

Chapter 743

1991 EDITION

Health and Life Insurance Policies

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GENERAL PROVISIONS

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

743.006 [Formerly 736.300; renumbered 742.003 in 1989]

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

743.010 Director to adopt rules with respect to certain health insurance policy forms. (1) In addition to all other powers of the director with respect thereto, the director may issue rules with respect to policy forms described in ORS 742.005 (6)(a) and (b):

(a) Establishing minimum benefit standards;

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

(c) Establishing requirements intended to discourage duplication or overlapping of coverage and replacement, without regard to the advantage to policyholders, of existing policies by new policies.

(2) The director shall issue rules pursuant to subsection (1) of this section with respect to policy forms marketed as supplements to federal Medicare benefits, and such rules shall provide for a minimum loss ratio of 60 percent. [1979 c.857 §2]

743.011 [1985 c.827 §2; repealed by 1989 c.255 §15]

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

743.013 Disclosure of differences in replacement health insurance policies; nonduplication for persons 65 and older.

(1) The Director of the Department of Insurance and Finance shall adopt by rule requirements for disclosure by group and individual health insurers to individual and group health insurance policyholders the difference between coverage under the existing policy and coverage being offered to replace that coverage.

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

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

743.015 Filing and approval of credit life and credit health insurance forms;

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

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

(3) If such a group policy of credit life or credit health insurance has been or is delivered in another state the insurer shall be required to file only the group certificate, the individual application and notice of proposed insurance delivered or issued for delivery in this state as specified in ORS 743.377 (2) and (4), and such forms shall be approved by the director if they conform with the requirements specified in such subsections and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates filed with the director. [Formerly 739.595; 1969 c.336 §12; 1971 c.231 §20]

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

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

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

an insurable interest in the individual insured.

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

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

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

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

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

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

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

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

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

743.030 Life insurance for benefit of charity. (1) Life insurance policies may be effected although the person paying the con-

sideration has no insurable interest in the life of the person insured if a charitable, benevolent, educational or religious institution is designated irrevocably as the beneficiary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) The insured under any policy within this section shall not be denied the right to

change the beneficiary when such right is expressly reserved in the policy.

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

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

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

743.048 [Formerly 736.315; renumbered 742.010]

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

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

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

(c) If the total benefits presently due and payable to any annuitant under all annuity policies under which the person is an annuitant shall at any time exceed payment at the rate of \$500 per month, the court may order such annuitant to pay to a judgment

creditor or apply on the judgment, in installments, the portion of such excess benefits as to the court may appear just and proper, after due regard for the reasonable requirements of the judgment debtor and family, if dependent upon the judgment debtor, as well as any payments required to be made by the annuitant to other creditors under prior court orders.

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

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

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

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

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

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

743.055 Prohibition on denial or limitation of benefits to insured or dependent who is eligible for or receives medical assistance. No individual, franchise, group or blanket health certificate or policy and no stop-loss or excess insurance issued in relation to a plan of a self-insured employer shall contain any provision which denies, limits or reduces benefits because services are rendered to an insured or dependent who is eligible for or who receives medical assistance under ORS chapter 411 or 414. [1991 c.875 §2]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

743.099 [Formerly 739.405; renumbered 743.046 in 1989]

POLICY LANGUAGE SIMPLIFICATION

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

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

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

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

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

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

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

(b) Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit health insurance policy. How-

ever, this paragraph shall not exempt any certificate issued pursuant to a group policy.

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

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

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

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

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

743.106 [1967 c.359 §368; renumbered 743.049 in 1989]

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

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

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

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

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

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

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

entire form. The samples shall be separated by at least 20 printed lines.

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

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

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

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

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

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

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

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

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

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

(3) Any other reading test may be approved by the director as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

(4) Each policy filing shall be accompanied by a certificate signed by an officer of the insurer stating that the policy meets the minimum required reading ease score on the test used, or stating that the score is lower than the minimum required but should be

authorized in accordance with ORS 743.107. To confirm the accuracy of a certification, the director may require the submission of further information.

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

743.107 Director may authorize lower reading ease standards; conditions. The director may authorize a lower score than the Flesch reading ease test score required by ORS 743.106 when, in the director's sole discretion, the director finds that a lower required score:

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

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

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

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

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

743.111 [Formerly 744.090; renumbered 742.058 in 1989]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

INDIVIDUAL LIFE INSURANCE AND ANNUITIES

(Generally)

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

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

743.154 Acceleration of death benefits.

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

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

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

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

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

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

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

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

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

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

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

(C) End-stage renal failure; or

(D) Acquired Immune Deficiency Syndrome.

(e) Any other event determined by the director to be life-threatening.

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

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

(b) May not require an insured to request payment, subject to loss of the accelerated benefits, prior to death.

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

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

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

(Individual Life Insurance Policies)

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

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

743.165 Grace period. A life insurance policy shall contain a provision that a grace period of 30 days, or, at the option of the insurer, of one month of not less than 30 days, or of four weeks in the case of industrial life insurance policies the premiums for which are payable more frequently than monthly, shall be allowed within which the payment of any premium after the first may

be made, during which period of grace the policy shall continue in full force. The insurer may impose an interest charge not in excess of six percent per annum for the number of days of grace elapsing before the payment of the premium. If a claim arises under the policy during such period of grace the amount of any premium due or overdue, together with interest and any deferred installment of the annual premium, may be deducted from the policy proceeds. [1967 c.359 §377]

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

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

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

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

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

743.177 Statements of insured. A life insurance policy shall contain a provision that all statements made by or on behalf of the insured shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in

defense of a claim under the policy unless contained in a written application and unless a copy of such application is indorsed upon or attached to the policy when issued. [1967 c.359 §381]

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

743.183 Dividends. (1) A life insurance policy other than a nonparticipating policy shall contain a provision that the policy shall participate in the divisible surplus of the insurer annually, beginning not later than the end of the third policy year. Any policy containing provision for participation beginning at the end of the first or the second policy year may provide that dividends for either or both of such years shall be paid subject to the payment of the premium for the next ensuing year. The owner of the policy shall have the right each year to have the dividend arising from such participation paid in cash, and if the policy provides other dividend options, it shall further provide which dividend option is effective if the owner does not elect one of such options on or before the expiration of the period of grace allowed for the payment of the premium.

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

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

743.186 Policy loan. (1) A life insurance policy shall contain a provision that after three full years' premiums have been paid and after the policy has a cash surrender value and while no premium is in default beyond the grace period for payment, the insurer will advance, on proper assignment or pledge of the policy and on the sole security thereof, an amount equal to or, at the

option of the party entitled thereto, less than the loan value of the policy, at a rate of interest not exceeding the maximum rate permitted by the policy loan provision. The interest rate provision shall comply with ORS 743.187. The loan value of the policy shall be equal to the cash surrender value at the end of the then current policy year, less any existing indebtedness not already deducted in determining such cash surrender value including any interest then accrued but not due, any unpaid balance of the premium for the current policy year, and interest on the loan to the end of the current policy year. The policy may also provide that:

(a) If interest on any indebtedness is not paid when due it shall be added to the existing indebtedness and shall bear interest at the rate applicable to the existing indebtedness; and

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

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

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

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

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

(2) The adjustable interest rate provision:

(a) Shall state in substance that in accordance with the policy and the law of the jurisdiction in which the policy is delivered,

the insurer will establish from time to time the interest rate for an existing or a new policy loan; and

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

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

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

(b) The Moody's Corporate Bond Yield Average - Monthly Average Corporates, as published by Moody's Investors Service, Inc., for the calendar month which precedes by two months the month in which the determination date for the policy loan interest rate falls. However, if the Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or if the National Association of Insurance Commissioners determines that the Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer an appropriate rate for this purpose, the director by rule may establish the method of determining the rate under this paragraph. The director's rule, to the maximum extent reasonable, shall be consistent with the pertinent actions of the National Association of Insurance Commissioners.

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

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

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

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

(a) In the case of a loan other than for payment of a premium to the insurer, the

insurer shall give notice of the initial interest rate on the loan when the loan is made.

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

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

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

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

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

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

(2) If the insurer fails to pay the proceeds of or make payment under the policy within 30 days after receipt of due proof of death and of the interest of the claimant, and if the beneficiary elects to receive a lump sum settlement, the insurer shall pay interest on any money due and unpaid after expiration of the 30-day period. The insurer shall com-

pute the interest from the date of the insured's death until the date of payment, at a rate not lower than that paid by the insurer on other withdrawable policy owner funds. At the end of the 30-day period, the insurer shall notify the named beneficiary or beneficiaries at their last-known address that interest at the applicable rate will be paid on the lump sum proceeds from the date of death of the insured.

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

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

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

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

policy may also include a similar provision applicable to any other payment due under the policy. [1967 c.359 §389]

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

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

(a) January 1, 1948; or

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

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

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

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

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

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

743.207 Required provisions relating to nonforfeiture. (1) A life insurance policy shall contain in substance the following pro-

visions, or corresponding provisions which in the opinion of the director are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this section, and which are essentially in compliance with ORS 743.221:

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

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

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

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

(e)(A) In the case of all policies other than those provided for in subparagraph (B) of this paragraph, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first 20 policy years or during the term of the policy, whichever is shorter.

Such values and benefits shall be calculated on the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy. At the option of the insurer such table may also show such values and benefits for any year or years beyond the 20th policy year.

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

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

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

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

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

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

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

743.210 Determination of cash surrender values; applicability to certain policies. (1) Except as otherwise provided in subsections (2) and (3) of this section, any cash surrender value available under a life insurance policy in the event of default in a

premium payment due on any policy anniversary, whether or not required by ORS 743.207, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

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

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

(2) This subsection applies to a life insurance policy issued on or after the operative date defined in ORS 743.215 which provides supplemental life insurance or annuity benefits by rider or supplemental policy provision at the option of the insured and for an identifiable additional premium. For such a policy, the cash surrender value shall be an amount not less than the cash surrender value required by subsection (1) of this section for a policy otherwise similar to the subject policy but without such rider or supplemental policy provision, plus the cash surrender value required by subsection (1) of this section for a policy which provides only the benefits provided by such rider or supplemental policy provision in the subject policy.

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

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

amount of any indebtedness to the insurer on the policy. [Formerly 739.350; 1981 c.609 §14]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) "Y" equals the sum of:

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

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

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

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

a higher nongraded amount or amounts of insurance on the standard basis.

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

(a) For ordinary life insurance mortality:

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

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

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

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

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

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

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

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

(d) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term

Insurance Table for policies of ordinary life insurance, and not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial life insurance.

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

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

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

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

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

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

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

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

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

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

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

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

(3) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be calculated in accordance with this subsection. The amounts specified in paragraphs (a) and (b) of this subsection shall be calculated separately. Each such amount shall be calculated as specified in subsections (1) and (2) of this section. However, for the purposes of paragraphs (b), (c) and (d) of subsection (1) of this section, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in paragraph (b) of this subsection shall be equal to the excess of the uniform or equivalent uniform amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in par-

agraph (a) of this subsection. The adjusted premiums for the entire policy shall equal the sum of:

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

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

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

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

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

(5) This subsection applies only to policies of ordinary life insurance to which this section applies and which are issued on or after the operative date of this subsection as defined in subsection (6) of this section. For such policies, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall, except as provided in paragraphs (a) and (b) of this subsection, be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture

benefits. Such calculations for any category of ordinary life insurance issued on female lives may, however, be based on an age not more than six years younger than the actual age of the insured. Such rate of interest shall not exceed three and one-half percent, except that a rate of interest not exceeding four percent may be used for policies issued from January 1, 1974, to December 31, 1977, and a rate of interest not exceeding five and one-half percent may be used for policies issued on or after January 1, 1978, and with the further exception that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent may be used. The following exceptions pertain:

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

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

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

(7) This subsection applies only to policies of industrial life insurance to which this section applies and which are issued on or after the operative date of this subsection as defined in subsection (8) of this section. For such policies, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall, except as provided in paragraphs (a) and (b) of this subsection, be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Such rate of interest shall not exceed three and one-half percent, except that a rate of interest not exceeding four percent may be used for policies issued from January 1, 1974, to December 31, 1977, and a rate of interest not exceeding five and one-half percent may be used for policies issued on or

after January 1, 1978, and with the further exception that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent may be used. The following exceptions pertain:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Supplemental life insurance or annuity benefits and family coverage, as described

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

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

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

(i) The fifth policy anniversary; and

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

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

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

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

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

(b) The amounts of any cash surrender values and any paid-up nonforfeiture benefits

granted in connection with additional benefits such as those described in ORS 743.222 shall conform with the principles of this section. [1981 c.609 §21]

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

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

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

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

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

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

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

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

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

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

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

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

743.228 Acts of corporate insured or beneficiary with respect to policy. (1)

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

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

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

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

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

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

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

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

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

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

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

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

743.231 "Profit-sharing policy" defined. "Profit-sharing policy" means:

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

(2) A life insurance policy the provisions of which, through sales material or oral presentations, are interpreted by the insurer

to prospective policyholders as entitling the policyholder to the benefits described in subsection (1) of this section. [Formerly 739.705]

743.234 "Charter policy" or "founders policy" defined. "Charter policy" or "founders policy" means:

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

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

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

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

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

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

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

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

(4) A separate premium for the periodic endowment benefits must be shown in the policy adjacent to the rest of the policy premium information and must be given the

same emphasis in the policy and in the sale thereof as that given the rest of the policy premium information. This premium shall be calculated with mortality, interest and expense factors which are consistent with those for the basic policy premium. [1967 c.359 §403]

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

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

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

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

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

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

(Individual Annuity and Pure Endowment Policies)

743.252 Scope of ORS 743.255 to 743.273. ORS 743.255 to 743.273 apply only to annuity and pure endowment policies, other than reversionary annuity policies except as provided in ORS 743.273, and other than group annuity policies, and shall not apply to reversionary or deferred annuity benefits included in life insurance policies. Such sections apply to such policies that are variable annuity policies, except to the extent the provisions of such sections are obviously inapplicable to variable annuities or are in conflict with other provisions of such sections that are expressly applicable to variable annuities. [1967 c.359 §404; 1973 c.435 §19]

743.255 Grace period, annuities. An annuity or pure endowment policy shall contain a provision that there shall be a period of grace of one month, but not less than 30 days, within which any stipulated payment

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

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

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

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

743.267 Dividends, annuities. If an annuity or pure endowment policy is partic-

ipating, it shall contain a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy. [1967 c.359 §409]

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

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

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

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

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

743.272 Computing benefits, variable annuities. (1) A variable annuity policy shall specify the investment increment factors to be used in computing the dollar amount of

variable benefits or other variable payments or values under the policy, and may guarantee that expense or mortality results or both will not adversely affect such dollar amounts. In the case of an individual variable annuity policy under which the expense or mortality results may adversely affect the dollar amount of benefits, the expense and mortality factors shall be correspondingly specified in the policy. "Expense" as used in this subsection may exclude some or all taxes, as specified in the policy.

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

(a) The annual net investment increment assumption shall not exceed five percent, except with the approval of the director; and

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

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

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

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

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

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

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

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

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

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

(b) A premium deposit fund.

(c) A variable annuity policy.

(d) An investment annuity policy.

(e) An immediate annuity policy.

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

(g) A reversionary annuity.

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

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

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

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

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

(d) A statement that paid-up annuity, cash surrender and death benefits available

under the policy are not less than the minimums required by the statutes of the jurisdiction in which the policy is delivered, with an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the insurer to the policy, any indebtedness to the insurer on the policy or any prior withdrawals from or partial surrenders of the policy.

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

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

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

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

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

erations in previous years for which the percentage was 65 percent.

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

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

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

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

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

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

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

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

than the minimum nonforfeiture amount on the date of surrender. The death benefit under an annuity policy that provides cash surrender benefits shall be at least equal to the cash surrender benefit.

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

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

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

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

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

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

GROUP LIFE INSURANCE

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

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

(a) Group policies of credit life insurance; or

(b) Group policies of mortgage life insurance on first secured mortgages;

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

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

(4) The person contracting for the group coverage shall be responsible for the pay-

ment of premiums. [1967 c.359 §412; 1971 c.231 §44; 1991 c.182 §4]

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

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

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

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

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

743.318 Application; representations by policyholders and insureds. A group life insurance policy shall contain a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest

unless a copy of the instrument containing the statement is or has been furnished to such person or the beneficiary of the person. [1967 c.359 §417]

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

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

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

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

(3) Nothing in this section shall be construed to allow an insurer to withhold payment of money payable under a group life insurance policy to any designated beneficiary for a period longer than reasonably nec-

essary to transmit the payment. [1967 c.359 §420; 1983 c.754 §3]

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

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

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

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

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

743.336 Termination of policy or class of insured persons. A group life insurance policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured there-

under at the date of such termination whose insurance terminates and who has been so insured for at least five years prior to such termination date shall be entitled to have issued by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by ORS 743.333, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of:

(1) The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which the person is or becomes eligible under any group policy issued or reinstated by the same or another insurer within 31 days after such termination; and

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

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

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

743.345 Assignability of group life policies. Nothing in the Insurance Code or in any other law shall be construed to prohibit any person insured under a group life insurance policy from making an assignment of all or any part of the incidents of ownership under such policy, including but not limited to the privilege to have issued an individual policy of life insurance pursuant to the provisions of ORS 743.333 to 743.339 and the right to name a beneficiary. Subject to the terms of the policy or an agreement between the insured, the group policyholder and the insurer relating to assignment of incidents of ownership under the policy, such an as-

ignment by an insured, made either before or after September 9, 1971, is valid for the purpose of vesting in the assignee, in accordance with any provisions included in the assignment as to the time at which it is to be effective, all of such incidents of ownership so assigned, but without prejudice to the insurer on account of any payment it may make, or individual policy it may issue in accordance with ORS 743.333 to 743.339, prior to receipt of notice of the assignment. [1971 c.231 §6]

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

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

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

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

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

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

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

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

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

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

(5) For purposes of this section:

(a) An association includes a labor union.

(b) "Employees" may include retired employees.

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

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

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

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

(b) One or more labor unions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

certificates issued under a group policy for which the loan value is established by federal law. [1991 c.182 §9]

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

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

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

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

CREDIT LIFE AND CREDIT HEALTH INSURANCE

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

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

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

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

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

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

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

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

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

743.373 Forms of credit life and credit health insurance. Credit life and credit

health insurance shall be issued only in the following forms:

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

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

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

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

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

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

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

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

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

debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

promptly make an appropriate credit to the account.

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

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

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

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

HEALTH INSURANCE

(Individual)

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

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

(2) Any policy of reinsurance;

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

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

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

(b) Operate to safeguard such policy against lapse, or to give a special surrender value or special benefit or an annuity in the

event the insured shall become totally and permanently disabled, as defined by the policy or supplemental policy. [Formerly 741.022]

743.405 General requirements, individual health insurance policies. A health insurance policy shall meet the following requirements:

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

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

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

(4) Except as provided in ORS 743.498, the style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any indorsements or attached papers shall be plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point. Captions shall be printed in not less than 12-point type. The "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions;

(5) The exceptions and reductions of indemnity shall be set forth in the policy and, except those which are set forth in ORS 743.411 to 743.480, shall be printed at the insurer's option either included with the benefit provision to which they apply or under an appropriate caption such as **EXCEPTIONS**, or **EXCEPTIONS AND REDUCTIONS**, provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(6) Each form constituting the policy, including riders and indorsements, shall be identified by a form number in the lower lefthand corner of the first page thereof; and

(7) It shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement

of rates or classification of risks, or short rate table filed with the director. [Formerly 741.120]

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

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

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

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

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

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

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

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

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

(c) A rehabilitation clinic and agency established, maintained, contracted with or operated by the Mental Health and Developmental Disability Services Division under ORS 430.260.

(5) Except as permitted by subsection (3) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than \$4,500 in any

24-consecutive month period and the policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the hospital and medical expenses for treatment for alcoholism. [1977 c.632 §2; 1981 c.319 §1]

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

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

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

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

743.417 Grace period. (1) A health insurance policy shall contain a provision as follows: "GRACE PERIOD: A grace period of _____ (insert a number not less than '7' for weekly premium policies, '10' for monthly premium policies and '31' for all other poli-

cies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

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

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

743.420 Reinstatement. (1) A health insurance policy shall contain a provision as follows: "REINSTATEMENT: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

(2) The last sentence of the provision set forth in subsection (1) of this section may be omitted from any policy which the insured

has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. [1967 c.359 §432]

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

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

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

743.429 Proofs of loss. A health insurance policy shall contain a provision as follows: "PROOFS OF LOSS: Written proof of

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

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

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

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

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

discharge the insurer to the extent of such payment."

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

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

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

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

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

743.447 Optional provisions, individual health insurance. Except as provided in ORS 742.021, provisions in a health insurance policy respecting the matters set forth in ORS 743.450 to 743.480 shall be in the words which appear in such sections. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in such sections or, at the option of the insurer, by such appropriate individual or

group captions or subcaptions as the director may approve. [1967 c.359 §441]

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

743.453 Misstatement of age. A health insurance policy may contain a provision as follows: "MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age." [1967 c.359 §443]

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

(2) In lieu of the provisions set forth in subsection (1) of this section, the policy may

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

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

(2) If the policy provision set forth in subsection (1) of this section is included in a policy which also contains the policy provision set forth in ORS 743.462, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "EXPENSE INCURRED BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the director, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the director. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured

pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage." [1967 c.359 §445]

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

(2) If the policy provision set forth in subsection (1) of this section is included in a policy which also contains the policy provision set forth in ORS 743.459, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "OTHER BENEFITS." The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the director, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the director. In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice. In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage." [1967 c.359 §446]

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

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

743.468 Unpaid premium. A health insurance policy may contain a provision as follows: "UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any

note or written order may be deducted therefrom." [1967 c.359 §448]

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

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

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

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

(3) Nonpayment of premium; or

(4) Any other reason specified by the director by rule. [1989 c.784 §18; 1991 c.182 §5]

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

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

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

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

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

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

743.489 Extension of coverage beyond policy period; effect of misstatement of age. If any health insurance policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the

coverage provided by the policy shall continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy. [Formerly 741.170]

743.492 Policy return and premium refund provision. Every health insurance policy except single premium nonrenewable policies shall have printed on its face or attached thereto a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to the purchaser and to have the premium paid refunded if, after examination of the policy, the purchaser is not satisfied with it for any reason. If a policyholder or purchaser pursuant to such notice returns the policy to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. [Formerly 741.180]

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

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

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

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

any synonymous term such as "guaranteed continuable." [Formerly 741.190]

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

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

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

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

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

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

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

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

(Franchise)

743.516 "Franchise health insurance" defined. (1) "Franchise health insurance" means that form of individual health insurance issued on a franchise plan to:

(a) Four or more employees of a corporation, partnership, individual employer, or of a governmental corporation or agency or department thereof; or

(b) Ten or more members, employees or employees of members of any trade or professional association or of a labor union or of any other association that has an active existence for at least two years, has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance.

(2) "Employees" as used in this section includes the officers, managers and employees and retired employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. [1967 c.359 §459]

743.519 Requirements for franchise health insurance. Franchise health insurance shall be sold only pursuant to a written agreement between the insurer and an employer, association or union. Franchise health insurance shall be issued only where the insureds, with or without their dependents, are each issued the same form of an individual health insurance policy varying only as to amounts and kinds of coverage applied for by such persons. Franchise health insurance may be issued under an arrangement whereby the premiums on such policies are paid to the insurer periodically by the employer, with or without payroll deductions, by the association or union for its members or by some designated person acting on behalf of such employer or association or union. Franchise health insurance premiums may be paid directly by the covered person if a periodic certification is made by the employer, association or union that the person is entitled to such coverage. [1967 c.359 §460; 1971 c.231 §25]

743.520 Sale of union or association membership to qualify for franchise health insurance prohibited. No person soliciting or selling franchise health insurance may solicit or sell membership in any association or labor union for the purpose of qualifying an applicant for franchise health insurance. [1971 c.231 §4]

(Group and Blanket)

743.522 "Group health insurance" defined. "Group health insurance" means that form of health insurance covering groups of persons as defined in this section, with or without one or more members of their families or one or more of their dependents, or cover-

ing one or more members of the families or one or more dependents of such groups of persons, and issued upon one of the following bases:

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. The term "employees" as used in this subsection shall be deemed to include the officers, managers, and employees of the employer, the individual proprietor or partners if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise. The term "employees" as used in this subsection may include retired employees. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

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

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

both, if their duties are principally connected with such trusteeship.

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

(5) Under a policy issued to cover any other substantially similar group which, in the discretion of the director, may be subject to the issuance of a group health insurance policy. [1967 c.359 §461; 1975 c.229 §1; 1989 c.784 §13]

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

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

743.524 Eligibility of association to be group health policyholder; rules. (1) An insurer shall not offer a policy of group health insurance to an association as the policyholder or offer coverage under such a policy, whether issued in this or another state, unless the Director of the Department of Insurance and Finance determines that the association satisfies the requirements of an association under ORS 743.522 (2).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) A provision that the insurer will furnish to the policyholder for delivery to each employee or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employee or member, to whom the insurance benefits are payable, and the applicable rights

and conditions set forth in ORS 743.527, 743.529 and 743.600 to 743.622. If dependents are included in the coverage, only one statement need be issued for each family unit.

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

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

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

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

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

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

743.531 Direct payment of hospital and medical services; rate limitations. (1) A group health insurance policy may on request by the group policyholder provide that all or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

743.537 Required provisions, blanket health insurance policies. A blanket health insurance policy shall contain provisions

which in the opinion of the director are not less favorable to the policyholder and the individual insureds than the provisions described in ORS 743.411, 743.423, 743.426, 743.429, 743.432, 743.438 and 743.441. [1967 c.359 §466]

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

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

743.546 Policy form approval, blanket health insurance. The director may exempt from the policy form filing and approval requirements of ORS 743.003, for so long as the director deems proper, any blanket health insurance policy to which in the opinion of the director such requirements may not practicably be applied, or may dispense with such filing and approval whenever, in the opinion of the director, it is not desirable or necessary for the protection of the public. [1967 c.359 §469]

743.549 Restriction on reduction of benefits provisions in group and blanket health policies. No group or blanket health insurance policy providing hospital, medical or surgical expense benefits, and which contains a provision for the reduction of benefits otherwise payable thereunder on the basis of other existing coverages, shall provide that such reduction operates to reduce total benefits payable below an amount equal to 100 percent of total allowable expenses, except as provided for in a collective bargaining agreement. [1973 c.143 §2; 1989 c.1080 §2]

743.552 Guidelines for application of ORS 743.549. The director shall by rule establish guidelines for the application of ORS 743.549, including:

- (1) The procedures by which persons insured under such policies are to be made aware of the existence of such a provision;
- (2) The benefits which may be subject to such a provision;
- (3) The effect of such a provision on the benefits provided;
- (4) Establishment of the order of benefit determination; and
- (5) Reasonable claim administration procedures to expedite claim payments under such a provision which shall include a time limit of 14 days beyond which the insurer shall not delay payment of a claim by reason of the application of coordination of benefits provision. [1973 c.143 §3]

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

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

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

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

(a) Programs or providers described in ORS 430.010 or approved by the office of Alcohol and Drug Abuse Programs or by the Mental Health and Developmental Disability Services Division under subsection (3) of this section.

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

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

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

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

(3) Subject to ORS 430.065, the office of Alcohol and Drug Abuse Programs shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient chemical dependency programs that are not related to the division or any county mental health program. The Mental Health and Developmental Disability Services Division shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient programs for mental or nervous conditions that are not related to the division or any county mental health program.

(4) A program that provides services for persons with both a chemical dependency diagnosis and a mental or nervous condition shall be considered to be a distinct and specialized type of program for both chemical dependency and mental or nervous conditions. The Mental Health and Developmental Disability Services Division and the office of Alcohol and Drug Abuse Programs jointly shall develop specific standards related to such programs for program approval purposes and shall adopt rules relating to the approval, for insurance reimbursement purposes, of such noninpatient programs that are not related to the office or the division and any county mental health program.

(5) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alco-

hol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

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

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

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

(6) Notwithstanding the limits for particular types of services specified in this section, a policy shall not limit the total of payments for all treatment of any kind under this section for chemical dependency, together with payments for all treatment of any kind for mental or nervous conditions, to less than \$10,500 for adults and \$12,500 for children or adolescents. For persons requesting payments for treatment of any kind for chemical dependency, but not requesting payments for treatment of any kind of mental or nervous condition, a policy shall not limit the total of payments for all treatment to less than \$6,500 for adults and \$10,500 for children and adolescents.

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

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

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

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

(a) For chemical dependency to an amount less than \$4,500 for adults and \$4,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than \$4,000 for adults and \$6,000 for children or adolescents.

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

(a) For chemical dependency to an amount less than \$3,500 for adults and \$3,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than \$1,000 for adults and \$2,500 for children or adolescents.

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

(a) For chemical dependency to an amount less than \$8,500 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than \$8,500 for adults and \$10,500 for children or adolescents.

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

(a) For chemical dependency to an amount less than \$1,500 for adults and \$2,000 for children or adolescents; and

(b) For mental or nervous conditions to an amount less than \$2,000.

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

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

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

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

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

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

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

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

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

(E) An appeals process shall be provided.

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

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

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

(a) The current living situation;

(b) An alternative, nontreatment living situation;

(c) An alternative residential program or facility; or

(d) A day or partial hospitalization program.

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

(a) Are not presently appropriate and available;

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

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

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

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

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

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

(a) Notwithstanding the provisions of subsection (1) of this section, health maintenance organizations may establish reasonable provisions for enrollee cost-sharing, so long as the amount the enrollee is required to pay does not exceed the amount of coinsurance and deductible customarily required by other

insurance policies which are subject to the provisions of this chapter for that type and level of service.

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

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

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

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

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

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

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

(d) Insurers and health care service contractors other than health maintenance organizations shall pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions at the same level of deductible or coinsurance as would apply to covered charges of noncontracting providers of other health services under the same group policy or contract. The insured shall have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions. Policies described in this subsection shall be subject to the provisions of subsection (1) of this section,

whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

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

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

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

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

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

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

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

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

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

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

743.560 Notice upon termination of policy; consequences of failure to notify.

(1) On and after July 1, 1992, a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision requiring that the insurer shall notify the group policyholder, the Bureau of Labor and Industries and the Department of Insurance and Finance on a form prescribed by the bureau and the department when the policy is terminated and the coverage is not replaced by the group policyholder. The provision shall also require that the insurer shall mail a notice of the termination to the group policyholder, the Bureau of Labor and Industries and the Department of Insurance and Finance. Each certificate issued under the policy shall also

contain a statement of the provision required under this subsection.

(2) When an insurer gives notice pursuant to the requirement of subsection (1) of this section, the notice:

(a) Must explain the rights of the certificate holders regarding continuation or conversion of coverage provided by federal and state law; and

(b) Must be mailed not later than 10 working days after the termination of the group policy.

(3) If an insurer fails to give notice pursuant to subsection (1) of this section, the insurer shall waive premiums for continued or converted coverage from the date notice should have been provided until the date that the notice is received by the Bureau of Labor and Industries and the Department of Insurance and Finance. The time period within which the certificate holder may exercise the right to continuation or conversion shall commence on the date that the Bureau of Labor and Industries and the Department of Insurance and Finance receive the notice.

(4) The insurer shall supply the employer holding the terminated policy with the necessary information for the employer to be able to notify properly the employee of the employee's right to continuation or conversion of coverage under state and federal law.

(5) If the insurer fails to notify the policyholder, the Bureau of Labor and Industries and the Department of Insurance and Finance as required by subsection (1) of this section, the insurer shall waive premiums for the period beginning on the date the notice should have been provided as required under this section until the date that the notice is received by the policyholder, the Bureau of Labor and Industries and the Department of Insurance and Finance. [1991 c.673 §§3, 4]

743.561 [Formerly 739.565; renumbered 743.371 in 1989]

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

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

743.567 [Formerly 739.575; renumbered 743.373 in 1989]

743.570 [1967 c.359 §473; renumbered 743.374 in 1989]

743.573 [Formerly 741.425; renumbered 743.375 in 1989]

743.576 [Formerly 739.585; renumbered 743.376 in 1989]

743.579 [Formerly 739.590; renumbered 743.377 in 1989]

743.582 [Formerly 739.600; renumbered 743.378 in 1989]

743.585 [Formerly 739.603; renumbered 743.379 in 1989]

743.588 [Formerly 739.610; renumbered 743.380 in 1989]

(Continuation and Conversion)

743.600 Availability of continued coverage under group policy for surviving, divorced or separated spouse 55 or older.

(1) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision that:

(a) The surviving spouse of a certificate holder may continue coverage under the policy, at the death of the certificate holder, with respect to the spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death of the certificate holder if the surviving spouse is 55 years of age or older at the time of the death; and

(b) The divorced or legally separated spouse of a certificate holder may continue coverage under the policy, upon dissolution of marriage with, or legal separation from, the certificate holder, with respect to the divorced or legally separated spouse and any dependent children whose coverage under the policy otherwise would terminate because of the dissolution of marriage or legal separation, if the divorced or legally separated spouse is 55 years of age or older at the time of the dissolution or legal separation.

(2) Continued coverage for dental, vision care or prescription drug expenses shall be offered to legally separated, divorced or surviving spouses and any dependent children eligible under subsection (1) of this section if such coverage is or was available to the certificate holder. [Formerly 743.851]

743.601 Procedure for obtaining continuation of coverage under ORS 743.600.

(1) As used in subsections (1) to (6) of this section, "plan administrator" means:

(a) The person designated as the plan administrator by the instrument under which the group health insurance plan is operated; or

(b) If no plan administrator is designated, the plan sponsor.

(2) Within 60 days of legal separation or the entry of a decree of dissolution of marriage, a legally separated or divorced spouse eligible for continued coverage under ORS 743.600 who seeks such coverage shall give the plan administrator written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse.

(3) Within 30 days of the death of a certificate holder whose surviving spouse is eligible for continued coverage under ORS 743.600, the group policy holder shall give the plan administrator written notice of the death and of the mailing address of the surviving spouse.

(4) Within 14 days of receipt of notice under subsection (2) or (3) of this section, the plan administrator shall notify the legally separated, divorced or surviving spouse that the policy may be continued. The notice shall be mailed to the mailing address provided to the plan administrator and shall include:

(a) A form for election to continue the coverage;

(b) A statement of the amount of periodic premiums to be charged for the continuation of coverage and of the method and place of payment; and

(c) Instructions for returning the election form by mail within 60 days after the date of mailing of the notice by the plan administrator.

(5) Failure of the legally separated, divorced or surviving spouse to exercise the election in accordance with subsection (4) of this section shall terminate the right to continuation of benefits.

(6) If a plan administrator fails to notify the legally separated, divorced or surviving spouse as required by subsection (4) of this section, premiums shall be waived from the date the notice was required until the date notice is received by the legally separated, divorced or surviving spouse.

(7) The provisions of ORS 743.600 to 743.602 apply only to employers with 20 or more employees and group health insurance plans with 20 or more certificate holders. [Formerly 743.852]

743.602 Premium for continuation of coverage under ORS 743.600; termination of right to continuation. If a legally separated, divorced or surviving spouse elects continuation of coverage under ORS 743.601 (1) to (6):

(1) The monthly premium for the continuation shall not be greater than the amount that would be charged if the legally separated, divorced or surviving spouse were a current certificate holder of the group plan plus the amount that the group policy holder would contribute toward the premium if the legally separated, divorced or surviving spouse were a certificate holder of the group plan, plus an additional amount not to exceed two percent of the certificate holder and group plan holder contributions, for the costs of administration.

(2) The first premium shall be paid by the legally separated, divorced or surviving

spouse within 45 days of the date of the election.

(3) The right to continuation of coverage shall terminate upon the earliest of any of the following:

(a) The failure to pay premiums when due, including any grace period allowed by the policy;

(b) The date that the group policy is terminated as to all group members except that if a different group policy is made available to group members, the legally separated, divorced or surviving spouse shall be eligible for continuation of coverage as if the original policy had not been terminated;

(c) The date on which the legally separated, divorced or surviving spouse becomes insured under any other group health plan;

(d) The date on which the legally separated, divorced or surviving spouse remarries and becomes covered under another group health plan; or

(e) The date on which the legally separated, divorced or surviving spouse becomes eligible for federal Medicare coverage. [Formerly 743.853]

743.603 [Formerly 744.070; renumbered 742.200 in 1989]

743.606 [1967 c.359 §481; 1967 c.453 §3; renumbered 742.202 in 1989]

743.607 [1967 c.453 §2; renumbered 742.204 in 1989]

743.609 [1967 c.359 §482; 1971 c.231 §26; renumbered 742.206 in 1989]

743.610 Continuation of coverage under group policy upon termination of employment or membership or dissolution of marriage; applicability of waiting period to rehired employee. (1) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision that certificate holders whose coverage under the policy otherwise would terminate because of termination of employment or membership may continue coverage under the policy for themselves and their eligible dependents as provided in this section.

(2) Continuation of coverage shall be available only to a certificate holder who has been insured continuously under the policy or similar predecessor policy during the three-month period ending on the date of the termination of employment or membership.

(3) Continuation of coverage shall not be available to a certificate holder who is eligible for:

(a) Federal Medicare coverage; or

(b) Coverage for hospital or medical expenses under any other program which was

not covering the certificate holder immediately before the certificate holder's termination of employment or membership.

(4) The continued coverage need not include benefits for dental, vision care or prescription drug expense, or any other benefits under the policy additional to hospital and medical expense benefits.

(5) A certificate holder who has terminated employment or membership and who wishes to continue coverage must request continuation in writing not later than 10 days after the later of the date on which employment or membership terminated and the date on which the employer or group policyholder gave the certificate holder notice of the right to continue coverage. However, a certificate holder may not make a request for continuation more than 31 days after the date of termination of employment or membership.

(6) A certificate holder who requests continuation of coverage must pay the premium on a monthly basis and in advance, as provided in this subsection. The certificate holder shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment may not exceed the group premium rate, for the insurance being continued under the group policy, as of the date the premium payment is due. The certificate holder must pay the first premium not later than 31 days after the date on which the certificate holder's coverage under the policy otherwise would end.

(7) Continuation of coverage as provided under this section shall end upon the earliest of the following dates:

(a) Six months after the date on which the certificate holder's coverage under the policy otherwise would have ended because of termination of employment or membership.

(b) The end of the period for which the certificate holder last made timely premium payment, if the certificate holder fails to make timely payment of a required premium payment.

(c) The premium payment due date coinciding with or next following the date the certificate holder becomes eligible for federal Medicare coverage.

(d) The date on which the policy is terminated or the certificate holder's employer terminates participation under the policy. However, if the employer replaces the coverage which is terminating for the certificate holder with similar coverage under another group policy:

(A) The certificate holder may obtain coverage under the replacement group policy for the balance of the period that the certificate

holder would have remained covered under the replaced group policy under this section;

(B) The minimum level of benefits to be provided the certificate holder by the replacement group policy shall be the applicable level of benefits of the replaced policy reduced by any benefits still payable under that policy; and

(C) The replaced policy shall continue to provide benefits to the certificate holder to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred.

(8) The group health insurance policy also shall contain a provision that:

(a) The surviving spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under the policy, at the death of the certificate holder, with respect to the spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death, in the same manner that a certificate holder may exercise the right under this section.

(b) The spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.600 may continue coverage under the policy, upon dissolution of marriage with the certificate holder, with respect to the spouse and any children whose coverage under the policy otherwise would terminate because of the dissolution of marriage, in the same manner that a certificate holder may exercise the right under this section.

(c) A spouse who requests continuation of coverage under this subsection must pay the premium for the spouse and any dependent children, on a monthly basis and in advance, as provided in this paragraph. The spouse shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment under this subsection may not exceed the group premium rate, for the insurance being continued under the group policy, as of the date the premium payment is due.

(9) A certificate holder who has terminated employment by reason of layoff shall not be subject upon any rehire that occurs within six months of the time of the layoff to any waiting period prerequisite to coverage under the employer's group health insurance policy if the certificate holder was eligible for coverage at the time of the termination and regardless of whether the certificate holder continued coverage during the layoff.

(10) This section applies only to employers who are not required to make available continuation of health insurance benefits under Titles X and XXII of the Consolidated

Omnibus Reconciliation Act of 1985, as amended, P.L. 99-272, April 7, 1986. [Formerly 743.850]

743.611 Conversion of coverage under group policy to individual policy. (1) Except as provided in subsection (10) of this section, a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision that a certificate holder whose insurance under the policy terminates may obtain an individual health insurance policy from the insurer without furnishing evidence of insurability. Coverage under the individual policy shall be provided according to ORS 743.613.

(2) The individual health insurance policy need not be made available to a certificate holder if the certificate holder's coverage under the group policy terminates for any of the following reasons:

(a) Because of termination of the certificate holder's employment or membership and the certificate holder either is not entitled to obtain, or fails to request, continued coverage under the group policy.

(b) Because the certificate holder failed to make timely payment of a required contribution under the group policy.

(3) To obtain the individual health insurance policy, the certificate holder must submit a written application and the first premium payment for the coverage not later than 31 days after the date on which the certificate holder's coverage terminated under the group policy. The individual policy shall become effective on the day following the termination of coverage under the group policy.

(4) The insurer shall determine the premium for the individual policy in accordance with the insurer's table of premium rates applicable to the age and class of risk of each individual to be covered under the policy and the type and amount of insurance provided.

(5) The individual policy shall cover the certificate holder and the dependents of the certificate holder who were covered by the group policy immediately before the termination of insurance under that policy, except that an insurer may issue a separate individual policy to provide coverage for one or more dependents. Coverage under the separate individual policy shall be the same as the individual policy coverage provided the certificate holder.

(6) The insurer is not required to provide coverage for an individual under an individual policy issued pursuant to this section if:

(a) The individual is eligible for federal Medicare coverage; or

(b) The individual is covered under another individual policy providing benefits similar to those under the group policy, or is eligible for similar benefits under any state or federal law or group coverage program whether insured or uninsured, and the benefits available from these sources together with the benefits available under the individual policy issued pursuant to this section would result in overinsurance according to the insurer's standards. An individual policy issued under this section may provide that the insurer at any time may request information of any individual covered under the policy in order to determine whether the individual is covered or is eligible for benefits described in this paragraph.

(7) An individual policy issued under this section may provide that the insurer may refuse to renew the policy or the coverage of any insured individual as of any premium due date, but only for one or more of the following reasons:

(a) That the benefits described in paragraph (b) of subsection (6) of this section for which the individual is covered or is eligible, together with benefits under the individual policy issued under this section, would result in overinsurance according to the insurer's standards.

(b) That the insured individual has failed to provide information requested under subsection (6) of this section.

(c) That the individual has committed fraud or made a material misrepresentation in applying for any benefits under the individual policy.

(d) That the individual is eligible for federal Medicare coverage.

(e) Any other reason that the director allows by rule.

(8) The insurer shall not be required under this section to issue an individual policy providing hospital and medical benefits in excess of the benefits provided under the group policy giving rise to the issuance of the individual policy.

(9) The individual policy shall not exclude as a preexisting condition any condition covered by the group policy. However, the individual policy may provide that hospital and medical expense benefits under the policy may be reduced by the amount of benefits payable for this expense under the group policy. The individual policy also may provide that, during the first policy year, the benefits payable under the individual policy and the benefits payable under the group policy shall not exceed in total the benefits that would have been payable had the individual's coverage under the group policy remained in force.

(10) Instead of issuing an individual policy as provided in this section, the insurer may provide coverage under a group policy that is at least as favorable to each individual exercising the right to obtain coverage.

(11) A group health insurance policy providing coverage for hospital or medical expenses, other than expenses arising from accidents or specific diseases, shall contain a provision that makes conversion available if the employer terminates the policy or participation under the policy. Such conversion need not be made available if the terminated insurance is replaced by similar coverage under another group policy within 31 days of the termination. [Formerly 743.855; 1991 c.673 §6]

743.612 [1967 c.359 §483; 1985 c.465 §3; renumbered 742.208 in 1989]

743.613 Individual policy plans. (1) The certificate holder may obtain an individual policy issued under ORS 743.611 under one of the following plans, as selected by the certificate holder:

(a) Plan A, covering:

(A) Daily hospital room and board expenses, in a maximum daily amount approximating the average semiprivate room rate charged in the major metropolitan area of this state, for a maximum duration of 70 days;

(B) Miscellaneous hospital expenses up to a maximum amount of 10 times the daily hospital room and board expense benefit; and

(C) Surgical expenses according to a surgical procedures schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of \$800.

(b) Plan B, providing the same coverage as Plan A under this subsection except that:

(A) The maximum hospital room and board daily expense benefit is 75 percent of the corresponding maximum under Plan A; and

(B) The maximum surgical expense benefit is \$600.

(c) Plan C, providing the same coverage as Plan A under this subsection except that:

(A) The maximum hospital room and board daily expense benefit is 50 percent of the corresponding maximum under Plan A; and

(B) The maximum surgical expense benefit is \$400.

(2) The director shall determine by rule the maximum hospital room and board daily expense benefit to be provided under Plan A in subsection (1) of this section. The director may redetermine by rule, from time to time, the amount of that maximum for individual policies issued under Plan A subsequent to the redetermination. The director shall not make a redetermination more often than once every

three years. In determining the maximum hospital room and board daily expense benefit for Plans A, B and C, the director shall round the actual amounts to the nearer multiple of \$10. [Formerly 743.860]

743.614 Alternative plans for conversion. An insurer may offer plans for conversion of group health insurance coverage to individual health insurance coverage in addition to the plans required by ORS 743.613. If an insurer customarily offers individual policies on a service basis, the insurer may make available individual policies on a service basis rather than on an expense-incurred basis, upon approval of the individual policies for this purpose by the director. A health maintenance organization qualified pursuant to Title XIII of the Public Health Service Act (42 U.S.C. 300e et seq.) is required to make available only coverage under an individual policy which meets the requirements of that Act. [Formerly 743.865]

743.615 [1967 c.359 §484; renumbered 742.210 in 1989]

743.616 Availability of coverage under group or individual policy for retired certificate holder. If a group health insurance policy allows a certificate holder to continue coverage under the group policy after retirement and before the certificate holder is eligible for federal Medicare coverage, the certificate holder either may continue the group coverage or may exercise the right to convert the group coverage to individual coverage as if the group coverage had terminated at retirement. [Formerly 743.870]

743.617 Reduction or termination of coverage under individual policy upon eligibility for Medicare. The individual policy issued under ORS 743.613 may provide for reduction or termination of coverage of any individual upon eligibility for federal Medicare coverage or coverage under any other state or federal law providing for benefits similar to those provided by the individual policy. [Formerly 743.875]

743.618 [1967 c.359 §485; renumbered 742.212 in 1989]

743.619 Availability of coverage under individual policy to persons other than certificate holder. As provided in this section and notwithstanding ORS 743.611 (2)(a), the following persons may exercise the right to obtain coverage under an individual health insurance policy in the same manner that a certificate holder may exercise that right under ORS 743.611 to 743.617:

(1) The surviving spouse of the certificate holder, if any, may exercise the right within 31 days following the death of the certificate holder or at anytime thereafter during the period that coverage under the policy is continued under ORS 743.610 (8).

(2) If there is no surviving spouse, each surviving child may exercise the right within 31 days following the death of the certificate holder, or at anytime thereafter during the period that coverage under the policy is continued if the group policy provides for continuation of dependents' coverage following the certificate holder's death.

(3) The spouse of the certificate holder may exercise the right if the coverage of the spouse under the group policy ends because the spouse is no longer a qualified family member. The spouse may exercise the right, with respect to the spouse and any children whose coverage under the group policy terminates at the same time, within 31 days following the date on which coverage under the group policy would terminate because the spouse is no longer a qualified family member or at any time thereafter during the period that coverage under the group policy is continued under ORS 743.610 (8).

(4) A child of a certificate holder may exercise the right solely with respect to the child if coverage terminates because the child is no longer a qualified family member under the group policy and if the right to obtain individual coverage is not otherwise provided under this section. The child must exercise the right within 31 days following the date on which coverage under the group policy terminates because the child is no longer a qualified family member. [Formerly 743.880]

743.620 Individual policy benefits substantially similar to group policy. If the benefits required under ORS 743.613 exceed the benefits provided under the group policy, the individual policy may offer benefits substantially similar to those provided under the group policy instead of those required under ORS 743.613. [Formerly 743.885]

743.621 [1967 c.359 §486; renumbered 742.214 in 1989]

743.622 Out-of-state individual policy form. An individual policy issued under ORS 743.611 and delivered outside this state may be on a form meeting the requirements of the jurisdiction of delivery for an individual policy issued as a conversion from a group policy delivered in that jurisdiction. [Formerly 743.890]

743.624 [1967 c.359 §487; renumbered 742.216 in 1989]

743.627 [1967 c.359 §488; renumbered 742.218 in 1989]

743.630 [1967 c.359 §489; renumbered 742.220 in 1989]

743.633 [1967 c.359 §490; renumbered 742.222 in 1989]

743.636 [1967 c.359 §491; 1989 c.426 §2; renumbered 742.224 in 1989]

743.639 [1967 c.359 §492; renumbered 742.226 in 1989]

743.642 [1967 c.359 §493; renumbered 742.228 in 1989]

743.645 [1967 c.359 §494; 1989 c.426 §1; renumbered 742.230 in 1989]

743.648 [1967 c.359 §495; renumbered 742.232 in 1989]

(Long Term Care)

743.650 Long Term Care Insurance Act; purpose; application. (1) ORS 743.650 to 743.656, 748.603 and 750.055 may be known and cited as the "Long Term Care Insurance Act."

(2) The purpose of ORS 743.650 to 743.656, 748.603 and 750.055 is to:

(a) Promote the public interest in long term care insurance;

(b) Promote the availability of long term care insurance policies;

(c) Protect applicants for long term care insurance from unfair or deceptive sales or enrollment practices;

(d) Establish standards for long term care insurance;

(e) Facilitate public understanding and comparison of long term care insurance policies;

(f) Facilitate flexibility and innovation in the development of long term care insurance coverage; and

(g) Assure that Oregon residents who purchase insurance for long term care shall have access to policies providing for a comprehensive range of benefits.

(3) The requirements of ORS 743.650 to 743.656, 748.603 and 750.055 apply to policies and certificates delivered or issued for delivery in this state on or after December 31, 1989. ORS 743.650 to 743.656, 748.603 and 750.055 are not intended to supersede the obligations of entities subject to ORS 743.650 to 743.656, 748.603 and 750.055 to comply with the substance of other applicable insurance laws insofar as such laws do not conflict with ORS 743.650 to 743.656, 748.603 and 750.055, except that laws and rules designed and intended to apply to Medicare supplement insurance policies shall not be applied to long term care insurance. A policy that is not advertised, marketed or offered as long term care insurance or nursing home insurance is not required to meet the requirements of ORS 743.650 to 743.656, 748.603 and 750.055. [1989 c.1022 §§1, 2, 3]

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

743.652 Definitions. As used in ORS 743.650 to 743.656, 748.603 and 750.055, unless the context requires otherwise:

(1) "Applicant" means:

(a) In the case of an individual long term care insurance policy, the person who seeks to contract for benefits; and

(b) In the case of a group long term care insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group long term care insurance policy, if the policy has been delivered or issued for delivery in this state.

(3) "Director" means the Director of the Department of Insurance and Finance.

(4) "Elimination period" means the period at the beginning of a disability during which no benefits are payable.

(5) "Functionally necessary" or "functionally impaired" means a need of a person who is not able to perform independently activities of daily living because of a physical or cognitive impairment.

(6) "Group long term care insurance" means a long term care insurance policy that is delivered or issued for delivery in this state and issued to:

(a) One or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations; or

(b) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

(A) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(B) Has been maintained in good faith for purposes other than obtaining insurance; or

(c)(A) An association or a trust or the trustee of a fund established, created or maintained for the benefit of members of one or more associations. Prior to advertising, marketing or offering such policy within this state, the association or associations, or the insurer of the association or associations shall file evidence with the director that the association or associations have been organized and maintained in good faith for purposes other than that of obtaining insurance; have been in active existence for at least one year; and have a constitution and bylaws that provide that:

(i) The association or associations hold regular meetings not less than annually to further purposes of the members;

(ii) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(iii) The members have voting privileges and representation on the governing board and committees; and

(B) Sixty days after such filing, the association or associations shall be considered to

satisfy such organizational requirements, unless the director makes a finding that the association or associations do not satisfy those organizational requirements; and

(d) A group other than as described in paragraphs (a), (b) and (c) of this subsection, subject to a finding by the director that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

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

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

(7) "Long term care insurance" means any insurance advertised, marketed, offered or designed to provide coverage for not less than 24 months for each covered person on an expense incurred, indemnity, prepaid or other basis; for one or more functionally necessary or medically necessary services, including but not limited to nursing, diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. "Long term care insurance" includes group and individual policies or riders whether issued by insurers; fraternal benefit societies; nonprofit health, hospital and medical service corporations; prepaid health plans; health maintenance organizations, health care service contractors or any similar organization. "Long term care insurance" shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, accident only coverage, specified disease or specified accident coverage.

(8) "Policy" means any policy, contract, subscriber agreement, rider or indorsement delivered or issued for delivery in this state by an insurer; fraternal benefit society; nonprofit health, hospital or medical service corporation; prepaid health plan; health maintenance organization, health care service contractor or any similar organization. [1989 c.1022 §4]

743.653 Prohibition on certain policies.

No group long term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in ORS 743.652 (6)(d), unless the other state has statutory and regulatory long term care insurance requirements substantially similar to those adopted in this state and the director has made a determination that such requirements are substantially similar. [1989 c.1022 §5; 1991 c.67 §199]

743.654 [1967 c.359 §497; renumbered 742.236 in 1989]

743.655 Rules; disclosure; contents of policy. (1)(a) The director shall adopt rules that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, program for public understanding, continuation or conversion, probationary periods, limitations, exceptions, reductions, elimination periods, underwriting at time of application, requirements for replacement, recurrent conditions and definitions of terms. The director shall adopt rules establishing standards for loss ratios and reserves, provided that a specific reference to long term care insurance is contained in the rules.

(b) In adopting rules setting standards under this section, the director shall give timely notice to, and shall consider recommendations from the Director of Human Resources.

(2) No long term care insurance policy shall:

(a) Be canceled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(b) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder;

(c) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care. This evaluation of the amount of coverage provided shall be based on aggregate days of care covered for lower levels of care, when compared to days of care covered for skilled care;

(d) Exclude coverage for Alzheimer's disease and related dementias;

(e) Be nonrenewed or otherwise terminated for nonpayment of premiums until 31 days overdue and then only after notice of nonpayment is given the policyholder prior to expiration of the 31 days; or

(f) Be sold after December 31, 1989, to provide less than 24 months' coverage.

(3)(a) No long term care insurance policy or certificate other than a policy or certificate issued to a group, as defined in ORS 743.652 (6)(a), (b) or (c), shall use a definition of "preexisting condition" which is more restrictive than the following: "Preexisting condition"

means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment, or a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(b) No long term care insurance policy or certificate other than a policy or certificate thereunder issued to a group as defined in ORS 743.652 (6)(a), (b) or (c) may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(c) The director may extend the limitation periods set forth in paragraphs (a) and (b) of this subsection as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

(d) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, over the 10 years immediately prior to the date of application, and, on the basis of the answers on the application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (b) of this subsection expires. No long term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (b) of this subsection, unless such waiver or rider has been specifically approved by the director.

(4) No long term care insurance policy shall be delivered or issued for delivery in this state if the policy:

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

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

(5)(a) Individual long term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance

that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

(b) A person insured under a long term care insurance policy or certificate issued in this state or any other state to a group described in ORS 743.652 (6)(b), (c) or (d) shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination, the insured person is not satisfied for any reason. Long term care insurance policies shall have a notice prominently printed in 10 point type on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(6)(a) An outline of coverage shall be delivered to a prospective applicant for long term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(A) The director shall prescribe a standard format including style, arrangement and overall appearance and the content of an outline of coverage.

(B) In the case of agent solicitations, an agent must deliver the outline of coverage prior to the presentation of an application or enrollment form.

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

(b) The outline of coverage shall include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) A statement of the principal exclusions, reductions and limitations contained in the policy;

(C) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(D) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(E) A description of the terms under which the policy or certificate may be returned and premium refunded; and

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

(7) A certificate issued pursuant to a group long term care insurance policy if the policy is delivered or issued for delivery in this state shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the principal exclusions, reductions and limitations contained in the policy; and

(c) A statement that the group master policy determines governing contractual provisions.

(8) No policy may be advertised, marketed or offered as long term care or nursing home insurance unless it complies with the provisions of ORS 743.650 to 743.656, 748.603 and 750.055.

(9) ORS 743.414 applies to long term care insurance regulated under ORS 743.650 to 743.656, 748.603 and 750.055.

(10) Rules adopted pursuant to ORS 743.650 to 743.656, 748.603 and 750.055 shall be in accordance with the provisions of ORS 183.310 to 183.550. [1989 c.1022 §§6, 7; 1991 c.67 §200]

743.656 Eligibility for benefits; providers required to be covered. (1) No long term care insurance policy shall be delivered or issued for delivery in this state after January 1, 1992, unless such policy determines eligibility for benefits through a determination that is not more restrictive than requiring that:

(a) The policyholder be functionally impaired and needing assistance in any three or more activities of daily living as defined by the director, by rule, after consultation with the Director of Human Resources.

(b) Benefits must be payable when the beneficiary is receiving covered services from any of the following providers approved by the insurer:

- (A) Nursing home;
- (B) Assisted living;
- (C) Home care; and
- (D) Adult foster care.

(c) The insurer shall approve nursing home, assisted living, home care, adult foster home and any other providers of covered services by using standards that have been submitted to and approved by the director in consultation with the Director of Human Resources.

(2) After January 1, 1992, no long term care policy shall be sold in this state that offers only nursing home benefits. [1989 c.1022 §§13, 14]

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

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

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

743.666 [Formerly 744.125; renumbered 742.244 in 1989]

743.669 [Formerly 744.130; renumbered 742.246 in 1989]

743.672 [Formerly 744.430; renumbered 742.248 in 1989]

743.675 [Formerly 744.440; renumbered 742.250 in 1989]

743.678 [Formerly 744.450; renumbered 742.252 in 1989]

(Medicare Supplement)

743.680 Definitions for ORS 743.680 to 743.689. As used in ORS 743.680 to 743.689, unless the context requires otherwise:

(1) "Applicant" means:

(a) In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits.

(b) In the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

(3) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965.

(4) "Medicare supplement policy" means a group or individual policy of insurance or a subscriber contract which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age. [1989 c.255 §1]

743.681 [Formerly 744.460; renumbered 742.254 in 1989]

743.682 Application of 743.680 to 743.689.

(1) Except as otherwise specifically provided, ORS 743.680 to 743.689 apply to:

(a) All Medicare supplement policies and subscriber contracts delivered or issued for delivery in this state on or after May 31, 1989; and

(b) All certificates issued under group Medicare supplement policies or subscriber contracts, which certificates have been delivered or issued for delivery in this state on or after May 31, 1989.

(2) ORS 743.680 to 743.689 do not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former

members, or a combination thereof, of the labor organizations. [1989 c.255 §2]

743.683 Policy contents; standards for benefit and claims payments. (1) No Medicare supplement insurance policy, contract or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

(2) The Director of the Department of Insurance and Finance shall adopt by rule specific standards for policy provisions of Medicare supplement policies and certificates. The standards shall be in addition to and in accordance with applicable laws of this state. No requirement of the Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in ORS 743.680 to 743.689, shall apply to Medicare supplement policies. The standards may cover, but not be limited to:

- (a) Terms of renewability;
- (b) Initial and subsequent conditions of eligibility;
- (c) Nonduplication of coverage;
- (d) Probationary periods;
- (e) Benefit limitations, exceptions and reductions;
- (f) Elimination periods;
- (g) Requirements for replacement;
- (h) Recurrent conditions; and
- (i) Definitions of terms.

(3) The director may adopt by rule standards that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the director, are unjust, unfair or unfairly discriminatory to any person insured or proposed for coverage under a Medicare supplement policy.

(4) Notwithstanding any other provision of law of this state, a Medicare supplement policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. The policy may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(5) The Director of the Department of Insurance and Finance shall adopt by rule standards for benefits and claims payment under Medicare supplement policies. [1989 c.255 §§3, 4]

743.684 Filing of policy; loss ratio standards; agent compensation. (1) Every insurer providing group Medicare supplement insurance benefits to a resident of this state pursuant to ORS 743.682 shall file a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state. However, no insurer shall be required to make a filing earlier than 30 days after insurance was provided to a resident of this state under a master policy issued for delivery outside this state.

(2) Medicare supplement policies shall return benefits which are reasonable in relation to the premium charged. The Director of the Department of Insurance and Finance shall adopt by rule minimum standards for loss ratio of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices. Every entity providing Medicare supplement policies or certificates in this state shall file annually its rates, rating schedule and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this state. All filings of rates and rating schedules shall demonstrate that the actual and expected losses in relation to premiums comply with the requirements of ORS 743.680 to 743.689.

(3) No entity shall provide compensation to its agents or other producers which is greater than the renewal compensation which would have been paid on an existing policy if the existing policy is replaced by another policy with the same company where the new policy benefits are substantially similar to the benefits under the old policy and the old policy was issued by the same insurer or insurer group. [1989 c.255 §5]

743.685 Fact sheet; information brochure. (1) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless a fact sheet is delivered to the applicant at the time application is made.

(2) The Director of the Department of Insurance and Finance shall prescribe the format and content of the fact sheet required by subsection (1) of this section. The director shall consult with the Governor's Commission on Senior Services concerning the content and format of the fact sheet, especially in reference to the ease with which senior citizens may understand the form and compare the coverage provided under the policy to which

the fact sheet refers. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The fact sheet required by subsection (1) of this section shall include at least the following:

(a) An identification of the type and extent of hospital, skilled nursing home, physician and other medical services and prescriptions covered in whole or part by Medicare, and a description of the extent to which Medicare part A and part B cover the services and prescriptions;

(b) Premium information on the supplemental Medicare coverage;

(c) A description of the extent to which the supplemental Medicare coverage offered by the insurer pays the cost of services and prescriptions described in paragraph (a) of this subsection that is not covered by Medicare and the extent to which the supplemental Medicare coverage covers other services;

(d) A statement of the exceptions, reductions and limitations contained in the policy;

(e) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;

(f) A statement that the fact sheet is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(g) A statement that the information contained in the fact sheet is approved for accuracy by the director.

(3) Insurers shall fill out the standardized form and have the completed information included on the form approved by the director before selling supplemental Medicare coverage in this state.

(4)(a) In the purchase or renewal of a Medicare supplement policy, a copy of the fact sheet must be used in explaining policy coverage to a purchaser and shall be provided to the applicant at the time the sales presentation is made. The completed fact sheet shall be considered part of the sales presentation materials for the purposes of ORS 742.009.

(b) In the case of renewals, if the policy or certificate is issued on a basis that is at variance with the previously delivered fact sheet, a revised fact sheet of coverage must accompany the policy or certificate when it is delivered. The revised fact sheet shall contain the following statement, or similar language approved by the director, in no less than 12-point type immediately above the insurer's name:

NOTICE: Read this fact sheet of coverage carefully. It is not identical to the fact sheet of coverage provided upon application. The coverage originally applied for has not been issued.

(5) The insurer shall obtain acknowledgment of receipt or certify delivery of the fact sheet at the time of sale.

(6) The director may adopt by rule a standard form and the contents of an informational brochure for persons eligible for Medicare by reason of age, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the director may require by rule that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the fact sheet. With respect to direct response insurance policies, the director may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare by reason of age, but in no event later than the time of policy delivery.

(7) The director may adopt by rule captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all health insurance policies sold to persons eligible for Medicare by reason of age, other than:

(a) Medicare supplement policies;

(b) Disability income policies;

(c) Basic, catastrophic or major medical expense policies; or

(d) Single premium, nonrenewable policies.

(8) The director may adopt rules governing the full and fair disclosure of the information in connection with the replacement of health insurance policies, subscriber contracts or certificates by persons eligible for Medicare by reason of age. [1989 c.255 §6]

743.686 Right to return of policy; premium refund. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this

section shall be paid directly to the applicant by the insurer in a timely manner. [1989 c.255 §7]

743.687 Advertising. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Director of the Department of Insurance and Finance of this state for review or approval by the director to the extent it may be required under state law. [1989 c.255 §8]

743.688 Rules. Rules adopted pursuant to ORS 743.680 to 743.689 shall be subject to the provisions of ORS 183.310 to 183.550. [1989 c.255 §9]

743.689 Director's authority upon violation of 743.680 to 743.689. In addition to any other applicable penalties for violations of the Insurance Code, the Director of the Department of Insurance and Finance may require insurers violating any provision of ORS 743.680 to 743.689 or rules adopted pursuant to ORS 743.680 to 743.689 to cease marketing any Medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require such insurer to take such actions as are necessary to comply with the provisions of ORS 743.680 to 743.689, or both. [1989 c.255 §10]

743.690 [1981 c.247 §17; renumbered 742.280 in 1989]

(Required Reimbursements)

743.700 Automatic repeal of certain statutes on individual and group health insurance. (1) Any statute described in subsection (2) of this section that becomes effective on or after July 13, 1985, shall stand repealed on the sixth anniversary of the effective date of the statute, unless the Legislative Assembly specifically provides otherwise.

(2) This section governs any statute that applies to individual or group health insurance policies and does any of the following:

(a) Requires the insurer to include coverage for specific physical or mental conditions or specific hospital, medical, surgical or dental health services.

(b) Requires the insurer to include coverage for specified persons.

(c) Requires the insurer to provide payment or reimbursement to specified providers of services if the services are within the lawful scope of practice of the provider and the insurance policy provides payment or reimbursement for those services.

(d) Requires the insurer to provide any specific coverage on a nondiscriminatory basis.

(e) Forbids the insurer to exclude from payment or reimbursement any covered services.

(f) Forbids the insurer to exclude coverage of a person because of that person's medical history.

(3) A repeal of a statute under subsection (1) of this section shall not apply to any insurance policy in effect on the effective date of the repeal. However, the repeal of the statute shall apply to a renewal or extension of an existing insurance policy on or after the effective date of the repealer as well as to a new policy issued on or after the effective date of the repealer. [Formerly 743.145]

Note: Section 1, chapter 349, Oregon Laws 1991, provides:

Sec. 1. The provisions of ORS 743.700 shall not apply to ORS 743.530, 743.716 and 743.717 until July 1, 1995. [1991 c.349 §1]

743.701 Reimbursement for services performed by state hospital or state approved program. No policy of health insurance shall exclude from payment or reimbursement losses incurred by an insured for any covered service because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program. [Formerly 743.116]

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

743.703 Reimbursement for services of optometrist. (1) Notwithstanding any provision of any policy of health insurance, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such policy shall be entitled to reimbursement for such service, whether such service is performed by a physician or duly licensed optometrist. Unless such policy shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto.

(2) The provisions of this section shall not apply to any policy in effect upon September 13, 1967. [Formerly 743.117]

743.704 Reimbursement for diabetes self-management education programs. (1) Every group health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage for diabetes self-management education programs.

(2) In order to be covered, a diabetes self-management education program must be provided by health care professionals such as physicians, nurses, pharmacists or registered dietitians who are knowledgeable about the

disease process of diabetes and treatment of a person with diabetes.

(3) Coverage shall only be required to apply to the first diabetes self-management education program which the insured is certified as having successfully completed.

(4) Coverage under this section shall allow insurers to require the insured to pay initially for the diabetes self-management education program as follows:

(a) If the policy contains a deductible, and if the insured pays for the program and then maintains coverage, in each of the three subsequent deductible periods the deductible for the period shall be reduced by a credit not less than 25 percent of the cost of the program or \$40, whichever is the lesser. If such credit is greater than the deductible, the insurer shall apply to the deductible so much of the credit as equals the deductible and refund the excess to the insured.

(b) If the policy does not contain a deductible, the insurer shall either provide immediate coverage for the program up to not less than 75 percent of the cost or \$120, whichever is the lesser, or refund to the insured not less than 25 percent of the cost of the program or \$40, whichever is the lesser, at the beginning of each of the three calendar years next following the year in which the insured paid for the program.

(c) Nothing in this subsection prohibits any insurer from providing immediate reimbursement for the costs of a diabetes self-management education program. Such coverage must, however, provide reimbursement of not less than 75 percent of the cost of the program or \$120, whichever is the lesser, regardless of the deductible and coinsurance benefits applicable to other benefits under the plan.

(5) As used in this section, "diabetes self-management education programs" means instruction on an outpatient basis for a person with diabetes to learn the disease and its control. [Formerly 743.118]

743.706 [Formerly 746.030; 1969 c.692 §9; 1973 c.179 §1; 1982 s.s.1 c.5 §1; 1987 c.846 §13; renumbered 742.282 in 1989]

743.706 Reimbursement for maxillofacial prosthetic services. (1) The Legislative Assembly declares that all group health insurance policies providing hospital, medical or surgical expense benefits include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment.

(2) As used in this section, "maxillofacial prosthetic services considered necessary for adjunctive treatment" means restoration and management of head and facial structures that cannot be replaced with living tissue and that

are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of:

(a) Controlling or eliminating infection;

(b) Controlling or eliminating pain; or

(c) Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions.

(3) The coverage required by subsection (1) of this section may be made subject to provisions of the policy that apply to other benefits under the policy including, but not limited to, provisions relating to deductibles and coinsurance.

(4) The services described in this section shall apply to individual health policies entered into or renewed on or after January 1, 1982. [Formerly 743.119]

743.707 Health insurance coverage for newly born and adopted children. (1) All individual and group health insurance policies providing hospital, medical or surgical expense benefits that include coverage for a family member of the insured shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to:

(a) A newly born child of the insured from the moment of birth; and

(b) An adopted child of the insured from the date of placement of the child in the insured's custody.

(2) The coverage of newly born and adopted children required by subsection (1) of this section shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The policy shall not contain any provision concerning preexisting condition limitations, insurability, eligibility or health underwriting approval that solely concerns adopted children.

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of the birth of the child or of the legal placement of the child in the insured's custody and payment of the premium be furnished the insurer within 31 days after the date of birth or date of placement in order to have the coverage extended beyond the 31-day period.

(4) The coverage required by paragraph (b) of subsection (1) of this section is effective from the date of placement for the purpose of adoption and continues unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage shall include the necessary care and treat-

ment of medical conditions existing prior to the date of placement.

(5) As used in this section, "placement" means the family's assuming of the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child by the adoptive parent. [Formerly 743.120; 1991 c.674 §2]

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

743.709 Reimbursement for services provided by psychologist. Whenever any provision of any individual or group health insurance policy or contract provides for payment or reimbursement for any service which is within the lawful scope of a psychologist licensed under ORS 675.010 to 675.150:

(1) The insured under such policy or contract shall be free to select, and shall have direct access to, a psychologist licensed under ORS 675.010 to 675.150, without supervision or referral by a physician or another health practitioner, and wherever such psychologist is authorized to practice.

(2) The insured under such policy or contract shall be entitled to have payment or reimbursement made to the insured or on the insured's behalf for the services performed. Such payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be the same whether performed by a physician or a psychologist licensed under ORS 675.010 to 675.150. [Formerly 743.123]

743.710 Denial or cancellation of health insurance because of diethylstilbestrol use by mother prohibited. No policy of health insurance may be denied or canceled by the insurer solely because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth. [Formerly 743.125]

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

743.712 Reimbursement for services of nurse practitioner. (1) Whenever any policy of health insurance provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed and certified nurse practitioner, including prescribing or dispensing drugs, the insured under the policy is entitled to reimbursement for such service whether it is performed by a physician licensed by the Board of Medical Examiners for the State of Oregon or by a duly licensed nurse practitioner.

(2) This section does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act. [Formerly 743.128]

743.713 Reimbursement for services of dentist. Notwithstanding any provisions of any policy of insurance covering dental

health, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a dentist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a certified dentist. This section shall apply to any policy covering dental insurance which is issued after July 1, 1980. Policies which are in existence on July 1, 1980, shall be brought into compliance on the next anniversary date, renewal date, or the expiration date of the applicable collective bargaining contract, if any, whichever date is latest. [Formerly 743.132]

Note: 743.713 [formerly 743.132] was added to and made a part of the Insurance Code by the people in the exercise of their initiative power but was not added to or made a part of ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.714 Reimbursement for services of clinical social worker. Whenever any individual or group health insurance policy or blanket health insurance policy described in ORS 743.534 (3) provides for payment or reimbursement for any service which is within the lawful scope of service of a clinical social worker licensed under ORS 675.510 to 675.600:

(1) The insured under the policy shall be entitled to the services of a clinical social worker licensed under ORS 675.510 to 675.600, upon referral by a physician or psychologist.

(2) The insured under the policy shall be entitled to have payment or reimbursement made to the insured or on behalf of the insured for the services performed. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician, by a psychologist or by a clinical social worker, according to the customary and usual fee of clinical social workers in the area served. [Formerly 743.135]

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

743.716 Coverage of children not residing in household of policyholder or employee of policyholder. (1) All policies providing health insurance as defined in ORS 731.162 and containing coverage for children of policyholders or children of employees of policyholders shall provide that children not residing in a policyholder's or employee's household shall be eligible for coverage to the same extent as children residing with the employee or policyholder, so long as the policyholder or employee is under a legal obligation to support or contribute to the ongoing support of the children not residing in the household and providing that there is not a court order to the contrary.

(2) Subsection (1) of this section does not require a health maintenance organization as defined in ORS 442.015 to provide coverage for

any children of a policyholder or employee who reside outside the service area of the health maintenance organization. [Formerly 743.140]

Note: 743.716 [formerly 743.140] was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 743 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

743.717 Tourette Syndrome; reimbursement for treatment. For purpose of coverage by group health insurers, health care service contractors and health maintenance organizations, reimbursement for treatment of Tourette Syndrome shall be made on the basis of the diagnosis and treatment modality employed. [Formerly 743.143]

743.718 Payments for ambulance care and transportation. Any insurance policy issued or issued for delivery in this state that provides coverage for ambulance care and transportation shall provide that payments will be made jointly to the provider of the ambulance care and transportation and to the insured, unless the policy provides for direct payment to the provider. [Formerly 743.147]

743.719 Reimbursement for certain surgical services performed by dentists. Notwithstanding any provision of a policy of health insurance, whenever the policy provides for payment of a surgical service, the performance for the insured of such surgical service by any dentist acting within the scope of the dentist's license is compensable if performance of that service by a physician acting within the scope of the physician's license would be compensable. [Formerly 743.052]

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

743.721 Nondiscriminatory health insurance coverage for women. Each policy of health insurance shall provide:

(1) The same payments for costs of maternity to unmarried women that it provides to married women, including the wives of insured persons choosing family coverage; and

(2) The same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives. [Formerly 743.037]

743.722 Reimbursement for acupuncturist. (1) Whenever any individual or group health insurance policy provides for payment or reimbursement for acupuncture services performed by a physician, the policy also shall pay or reimburse the insured for acupuncture services performed by an acupuncturist licensed under ORS 677.755 to 677.770. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician or

an acupuncturist, according to the customary and usual fee of acupuncturists in the area served.

(2)(a) Subsection (1) of this section does not require the employment of acupuncturists licensed under ORS 677.755 to 677.770 by group practice health maintenance organizations that are federally qualified pursuant to Title XIII subchapter XI of the Public Health Service Act (42 U.S.C. §300e et seq.).

(b) When a group practice health maintenance organization reimburses its members for acupuncture services performed by physicians outside its employ, it shall also reimburse its members for acupuncture services performed by an acupuncturist. [1989 c.832 §2; 1991 c.314 §3]

743.723 [1979 c.866 §5; 1981 c.525 §1; 1987 c.774 §57; renumbered 742.302 in 1989]

743.724 Claim submitted by physician assistant. No insurer shall refuse a claim solely on the ground that the claim was submitted by a physician assistant practicing under the circumstances set forth in ORS 677.515 (4) rather than by the supervising physician for the physician assistant. [Formerly 746.307]

(Small Employer Health Insurance)

743.730 Definitions for ORS 743.730 to 743.745 and others. As used in ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055:

(1) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Director of the Department of Insurance and Finance that a small employer carrier is in compliance with the provisions of ORS 743.736, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(2) "Basic health care plan" means a health care plan for small employers that is required to be offered by all small employer carriers and approved by the Director of the Department of Insurance and Finance in accordance with ORS 743.736.

(3) "Board" means the board of directors of the Oregon Small Employer Health Reinsurance Pool.

(4) "Carrier" means any person who provides health benefit plans in this state, including a licensed insurance company, a health care service contractor, a health maintenance organization, a multiple employer welfare arrangement or any other person or corporation responsible for the payment of benefits or provision of services. For purposes of ORS 316.096, 317.113, 414.720, 743.730 to

743.745 and 750.055, companies that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one carrier except that any insurance company or health maintenance organization that is an affiliate of a health care service contractor located in this state or any health maintenance organization located in this state that is an affiliate of an insurance company or health care service contractor may treat the health maintenance organization as a separate carrier and each health maintenance organization that operates only one health maintenance organization in a service area in this state may be considered a separate carrier.

(5) "Committee" means the Small Employer Carrier Advisory Committee created under ORS 743.745.

(6) "Department" means the Department of Insurance and Finance.

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

(8) "Director" means the Director of the Department of Insurance and Finance.

(9) "Eligible employee" means an employee of a small employer who works on a regularly scheduled basis, with a normal work week of 17.5 or more hours. The term includes sole proprietors, partners of a partnership or independent contractors, if they are included as employees under a health care plan of a small employer, but does not include employees who work on a temporary or substitute basis, or are engaged as independent contractors, or have been employed by the small employer for fewer than 90 days.

(10) "Financially impaired" means a member that, after September 29, 1991, is not insolvent and is:

(a) Considered by the Director of the Department of Insurance and Finance to be potentially unable to fulfill its contractual obligations; or

(b) Placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(11) "Geographic average rate" means the arithmetical average of the lowest premium and the corresponding highest premium to be charged by a small employer carrier to small employers in a geographic area established by the Director of the Department of Insurance and Finance for the carrier's basic health care plan, except for differences in family size and composition.

(12) "Health benefit plan" means any hospital expense, medical expense or hospital or medical expense policy or certificate, health care service contractor or health maintenance

organization subscriber contract, any plan provided by a multiple employer welfare arrangement or any plan provided by another benefit arrangement, to the extent permitted by the federal Employee Retirement Income Security Act of 1974, as amended, which is issued as health benefit coverage subject to ORS 743.734. "Health benefit plan" does not include coverage for accident only, credit, disability income, coverage of Medicare services pursuant to contracts with the Federal Government, Medicare supplement insurance policies, long term care insurance, hospital indemnity only, dental only, vision only, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(13) "Implementation of chapter 836, Oregon Laws 1989" means that the Health Services Commission has prepared a priority list, the Legislative Assembly has enacted funding of the list and all necessary federal approval, including waivers, has been obtained.

(14) "Insurance Pool Governing Board" means the Insurance Pool Governing Board established by ORS 653.725.

(15) "Late enrollee" means an eligible employee or dependent who enrolls in a health benefit plan of a small employer following the initial enrollment period provided under the terms of the plan or arrangement. The initial enrollment period shall be a period of at least 30 days following either commencement of the plan or commencement of the eligibility period for a new employee. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual:

(A) Is covered under another employer health benefit plan at the time the individual was eligible to enroll;

(B) Certified at the time of the initial enrollment that coverage under another employer health benefit plan was the reason for declining enrollment;

(C) Loses coverage under another employer health benefit plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse or divorce; and

(D) Requests enrollment within 30 days after termination of coverage provided under another employer health benefit plan;

(b) A court has ordered that coverage be provided for a spouse or minor child under a

covered employee's plan or arrangement and request for enrollment is made within 30 days after issuance of the court order; or

(c) The individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period.

(16) "Member" means all carriers issuing health benefit plans and multiple employer welfare arrangements and other benefit arrangements, to the extent permitted by the federal Employee Retirement Income Security Act of 1974, as amended, providing health benefit plans in this state except any small employer carrier electing to be a risk assuming carrier pursuant to ORS 743.740.

(17) "Multiple employer welfare arrangement" means a multiple employer welfare arrangement as defined in section 3 of the federal Employee Retirement Income Security Act of 1974, as amended, except for any such arrangement that is fully insured within the meaning of section 514(b)(6) of the federal Act, as amended.

(18) "Plan of operation" means the plan of operation of the Oregon Small Employer Health Reinsurance Pool, including articles, bylaws and operating rules, adopted by the board pursuant to ORS 743.743.

(19) "Preexisting conditions provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition for which medical advice, diagnosis, care or treatment was recommended or received during the specified period, as described in this subsection, immediately preceding the insured's effective date of coverage. Pregnancy does not constitute a preexisting condition under ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055.

(20) "Premium" includes insurance premiums or other fees charged for a health benefit plan, including the costs of benefits paid or reimbursements made to or on behalf of persons covered by the plan.

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

(22) "Reinsurance pool" means the Oregon Small Employer Health Reinsurance Pool created by ORS 743.743.

(23) "Reinsuring carrier" means a small employer carrier electing to comply with the requirements set forth in ORS 743.742.

(24) "Risk assuming carrier" means a small employer carrier electing to comply

with the requirements set forth in ORS 743.740.

(25) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business that, on at least 50 percent of its working days during the preceding year, employed no more than 25 eligible employees and no fewer than three eligible employees, the majority of whom are employed within this state. "Small employer" includes companies that are affiliated companies or which are eligible to file a consolidated tax return pursuant to ORS 317.715. "Small employer" does not include small employers that purchase a health benefit plan through the Insurance Pool Governing Board.

(26) "Small employer carrier" means any carrier, multiple employer welfare arrangement or other benefit arrangement to the extent permitted by the federal Employee Retirement Income Security Act of 1974, as amended, that offers health benefit plans or arrangements covering eligible employees of one or more small employers. A fully insured multiple employer welfare arrangement otherwise exempt under subsection (17) of this section may elect to be a small employer carrier governed by the provisions of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055.

(27) "Standard health benefit plan" means a health benefit plan that is approved by the Director of the Department of Insurance and Finance pursuant to ORS 743.736 that offers health services substantially similar to those offered through the Medicaid reform program under chapter 836, Oregon Laws 1989, as funded by the Legislative Assembly. [1991 c.916 §3]

743.731 Purposes. The purposes of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055:

(1) To promote the availability of health insurance coverage to small employers;

(2) To prevent abusive rating practices;

(3) To require disclosure of rating practices to purchasers;

(4) To establish rules for continuity of coverage for employers and covered individuals; and

(5) To improve the efficiency and fairness of the small group health insurance marketplace. [1991 c.916 §2]

743.732 [Formerly 747.080; renumbered 742.350 in 1989]

743.733 Determination of number of employees for purposes of determining eligibility. Subsequent to the issuance of a health benefit plan to a small employer pursuant to the provisions of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and

750.055, and for the purposes of determining eligibility, the number of employees of a small employer shall be determined annually. Except as otherwise provided, the provisions of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055, that apply to a small employer shall continue to apply until the plan anniversary date following the date the employer no longer meets the requirements of this section. [1991 c.916 §4]

743.734 Plans subject to provisions of specified laws; exemptions from other laws. (1) Every individual or group health benefit plan shall be subject to the provisions of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055, if the plan provides health benefits covering one or more employees of a small employer and if any one of the following conditions is met:

(a) Any portion of the premium or benefits is paid by a small employer or any covered individual is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium; or

(b) The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purposes of section 106 or section 162 of the Internal Revenue Code of 1986, as amended.

(2) The provisions of ORS 742.005 shall not apply to individual health insurance policies or contracts to the extent subject to the provisions of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055.

(3) Except as provided in ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055, no law requiring the coverage or the offer of coverage of a health care service or benefit applies to the basic health benefit plans offered or delivered to a small employer.

(4) Except as otherwise provided by law or ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055, no health benefit plan offered to a small employer shall:

(a) Inhibit a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits; or

(b) Impose any restriction on the ability of a small employer carrier to negotiate with providers regarding the level or method of reimbursing care or services provided under health benefit plans. [1991 c.916 §5]

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

743.736 Requirements for basic plans; approval of plans and forms; offering of plan by carriers. (1) In order to improve the availability and affordability of health benefit coverage for small employers, the Small Employer Carrier Advisory Committee created

under ORS 743.745 shall submit to the Director of the Department of Insurance and Finance two basic health care plans pursuant to ORS 743.745, one of which shall be in the form of insurance and the second of which shall be consistent with the requirements of the federal Health Maintenance Organization Act, 42 U.S.C. §300e et seq.

(2)(a) The director shall approve the basic health care plans following a determination that the plans provide for maximum accessibility and affordability of needed health care services and substantially meet the social values that underlie the ranking of benefits by the Health Services Commission and that the plans are substantially similar to the Medicaid reform program under chapter 836, Oregon Laws 1989, funded by the Legislative Assembly.

(b) The basic plans shall include benefits mandated under ORS 743.556 until mental health, alcohol and chemical dependency services are fully integrated into the Health Services Commission's priority list, and as funded by the Legislative Assembly, and chapter 836, Oregon Laws 1989, is implemented.

(c) The commission shall aid the director by reviewing the plans and commenting on the extent to which the plans meet these criteria.

(3) After the director's approval of the plans submitted by the committee pursuant to subsection (1) of this section, each small employer carrier shall submit to the director the policy form or forms containing the basic health care plan. Each policy form must be submitted as prescribed by the director and is subject to review and approval pursuant to ORS 742.003.

(4) Within 180 days after approval by the director of the plans submitted by the committee, as a condition of transacting business in the small group market in this state, every small employer carrier shall offer small employers an approved basic health care plan. Every small employer that elects to be covered under such plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier, except as provided in subsections (5) to (7) of this section. Nothing in this subsection shall require a multiple employer welfare arrangement established or maintained to provide benefits to a particular trade, business, profession or industry to issue coverage to a small employer that is not in the same trade, business, profession or industry as that covered by the multiple employer welfare arrangement.

(5) No small employer carrier shall be required to offer coverage or accept applications pursuant to subsection (4) of this section from

a group already covered under a health benefit plan except for coverage that is to commence following the group's next regularly scheduled enrollment period.

(6) No small employer carrier shall be required to offer coverage or accept applications pursuant to subsection (4) of this section if the director finds that acceptance of an application or applications would endanger the carrier's ability to fulfill its contractual obligations or result in financial impairment of the carrier.

(7) Every small employer carrier shall market fairly the basic health care plan to small employers in the geographical areas in which the carrier makes coverage available or provides benefits.

(8)(a) No health maintenance organization operating as either a risk assuming carrier or a reinsuring carrier shall be required to offer coverage or accept applications pursuant to subsection (4) of this section in the case of any of the following:

(A) To a small employer if the small employer is not physically located in the health maintenance organization's approved service area;

(B) To an employee if the employee does not work or reside within the health maintenance organization's approved service areas; or

(C) Within an area where the health maintenance organization reasonably anticipates, and demonstrates to the satisfaction of the director, that it will not have the capacity in its network of providers to deliver services adequately to the enrollees of those groups because of its obligations to existing group contract holders and enrollees.

(b) A health maintenance organization that does not offer coverage pursuant to subparagraph (C) of paragraph (a) of this subsection shall not offer coverage in the applicable service area to new employer groups with more than 25 eligible employees until the small employer carrier resumes enrolling groups of new small employers in the applicable area.

(9) Within two years of the implementation of chapter 836, Oregon Laws 1989, and upon the full integration of mental health and chemical dependency services into the health care services ranked by the Health Services Commission, the Small Employer Carrier Advisory Committee shall recommend to the director a standard health benefit plan.

(10) The Legislative Assembly shall determine whether the standard health benefit plan shall be required to be offered by small employer carriers. [1991 c.916 §6]

743.737 Required provisions of plans; renewability; premium rates; carrier disclosures; annual actuarial certification. Health benefit plans covering small employers shall be subject to the following provisions:

(1) Except in the case of a late enrollee, any preexisting conditions provision shall not exclude coverage for a period beyond six months following the insured's effective date of coverage. Late enrollees may be offered a health benefit plan with a preexisting conditions provision for a period not to exceed 12 months.

(2) In determining whether a preexisting conditions provision applies to an eligible employee or dependent, all health benefit plans and arrangements shall credit the time the person was covered under a previous group or individual health benefit plan if the previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable waiting period.

(3) Except in the case of a late enrollee, the health care plan may not exclude any eligible employee or dependent who would otherwise be covered under such plan on the basis of the actual or expected health condition of such person. Late enrollees may be excluded from coverage for the greater of 12 months or a 12-month preexisting conditions exclusion. If both an exclusion from coverage period and a preexisting conditions exclusion are applicable to a late enrollee, the combined period shall not exceed 12 months.

(4) The plan or arrangement shall be renewable with respect to all eligible employees or dependents at the option of the policyholder, small employer or contract holder except:

(a) For nonpayment of the required premiums by the policyholder, small employer or contract holder;

(b) For fraud or misrepresentation of the policyholder, small employer or contract holder or, with respect to coverage of individual enrollees, the enrollees or their representatives;

(c) For noncompliance with plan provisions regarding renewability that have been approved by the Director of the Department of Insurance and Finance;

(d) When the number of enrollees covered under the plan is less than the number or percentage of enrollees required by participation requirements under the plan;

(e) For noncompliance with the small employer carrier's employer contribution requirements under the health benefit plan;

(f) For misuse of a provider network provision;

(g) When the small employer carrier ceases to offer health benefit plans to small employer groups, provided, however, that the following conditions are satisfied:

(A) Notice of the decision to cease writing new business in the small employer market is provided to the director and either the policyholder, small employer or contract holder;

(B) Health benefit plans subject to ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055 shall not be canceled for 180 days after the date of the notice required under subparagraph (A) of this paragraph and for that business in the small employer market which remains in force, any small employer carrier that ceases to write new business in the small employer market shall continue to be governed by ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055 with respect to business conducted under ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055; and

(C) A small employer carrier that ceases to write new business in the small employer market in this state after September 29, 1991, shall be prohibited from writing new business in the small employer market in this state for a period of five years from the date of notice to the director. In the case of a health care service contractor doing business in one service area of the state, the rules set forth in this subsection shall apply to the health care service contractor's operations in that service area; or

(h) Notwithstanding any provision of this subsection to the contrary, any small employer carrier plan subject to the provisions of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055 may be rescinded for fraud, material misrepresentation or concealment by an applicant or a small employer.

(5) A small employer carrier may continue to enforce reasonable employer participation and contribution requirements on small employers applying for coverage, provided, however, that participation and contribution requirements shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier. In determining minimum participation requirements, a carrier shall count only those employees who are not covered by an existing health benefit plan.

(6) Premium rates for health benefit plans subject to ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055 shall be subject to the following provisions:

(a) Each small employer carrier issuing health benefit plans to small employers must

file its geographic average rate for a rating period with the director on or before January 1 of each year.

(b) The premium rates charged during a rating period for health benefit plans issued to small employers shall not vary from the geographic average rate by more than 33 percent, except that the premium rate may be adjusted to reflect the provision of additional benefits not required to be covered by the basic health care plan and differences in family size and composition.

(c) A small employer carrier may not increase the rates of a health benefit plan issued to a small employer more than once in a 12-month period. Annual rate increases shall be effective on the plan anniversary date of the health benefit plan issued to a small employer. The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(A) The percentage change in the geographic average rate measured from the first day of the prior rating period to the first day of the new period; and

(B) Any adjustment, not to exceed 15 percent annually, except an additional adjustment may be made to reflect the provision of benefits not required to be covered by the basic health care plan and differences in family size and composition.

(d) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any reinsurance premiums and assessments paid or payable by small employer carriers in accordance with ORS 743.742.

(7) In connection with the offering for sale of any health benefit plan to a small employer, each small employer carrier shall make a reasonable disclosure as part of its solicitation and sales materials of:

(a) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in the health conditions of the employees and dependents of such small employer;

(b) Provisions concerning the small employer carrier's right to change premium rates and the factors other than claims experience that affect changes in premium rate;

(c) Provisions relating to renewability of policies and contracts; and

(d) Provisions affecting any preexisting conditions provision.

(8)(a) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating

practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(b) Each small employer carrier shall file with the director annually on or before January 1 an actuarial certification certifying that the carrier is in compliance with ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055 and that the rating methods of the small employer carrier are actuarially sound. A copy of such certification shall be retained by the small employer carrier at its principal place of business.

(c) A small employer carrier shall make the information and documentation described in paragraph (a) of this subsection available to the director upon request. Except in cases of violations of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the director to persons outside the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

(9) A small employer carrier shall not provide any financial or other incentive to any broker or agent that would encourage such broker or agent to market and sell health benefit plans of the carrier to small employer groups based on a small employer group's anticipated claims experience.

(10)(a) The provisions of this section shall apply to health benefit plans delivered, issued for delivery, renewed or continued in this state on or after the date the Oregon Small Employer Health Reinsurance Pool becomes operational, as designated by the director.

(b) For purposes of this subsection, the date a health benefit plan is continued shall be the plan anniversary date of the issuance of the health benefit plan. [1991 c.916 §7]

743.738 [Formerly 747.110; renumbered 742.354 in 1989]

743.739 Types of small employer carriers. (1) A small employer carrier shall elect to become either a risk assuming carrier and comply with the provisions of ORS 743.740 or reinsuring carrier and comply with the provisions of ORS 743.742, which election shall be made by informing the board of the Oregon Small Employer Health Reinsurance Pool and the Director of the Department of Insurance and Finance in writing of the small employer carrier's intention. The election shall be binding for a five-year period except that the initial election shall be made within 90 days of September 29, 1991, and shall be made for two years. The director may permit a small em-

ployer carrier to modify its election during the five-year period for good cause following a public hearing. All small employer carriers under common ownership or control must make the same election. However, the director may permit an affiliated carrier to make a separate election for good cause.

(2) A small employer carrier that elects to cease participation as a reinsuring carrier pursuant to subsection (1) of this section and elects to become a risk assuming carrier shall continue to be governed by the restrictions set forth in ORS 743.742 with respect to coverage issued as a reinsuring carrier pursuant to ORS 743.742 and continue to pay prorated assessments based upon coverage issued as a reinsuring carrier pursuant to ORS 743.742. [1991 c.916 §8]

743.740 Risk assuming carrier. (1) Any small employer carrier may elect to operate as a risk assuming carrier under this section if its application for such status is not disapproved by the Director of the Department of Insurance and Finance after formal hearing within 180 days of receipt of the application.

(2) A small employer carrier shall be approved as a risk assuming carrier unless the director establishes that the carrier is incapable of assuming the status pursuant to the criteria set forth in this section. The director shall provide public notice of an application by a small employer carrier to become a risk assuming carrier and shall request comments from the board of directors of the Oregon Small Employer Health Reinsurance Pool regarding the small employer carrier application prior to rendering a decision on the application. A small employer carrier which has applied for approval as a risk assuming carrier prior to implementation of the reinsurance program authorized by ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055 may operate as such a carrier until its application has been disapproved by the director after formal hearing, and in no event later than 180 days from application.

(3) A small employer carrier shall be allowed to operate as a risk assuming carrier, unless and until the director shall establish that the carrier:

(a) Does not have a financial condition adequate to support the assumption of the risk of small employer groups;

(b) Does not have a history of assuming and managing risk;

(c) Does not have a sufficient commitment to market fairly to all small employers in the state or its service area, as applicable; or

(d) Does not have the ability to assume and manage risk of enrolling small employer groups without the protection of the reinsurance program established by ORS 316.096,

317.113, 414.720, 743.730 to 743.745 and 750.055, in that the carrier cannot self-reinsure or obtain reinsurance elsewhere.

(4) A risk assuming carrier may not reinsure risks with the reinsurance pool, but it may purchase or obtain any other reinsurance not otherwise prohibited by law.

(5) A risk assuming carrier must offer at least a basic health care plan to any small employer requesting such a plan and must provide at least the coverage of a basic health care plan to any small employer requesting such coverage. [1991 c.916 §9]

743.741 [Formerly 747.130; renumbered 742.356 in 1989]

743.742 Reinsuring carrier. (1) Any small employer carrier may elect to operate under the provisions of this section as a reinsuring carrier.

(2) Each reinsuring carrier shall conduct business with its members and subscribers and administer claims for coverage reinsured by the Oregon Small Employer Health Reinsurance Pool in the same manner as the reinsuring carrier would administer health claims that it writes without reinsurance.

(3) Reinsuring carriers must offer at least a basic health care plan to any small employer requesting such a plan and must provide at least the coverage of a basic health care plan to any small employer requesting such coverage.

(4) Reinsuring carriers may reinsure individuals within a group or an entire group subject to the provisions of ORS 743.743.

(5) If provided in the plan of operation of the reinsurance pool, reinsuring carriers may make special arrangements to cover employees in small employer groups with exceptionally high rates of employee turnover.

(6) Reinsuring carriers may appeal to the board of the Oregon Small Employer Health Reinsurance Pool for a finding that the carrier is experiencing a disproportionate share of significantly late payments from small employer groups, as determined by the board in the plan of operation. When the board determines that a carrier has experienced such an unfair burden, the board may grant the carrier a decreased reinsurance premium as an offset. [1991 c.916 §10]

743.743 Oregon Small Employer Health Reinsurance Pool; members; board; plan of operation; powers; premium rates; assessments; taxation exemption. (1) There is created a nonprofit entity to be known as the Oregon Small Employer Health Reinsurance Pool. All carriers and multiple employer welfare arrangements issuing or providing health benefit coverage in this state on and after September 29, 1991, except any small

employer carrier electing to be a risk assuming carrier pursuant to ORS 743.740, shall be members of the reinsurance pool.

(2)(a) Within 60 days following September 29, 1991, the Director of the Department of Insurance and Finance shall give notice to all members of the time and place for the initial organizational meeting that shall take place within 120 days following September 29, 1991.

(b) The members shall select the initial board of directors, subject to approval by the director. The director shall serve as a member of the board. In approving the selection of the board, the director shall assure that all members of the pool are fairly represented. The board shall consist of nine additional members who shall serve staggered terms as determined by the plan of operation of the reinsurance pool. At least two-thirds of the members of the board shall be small employer carriers. In the event that there are not sufficient small employer carriers to serve on the board, the remaining seats may be filled by any member.

(c) At least one member of the board shall be, to the extent possible:

(A) A carrier whose principal health insurance business is in the small employer market;

(B) A carrier whose principal health insurance business is in the large employer market;

(C) A health care service contractor;

(D) A health maintenance organization; and

(E) Another health benefit arrangement.

(3) If the initial board is not elected at the organizational meeting, the director shall appoint the initial board within 15 days of the organizational meeting.

(4) Within 180 days after the appointment of the initial board, the board shall submit to the director a plan of operation and any amendments thereto necessary or suitable for administration of the reinsurance pool. The director shall, after notice and hearing, approve the plan of operation if it is suitable to assure the fair, reasonable and equitable administration of the reinsurance pool and if it provides for the sharing of reinsurance pool gains or losses on an equitable proportionate basis in accordance with the provisions of subsection (12) of this section. The plan of operation shall become effective upon approval in writing by the director consistent with the date on which the coverage under this section shall be made available. Any plan of operation, or amendments thereto, submitted to the director by the board pursuant to this subsection shall be deemed approved by the director if not expressly disapproved in writing by the director within 90 days of its receipt

by the director. If the board fails to submit a suitable plan of operation within 180 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the director shall adopt, after notice and hearing, a temporary plan of operation. The director shall amend or rescind any plan adopted, as necessary, after the time a plan of operation is submitted by the board and approved by the director.

(5) The plan of operation shall include but not be limited to rules, conditions and procedures for:

(a) Handling and accounting of assets and moneys of the reinsurance pool.

(b) Filling vacancies on the board, subject to approval by the director.

(c) Selecting an administering carrier which shall be a health insurance company, health care service contractor or health maintenance organization authorized to do business in this state and setting forth the powers and duties of the administering carrier.

(d) Reinsuring risks in accordance with the provisions of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055.

(e) Collecting assessments from members subject to assessment to provide for claims reinsured by the reinsurance pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made.

(f) Any additional matters at the discretion of the board.

(6) The reinsurance pool shall have the general powers and authority granted under the laws of Oregon to insurance companies licensed to transact health insurance except the power to issue health benefit plans directly to either groups or individuals. The reinsurance pool has specific authority to do all of the following:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055, including the authority, with the approval of the director, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal action necessary or proper for recovery of any assessments and penalties for, on behalf of or against members;

(c) Take any legal action necessary to avoid the payment of improper claims against the reinsurance pool or the coverage reinsured by the reinsurance pool;

(d) Issue various reinsurance policies, in accordance with the requirements of this section;

(e) Establish rules, conditions and procedures pertaining to the reinsurance of members' risks by the reinsurance pool;

(f) Establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the reinsurance pool;

(g) Assess members in accordance with the provisions of subsections (12) and (13) of this section and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(h) Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the reinsurance pool, policy and other contract design and any other function within the authority of the reinsurance pool; and

(i) Borrow money for the purposes of the reinsurance pool. Any notes or other evidence of indebtedness of the reinsurance pool not in default shall be legal investments for insurers and may be carried as admitted assets.

(7) Any member that elects to be a reinsuring carrier may reinsure with the reinsurance pool coverage under a basic health care plan of a group or an eligible employee, or any dependent of such an employee, subject to all of the following:

(a) The reinsurance pool shall reinsure the level of coverage provided in any basic health care plan.

(b) Such coverage may be reinsured within 60 days of the commencement of the eligible employees' or dependents' coverage under the plan, with respect to either:

(A) Eligible employees, and their dependents, who are employed by a small employer as of the date such employer's coverage by the member commences; or

(B) Eligible employees, and their dependents, who are hired subsequent to the commencement of the employer's coverage by the member.

(c) With respect to eligible employees and their dependents when the entire employer group is eligible for reinsurance, a small employer carrier may reinsure the entire employer group within 60 days of the commencement of the group's coverage under the plan.

(d) With respect to any person reinsured, no reinsurance may be provided for a reinsured employee or dependent until \$5,000 in benefit payments have been made for services provided during a calendar year for that reinsured employee or dependent, which payments would have been reimbursed through reinsurance in the absence of the \$5,000 deductible. The amount of the deductible shall be periodically reviewed by the board and adjusted for inflation, as determined by the board. In addition, the member shall retain 15 percent of the next \$100,000 of benefit payments during a calendar year and the reinsurance pool shall reinsure the remainder, provided that the member's liability under this paragraph shall not exceed \$20,000 in any one calendar year with respect to any one person reinsured.

(e) Reinsurance may be terminated for each reinsured employee or dependent on any plan anniversary date.

(f) Premium rates charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. §300e et seq. shall be reduced to reflect the restrictions and requirements of 42 U.S.C. §300e et seq.

(g) The board may consider adjustments to the premium rates charged for reinsurance by the reinsurance pool for carriers using effective cost containment or if the carrier is experiencing an unfair share of credit risks or administrative expenses, as defined by the board.

(h) Every reinsuring carrier must apply its case management and claims handling techniques, including but not limited to utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured and nonreinsured business.

(8) Except as provided in paragraph (f) of subsection (7) of this section, premium rates charged for coverage reinsured by the pool shall be established as follows:

(a) One and one-half times the rate established by the board with respect to eligible employees and their dependents of a small employer, all of whose coverage is reinsured with the reinsurance pool in accordance with paragraph (b) of subsection (7) of this section.

(b) Three times the rate established by the board with respect to an eligible employee or dependent who is reinsured in accordance with paragraph (d) of subsection (7) of this section.

(9) The reinsurance pool shall not reinsure health benefit plans issued through the Insurance Pool Governing Board.

(10) In any case where a health benefit plan for a small employer is entirely or partially reinsured with the reinsurance pool, the premium charged to the small employer for any rating period for the coverage shall be consistent with the requirements set forth in ORS 743.737 (6).

(11) Following the close of each fiscal year, the administering carrier shall determine the net premiums, the reinsurance pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Reinsurance premiums and benefits paid by a member that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessment.

(12) Any net loss for the year shall be recouped by assessments of all members as follows:

(a) Each member's assessment shall be determined first by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of persons in Oregon who are covered by small group health benefit plans issued or reinsured with excess insurance by the member, and the denominator of which equals the total number of persons in Oregon who are covered by small group health benefit plans issued or reinsured with excess insurance by members of the Oregon Small Employer Health Reinsurance Pool. In no event shall this assessment exceed four percent of the premiums for any health benefit coverage issued to small employers by members who are small employer carriers.

(b) In the event the assessment authorized by paragraph (a) of this subsection is not sufficient, any balance remaining shall be determined by multiplying the total amount to be assessed by a fraction, the numerator of which equals the number of persons in Oregon who are covered by health benefit plans issued or reinsured with excess insurance by the member, and the denominator of which equals the total number of persons in Oregon who are covered by health benefit plans issued or reinsured with excess insurance by any carrier other than risk assuming carriers. In no event shall this assessment exceed one percent of the premiums for any health benefit coverage issued by members.

(c) No assessment to one member in any year shall exceed 40 percent of that year's total assessment. Each member's proportion of the assessment shall be determined annually by the board based on annual statements deemed necessary by the board and filed by

the member with the Director of the Department of Insurance and Finance.

(d) Subject to the approval of the director, the board shall make an adjustment to the assessment formula for member health maintenance organizations which are approved as federally qualified by the Secretary of Health and Human Services pursuant to 42 U.S.C. §300e et seq. to the extent, if any, that restrictions are placed on them.

(13) The director shall insure that each person who is covered by a health benefit plan or who is reinsured with excess insurance is counted once with respect to any assessment. For that purpose, the director shall require each member that obtains reinsurance for its insureds and its certificate holders to include in its count of insureds and certificate holders all insureds and certificate holders whose coverage is reinsured in whole or in part. The director shall allow a member who is a reinsurer to exclude from its number of insureds and its certificate holders those that have been counted by the primary insurer for the purpose of determining its assessment under this section.

(14) Each member shall pay its assessment as required by the board. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

(15) If assessments exceed actual losses and administrative expenses, the excess shall be held and invested and, with the earnings and interest, used by the board to offset future losses or to reduce reinsurance pool premiums. For the purposes of this subsection, future losses include reserves for incurred but not reported claims.

(16) Each member's proportion of participation in the reinsurance pool shall be determined by the board based on annual statements and other reports deemed necessary by the board and filed by the member with the director.

(17) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this section. The member receiving the abatement or deferment shall remain liable to the reinsurance pool for the deficiency for four years.

(18) The participation in the reinsurance pool as members, the establishment of rates, forms or procedures or any other joint or col-

lective action required by ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055 shall not be the basis of any legal action, criminal or civil liability or penalty against the reinsurance pool or any of its members either jointly or separately.

(19) The reinsurance pool shall be exempt from taxes. [1991 c.916 §11]

743.744 [Formerly 747.140; renumbered 742.358 in 1989]

743.745 Small Employer Carrier Advisory Committee; appointment; duties; study. The director shall appoint a Small Employer Carrier Advisory Committee with fair representation of risk assuming carriers and reinsuring carriers. This committee shall consist of at least one health maintenance organization, one health care service contractor and one domestic insurer and shall have the following duties:

(1)(a) Subject to approval by the director, the committee shall recommend the form and level of coverages under the basic health care plans pursuant to ORS 743.736 to be made available by small employer carriers. The committee shall take into consideration the levels of health benefit plans provided in Oregon and the appropriate medical and economic factors and shall establish benefit levels, cost sharing, exclusions and limitations. The basic health care plans may include cost containment features including, but not limited to:

(A) Preferred provider provisions;

(B) Utilization review of health care services including review of medical necessity of hospital and physician services;

(C) Case management benefit alternatives;

(D) Other managed care provisions;

(E) Selective contracting with hospitals, physicians and other health care providers; and

(F) Reasonable benefit differentials applicable to participating and nonparticipating providers.

(b) The committee shall submit the health benefit plans to the director within 120 days after the appointment of the committee pursuant to this section. The health benefit plans shall be deemed approved unless expressly disapproved by the director within 30 days after the date the director receives the plans.

(2) In order to assure the broadest availability of health benefit plans to small employers, the committee shall recommend for approval by the director market conduct and other requirements for carriers and agents, including requirements developed as a result of a request by the director, relating to the following:

(a) Registration by each carrier with the department of its intention to be a small employer carrier under ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055.

(b) Publication by the department, the committee or the board of a list of all small employer carriers, including a potential requirement applicable to agents and carriers that no health benefit plan be sold to a small employer by a carrier not so identified as a small employer carrier.

(c) The availability of a broadly publicized toll-free telephone number for access by small employers to information concerning ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055.

(d) To the extent deemed necessary by the committee to assure the fair distribution of high-risk individuals and groups among carriers, periodic reports by carriers and agents concerning health benefit plans issued, provided that reporting requirements shall be limited to information concerning case characteristics and numbers of health benefit plans in various categories marketed or issued, or both, to small employers.

(e) Registration by agents of the intention to be agents for health benefit plans marketed to small employers under ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055.

(f) Methods concerning periodic demonstration by small employer carriers and agents that the small employer carriers are marketing or issuing, or both, health benefit plans to small employers in fulfillment of the purposes of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055.

(3) Within three years from September 29, 1991, the committee shall conduct a study of the effectiveness of the provisions of ORS 316.096, 317.113, 414.720, 743.730 to 743.745 and 750.055, recommend further improvements to achieve greater stability, accessibility and affordability in the small employer marketplace and submit a report to the director. The study shall consider and make recommendations concerning the extent, if any, to which further narrowing of the rate bands applicable to small employer carriers is warranted because of the requirement that all employers provide health benefit coverage for their employees. [1991 c.916 §12]

743.747 [Formerly 747.150; renumbered 742.360 in 1989]

743.750 [1967 c.359 §516; renumbered 742.362 in 1989]

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

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

743.756 [Formerly 747.180; renumbered 742.368 in 1989]

743.759 [Formerly 747.190; renumbered 742.370 in 1989]

743.762 [Formerly 747.082; 1989 c.634 §1; renumbered 742.372 in 1989]

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

743.768 [Formerly 747.086; 1983 c.338 §964; 1989 c.634 §3; renumbered 742.376 in 1989]

743.770 [Formerly 743.780; 1987 c.774 §60; renumbered 742.400 in 1989]

743.771 [1987 c.774 §151; renumbered 742.405 in 1989]

743.772 [Formerly 743.783; renumbered 742.031 in 1989]

743.774 [Formerly 486.097; renumbered 806.190 in 1987]

743.776 [Formerly 486.541; renumbered 742.450 in 1989]

743.778 [Formerly 486.546; renumbered 742.454 in 1989]

743.779 [Formerly 486.551; 1989 c.700 §14; renumbered 742.456 in 1989]

743.780 [1975 c.796 §10; 1977 c.448 §12; 1985 c.103 §14; 1985 c.323 §10; 1985 c.624 §17a; renumbered 743.770]

743.781 [Formerly 486.556; 1989 c.700 §15; renumbered 742.458 in 1989]

743.782 [Formerly 486.561; 1989 c.700 §16; renumbered 742.460 in 1989]

743.783 [Formerly 736.320; renumbered 743.772]

743.784 [Formerly 486.564; 1989 c.700 §17; renumbered 742.462 in 1989]

743.785 [Formerly 486.566; renumbered 742.464 in 1989]

743.786 [1967 c.482 §1; 1971 c.523 §11; 1979 c.842 §7; 1983 c.338 §965; renumbered 742.500 in 1989]

743.789 [1967 c.482 §2; 1975 c.390 §1; 1981 c.586 §1; 1983 c.338 §966; 1987 c.632 §1; renumbered 742.502 in 1989]

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

743.795 [1979 c.842 §10; renumbered 742.506 in 1989]

743.796 [1987 c.742 §3; renumbered 742.508 in 1989]

743.797 [1987 c.742 §2; renumbered 742.510 in 1989]

743.800 [1971 c.523 §2; 1973 c.551 §1; 1975 c.784 §1; 1979 c.871 §45; 1981 c.414 §1; 1983 c.338 §968; 1987 c.588 §1; renumbered 742.520 in 1989]

743.802 [1987 c.588 §5; renumbered 742.522 in 1989]

743.805 [1971 c.523 §3; 1973 c.551 §2; 1975 c.784 §2; 1981 c.414 §2; 1987 c.588 §2; 1989 c.775 §1; renumbered 742.524 in 1989]

743.810 [1971 c.523 §4; 1973 c.551 §4; 1975 c.784 §3; renumbered 742.526 in 1989]

743.812 [1987 c.588 §4; renumbered 742.528 in 1989]

743.815 [1971 c.523 §5; 1973 c.551 §3; 1975 c.784 §4; 1981 c.414 §3; renumbered 742.530 in 1989]

743.820 [1971 c.523 §6; 1975 c.784 §5; 1981 c.414 §4; renumbered 742.532 in 1989]

743.825 [1971 c.523 §7; 1975 c.784 §6; 1987 c.569 §4; 1987 c.632 §2; renumbered 742.534 in 1989]

743.828 [1975 c.784 §8; renumbered 742.536 in 1989]

743.830 [1971 c.523 §8; 1975 c.784 §9; renumbered 742.538 in 1989]

743.833 [1975 c.784 §12; renumbered 742.540 in 1989]

743.835 [1971 c.523 §9; 1975 c.784 §10; 1987 c.632 §3; renumbered 742.542 in 1989]

743.840 [1985 c.527 §2; renumbered 742.466 in 1989]

743.850 [1981 c.752 §1; 1983 c.817 §1; 1987 c.505 §1; renumbered 743.610 in 1989]

743.851 [1987 c.505 §3; renumbered 743.600 in 1989]

743.852 [1987 c.505 §§3a, 4; 1989 c.784 §22; renumbered 743.601 in 1989]

743.853 [1987 c.505 §5; renumbered 743.602 in 1989]

743.855 [1981 c.752 §2; renumbered 743.611 in 1989]

743.860 [1981 c.752 §3; renumbered 743.613 in 1989]

743.865 [1981 c.752 §4; renumbered 743.614 in 1989]

743.870 [1981 c.752 §5; renumbered 743.616 in 1989]

743.875 [1981 c.752 §6; renumbered 743.617 in 1989]

743.880 [1981 c.752 §7; renumbered 743.619 in 1989]

743.885 [1981 c.752 §8; renumbered 743.620 in 1989]

743.890 [1981 c.752 §9; renumbered 743.622 in 1989]

743.900 [1971 c.476 §2; 1975 c.570 §1; renumbered 742.560 in 1989]

743.905 [1971 c.476 §3; renumbered 742.562 in 1989]

743.910 [1971 c.476 §4; 1977 c.600 §7; 1989 c.426 §3; renumbered 742.564 in 1989]

743.915 [1971 c.476 §5; repealed by 1975 c.570 §2 (743.916 enacted in lieu of 743.915)]

743.916 [1975 c.570 §3 (enacted in lieu of 743.915); 1977 c.600 §8; 1989 c.426 §4; renumbered 742.566 in 1989]

743.920 [1971 c.476 §6; renumbered 742.568 in 1989]

743.925 [1971 c.476 §7; renumbered 742.570 in 1989]

743.930 [1971 c.476 §8; 1977 c.600 §4; renumbered 742.572 in 1989]

743.940 [1987 c.774 §36; renumbered 742.700 in 1989]

743.942 [1987 c.774 §37; renumbered 742.702 in 1989]

743.944 [1987 c.774 §38; renumbered 742.704 in 1989]

743.946 [1987 c.774 §§39, 40; 1989 c.700 §18; renumbered 742.706 in 1989]

743.948 [1987 c.774 §41; renumbered 742.708 in 1989]

743.950 [1987 c.774 §42; 1989 c.181 §1; renumbered 742.710 in 1989]