report; content; names of sales and marketing representatives to be submitted
750.655 Filing schedule of legal service rates required
750.675 Filing of provider and membership agreement with director
750.685 Indemnification insurance or bond required
750.695 ORS 750.505 to 750.715 not to affect regulation of practice of law; plan not subject to Insurance Code
750.705 Application of Insurance Code
750.715 Rulemaking authority of director

HEALTH CARE SERVICE CONTRACTORS

750.003 Purpose. The purpose of this section and ORS 750.005, 750.025 and 750.045 is to encourage and guarantee the development of health care service contractors by licensing and regulating their operation to insure that they provide high quality health care services through state licensed organizations meeting reasonable standards as to administration, services and financial soundness. [1985 c.747 §64]

750.005 Definitions. As used in ORS 750.005 to 750.095:

(1) "Claims" means any amount incurred by the insurer covering contracted benefits.

(2) "Complementary health services" means the following health care services:

(a) Chiropractic as defined in ORS 684.010;

(b) Naturopathic medicine as defined in ORS 685.010;

(c) Massage therapy as defined in ORS 687.011; or

(d) Acupuncture as defined in ORS 677.757.

(3) "Doctor" means any person lawfully licensed or authorized by statute to render any health care services.

(4) "Health care service contractor" means:

(a) Any corporation that is sponsored by or otherwise intimately connected with a group of doctors licensed by this state, or by a group of hospitals licensed by this state, or both, under contracts with groups of doctors or hospitals that include conditions holding the subscriber harmless in the event of nonpayment by the health care service contract as provided in ORS 750.095, and that accepts prepayment for health care services; or

(b) Any person referred to in ORS 750.035.

(5) "Health care services" means the furnishing of medicine, medical or surgical treatment, nursing, hospital service, dental service, optometrical service, complementary health services or any or all of the enumerated services or any other necessary services of like character, whether or not contingent upon sickness or personal injury, as well as the furnishing to any person of any and all other services and goods for the purpose of preventing, alleviating, curing or healing human illness, physical disability or injury.

(6) "Health maintenance organization" means any health care service contractor operated on a for-profit or not for-profit basis which:

(a) Qualifies under Title XIII of the Public Health Service Act; or

(b)(A) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services:

(i) Usual physician services;

(ii) Hospitalization;

(iii) Laboratory;

(iv) X-ray;

(v) Emergency and preventive services; and

(vi) Out-of-area coverage;

(B) Is compensated, except for copayments, for the provision of basic health care services listed in subparagraph (A) of this paragraph to enrolled participants on a predetermined periodic rate basis;

(C) Provides physicians' services primarily directly through physicians who are either employees or partners of such organization, or through arrangements with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis; and

(D) Employs the terms "health maintenance organization" or "HMO" in its name, contracts, literature or advertising media on or before July 13, 1985. [Formerly 742.010; 1973 c.515 §5; 1979 c.799 §1; 1985 c.747 §65; 1989 c.783 §4; 1991 c.958 §3; 2003 c.33 §1]

750.010 [Amended by 1957 c.301 §1; 1961 c.116 §1; 1967 c.359 §548; renumbered 744.305]

750.015 Management to include representatives of public. (1) Except as provided in subsection (2) of this section, not less than one-third of the group of persons vested with the management of the affairs of a health care service contractor, as defined in ORS 750.005 (4)(a), shall be representatives of the public who are not practicing doctors or employees or trustees of a participant hospital.

(2)(a) Notwithstanding subsection (1) of this section, the group of persons vested with the management of the affairs of a nonprofit private organization described in this subsection shall have at least two representatives of the public who are not practicing doctors, as defined in ORS 750.005, or employees or trustees of a participant hospital.

(b) This subsection applies to a nonprofit private organization that is a health maintenance organization, as defined in ORS 442.015, that is controlled by a single nonprofit hospital or by a group of nonprofit hospitals under common ownership and that operates in a county with a population of 200,000 or more. [Formerly 742.015; 1983 c.804 §1; 2003 c.33 §6]

750.020 [Amended by 1961 c.116 §2; 1967 c.359 §549; renumbered 744.315]

750.025 Restricting distribution of income and representation as health maintenance organization. (1) A health care service contractor which is a not-for-profit corporation, shall not distribute, upon liquidation or otherwise, any part of its income to its members, directors, trustees or officers except for the reasonable value of services rendered such contractor.

(2) An organization that does not meet the definition of health maintenance organization in ORS 750.005 shall not hold itself out to the public to be a health maintenance organization. [Formerly 742.025; 1985 c.747 §66]

750.030 [Repealed by 1967 c.359 §704]

750.035 Regulation of hospital care associations under prior law; exceptions. (1) Notwithstanding any other provision of law, except as provided in subsection (2) of this section, any persons doing a hospital association business, as defined in ORS 742.010 (1959 Replacement Part) in compliance with ORS chapter 742 (1959 Replacement Part) on August 12, 1965, may continue such business in compliance with ORS chapter 742 (1959 Replacement Part).

(2) Every person doing a hospital association business, as defined in ORS 742.010 (1959 Replacement Part), on August 12, 1965, shall comply with the provisions of ORS 750.045, 750.055, 750.085 and 750.095. [Formerly 742.035; 1989 c.783 §5]

750.040 [Amended by 1967 c.359 §552; renumbered 744.345]

750.045 Required capitalization; bond, security or letter of credit; exemptions. (1) A health care service contractor that is a for-profit or not-for-profit corporation shall possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $2.5 million.

(2) A health care service contractor that is a for-profit or not-for-profit corporation shall file a surety bond or such other bond or securities in the sum of $250,000 as are authorized by the Insurance Code as a guarantee of the due execution of the policies to be entered into by such contractor in accordance with ORS 750.005 to 750.095. In lieu of such bond or securities, a health care service contractor may file an irrevocable letter of credit issued by an insured institution as defined in ORS 706.008 in the sum of $250,000. This subsection does not apply to a health care service contractor that has at least 75 percent of its assets invested in health care service facilities pursuant to ORS 733.700.

(3) Subsections (1) and (2) of this section do not apply to a health care service contractor furnishing only complementary health services, dental service or optometrical service operated on a for-profit or not-for-profit basis if:

(a) The services referred to in this subsection maintain capital or surplus, or any combination thereof, of not less than $1 million.

(b) The services referred to in this subsection file a surety bond or other such bond or securities in the sum of $50,000 as are authorized by the Insurance Code as a guarantee of the due execution of the policies to be entered into by such contractor in accordance with ORS 750.005 to 750.095.

(4) A health care service contractor that is a for-profit or not-for-profit corporation applying for its original certificate of authority in this state shall possess, when first so authorized, additional capital or surplus, or any combination thereof, of not less than $500,000.

(5) For the protection of the public, the Director of the Department of Consumer and Business Services may require a health care service contractor to possess and maintain capital or surplus, or any combination thereof, in excess of the amount otherwise required under this section owing to the type, volume and nature of insurance business transacted by the health care service contractor, if the director determines that the greater amount is necessary for maintaining the health care service contractor's solvency according to standards established by rule. In developing such standards, the director shall consider model standards adopted by the National Association of Insurance Commissioners or its successor organization. For the purpose of determining the reasonableness and adequacy of a health care service contractor's capital and surplus, the director must consider at least the following factors, as applicable:

(a) The size of the health care service contractor, as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria.

(b) The number of lives insured.

(c) The extent of the geographical dispersion of the lives insured by the health care service contractor.

(d) The nature and extent of the reinsurance program of the health care service contractor.

(e) The quality, diversification and liquidity of the investment portfolio of the health care service contractor.

(f) The recent past and projected future trend in the size of the investment portfolio of the health care service contractor.

(g) The combined capital and surplus maintained by comparable health care service contractors.

(h) The adequacy of the reserves of the health care service contractor.

(i) The quality and liquidity of investments in affiliates. The director may treat any such investment as a disallowed asset for purposes of determining the adequacy of combined capital and surplus whenever in the judgment of the director the investment so warrants.

(j) The quality of the earnings of the health care service contractor and the extent to which the reported earnings include extraordinary items. [Formerly 742.050; 1975 c.273 §1; 1977 c.402 §1; 1985 c.747 §67; 1991 c.331 §132; 1991 c.958 §4; 1997 c.631 §552; 2001 c.318 §6; 2003 c.33 §2]

Note: Section 5, chapter 318, Oregon Laws 2001, provides:

Sec. 5. (1) To qualify for authority to transact insurance in this state on and after January 1, 2002, an insurer that is not authorized to transact insurance in this state on the day before January 1, 2002, must possess and thereafter maintain the applicable capital and surplus required by ORS 731.554, 731.562 and 731.566, as amended by sections 1 to 3, chapter 318, Oregon Laws 2001.

(2) To qualify for authority to transact health care services in this state on and after January 1, 2002, a health care service contractor that is not authorized to transact health care services in this state on the day before January 1, 2002, must possess and thereafter maintain the applicable capital and surplus required by ORS 750.045, as amended by section 6, chapter 318, Oregon Laws 2001.

(3) An insurer that is authorized to transact insurance in this state on the day before January 1, 2002, and that possesses on that date the applicable capital and surplus required under ORS 731.554, 731.562 and 731.566, as amended by sections 1 to 3, chapter 318, Oregon Laws 2001, must thereafter maintain that capital and surplus.

(4) A health care service contractor that is authorized to transact health care services in this state on the day before January 1, 2002, and that possesses on that date the applicable capital and surplus required under ORS 750.045, as amended by section 6, chapter 318, Oregon Laws 2001, must thereafter maintain that capital and surplus.

(5) Notwithstanding the effective date of chapter 318, Oregon Laws 2001, an insurer that is authorized to transact insurance in this state on the day before January 1, 2002, and that does not possess on January 1, 2002, the applicable capital and surplus required under ORS 731.554 (1) and (2), 731.562 and 731.566, as amended by sections 1 to 3, chapter 318, Oregon Laws 2001, must possess and maintain at least the amounts of capital and surplus as follows:

(a) For insurers other than insurers transacting workers' compensation insurance:

(A) $1,300,000, not later than December 31, 2002.

(B) $1,600,000, not later than December 31, 2003.

(C) $1,900,000, not later than December 31, 2004.

(D) $2,200,000, not later than December 31, 2005.

(E) $2,500,000, not later than December 31, 2006.

(b) For insurers transacting workers' compensation insurance:

(A) $3,400,000, not later than December 31, 2002.

(B) $3,800,000, not later than December 31, 2003.

(C) $4,200,000, not later than December 31, 2004.

(D) $4,600,000, not later than December 31, 2005.

(E) $5,000,000, not later than December 31, 2006.

(6) Notwithstanding the effective date of chapter 318, Oregon Laws 2001, a health care service contractor that is authorized to transact health care services in this state on the day before January 1, 2002, and that does not possess on January 1, 2002, the applicable capital and surplus required under ORS 750.045, as amended by section 6, chapter 318, Oregon Laws 2001, must possess and maintain at least the amounts of capital and surplus as follows:

(a) As of each date specified in this paragraph, a health care service contractor other than one to which ORS 750.045 (3) applies shall possess and maintain capital or surplus, or any combination thereof, of not less than the minimum amount specified in connection with the date or an amount equal to 50 percent of the average claims as defined in ORS 750.005 for the preceding 12-month period, whichever is greater. The required amount of capital and surplus for each date, however, shall not be more than the maximum amount specified in connection with that date. The dates and minimum and maximum required amounts of capital and surplus are as follows:

(A) As of December 31, 2002, not less than $650,000 and not more than $1,300,000.

(B) As of December 31, 2003, not less than $800,000 and not more than $1,600,000.

(C) As of December 31, 2004, not less than $950,000 and not more than $1,900,000.

(D) As of December 31, 2005, not less than $1,100,000 and not more than $2,200,000.

(E) As of December 31, 2006, not less than $2,500,000.

(b) As of each date specified in this paragraph, a health care service contractor to which ORS 750.045 (3) applies shall possess and maintain capital or surplus, or any combination thereof, of not less than the minimum amount specified in connection with the date or an amount equal to 50 percent of the average claims as defined in ORS 750.005 for the preceding 12-month period, whichever is greater. The required amount of capital and surplus for each date, however, shall not be more than the maximum amount specified in connection with that date. The dates and minimum and maximum required amounts of capital and surplus are as follows:

(A) As of December 31, 2002, not less than $300,000 and not more than $600,000.

(B) As of December 31, 2003, not less than $350,000 and not more than $700,000.

(C) As of December 31, 2004, not less than $400,000 and not more than $800,000.

(D) As of December 31, 2005, not less than $450,000 and not more than $900,000.

(E) As of December 31, 2006, not less than $1 million.

(7) An insurer authorized to transact insurance in this state on the day before January 1, 2002, shall not be granted authority to transact any other or additional class of insurance until the insurer complies with the applicable provisions of ORS 731.554, 731.562 or 731.566, as amended by sections 1 to 3, chapter 318, Oregon Laws 2001.

(8) An insurer or health care service contractor authorized to transact insurance or health care services in this state on the day before January 1, 2002, that reapplies for a certificate of authority after having a certificate of authority revoked for any cause shall not be granted authority to transact any insurance or health care services until the insurer or health care service contractor complies with the applicable pro-

visions of ORS 731.554, 731.562, 731.566 or 750.045, as amended by sections 1 to 3 and 6, chapter 318, Oregon Laws 2001.

(9) If an insurer to which subsection (5) of this section applies or a health care service contractor to which subsection (6) of this section applies does not possess and maintain the minimum amount of capital and surplus required by ORS 731.554 (1) and (2), 731.562, 731.566 and 750.045, as amended by sections 1 to 3 and 6, chapter 318, Oregon Laws 2001, on or before December 31, 2006, the insurer or health care service contractor may apply to the Director of the Department of Consumer and Business Services for an extension of time within which to attain the amount. The application must state the reasons for the failure to attain the required minimum amount, the date by which the amount is expected to be attained and the means and likelihood of attaining the amount by that date. The director may grant the extension if the director determines that the extension is reasonable and appropriate in the circumstances, taking into account factors that include but are not limited to the following:

(a) Whether the insurer or health care service contractor has made reasonable progress toward attaining the required minimum amount during the time periods specified in this section; and

(b) Whether the insurer or health care service contractor is likely to attain the required minimum amount by the date proposed by the insurer or health care service contractor. [2001 c.318 §5; 2003 c.33 §3]

750.047 Permitted investments. (1) Except as provided in subsections (2) and (3) of this section, funds of a health care service contractor may be invested in the stocks or obligations of one or more corporations without regard to the provisions and limitations of ORS 733.590, 733.620, 733.770 and 733.780 (1)(a) if such a corporation is engaged, or will be engaged, in the kind of business or activity that is related to the insurance business as described in ORS 733.635, provided 80 percent or more of the shares of such corporation having voting powers are owned by the health care service contractor either by itself or with prior approval of the Director of the Department of Consumer and Business Services in cooperation with one or more other persons.

(2) Except as provided in subsection (4) of this section, the amount of funds so invested shall not exceed, in the aggregate, 50 percent of the amount of the combined capital and surplus of the health care service contractor, unless such investment is made pursuant to a plan of acquisition that has been approved by the director.

(3) The limitations of ORS 733.770 shall apply to funds invested in a subsidiary described in ORS 733.635 (3) to (12).

(4) Funds invested in one or more subsidiary corporations described in ORS 733.635 (9) shall not be subject to the limitation prescribed in subsection (2) of this section and shall not be considered in determining the aggregate limitation presented in subsection (2) of this section. [1993 c.447 §115a]

750.050 [Amended by 1961 c.116 §3; 1967 c.359 §553; renumbered 744.355]

750.055 Other provisions applicable to health care service contractors. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804 and 731.844 to 731.992.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c)(A) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.620, 733.635 to 733.680 and 733.695 to 733.780 apply to not-for-profit health care service contractors.

(B) ORS chapter 733, not including ORS 733.630, applies to for-profit health care service contractors.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.412, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.555, 743.556, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.691, 743.693, 743.694, 743.697, 743.699, 743.701, 743.706 to 743.712, 743.721, 743.722, 743.726, 743.727, 743.728, 743.729, 743.793, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.866 and 743.868.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(h) ORS 743.714, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state which is not governed by the insurance laws of such state, will be subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions. [1967 c.359 §659; 1969 c.336 §18; 1971 c.231 §41; 1973 c.143 §5; 1973 c.515 §6; 1973 c.613 §4a; 1975 c.135 §3; 1975 c.338 §4a; 1975 c.689 §4; 1975 c.784 §13c; 1977 c.402 §6; 1979 c.268 §7; 1979 c.708 §11; 1979 c.785 §22a; 1979 c.797 §3a; 1981 c.254 §3; 1981 c.319 §3; 1981 c.422 §6; 1981 c.649 §22; 1981 c.752 §14; 1983 c.601 §9; 1985 c.747 §68; 1985 c.827 §3; 1987 c.411 §3; 1987 c.720 §3; 1987 c.739 §5; 1987 c.774 §62; 1987 c.838 §16; 1989 c.255 §13; 1989 c.425 §15; 1989 c.474 §4; 1989 c.701 §76; 1989 c.784 §14; 1989 c.832 §3; 1989 c.1022 §11; 1991 c.182 §18; 1991 c.401 §33; 1991 c.673 §8; 1991 c.812 §24; 1991 c.875 §3; 1991 c.916 §19; 1993 c.391 §3; 1993 c.447 §118; 1993 c.649 §14; 1995 c.30 §13; 1995 c.506 §3; 1995 c.623 §3; 1995 c.638 §9; 1995 c.669 §3; 1995 c.672 §8; 1997 c.343 §22; 1997 c.496 §4; 1997 c.573 §4; 1997 c.759 §5; 1999 c.428 §§4,5; 1999 c.633 §§7,8; 1999 c.749 §§3,4; 1999 c.987 §§22,23; 2001 c.191 §60; 2001 c.266 §16; 2001 c.377 §20; 2001 c.742 §4; 2001 c.747 §6; 2003 c.87 §19; 2003 c.91 §5; 2003 c.363 §14; 2003 c.364 §169; 2003 c.748 §3; 2003 c.802 §172]

Note 1: The amendments to 750.055 by section 3, chapter 263, Oregon Laws 2003, become operative July 3, 2009. See section 5, chapter 263, Oregon Laws 2003. The text that is operative from July 3, 2009, until October 4, 2009, is set forth for the user's convenience.

750.055. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804 and 731.844 to 731.992.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c)(A) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.620, 733.635 to 733.680 and 733.695 to 733.780 apply to not-for-profit health care service contractors.

(B) ORS chapter 733, not including ORS 733.630, applies to for-profit health care service contractors.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.412, 743.472, 743.492, 743.495, 743.498, 743.522, 743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.555, 743.556, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.691, 743.693, 743.694, 743.697, 743.699, 743.701, 743.706 to 743.712, 743.721, 743.722, 743.727, 743.728, 743.729, 743.793, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.866 and 743.868.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(h) ORS 743.714, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state which is not governed by the insurance laws of such state, will be subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

Note 2: The amendments to 750.055 by section 7, chapter 137, Oregon Laws 2003, become operative October 4, 2009. See section 9, chapter 137, Oregon Laws 2003. The text that is operative on and after October 4, 2009, is set forth for the user's convenience.

750.055. (1) The following provisions of the Insurance Code shall apply to health care service contractors to the extent so applicable and not inconsistent with the express provisions of ORS 750.005 to 750.095:

(a) ORS 705.137, 705.139, 731.004 to 731.150, 731.162, 731.216 to 731.362, 731.382, 731.385, 731.386, 731.390, 731.398 to 731.430, 731.428, 731.450, 731.454, 731.488, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.574 to 731.620, 731.592, 731.594, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.750, 731.752, 731.804 and 731.844 to 731.992.

(b) ORS 732.215, 732.220, 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.592, not including ORS 732.582.

(c)(A) ORS 733.010 to 733.050, 733.080, 733.140 to 733.170, 733.210, 733.510 to 733.620, 733.635 to 733.680 and 733.695 to 733.780 apply to not-for-profit health care service contractors.

(B) ORS chapter 733, not including ORS 733.630, applies to for-profit health care service contractors.

(d) ORS chapter 734.

(e) ORS 742.001 to 742.009, 742.013, 742.061, 742.065, 742.150 to 742.162, 742.400, 742.520 to 742.540, 743.010, 743.013, 743.018 to 743.030, 743.050, 743.100 to 743.109, 743.402, 743.412, 743.472, 743.492, 743.495, 743.498, 743.522,

743.523, 743.524, 743.526, 743.527, 743.528, 743.529, 743.549 to 743.555, 743.556, 743.560, 743.600 to 743.610, 743.650 to 743.656, 743.691, 743.693, 743.694, 743.697, 743.701, 743.706 to 743.712, 743.721, 743.722, 743.727, 743.728, 743.729, 743.793, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863, 743.864, 743.866 and 743.868.

(f) The provisions of ORS chapter 744 relating to the regulation of insurance producers.

(g) ORS 746.005 to 746.140, 746.160, 746.220 to 746.370, 746.600, 746.605, 746.607, 746.608, 746.610, 746.615, 746.625, 746.635, 746.650, 746.655, 746.660, 746.668, 746.670, 746.675, 746.680 and 746.690.

(h) ORS 743.714, except in the case of group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act unless the patient is referred by a physician associated with a group practice health maintenance organization.

(i) ORS 735.600 to 735.650.

(j) ORS 743.680 to 743.689.

(k) ORS 744.700 to 744.740.

(L) ORS 743.730 to 743.773.

(m) ORS 731.485, except in the case of a group practice health maintenance organization that is federally qualified pursuant to Title XIII of the Public Health Service Act and that wholly owns and operates an in-house drug outlet.

(2) For the purposes of this section only, health care service contractors shall be deemed insurers.

(3) Any for-profit health care service contractor organized under the laws of any other state which is not governed by the insurance laws of such state, will be subject to all requirements of ORS chapter 732.

(4) The Director of the Department of Consumer and Business Services may, after notice and hearing, adopt reasonable rules not inconsistent with this section and ORS 750.003, 750.005, 750.025 and 750.045 that are deemed necessary for the proper administration of these provisions.

750.059 Application of reimbursement requirement to group practice maintenance organizations for services by state hospital or state-approved program. ORS 743.701 does not apply to group practice maintenance organizations that are federally qualified pursuant to Title XIII of the Public Health Service Act (42 U.S.C. 300e et seq.). [1981 c.422 §2; 1981 c.891 §3]

750.060 [Amended by 1967 c.359 §555; renumbered 744.375]

750.065 Reimbursement for services within scope of practice of optometrists. (1) Notwithstanding any provision of contract or agreement entered into by a corporation, association, society, firm, partnership or individual doing business as a hospital association or as a health care service contractor, whenever such contract or agreement provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such contract or agreement shall be entitled to reimbursement for such service, whether the said service is performed by a physician or duly licensed optometrist. Unless such contract or agreement shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto.

(2) Nothing in subsection (1) of this section shall apply to any contract or agreement limited to the furnishing of services to be performed exclusively by members of the association, society, group or partnership issuing such contract or agreement. [1971 c.97 §2]

750.070 [Repealed by 1967 c.359 §704]

750.075 [1979 c.799 §3; repealed by 1991 c.958 §6]

750.080 [Amended by 1967 c.359 §557; renumbered 744.396]

INSOLVENCY OF HEALTH CARE SERVICE CONTRACTOR

750.085 Offer of replacement coverage upon order of liquidation; procedure. (1) When a final order of liquidation with a finding of insolvency has been entered with respect to a health care service contractor by a court of competent jurisdiction in the domicile of the health care service contractor, subscribers of the health care service contractor shall be offered replacement coverage as provided in this section.

(2) All insurers and health care service contractors that participated with the insolvent health care service contractor in the open enrollment process at the last regular open enrollment period for a group shall offer members of the group that are subscribers of the insolvent health care service contractor an open enrollment period of 30 days, commencing on the date on which the final order of liquidation with a finding of insolvency was entered. Each of the insurers and health care service contractors shall offer the subscribers of the insolvent health care service contractor the same coverages and rates that the insurer or health care service contractor had offered to members of the group at its last regular open enrollment period.

(3) If no other insurer or health care service contractor offered health insurance coverage to a group or groups whose members are enrolled with the insolvent health care service contractor, or if the other insurers and health care service contractors lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group subscribers of the insolvent health care service contractor, the Director of the Department of Consumer and Business Services shall equitably allocate the contract or contracts for the group or groups among all health care service contractors that operate within a portion of the service area of the insolvent health care service contractor. The director shall take into consideration the

health care delivery resources of each health care service contractor. Each health care service contractor to which a group or groups are so allocated shall offer to each such group the existing coverage of the health care service contractor, at rates determined by the health care service contractor in accordance with its existing rating methodology. Each health care service contractor to whom a group or groups are allocated may reevaluate the group or groups at the end of the contractual period or at the end of six months after the allocation, whichever occurs first, in order to determine the appropriate premium for each such group.

(4) The director shall equitably allocate the nongroup subscribers of the insolvent health care service contractor that are unable to obtain other coverage among all health care service contractors that operate within a portion of the service area of the insolvent health care service contractor. The director shall take into consideration the health care delivery resources of each health care service contractor. Each health care service contractor to which nongroup subscribers are allocated shall offer its existing individual or conversion coverage to nongroup subscribers, at rates determined in accordance with its existing rating methodology. A health care service contractor that does not offer direct nongroup enrollment may aggregate all of the allocated nongroup subscribers into one group for rating and coverage purposes. [1989 c.783 §2]

750.090 [Amended by 1967 c.359 §558; renumbered 744.405]

750.095 Requirements of contract between provider and subscriber; content. (1) For the purpose of this section only, and only in the event of a finding of impairment by the Director of the Department of Consumer and Business Services or of a final order of liquidation, as described in ORS 750.085, any covered health care service furnished within the state by a provider to a subscriber of a health care service contractor shall be considered to have been furnished pursuant to a contract between the provider and the health care service contractor with whom the subscriber was enrolled when the services were furnished.

(2) Each contract between a health care service contractor and a provider of health care services shall provide that if the health care service contractor fails to pay for covered health care services as set forth in the subscriber's evidence of coverage or contract, the subscriber is not liable to the provider for any amounts owed by the health care service contractor.

(3) If the contract between the contracting provider and the health care service contractor has not been reduced to writing or fails to contain the provisions required by subsection (2) of this section, the subscriber is not liable to the contracting provider for any amounts owed by the health care service contractor.

(4) No contracting provider or agent, trustee or assignee of the contracting provider may maintain a civil action against a subscriber to collect any amounts owed by the health care service contractor for which the subscriber is not liable to the contracting provider under this section.

(5) Nothing in this section impairs the right of a provider to charge, collect from, attempt to collect from or maintain a civil action against a subscriber for any of the following:

(a) Deductible, copayment or coinsurance amounts.

(b) Health care services not covered by the health care service contractor.

(c) Health care services rendered after the termination of the contract between the health care service contractor and the provider, unless the health care services were rendered during the confinement in an inpatient facility and the confinement began prior to the date of termination or unless the provider has assumed post-termination treatment obligations under the contract.

(6) Nothing in this section prohibits a subscriber from seeking noncovered health care services from a provider and accepting financial responsibility for these services.

(7) No health care service contractor shall limit the right of a provider of health care services to contract with the patient for payment of services not within the scope of the coverage offered by the health care service contractor. [1989 c.783 §3]

750.100 [Amended by 1967 c.359 §556; renumbered 744.385]

750.110 [Repealed by 1967 c.359 §704]

750.210 [Repealed by 1967 c.359 §704]

750.220 [Repealed by 1967 c.359 §704]

750.230 [Repealed by 1967 c.359 §704]

750.240 [Repealed by 1967 c.359 §704]

750.250 [Repealed by 1967 c.359 §704]

750.260 [Repealed by 1967 c.359 §704]

750.270 [Repealed by 1967 c.359 §704]

750.300 [1973 c.97 §3; repealed by 1989 c.331 §35]

MULTIPLE EMPLOYER WELFARE ARRANGEMENTS

750.301 Definitions for ORS 750.301 to 750.341. As used in ORS 750.301 to 750.341, "multiple employer welfare arrangement" has the meaning given that term in section 3 of

the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002. [1993 c.615 §2]

Note: 750.301 to 750.341 were added to and made a part of the Insurance Code by legislative action but were not added to ORS chapter 750 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

750.303 Conditions for use of multiple employer welfare arrangement; permitted coverage. (1) An association or group of employers shall not provide health benefits to employees of the association or employees of any of the employers through a multiple employer welfare arrangement in this state except as authorized by a subsisting certificate of multiple employer welfare arrangement issued by the Director of the Department of Consumer and Business Services.

(2) Only health benefits may be transacted through a multiple employer welfare arrangement. Health benefits may include benefits for disablement only if the benefits for disablement do not exceed $2,000 each year for each person covered by the disablement benefit.

(3) Life insurance or insurance for disablement other than benefits described in subsection (2) of this section, or both, may be provided through a multiple employer welfare arrangement only if the insurance benefits meet the following conditions:

(a) The insurance benefits must be fully insured through an authorized insurer.

(b) The insurance benefits must be ancillary to the health benefits being provided under subsection (2) of this section.

(4) ORS 750.301 to 750.341 do not apply to a multiple employer welfare arrangement that is fully insured within the meaning of section 514(b)(6) of the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1144(b)(6). [1993 c.615 §3]

Note: See note under 750.301.

750.305 Application for certificate. An association or group of employers seeking to provide health benefits through a multiple employer welfare arrangement must apply for a certificate of multiple employer welfare arrangement on a form prescribed by the Director of the Department of Consumer and Business Services. The application must be completed and submitted to the director along with all of the following:

(1) Copies of all articles, bylaws, agreements and other documents or instruments describing the rights and obligations of employers, employees and beneficiaries with respect to the multiple employer welfare arrangement.

(2) A copy of the trust agreement of the multiple employer welfare arrangement.

(3) Current financial statements of the multiple employer welfare arrangement on the basis of statutory accounting principles.

(4) Proof of a bond for the purpose and in the form and amount required by ORS 750.318.

(5) A statement showing in full detail the plan for offering health care benefits through the multiple employer welfare arrangement. The plan must show that the association or group of employers and the trust meet the requirements of ORS 750.307 and 750.309 and must show the procedure established for handling claims for benefits in the event of dissolution of the multiple employer welfare arrangement.

(6) Copies of all contracts or other instruments proposed to be made, offered or sold through the multiple employer welfare arrangement to its member employers, together with a copy of its plan description and the proposed printed matter to be used in the solicitation of member employers.

(7) Evidence that the multiple employer welfare arrangement has applications from five or more employers meeting the requirements of ORS 750.307 and will provide similar benefits for 200 or more participating employees.

(8) Proof of adequate reserves according to the requirements of ORS 750.315.

(9) Proof of deposit with the Department of Consumer and Business Services of the initial amount required under ORS 750.309 (4) as a guarantee of the due execution of the trust obligation. [1993 c.615 §4; 1999 c.196 §13]

Note: See note under 750.301.

750.307 Requirements for association or group. A trust carrying out a multiple employer welfare arrangement must be established and maintained by an association or group of employers meeting the following requirements:

(1) The association or group must be composed of five or more employers that are in the same trade or industry, including employers in closely related businesses that provide support, services or supplies primarily to that trade or industry.

(2) The association or group must be engaged in substantive activity for its members other than sponsorship of an employee welfare benefit plan.

(3) At the time of application for a certificate of multiple employer welfare arrangement, the association or group must have applications for participation in the multiple employer welfare arrangement from five or more employers and show that it will

provide similar benefits for 200 or more participating employees.

(4) The association or group must have been in existence as an association or group described in subsection (1) of this section for a period of not less than two years prior to the date of application for the certificate of multiple employer welfare arrangement.

(5) The association or group must establish and maintain an employee welfare benefit plan through the multiple employer welfare arrangement, and the plan must be controlled and sponsored directly by participating employers.

(6) The association or group must show that the annual gross contributions of the employee welfare benefit plan will be not less than $50,000 for a plan that provides only vision benefits, $175,000 for a plan that provides only dental benefits, and $450,000 for any other plan. [1993 c.615 §5]

Note: See note under 750.301.

750.309 Requirements for trust. The following requirements apply to the trust carrying out a multiple employer welfare arrangement:

(1) The trust must hold and maintain adequate facilities for purposes of the multiple employer welfare arrangement and either must have sufficient personnel to service the employee benefit plan or must contract with a third party administrator licensed under ORS chapter 744 as a third party administrator to provide such services. For purposes of satisfying the requirements of this subsection, the trust may use the premises, facilities and personnel of the association or group of employers and pay reasonable compensation to the association or group for such use.

(2) The trust must hold and maintain an excess loss insurance policy issued to the board of trustees in the name of the multiple employer welfare arrangement by an insurer authorized to transact casualty or health insurance in Oregon. Except as provided in this subsection, the policy must insure the multiple employer welfare arrangement against its liabilities for health benefits with regard to any one participant in excess of 10 percent of the capital and surplus of the trust. A trust may demonstrate to the Director of the Department of Consumer and Business Services that the trust is capable of supporting an exposure exceeding 10 percent of the capital and surplus of the trust. The trust may make such a demonstration only by means of a certification by a qualified actuary that the capital and surplus of the trust is sufficient to support the increased exposure. In any event, such a trust shall not have any exposure exceeding 15 percent of the capital and surplus of the trust. For purposes of this subsection, "participant" refers individually to each person benefited as a separate subject under the plan operated by the multiple employer welfare arrangement. The following also apply to a policy required under this subsection:

(a) The coverage must be evidenced by a binder or policy.

(b) The excess loss insurance policy must contain a provision that it may not be terminated for any reason by any person unless the Director of the Department of Consumer and Business Services receives a written notice of termination from the insurer at least 30 days before the effective date of the termination.

(c) If more than one policy is purchased, the expiration dates of all such policies must be the same.

(3) The trust must possess and thereafter maintain capital or surplus, or any combination thereof, of not less than $250,000 or an amount equal to 35 percent of incurred claims for the preceding 12-month period by the trust, whichever is greater. However, the required amount under this subsection may not be more than $500,000.

(4) As a guarantee of the due execution of the trust obligation under the benefit plan or plans to be entered into by the trust in accordance with ORS 750.301 to 750.341, the trust must make and maintain a deposit with the Department of Consumer and Business Services as provided in this subsection. The deposit required under this subsection is in addition to the capital and surplus or other amount required to be possessed and maintained by the trust under subsection (3) of this section and may not be included in or counted toward the required capital and surplus or other amount. The following provisions apply to the deposit:

(a) As a condition of obtaining a certificate of multiple employer welfare arrangement, a trust shall make an initial deposit in an amount that is the greater of $50,000 or the amount of the deposit required under paragraph (b) of this subsection.

(b) The amount of the deposit to be maintained under this subsection shall be the lesser of $250,000 or a current required amount calculated by determining the average monthly amount of claims paid by the trust during the preceding 12-month period and multiplying the average monthly amount by three. The current required amount of the deposit shall be calculated as of March 31, June 30, September 30 and December 31 of each calendar year.

(5) In lieu of the deposit required by subsection (4) of this section, a trust may file

and maintain a surety bond or such other bond or cash or securities in the sum of $250,000 as are authorized by the Insurance Code.

(6) A trust carrying out a multiple employer welfare arrangement that is established after January 1, 1993, shall maintain the deposit required under subsection (4) of this section during the first four calendar quarters described in subsection (4)(b) of this section following the issuance of its certificate of multiple employer welfare arrangement as provided in this subsection. At the beginning of the second, third and fourth calendar quarters after such a trust receives its certificate of multiple employer welfare arrangement, the current required amount of the deposit to be maintained by the trust shall be calculated by determining the average monthly amount of claims paid during the preceding quarter. Beginning with the fifth calendar quarter following the issuance of its certificate of multiple employer welfare arrangement, the trust shall maintain the deposit as provided in subsection (4) of this section. [1993 c.615 §6; 1999 c.196 §14]

Note: See note under 750.301.

750.310 [1973 c.97 §4; repealed by 1989 c.331 §35]

750.311 Multiple employer welfare arrangements established in another state. An association or group of employers may provide health benefits in this state through a multiple employer welfare arrangement established in another state if the association or group of employers first obtains a certificate of multiple employer welfare arrangement in this state. Such a multiple employer welfare arrangement is a foreign multiple employer welfare arrangement. If the state in which the principal place of business of the multiple employer welfare arrangement is located issues certificates or licenses authorizing multiple employer welfare arrangements to transact insurance or provide health benefits, the foreign multiple employer welfare arrangement must show in its application that it is authorized to transact insurance or provide health benefits in that state. [1993 c.615 §7]

Note: See note under 750.301.

750.313 Issuance or refusal of certificate of multiple employer welfare arrangement. (1) The Director of the Department of Consumer and Business Services shall issue a certificate of multiple employer welfare arrangement to a multiple employer welfare arrangement by and through its board of trustees if, upon completion of the application for the certificate and upon investigation and review of all information acquired by the director, the director does all of the following:

(a) Approves the application for the certificate.

(b) Determines that the person applying for the certificate satisfies the requirements in ORS 750.305, 750.307 and 750.309 for qualifying for and holding a certificate of multiple employer welfare arrangement and satisfies all other applicable requirements in the Insurance Code.

(2) The director shall take all necessary action and shall either issue or refuse to issue a certificate within a reasonable time after the completion of the application for the certificate. [1993 c.615 §8]

Note: See note under 750.301.

750.315 Maintenance of reserves; actuarial opinion; rules. (1) For purposes of carrying out a multiple employer welfare arrangement, a trust shall maintain adequate reserves. Reserves must be held in cash or obligations guaranteed by the United States or invested in a registered investment company and invested exclusively in cash or obligations guaranteed by the United States. Reserves must be calculated with proper actuarial calculations of all of the following:

(a) Known claims, paid and outstanding.

(b) A history of incurred but not reported claims.

(c) Claims handling expenses.

(d) Unearned contributions.

(e) An estimate for bad debts.

(f) A trend factor.

(2) Each multiple employer welfare arrangement shall submit annually to the Director of the Department of Consumer and Business Services an opinion of a qualified actuary as provided in this subsection. The opinion shall determine the adequacy of reserves of the multiple employer welfare arrangement. The director by rule shall adopt requirements for the actuarial opinion and standards on which the opinion must be based. In adopting the standards, the director shall consider standards established by the National Association of Insurance Commissioners in its instructions for annual statements. The director by rule shall also define "qualified actuary" for purposes of this subsection by establishing qualifications required of an actuary for the purpose of giving the opinion. In establishing the definition, the director shall consider standards established from time to time by the American Academy of Actuaries. [1993 c.615 §9; 1995 c.166 §1]

Note: See note under 750.301.

750.317 Board of trustees. (1) The powers of a multiple employer welfare arrangement, except as otherwise provided, must be exercised by a board of trustees chosen to

carry out the purposes of the trust agreement. At least 50 percent of the trustees shall be persons who are covered under the multiple employer welfare arrangement. A trustee may not be an owner, officer or employee of a third party administrator who is licensed pursuant to ORS 744.700 to 744.740 and provides services to a multiple employer welfare arrangement.

(2) The trustees must give the attention and must exercise the vigilance, diligence, care and skill that prudent persons use in like or similar circumstances. Trustees are responsible for all operations of the multiple employer welfare arrangement and must take all necessary precautions to safeguard its assets. [1993 c.615 §10]

Note: See note under 750.301.

750.318 Officers and persons appointed to act on behalf of board; bond. (1) The board of trustees of a trust carrying out a multiple employer welfare arrangement shall select officers as designated in the articles or bylaws and may appoint persons to act on behalf of the board as the board determines to be necessary for transacting the business of the multiple employer welfare arrangement.

(2) Officers and persons appointed to act on behalf of the board have such authority and may perform such duties in the management of the property and affairs of the trust as may be delegated by the board of trustees.

(3) The board of trustees by bond must secure the fidelity of all officers and persons appointed to act on behalf of the board who handle the funds of the trust. The amount of the bond shall be determined annually. The requirement of this subsection may be satisfied by either of the following, whichever is the greater amount:

(a) By a bond in the amount required by the Director of the Department of Consumer and Business Services for an authorized insurer. To establish the amount, the director shall consider the formula established in the examiner's handbook of the National Association of Insurance Commissioners.

(b) By compliance with the bonding requirements set forth in the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1002, applicable to all fiduciaries as defined therein. [1993 c.615 §11]

Note: See note under 750.301.

750.319 Salaries; other compensation. (1) The trust carrying out a multiple employer welfare arrangement may not pay any salary, compensation or emolument to any officer or trustee of the trust unless the payment is first authorized by a majority vote of the board of trustees.

(2) The compensation of any trustee or officer may not be unreasonable and may not be calculated, directly or indirectly, as a percentage of contributions collected. [1993 c.615 §12]

Note: See note under 750.301.

750.320 [1973 c.97 §5; repealed by 1989 c.331 §35]

750.321 Assessment; maintenance of capital and surplus. (1) Benefit plans issued by a trust must provide for a charge or deposit payable in cash and, except as provided in this section, for an assessment against member employers for purposes of subsection (2) of this section at least equal to one month's contribution by the employer. The assessment may be prefunded. A member employer may not be liable under this subsection for an amount greater than the charge or deposit required in the plan.

(2) If at any time the capital and surplus of the trust are less than the requirement of ORS 750.309, the trust must immediately collect from member employers upon each plan a sufficient proportionate part of the amount assessable under subsection (1) of this section to restore the amount of capital and surplus required. An assessment of an employer under this subsection may not exceed the amount provided in the plan for an assessment for purposes of this subsection.

(3) In addition to assessments that may be collected under subsection (2) of this section, in the event of liquidation of a multiple employer welfare arrangement trust, the Director of the Department of Consumer and Business Services, acting in the capacity of receiver, may assess member employers an amount necessary to pay outstanding claims and costs necessary to administer the liquidation proceedings. An assessment of an employer under this subsection may not exceed the amount of one month's contribution by the employer.

(4) A member employer of an association or group shall not be liable for any part of an assessment imposed under subsection (2) or (3) of this section in excess of the amount demanded within one year after the termination of the member employer's participation in the plan. [1993 c.615 §13; 2001 c.318 §18]

Note: See note under 750.301.

750.323 Notice of coverage under plan. (1) A trust shall provide notice of the following in writing to each individual applying to be covered by a multiple employer welfare arrangement:

(a) The fact that the multiple employer welfare arrangement is subject to less stringent solvency protection and regulation than are insurers holding certificates of authority.

(b) The fact that in the event the trust does not pay medical expenses that are eligi-

ble for payment under the multiple employer welfare arrangement, the individuals covered through the multiple employer welfare arrangement may be liable for those expenses.

(2) Each evidence of health benefits provided through a multiple employer welfare arrangement must state that the coverage is obtained through a multiple employer welfare arrangement and that the coverage is not subject to the provisions of ORS 734.750 to 734.890 relating to the Oregon Life and Health Insurance Guaranty Association, and that if the multiple employer welfare arrangement or the trust issuing the coverage becomes insolvent, the Oregon Life and Health Insurance Guaranty Association has no obligation to pay claims under the coverage.

(3) The notice required under subsection (1) of this section and the statement required under subsection (2) of this section are subject to prior review and approval by the Director of the Department of Consumer and Business Services. [1993 c.615 §14]

Note: See note under 750.301.

750.325 Filings by trust. (1) Each multiple employer welfare arrangement holding a certificate of multiple employer welfare arrangement must file an annual financial statement with the Director of the Department of Consumer and Business Services. The statement must conform to the requirements of ORS 731.574 applicable to annual statements filed by insurers. The director may request additional filings as the director determines necessary.

(2) Each annual financial statement filed under subsection (1) of this section must be audited by a certified public accountant according to the requirements of ORS 731.488 and rules adopted thereunder.

(3) An actuarial opinion regarding reserves for known claims and associated expenses and incurred but not reported claims and associated expenses must be included with the audited annual statement.

(4) Not later than the 45th day after the end of each calendar quarter, each trust holding a certificate of multiple employer welfare arrangement must file with the director:

(a) An unaudited financial statement, affirmed by an appropriate officer of the trust or a representative authorized by the trust to make such an affirmation.

(b) A report certifying that the trust maintains reserves according to the requirements of ORS 750.315 that are sufficient to meet its contractual obligations, and that the trust maintains a policy for excess loss insurance issued by an insurer authorized to do business in this state. [1993 c.615 §15]

Note: See note under 750.301.

750.327 Examinations. A multiple employer welfare arrangement and its board of trustees and each administrator, insurer or trustee related to the trust or multiple employer welfare arrangement are subject to investigation and examination in the same manner and to the same extent as an insurer under ORS 731.296 to 731.316. [1993 c.615 §16]

Note: See note under 750.301.

750.329 Taxation. (1) A multiple employer welfare arrangement is subject to taxation to the same extent and in the same manner as an insurer transacting health insurance in this state.

(2) For purposes of this section, contributions received by a trust for a multiple employer welfare arrangement shall be considered to be premiums received for insurance. [1993 c.615 §17; 1995 c.786 §11]

Note: See note under 750.301.

750.330 [1973 c.97 §7; 1989 c.331 §26; renumbered 750.655 in 1989]

750.331 Prohibited activities for trustee or officer. In addition to limitations and restrictions imposed by the federal Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. 1001 et seq., on trustees or officers in their capacity as fiduciaries, a trustee or officer of a trust carrying out a multiple employer welfare arrangement shall not do any of the following:

(1) Receive directly or indirectly any payment for negotiating, procuring, recommending or aiding in:

(a) Any purchase by or sale to the trust; or

(b) Any loan from the trust.

(2) Be pecuniarily interested, as principal, coprincipal, agent or beneficiary, in a purchase, sale or loan described in subsection (1) of this section. [1993 c.615 §18]

Note: See note under 750.301.

750.333 Applicable provisions of Insurance Code. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 to 731.992.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.691, 743.693, 743.694, 743.699, 743.727, 743.728, 743.730 to 743.773 (except 743.760 to 743.773), 743.793, 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863 and 743.864.

(f) ORS 743.556, 743.701, 743.703, 743.706, 743.707, 743.709, 743.710, 743.712, 743.713, 743.714, 743.717, 743.718, 743.719, 743.721, 743.722, 743.725 and 743.726. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance. [1993 c.615 §19; 1995 c.506 §4; 1995 c.603 §30; 1995 c.669 §4; 1995 c.672 §9; 1997 c.343 §23; 1997 c.496 §5; 1997 c.759 §6; 1999 c.428 §§7,8; 1999 c.429 §§3,4; 1999 c.633 §§9,10; 1999 c.749 §§6,7; 1999 c.987 §§25,26; 2001 c.266 §17; 2001 c.742 §5; 2003 c.87 §25; 2003 c.91 §6; 2003 c.363 §15; 2003 c.364 §170; 2003 c.748 §4]

Note 1: The amendments to 750.333 by section 4, chapter 263, Oregon Laws 2003, become operative July 3, 2009. See section 5, chapter 263, Oregon Laws 2003. The text that is operative from July 3, 2009, until October 4, 2009, is set forth for the user's convenience.

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 to 731.992.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.691, 743.693, 743.694, 743.699, 743.727, 743.728, 743.730 to 743.773 (except 743.760 to 743.773), 743.793, 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863 and 743.864.

(f) ORS 743.556, 743.701, 743.703, 743.706, 743.707, 743.709, 743.710, 743.712, 743.713, 743.714, 743.717, 743.718, 743.719, 743.721, 743.722 and 743.725. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

Note 2: The amendments to 750.333 by section 8, chapter 137, Oregon Laws 2003, and section 3, chapter 446, Oregon Laws 2003, become operative October 4, 2009. See section 9, chapter 137, Oregon Laws 2003, and section 4, chapter 446, Oregon Laws 2003. The text that is operative on and after October 4, 2009, is set forth for the user's convenience.

750.333. (1) The following provisions of the Insurance Code apply to trusts carrying out a multiple employer welfare arrangement:

(a) ORS 731.004 to 731.150, 731.162, 731.216 to 731.268, 731.296 to 731.316, 731.324, 731.328, 731.378, 731.386, 731.390, 731.398, 731.406, 731.410, 731.414, 731.418 to 731.434, 731.454, 731.484, 731.486, 731.488, 731.512, 731.574 to 731.620, 731.640 to 731.652, 731.804 to 731.992.

(b) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.695 to 733.780.

(c) ORS chapter 734.

(d) ORS 742.001 to 742.009, 742.013, 742.061 and 742.400.

(e) ORS 743.028, 743.053, 743.524, 743.526, 743.527, 743.528, 743.529, 743.530, 743.560, 743.562, 743.600, 743.601, 743.602, 743.610, 743.691, 743.693, 743.694, 743.727, 743.728, 743.730 to 743.773 (except 743.760 to 743.773), 743.793, 743.801, 743.804, 743.807, 743.808, 743.814 to 743.839, 743.842, 743.845, 743.847, 743.854, 743.856, 743.857, 743.858, 743.859, 743.861, 743.862, 743.863 and 743.864.

(f) ORS 743.556, 743.701, 743.703, 743.706, 743.707, 743.709, 743.710, 743.712, 743.713, 743.714, 743.717, 743.718, 743.719, 743.721 and 743.722. Multiple employer welfare arrangements to which ORS 743.730 to 743.773 apply are subject to the sections referred to in this paragraph only as provided in ORS 743.730 to 743.773.

(g) Provisions of ORS chapter 744 relating to the regulation of insurance producers and insurance consultants, and ORS 744.700 to 744.740.

(h) ORS 746.005 to 746.140, 746.160 and 746.220 to 746.370.

(i) ORS 731.592 and 731.594.

(2) For the purposes of this section:

(a) A trust carrying out a multiple employer welfare arrangement shall be considered an insurer.

(b) References to certificates of authority shall be considered references to certificates of multiple employer welfare arrangement.

(c) Contributions shall be considered premiums.

(3) The provision of health benefits under ORS 750.301 to 750.341 shall be considered to be the transaction of health insurance.

Note 3: See note under 750.301.

750.335 Delinquency proceedings. The Director of the Department of Consumer and Business Services may initiate and carry out supervision and delinquency proceedings against a trust carrying out a multiple employer welfare arrangement in the same manner as provided with regard to insurers under ORS chapter 734. [1993 c.615 §20]

Note: See note under 750.301.

750.337 Exclusion from membership in guaranty funds, joint underwriting associations and other pools. (1) A trust carrying out a multiple employer welfare arrangement may not be permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this state. Neither such a trust nor its insureds may receive any benefit from any such fund for claims arising out of the operations of the multiple employer welfare arrangement.

(2) A trust carrying out a multiple employer welfare arrangement may not participate in any joint underwriting association or mandatory liability pool established under the laws of this state. [1993 c.615 §21; 1995 c.603 §39]

Note: See note under 750.301.

750.339 Liability of excess loss insurer. An insurer who provides excess loss insurance under ORS 750.309 to a multiple employer welfare arrangement that is offering or providing health benefits in this state without a certificate of multiple employer welfare arrangement or to employers or employees participating in such a multiple employer welfare arrangement shall be liable for any unpaid claims of the multiple employer welfare arrangement. [1993 c.615 §22]

Note: See note under 750.301.

750.340 [1973 c.97 §6; 1975 c.769 §9; 1989 c.331 §27; renumbered 750.705 in 1989]

750.341 Requirement for multiple employer welfare arrangement to become traditional insurer. A trust carrying out a multiple employer welfare arrangement shall not provide coverage to more than 20,000 lives unless the trust first obtains a certificate of authority as an insurer in this state. [1993 c.615 §23]

Note: See note under 750.301.

LEGAL EXPENSE ORGANIZATIONS

750.505 Definitions for ORS 750.505 to 750.715. As used in ORS 750.505 to 750.715:

(1) "Legal expense organization" or "organization" means any person or group of persons who provide or offer to provide a legal expense plan, including any person who acts as its administrator.

(2) "Legal expense plan" or "plan" means the agreement between an organization and a person or a group of persons whereby legal services are to be provided to the person or group of persons as members, or whereby the persons as members are to be reimbursed for charges incurred for legal services, in consideration of a specified payment.

(3) "Member" means a person who is eligible to receive legal services under a legal expense plan.

(4) "Membership agreement" means the written evidence of coverage of a member under a plan between an organization and members.

(5) "Provider agreement" means a written contract or agreement between an organization and a providing attorney for the rendering of legal services to a member or group of persons.

(6) "Providing attorney" means any attorney licensed and in good standing in this state who provides legal services pursuant to the membership agreement.

(7) "Sales or marketing representative" means any person who markets or solicits members for or on behalf of a plan. [1989 c.331 §2]

750.515 Certificate of registration required. A person shall not transact business as a legal expense organization or otherwise offer, provide, market or do business on behalf of a plan unless the person holds a valid certificate of registration as a legal expense organization. [1989 c.331 §3]

750.525 Inapplicability of ORS 750.505 to 750.715 to certain legal services. ORS 750.505 to 750.715 do not apply to the following arrangements:

(1) Retainer contracts made by an attorney or firm of attorneys with a specific individual, pursuant to which fees are based on reasonable estimates of the nature and amount of services to be provided, and similar contracts made by an attorney or firm of attorneys with a group of clients involved in the same or closely related legal matters.

(2) Any two-party agreement providing for the delivery of specified legal services in return for a specified payment including an administrative fee, whereby an arrangement is made between an attorney or firm of attorneys and a group of individuals who are

all members of the same bona fide nonprofit membership organization or group of individuals who are all employed by the same employer, the primary purpose of which is other than the provision of legal services. Such groups of individuals may be but are not limited to churches, trade groups, credit unions or associations. Under such an arrangement no third party such as a legal expense organization or sales or marketing representative may be involved in receiving any of the specified payments or in overseeing the delivery of the specified legal services.

(3) Referral of individual clients to an attorney to the extent that such referral is provided by a nonprofit lawyer referral service or public corporation such as a state or local bar association, so long as there is no charge for such referral.

(4) Employee welfare benefit plans to the extent that state regulation is preempted by Section 514 of the federal Employee Retirement Income Security Act of 1974, or successor legislation.

(5) Legal assistance plans financed primarily by public funds, interest on lawyers trust accounts funds under the regulation of the Oregon State Bar or other public service funds.

(6) Authorized insurers offering legal expense insurance in this state. [1989 c.331 §4]

750.535 Registration requirements. An applicant for registration as a legal expense organization must do all of the following in order to obtain registration:

(1) Apply for the registration under ORS 750.545.

(2) File with the Director of the Department of Consumer and Business Services in writing the address, including street and number, and mailing address, if different, of the organization's initial registered office and the name of its initial registered agent at that office.

(3) Meet the following qualifications:

(a) The applicant must be financially responsible and the organization able to meet its obligations to its members.

(b) The directors, officers or managers of the organization must be competent, trustworthy and experienced managerially, as determined by the director after investigation or upon receipt of reliable information. [1989 c.331 §5]

750.545 Application; fee. (1) An applicant for a certificate of registration shall apply to the Director of the Department of Consumer and Business Services on a form prescribed by the director. The application shall be accompanied by the applicable fee established by the director.

(2) An application shall include the following information:

(a) The applicant's name and the address of the principal office of the organization.

(b) Whether the applicant or any of its directors, officers or managers has ever been convicted of or is under indictment for a crime, has ever had a judgment entered against it or any of them for fraud, and whether any license to act as an insurance producer or in any other occupational or professional capacity has ever been refused, revoked or suspended in this or any other state with respect to the applicant or any of its directors, officers or managers.

(c) A statement of the financial condition of the applicant or of the organization. The statement must be in a form satisfactory to the director and verified by an official of the organization.

(d) Any other information required by the director. [1989 c.331 §6; 1991 c.67 §203; 1991 c.401 §11; 2003 c.364 §171]

750.555 Issuance of certificate of registration. (1) If the Director of the Department of Consumer and Business Services determines that an applicant has satisfied all requirements of ORS 750.535 and 750.545, the director shall issue the certificate of registration to the applicant.

(2) If the director denies a registration application, the director shall so inform the applicant, stating the grounds for the denial. [1989 c.331 §7]

750.565 Duration of certificate; renewal; fee. (1) A certificate of registration of a legal expense organization is effective for one year from the date of issue.

(2) A legal expense organization may renew its certificate of registration by paying the applicable fee established by the Director of the Department of Consumer and Business Services. [1989 c.331 §8; 1991 c.401 §12]

750.575 Grounds for suspension or revocation of certificate or refusal to issue or renew certificate. (1) The Director of the Department of Consumer and Business Services may suspend, revoke, refuse to issue or refuse to renew a certificate of registration for any one or any combination of the following reasons:

(a) Fraud or deceit in obtaining or applying for the certificate.

(b) Dishonesty, fraud or gross negligence in the transaction of insurance.

(c) Conduct resulting in a conviction of a felony under the laws of any state or of the United States, to the extent that such conduct may be considered under ORS 670.280.

(d) Conviction of any crime, an essential element of which is dishonesty or fraud, under the laws of any state or of the United States.

(e) Refusal to renew or cancellation, revocation or suspension of authority to transact insurance or business as a legal expense organization or similar entity in another state.

(f) Failure to pay a civil penalty imposed by final order of the director.

(2) An organization holding a certificate that has not been renewed or has been revoked shall surrender the certificate to the director at the director's request.

(3) The director may suspend or refuse to renew a certificate immediately and without hearing pursuant to ORS 183.430 if the facts giving rise to such action demonstrate the organization to be a serious danger to the public's safety, or untrustworthy to maintain the certificate.

(4) Except as provided in subsection (3) of this section, the director may suspend, revoke, refuse to renew or refuse to issue a certificate of registration only after giving an opportunity for a hearing pursuant to ORS chapter 183. [1989 c.331 §9]

750.585 Written provider agreement with providing attorney. An organization shall not operate or offer a plan in this state unless the organization first enters into a written provider agreement with the providing attorney or attorneys. The following provisions apply to such an agreement:

(1) A provider agreement shall not contain any provision that allows the providing attorney to seek payment from a member, other than any copayments and deductibles scheduled in the agreement, in the event of nonpayment by the organization for any services that have been performed under the plan by the providing attorney; and

(2) A provider agreement shall contain a guarantee that the providing attorney will furnish plan services to plan members whether or not the providing attorney has been or will be paid under the plan. Provider agreements shall require providing attorneys to give plan members the full benefit of plan membership until the member leaves the plan or until the anniversary date of the date the plan member joined the plan, whichever comes first. [1989 c.331 §10]

750.595 Membership agreement. An organization must provide a membership agreement to each member of a group that is a party to a legal expense plan. Each membership agreement shall contain at least the following:

(1) A listing and clear description of the legal services promised or for which expenses are to be reimbursed and a clear explanation of the limits of the services.

(2) The copayments, deductibles or fees, if any, that the member is required to pay.

(3) The name and address of the principal place of business of the legal expense organization offering the plan.

(4) If the plan offers a limited choice of providing attorneys, a mechanism for providing the services of an alternate attorney in case representation by the designated providing attorney would be improper, unethical or impractical under the circumstances.

(5) A provision for review for settling disagreements about the grounds for demanding an alternative attorney or any benefit.

(6) All criteria by which a member may be denied renewal of membership. [1989 c.331 §11]

750.605 Unfair, discriminatory or misleading provisions in agreements prohibited; record of transactions. (1) No provider agreement or membership agreement may contain provisions that are unfair, discriminatory or misleading, that encourage misrepresentation or misunderstandings of the agreement, that might endanger the solvency of the plan or legal expense organization or that are contrary to law.

(2) For the duration of each written membership and provider agreement and for six years following its termination, a legal expense organization shall maintain at its principal administrative office adequate books and records of all transactions between the plan and the providing attorneys, and adequate books and records of all transactions between the plan and members thereof. The Director of the Department of Consumer and Business Services shall have reasonable access to the books and records so long as access does not violate or conflict with the attorney-client privilege recognized under the laws of the State of Oregon. [1989 c.331 §13]

750.615 Deposit to reimburse members for unearned premiums required. An organization shall deposit in an account that is maintained separately from operating funds an amount reasonably calculated to reimburse plan members for unearned premiums. The organization shall hold the amount in a fiduciary capacity. Records shall be kept of all deposits and receipts for a period of not less than six years. [1989 c.331 §14]

750.625 Paying providing attorney contingent on claims experience prohibited. Compensation paid to a providing attorney shall not be contingent on claims

experience. This section does not prevent the compensation of a providing attorney from being based on membership fees collected or the number of claims paid or processed, nor does it prevent a providing attorney from sharing in a fund based on services performed. [1989 c.331 §15]

750.635 Registered agent and registered office in state required. (1) Each organization shall continuously maintain in this state a registered agent and registered office that may be, but need not be, the same as any of its places of business.

(2) A registered agent shall be:

(a) An individual who resides in this state and whose business office is identical to the registered office;

(b) A domestic corporation or domestic nonprofit corporation whose business office is identical to the registered office; or

(c) A foreign corporation or foreign nonprofit corporation authorized to transact business in this state whose business office is identical to the registered office.

(3) The Director of the Department of Consumer and Business Services shall be an agent of an organization upon whom process may be served whenever the organization fails to appoint or maintain a registered agent in this state or whenever the registered agent of the organization cannot with reasonable diligence be found at the registered office. [1989 c.331 §16; 2001 c.315 §57]

750.645 Annual report; content; names of sales and marketing representatives to be submitted. (1) Each organization shall provide annually to the Director of the Department of Consumer and Business Services in as much detail as the director may require:

(a) A verified financial statement detailing the legal expense organization's assets, liabilities, unearned premium reserve, loss records and such other items as the director may require so long as such reporting does not violate or conflict with the attorney-client privilege recognized under the laws of the State of Oregon; and

(b) A list of the names and addresses of the organization's providing attorneys.

(2) Every legal expense organization shall submit to the director the names of its sales and marketing representatives and their addresses not later than January 1 and July 1 of each year. [1989 c.331 §§17,18]

750.655 Filing schedule of legal service rates required. A legal expense organization shall file with the Director of the Department of Consumer and Business Services all schedules and tables of premium rates for legal service to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables. [Formerly 750.330]

750.675 Filing of provider and membership agreement with director. An organization shall file with the Director of the Department of Consumer and Business Services a copy of the current membership agreement forms and the current provider agreement forms used by the organization, and a schedule of the rates charged its members. An organization shall file any material change in the provider agreement or membership agreement with the director prior to use. [1989 c.331 §12]

750.685 Indemnification insurance or bond required. (1) Except as otherwise provided in this section, no legal expense plan shall be issued, sold or offered for sale in this state unless the organization offering the plan is insured under an insurance contract that provides indemnification for the services under the plan, or reimbursement for services performed under a service contract, in the event of default of the organization. Any such insurance shall be issued only by an insurer authorized to do business in this state.

(2) Instead of holding insurance under subsection (1) of this section, an organization offering an access plan described in subsection (5) of this section may post a bond or provide evidence of deposit pursuant to this subsection. The bond or other deposit is to be held in trust to the Director of the Department of Consumer and Business Services for the protection of members of the plan and other affected persons. The initial security bond or other deposit required for an access plan for at least the first full year of operation shall be in the amount of $10,000. The amount of deposit shall be adjusted annually and shall be in an amount equal to 10 percent of the gross written prepaid fees collected from plan members in the preceding calendar year, to a maximum of $50,000. The bond or other deposit is to be held in a bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation or in a savings and loan association insured by the Federal Deposit Insurance Corporation.

(3) Instead of holding insurance under subsection (1) of this section, an organization offering a comprehensive plan described in subsection (5) of this section may post a bond or provide evidence of deposit pursuant to this subsection. The bond or other deposit is to be held in trust to the director for the protection of members of the plan and other affected persons. The initial security bond or other deposit required for a comprehensive plan for at least the first full year of opera-

tion shall be in the amount of $25,000. The amount of deposit shall be adjusted annually and shall be in an amount equal to 10 percent of the gross written prepaid fees collected from plan members in the preceding calendar year, to a maximum of $100,000. The bond or other deposit is to be held in a bank authorized to do business in this state and insured by the Federal Deposit Insurance Corporation or in a savings and loan association insured by the Federal Deposit Insurance Corporation.

(4) Property used as security shall be held in trust and shall remain unencumbered, and shall have at all times a market value of at least 95 percent of the amount specified. Any bond issued in lieu of security shall be cancelable only upon 30 days' advance written notice filed with the director. Securities or bonds deposited pursuant to this section shall be for the benefit of and subject to action thereon in the event of insolvency of the plan by any person sustaining actionable injury due to failure of the organization to faithfully perform its obligations to its members.

(5) For purposes of this section:

(a) "Access plan" means a plan that provides legal advice or consultation on legal matters that can be reasonably handled over the phone or by a limited review of routine legal documents.

(b) "Comprehensive plan" means a plan that provides legal advice and consultation regarding more complex or time-consuming matters and may include advice and representation in and regarding administrative and civil or criminal judicial proceedings. [1989 c.331 §19; 1999 c.107 §18]

750.695 ORS 750.505 to 750.715 not to affect regulation of practice of law; plan not subject to Insurance Code. (1) ORS 750.505 to 750.715 do not affect the regulation of the practice of law.

(2) Except as provided in ORS 750.505 to 750.715, legal expense plans are not subject to the Insurance Code. [1989 c.331 §20]

750.705 Application of Insurance Code. (1) The following provisions of the Insurance Code apply to legal expense organizations to the extent so applicable and not inconsistent with the express provisions of ORS 750.505 to 750.715:

(a) ORS 731.004 to 731.026, 731.036 to 731.150, 731.158, 731.216 to 731.362, 731.385, 731.386, 731.398 to 731.430, 731.450, 731.454, 731.504, 731.508, 731.509, 731.510, 731.511, 731.512, 731.640 to 731.652, 731.730, 731.731, 731.735, 731.737, 731.804 and 731.844 to 731.992.

(b) ORS 732.230, 732.245, 732.250, 732.320, 732.325 and 732.517 to 732.546.

(c) ORS 733.010 to 733.050, 733.140 to 733.170, 733.210, 733.510 to 733.680 and 733.710 to 733.780.

(d) ORS 737.205, 737.215, 737.225, 737.235 to 737.340 and 737.505.

(e) ORS 742.001 to 742.009, 742.013 to 742.056 and 742.061.

(f) ORS 746.005 to 746.045, 746.065, 746.075, 746.100 to 746.130, 746.160 and 746.230 to 746.370.

(2) For the purposes of this section only, legal expense organizations shall be considered insurers. [Formerly 750.340; 1993 c.447 §119; 1995 c.79 §366; 2003 c.802 §178]

750.715 Rulemaking authority of director. The Director of the Department of Consumer and Business Services may make rules in order to carry out ORS 750.505 to 750.715. [1989 c.331 §21]